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# Increasing Awareness of Brazilian Family Health Team Professionals on Reporting Child Abuse: A Case Study

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Additional information is available at the end of the chapter

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## 1. Introduction

There are diverse and countless cases of child abuse reported by the media, giving the general public the impression that its number has drastically increased. We know that is not the case. Child abuse is, unfortunately, a very old habit in need of change, and it is, in fact being changed. Many cases come to health professionals in the very beginning, such as when a nurse witnesses a mother humiliating a child who refuses to eat. Unfortunately, many cases also appear only when it is too late, as when a physician signs a death certificate in a child abuse fatality.

This paper aims at pointing out the need for changes in health professional training regarding child abuse - a public health issue which directly affects individual and collective health. Preventing and coping with abuse demands the formulation of specific policies and organizational practices and services for the sector [1]. The World Report on Violence and the World Health Organization [2] mention that psychiatric disorders, depression, anxiety, substance abuse, and aggression, feelings of shame or cognitive disorders, posttraumatic stress, sleep disorders, thoughts and suicidal behavior, as potential consequences of child abuse. In addition, adult diseases, such as ischemic heart disease, cancer, chronic lung disease, irritable bowel syndrome and fibromyalgia may be intensified due to child abuse experiences.

A considerable amount of money is spent on treating cases related to child abuse. This includes: a) offender arrests and subsequent court issues, b) abuse investigation reports, c) mental health services for adults with a child abuse history; d) especial educational support; e) expenses associated with foster care and adoption; and f) costs in the employment sector due to absenteeism and low productivity [2]. In the health system, child abuse is responsible for increases in emergency assistance, and rehabilitation expenses, the latter more costly than most conventional medical procedures [1].

Due to the complexity of child abuse, its close link with Public Health and the fact that mandated reporting is regulated in many countries, health professionals involvement with the topic has been the focus of several studies. In Brazil, the Child and Adolescent ACT (ECA – *Estatuto da Criança e do Adolescente* 1990), in Article 245, [3] regulates mandated reporting to proper authorities of any suspected or confirmed child abuse case. Failure to do so may receive a penalty involving from 3-20 minimal wage fines.

The Child and Adolescent Act was implemented in Brazil in 1990, guarantying special rights and full protection of children. In addition, the Ministry of Health developed guidelines in the document "*National Policy for Reduction of Morbidity and Mortality from Accidents and Violence*", in existence since 1998. Later, with the publication of another document ("*National Policy for Reduction of Morbidity and Mortality from Accidents and Violence in Childhood and Adolescence*"), in 2001, child abuse mandated report by Unified Health System professionals was enforced [4]. Despite this requirement, violence underreporting in all areas is a reality in Brazil. It is estimated that for every reported case, at least two others exist which have not been reported [5].

## 1.2. Health professionals' role in dealing with child abuse

Health professionals are under-qualified to deal with child abuse, in part due to a lack of awareness on how to proceed when cases arise. There is lack of regulations to guarantee appropriate technical procedures to deal with abuse cases in Brazil. In addition, there is an absence of legal mechanisms to protect those who do report cases. Failure in child abuse identification by health professionals, and fear of breaching client confidentiality, are barriers that also contribute to under-reporting [6]. Additionally, the difficulties may include lack of basic information to identify abuse, a topic not been addressed in undergraduate or graduate curricula. Lack of infrastructure and an excessive workload by Child Protection Services (CPS), and even its non-existence in some counties are also barriers to be mentioned. Another peculiarity is a culture which values family privacy and, Finally, threats made to professionals by abusers are also arguments responsible for non-reporting [6].

Child abuse reporting is extremely important because it is a tool to curb and prevent maltreatment, allowing interventions to take place at various levels. When child abuse becomes public, one may see that it is more common than expected. Needless to say that no type of violence should be considered ordinary or normal [7].

In spite of Brazil's mandatory reporting laws, there is a large gap between legislation and reality. Iossi [8] conducted interviews and document analysis in the municipality of Guarulhos, in the greater São Paulo area, observing that 23% of child abuse referrals health professionals made to treatment centers were made without the awareness of CPS, that is, without proper reporting. This situation may result in duplication of referrals to health services, resulting in false demands, illustrating, thus, the need for effective communication among different stakeholders of the child protection network.

A survey [9] analyzed the child abuse reporting process with 359 family health team professionals in the city of Fortaleza, Northeast Brazil, showing that reporting by professionals

happens sporadically, rather than systematically. In that sense, the development of programs for continuing education and the increase of professional network support may reduce insecurity, and increase the number of child abuse reported cases.

Insecurity and difficulties faced by health professionals in identifying and reporting cases of child abuse were also addressed in other Brazilian studies. Health professionals' perception of child abuse, and responsibility to report cases according to past experience were analyzed through interviews (n=10) [10]. All professionals said that they discard organic hypothesis by examining the victims, and only then investigate "external causes". A third of interviewees said that when there are injuries suggesting abuse (such as bruises in a child admitted to the Hospital), it is difficult to confirm this diagnosis, as they fear committing "injustices". Whether or not the reporting occurred, feelings of frustration, powerlessness, and immobility were recurrent. In addition, in two reported cases, the police advised professionals to withdraw the notification. Psychological abuse was less valued than physical violence; as such acts were viewed as natural forms of child rearing. The study reports that mental health professionals tend to be silent about abuse, because "their training involves understanding and treating offenders and therefore do not consider reporting as their responsibility" (p.23).

The perception of 17 health professionals was analyzed [11] in relation to attitudes regarding child abuse, by means of semi-structured interviews. A swing between belief and disbelief of solving cases was noticed by researchers, as well as fear and emotional insecurity. Problems associated to lack of professional training, and the reproduction of cultural patterns of non-involvement beliefs regarding family issues were also identified. The study also highlighted the disbelief in the effective action of Child Protection Services, and previous negative experiences as reasons for not getting involved in child abuse cases.

Studies in the U.S. [12] also indicate difficulties professionals face in reporting abuse, as well as negative experiences with the legal system, contributing to non-reporting. Another study in Australia identifies problems with services available to children and families where child abuse reporting is made, indicating the need for continuing education of health professionals to identify symptoms and signs of physical abuse, as well as the physicians' role in multidisciplinary efforts to address child abuse [13].

This first author [14] sought to investigate problems found by pediatricians in identifying and reporting cases of abuse in a mid-size city of the State of São Paulo, Brazil. Main results pointed out that difficulties were related to lack of training, disbelief and doubts about CPS, fear of possible legal consequences, and fear of causing further trauma or discomfort in the family and/or the child. The study detected a general belief in the need to confirm the suspicion of abuse as a prerequisite to reporting.

Difficulties in dealing with child abuse are present in other health related areas besides medicine: 84% of dentists (n = 70) in the city of Blumenau, Southern Brazil, [15] reported feeling unprepared to deal with child abuse. Difficulties associated in reporting were related to not being sure about confirming the abuse (42%), lack of knowledge, (32%), and fear of consequences (6%). Likewise, Australian dentists were unaware about child abuse issues, as

shown by the high frequency of "I don't know" answers, when asked about procedures to be followed in child abuse cases [16].

### 1.3. Brazil's Family Health Program

The *Family Health Program* (*Programa Saúde da Família* or PSF), was initiated, in Brazil, in 1994, as a strategy for reorienting the healthcare model, through the implementation of multidisciplinary teams in primary healthcare units. These teams are responsible for monitoring a number of families (up to 4.500 persons) located in a defined geographical area. The teams act on health recovery, health promotion, disease rehabilitation, and more frequent disorders, as well as maintaining the community's health level [17].

Each team is responsible for becoming aware of family demographics by taking pertinent data from each family, filling out information on different diagnoses for all individuals in a given family. Health professionals and the families create bonds, which in turn, facilitates the identification and assistance to community health problems [18].

The Family Health Program in the city of San Carlos, where this study was conducted, was established in 2001 with four Teams. Currently this program benefits 64.000 people, and 16 teams are in operation. The municipality has a goal of reaching 50% of the population by the end of 2012, as the city undergoes a health service remodeling process.

Another peculiarity about this city is the fact that the Medicine Faculty from *Universidade Federal de São Carlos* (Federal University of São Carlos) has partnered with the municipality in terms of developing an innovative project geared towards family health care. The project involves adopting a model with a strong interaction between the public healthcare system in which the medical student starts his/her practice in the Family Health Program.

Working in the Family Health Program exposes professionals to various types of violence, such as family and urban violence which may affect professionals' mental health [19]. In addition to violence, through home visitation, professionals notice other adversities, such as extreme poverty, which in its turn, may trigger feelings of helplessness. Other potential problems are the non-recognition of efforts, no delimitation between professional and personal boundaries; fear of exposure to risks; feelings of moral and physical integrity threats, and fear of retaliation. All this context and challenges must be considered when proposing any intervention with such professionals [19].

### 1.4. The training of health professionals on child abuse

For Brazil's Ministry of Health [20], the development of a child abuse reporting system must overcome three challenges: 1) incorporating the reporting process in the healthcare activities routine, and in the organizational framework of welfare and educational services; 2) raising awareness and training health professionals and educators to understand the consequences of abuse to children's development, teaching professionals how to diagnose child abuse, how to report cases and make referrals when problems are found; and 3) building partnerships and alliances to ensure that reporting is only a first step of a much broader activity to

support children, adolescents, their families or institutions working with them, and not simply an obligation as an end in itself.

Researchers agree on the need to train professionals on child abuse, and to systematically evaluate such trainings in studies in order to overcome the difficulties mentioned [4,13,15-16]. In addition, there is a need to insert the topic into curricula, as knowledge of child abuse is essential for healthcare [21]. The literature indicates that for physicians already in practice, training is more relevant in terms of case variables which are more difficult to observe, such as: a) the explanation given for the injury in case of physical abuse; and b) the time taken to bring the child for medical care, instead of restricting training to injury severity and its relationship to child abuse exclusively [21]. For medical students, it is necessary to develop skills of information gathering, and case deductions, and from the onset of training, students should actively be involved in the process of identification and child abuse reporting, working with experienced professionals as role models [22].

Moreover, it is important for professionals to become familiar with epidemiological data on child abuse, as this helps in making decisions to evaluate the information collected, especially in relation to the explanation given when child abuse is suspected, or in differential diagnosis [13, 21]. The literature also indicates that the difficulties in identification and reporting child abuse are found in several health related areas [14], thus it would be possible to start training from a broader topic such as what is child abuse, and subsequently direct the training to specific areas, such as types of treatment that a physician and a dentist may have to perform with an abused child [14].

The literature [22] has also recommended that for the training to be appropriate it should consider the ecological context of child maltreatment to understand risk factors present in the child, the family, the community and society. Researchers also say that the disparity in knowledge of health professionals who work at the same institution should be reduced by training all staff, with emphasis in the need for continuing education. The same conclusion was reached by scholars [23] who found an increase in the number of reported cases after training, but a decrease in subsequent months, indicating the need for ongoing education. Additionally, it is suggested [13] having regular case discussion meetings, stressing the investigative nature of protective services, and to educate physicians in the multidisciplinary aspects of child abuse.

Furthermore, it is recommended [24] that challenges faced by pediatricians in dealing with child abuse cases may be inserted into the training, such as: having the families, not just the children and mothers as the focus of attention; assessing routinely risk and protective factors associated with the child and the family; strengthening protective factors; and working to minimize or eliminate the risk factors.

Experiences with training other professionals on child abuse prevention are also worth mentioning. A quasi-experimental study was conducted by the second author to train pre-school educators [25] to act as child sexual abuse primary prevention agents. 101 pre-school teachers, 2.918 children, and 2.732 family members of these children took part of the program, which was developed in partnership with the city of São Carlos' Board of Education. Teach-

ers participated of 12 weekly meetings, for three months, in which they learned to develop practical activities with the children, and their family members on child sexual abuse prevention. The program had a very positive impact in all involved, and the sexual abuse cases reported in the community nearly doubled at the program's end.

Training teachers in child abuse prevention is highly recommended. Hazzard and Rupp [26] compared child abuse-related knowledge and attitudes of pediatricians, mental health professionals (social workers, psychiatrists and psychologists), teachers and University students who completed a questionnaire on definitions, characteristics, causes and effects of child abuse. Mental health professionals were better informed than pediatricians. In contrast, teachers and University students were the least knowledgeable. On the basis of this study results, additional abuse-related education was recommended for pediatricians and, particularly, for teachers.

The training of health professionals should aim at increasing awareness of children's rights and needs, in ways to also increase the skills in identifying child abuse, maximizing the commitment to child abuse notification to ensure compliance with the law [7]. Thus, the aim of this study was to increase awareness of Family Health Program professionals in preventing child abuse, by evaluating a training course to identify and report abuse. Professional child abuse awareness was here defined in terms of the ability to identify child abuse cases, as well as specifying its different modalities, and to comply with legal requirement of case notification, when child abuse is suspected or confirmed.

## 2. Method

### 2.1. Participants

Two Family Health Unit teams (Group A and B) of the mid-size city of São Carlos, in the State of São Paulo, Southeast Brazil, took part of the study, encompassing a total of 22 health professionals. Group A consisted of one physician, a nurse, two nursing aids, a dentist, a dental assistant and six community health agents. Group B had similar members, minus the dentist and dental assistant, as configuration of the teams varies according to practical demands. The groups were similar regarding the number of participants, gender distribution, average age and average length of professional experience. Table 1 below presents a description of both family health teams.

The teams were chosen based in communities with higher prevalence of child abuse in the year of 2008, as reported to CPS. The Protection Service had only started to have reports with number of reported cases per neighborhood as of the year 2008.

	Group A	Group B	Total
Number of participants	11	11	22

Sex	Female	8	9	17
	Male	3	2	5
Age (years)		23 – 41	24 – 47	23-47
		M = 29	M = 33	M = 31
Length of professional experience		10 months – 18 years	16 months – 21 years	10 months – 21 years
		M = 7.6 years	M = 6.4 years	M = 6.9 years

**Table 1.** Demographic characteristics of participants in Groups A and B.

## 2.2. Instruments used in data collection

a) *Questionnaire on Hypothetical Cases*, [14] containing two vignettes with the aim of verifying which procedures the professional would adopt in the process of child abuse identification and reporting. The instrument was originally developed by the first author to pediatricians, and the vignettes were written based on reports from health professionals who had contact with suspected child maltreatment. For the present study, the instrument was adapted adding the context and routine of the Family Health Program. The first vignette involved a possible neglect case, and the second a suspected sexual abuse case. The choice of these two types of violence refers to the difficulty in identifying negligence by health professionals, in spite of being the most common type of abuse reported to CPS; as well as the fact that sexual abuse is still considered by many a taboo, and often, a family secret.

b) *Child Maltreatment in Pediatric Primary Care Evaluations* by Lane and Dubowitz [27]. The instrument contains three parts: the first being a survey of cases of physical, sexual abuse and neglect reported or not reported; the second part is made of 38 sentences in which the professional responds according to a five point Likert Scale of agreement, where 1 corresponds to *strongly disagree* with the statement, and 5 with *strongly agree* with the statement. The statements address reporting consequences to the professional, evaluate need for training and support in making decisions, and assess knowledge on the subject. The third part of the instrument characterizes the professional (giving information on age, gender, ethnicity, work experience, number of courses on the subject). For the present study only 37 sentences of the second part of the instrument were used. The authors gave authorization to the translation and adaptation of this instrument to Portuguese for this study.

c) *Questionnaire on Family Violence against Children and Adolescents*, developed by Rossi [28] whose definitions of types of violence were adapted by Giusto [29]. This questionnaire aimed at investigating whether reporting was a procedure adopted by health professionals working in the public sector. In addition, the instrument was designed to assess the knowledge of professionals about the signs of abuse, to identify if there are personal and professional consequences to child abuse reporting, and to identify whether discussion of family violence was part of the professionals' training. The instrument provides a definition of each type of Violence (physical, sexual, psychological abuse and neglect), giving information on professional demographic characteristics; on identification of signs and symptoms of child

abuse; knowledge of laws; aspects of personal consequences of reporting child abuse; knowledge of the professional ethics code; training on child abuse and the responsibility to report.

Data collection also involved monitoring child abuse reporting behavior to CPS by each team participant, prior to the training program (for one year) and afterwards.

### 2.3. Procedure

The project was approved by the University's Ethics Committee, and participants signed Informed Consent explaining the study's objectives, risks and benefits associated with the research, and guarantee of anonymity. The initial contact with the health teams was made by telephone, followed by a letter sent by email, with the course proposal attached. After interest in participation was expressed, a meeting was held with the first author to provide further explanations.

The intervention initially took place exclusively with Group A, and two pre-intervention assessments were done with Group B prior to their respective training. The training took place at each Family Health Unit's office, in rooms designated for staff meetings. Each Unit office was located in different geographical areas.

Before starting training with Group A, the *Questionnaire on Family Violence against Children and Adolescents* was administered to both groups to evaluate the initial repertoire on the subject and previous group experience. The instruments *Questionnaire on Hypothetical Cases* and *Child Maltreatment in Pediatric Primary Care Evaluations* were applied at pre-test to evaluate the course, as well as at post-test for comparison.

### 2.4. The training procedure

The training was aimed at overcoming the second challenge indicated by Brazil's Ministry of Health [20] which is to raise awareness, and train health professionals to understand the consequences of abuse to children's development, teaching professionals how to diagnose child abuse, how to report cases, and make referrals when problems are found.

The training contents were divided into four main themes:

1. Definition of child abuse according to Brazilian law, Brazil's Ministry of Health and the World Health Organization;
2. What is mandated reporting and its importance to society;
3. How do Child Protection Services, the Judiciary System and the Protection Support Network operate and some of the difficulties they face;
4. Proper use of the child abuse mandated reporting form to health professionals;

The training relied on LAPREV's (The Laboratory for Analysis and Prevention of Violence) past experience in teaching the topic of child abuse to different professionals, such as, teachers [25], police [30], CPS [31] and institutional staff [32].



The specific training involved that by the end of the course professionals should be able to: a) identify family violence as a phenomenon, b) identify different modalities of child abuse; c) identify the signs and symptoms associated with such violence; d) identify risk and protective factors for child abuse; e) analyze myths surrounding the subject; f) analyze appropriate ways to approach victimized children; g) identify the protective network in their community; h) identify and analyze factors that promote resilience; i) establish a dialogue with CPS, and j) correctly complete the mandated child abuse health professional reporting form.

Training lasted 15 hours in total, divided into 10 biweekly meetings, lasting one and a half hour each, inserted into their regular four-hour staff meetings. Different activities to increase participation were used throughout.

Different activities to increase participation were used throughout the training. In meetings 2 and 6 there were discussions about written material compiled by the first author. In meetings 3 and 7 excerpts from the film "*Bastard Out of Carolina*" [33] were shown, as well as an animation "*Once upon a family*" [34] to facilitate group discussion. In addition, at meeting 7, local and national newspaper clippings on child abuse cases were given for analysis of risk factors and procedures involved. At meeting 4 there was role-playing of a fatal child abuse hypothetical case by participants, who were divided into pairs, and given different roles. In the meeting 9, two reporting forms were analyzed: one used by the State Department of Health and another by the Ministry of Health. In meeting 5, a representative of the local Child Protection Service made a presentation, and answered questions, and in meeting 8 a forensic psychologist working in the Judiciary system made, likewise, a presentation.

After each meeting, the first author took records of the main procedures and verbalizations. At the end of the training course, a questionnaire was administered to assess the degree of participant satisfaction.

## 2.5. Data analysis

This case study had a pre-experimental A-B design which allowed comparing differences in scores on the pre-test and post-test in both groups [35].

In the *Questionnaire on Hypothetical Case* [14] data analysis is based on categories established by questions. The answers were analyzed qualitatively, enabling the creation of subcategories, and a descriptive analysis of the responses was performed.

The *Child Maltreatment Evaluations in Pediatric Primary Care* [27] uses a Likert scale of 5 points: *strongly disagree* (SD), *disagree* (D), *neutral* (N), *agree* (A) and *strongly agree* (SA). To verify if there were changes of opinion between the steps, the Wilcoxon test was used. The level of significance was set at 5%. Thus, the p-value obtained in each test rejected the hypothesis of equality groups and no change of opinion when the p-value is greater than 0.05. Data analyzes were performed using SPSS statistical software.

The *Questionnaire on Family Violence against Children and Adolescents* [29] has a predetermined set of response categories for each variable, thus the final score involved the frequency responses of presented options.

### 3. Results and discussion

We will initially present data on participant's previous experience with child abuse cases, for both groups. In sequence we will present the quantitative data from the instruments regarding pre and post measures, and lastly qualitative data will also be presented to compare changes in participants' views.

#### 3.1. Previous experience with child abuse

Table 2 presents the distribution of participants who had contact with suspected or confirmed cases of physical abuse, sexual abuse, psychological abuse, and neglect, illustrating participants' previous experience.

	Physical Abuse	Sexual Abuse	Psychological Abuse	Negligence
Yes, once	6	4	7	5
Yes, more than once	4	0	5	7
No, never	10	16	8	7
No answer	1	1	1	2

**Table 2.** Previous experience of suspected or confirmed child abuse cases in frequency per modality of abuse (n=21, both groups combined).

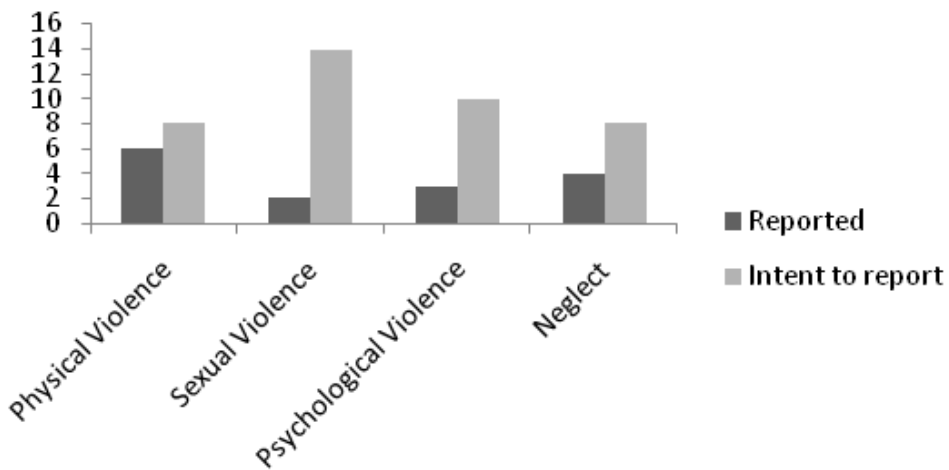
The data indicates that at least once a particular health team member had previous contact with a child abuse case. Lack of previous involvement with sexual abuse cases was high (76% of participants), which may indicate difficulty or uncertainty in identifying such cases, as well as how under-reported this type of violence still is in this country. Although there were two different teams in different geographical areas, previous experience was similar among the groups.

Figure 1 illustrates how many participants had reported child abuse cases in the past, and how many would hypothetically report if a child abuse case occurred. Previously reported cases involved discussing the issue with the immediate boss or with colleagues. Most of the reported cases involved physical violence for both groups. Sexual violence cases were the most frequently reported in supposition.

The large difference between actual reported cases and intention of reporting may indicate socially acceptable answers to the instrument. Nevertheless, one has to consider the possibil-

ity that it may also reflect a genuine intention or high motivation to report, if they were to identify a child abuse case. Unfortunately, we were unable to verify if professionals past reporting experience did in fact take place, as CPS data was only gathered after the year 2008.

Among reasons given by participants not to report previously, "not knowing how to do it" was noteworthy. In addition, there were written comments on the instrument suggesting a new category "the problem was solved in the workplace", which seems to indicate that the professional found a temporary solution, instead of fulfilling the reporting law.



**Figure 1.** Frequency of participants who had previously reported child abuse and who would report, if needed.

In summary, both groups had contact with child abuse cases, but there was a low frequency of reporting to Child Protection Services. Although several participants stated that they would indeed report child abuse if needed, they also said that lack of knowledge about the correct procedure or by difficulties in identifying these cases were barriers to be faced. This entry data reinforces the need for training to reduce misunderstandings and comply with current legislation, ensuring the protection of children.

### 3.2. Evaluation of the training course

Table 3 presents frequency of responses given by participants in the *Questionnaire on Hypothetical Cases* [14] about which procedures would be adopted in a hypothetical situation of suspected negligence.

Procedures	Before training (n=19)	After training (n=18)

Call Child Protection	4	12
Request assistance from the team	8	7
Make home visits	9	2
Speak to parents or neighbors	7	2
Confirm the suspicion	3	1

**Table 3.** Frequency and types of procedures given to a hypothetical situation of suspected neglect.

After the training, there was a marked increase in the decision to involve the Child Protection Services, as required by law. The category “request assistance from the team” maintained approximately the same level,, although the procedure is considered suitable for such situation.

The procedure “speaking to parents/neighbors” had an expressive change, decreasing the frequency as indicated. Similar to speaking with parents, home visitation is a common procedure in the Family Health Program. Nevertheless, the professional role in this case involves speaking to the family, but not conducting an investigative interview, as this would not be appropriate. One of the training course topics was how should the professional behave if child abuse is suspected, without doing an investigation or adopting different professional boundaries.

Table 4 presents the procedures that would be adopted in a hypothetical situation involving suspected sexual abuse. The data illustrates that after the intervention, most participants would call Child Protection Services.

Procedure	Before training (n=19)	After training (n=18)
Request assistance from team	10	6
Call Child Protection/Police	6	12
Refer to a psychologist	0	1
Visit/communicate school	2	4
Speak to parents/neighbors	5	4
Speak to the victim (child)	2	2
Making home visits	2	1

**Table 4.** Frequency and types of procedures given to a hypothetical situation of child sexual abuse.

More participants reported that they would call CPS, doubling before training data. However, the category “speak to parents” and “speak to the child” remained unchanged, and this may be an artifact of the vignette involved in the instrument.

The difficulties encountered by participants to the situations of neglect and sexual abuse presented in instrument [14] were similar for both groups, namely: possible resistance from the family to take responsibility for the abuse, fear of retaliation from the abuser, lack of experience with these cases, fear that CPS would not handle appropriately the reported case, fear of exposing the child and not knowing how to speak with the child. After the training, the most frequently cited difficulty was "*possible resistance from the family to take responsibility for the abuse and to receive help*".

Previous contact with the theme of child abuse during professional training was classified as "*none*", except for two participants (a Community Health Agent and a nurse) who had "*little*" experience and had attended talks about child abuse.

### **3.3. Professionals 'opinions about personal and work-related aspects of child abuse**

*Child Maltreatment Evaluations in Pediatric Primary Care* [27] responses were analyzed to see if the training had been responsible to change professionals 'opinions. The Wilcoxon test was conducted and significant changes of opinion between pre and post training (using both groups together) were seen for four instrument's questions (question 19 "*I feel competent to give a definitive opinion about physical abuse*"  $p = 0.027$ ; question 25 "*I Know the law involved in the reporting child abuse/neglect*"  $p = 0.005$ ; question 26 "*I know how to report a case of child who is being abused*"  $p = 0.013$  and question 27 "*I feel comfortable in talking with families about child abuse*"  $p = 0.031$ ).

It is somewhat frustrating that out of 32 questions, only 4 showed significant differences comparing pre-post results, suggesting that the training had little influence. However one must not discard the small size of the sample, difficulties answering the instrument, and the fact that participants may have given socially accepted answers.

The reasons provided in the instruments in general for not reporting child abuse corroborated the literature regarding the disbelief in CPS [10], lack of knowledge about activities of the Judiciary [12], lack of basic information to identify violence, peculiarities of each case which are influenced by professionals 'personal factors or by the structure of mostly insufficient services, [11], insufficient infrastructure and excessive workload of staff, and threats from the abuser to professionals, as well as fear of retaliation for living in the same community [6].

After the training, some of these factors did not change (nor could they have been changed), such as the excessive workload, and lack of infrastructure, but the positive assessment made by participants following the visit from Child Protection and the Forensic Psychologist may have been responsible to improve the image of this institutions as being inoperative. Participants gave testimonials regarding the changes in receiving information: "*The training was invaluable for learning and knowledge. It was a great achievement for the team.*" (PA11 – Participant 11 from Group A), and "*The course we had was very satisfactory; it has given us a new view of things, which sometimes, we passed unnoticed*" (PA7).

### 3.4. Effect of reporting behavior by participants

Monitoring of reporting behavior to Child Protection Services by health teams in the year preceding the training and afterwards was conducted. Group A reported *one* case to CPS after training and this same group had not reported *any* cases in the previous year. The report made by Group A employed the proper health notification form for child abuse, which was introduced in the training and it involved a sexual abuse case of 5 year old girl. The girl's mother who was pregnant had arrived for a routine check-up, and told the nurse that her daughter was *different* and that she thought her uncle might be doing "*the same thing to her daughter that he had done with her as a child*". Medical examination of the girl revealed a ruptured hymen. The team's nurse phoned the University, to confirm with the first author that all the necessary steps had been taken, and indeed the suggested procedure (reporting to CPS) had been adopted by the team.

Group B began the study without a history of reporting to CPS, but just before their training (while Group A had started to receive training), Group B made a report of a suspected case of sexual abuse. One may speculate if this reporting behavior was prompted by familiarity with the topic provided by the instruments. The reported case involved a 9 month-child, female, who was taken to Family Health Unit by her aunt because the baby had a rash in the genital area. Two professionals examined the child separately and found that the genital region did not have a rash, but was indeed, edematous and red, signaling possible sexual abuse. The girl's aunt told both professionals that she suspected sexual abuse by the child's stepfather. CPS was, then, called and a letter by the physician indicating possible sexual abuse was forwarded as well. When the first author examined this case at CPS, there was also a letter from the child's mother among the documentation, registering a complaint against the physician, as she felt that the reporting was aimed at harming her family.

According to staff reports, the child was sent for an exam at the city's Legal Medical Institute, but supposedly the expert had written that that "*because there is no hymen rupture one cannot claim that there was sexual abuse*". The family moved away from the neighborhood, and no longer visited that particular health unit. During the first training meeting with Group B, the case was narrated, and assessed by the team as an example of failure from the protection network. The general opinion was that even when the professional fulfilled his/her role, there were no guarantees that the case would have a proper resolution, point that was often discussed throughout the course.

This case illustrates the difficulties and shortcomings of the Protection Network and how difficult it is to prosecute child sexual abuse cases in the city [36]. The case also illustrates the need for ongoing training of all agencies involved, including experts from the Forensic Institute, who conduct medical examinations of children who may have been sexually abused.

After training, one more report record was observed by Group B, which may indicate that the intervention helped to overcome the initial negative experience. There is however another complication concerning notifications to CPS by Group B. At the fifth meeting in which a CPS staff made a presentation to the group, health participants reported five cases during

this visit (two cases involving adolescents with drug involvement, a case of suspected neglect and two cases of physical violence). CPS staff wrote down names and addresses of the five children, explaining that he would refer them to other staff members of CPS. Nevertheless, no such records existed when the first author examined CPS data, but one cannot say that the reporting steps were not taken because the cases could have been "old" in the sense of previously reported, and therefore inaccessible in their data base.

Despite the low number of reporting done by the groups after the training, the fact that they existed may be considered an important step and positive result, given the very low contact staff reported having had previously with sexual abuse cases.

To Brazil's Ministry of Health [37] the main consequences of notification are: facilitating a registration system with trusted information and to ensure that victims are receiving support in institutional routines [20]. In spite of this assertion, systematic record keeping is no guarantee of its proper use or potential. The data itself is not useful if it does not help to support concrete public policies and actions at the local level. Reporting per se does not warrant that proper service is incorporated into the routine of the unit. There is a risk that a professional may fill out a reporting form and subsequently feel that his/her responsibility is over. However, it is felt that continuing education on child abuse prevention may reduce this risk by empowering professionals and adding new elements for case analysis, such as identifying risk and protective factors.

#### **4. Conclusions**

The goal of this study was to increase awareness of Family Health Program professionals for preventing child abuse, by evaluating a training course to identify and report abuse. The choice of these professionals was based on the literature that indicates that training the team as a whole is more efficient than just training professionals individually [22].

Results indicated that there were positive changes of opinion and attitudes facing the topic of child abuse. From a quantitative point of view, results were not as robust as expected. Perhaps the instruments used in the study were not sensitive enough to observe changes, which would require investment in the construction of questionnaires with proper psychometric data, tested in large scale. Additionally, the reduced sample may have hampered the detection of quantitative improvements. From a qualitative viewpoint, on the basis of consumer satisfaction, the results were very encouraging. Additionally, there seems to have been initiated a systematic engagement with Child Protection Services, which did not exist before.

The prompt acceptability by staff, with which the teams agreed to take part of this training, reflects an interested and motivated attitude to learn about child abuse. However, because we provided training to a team in operation, many challenges had to be overcome as, for example, the insertion of a researcher in the teams and the floating of professionals during meetings for various reasons, hindering attendance. Initial questionnaire data confirmed

that there was a lack of familiarity with the topic and, this way, basic concepts such as the fact that humiliating a child corresponds to psychological violence, had to be discussed with the teams.

One aspect that may have contributed to participants' positive course evaluation were the visits from CPS staff and the forensic psychologist, which helped to provide a realistic picture of the work involved, diminishing negative impressions. Some of the comments professionals made after such visits were: "*now I understand how Child Protection Services work, it was very enlightening*" (PA1), and "*It was enough to get a sense of how difficult it is to work there*" (PA6).

Authors [22] indicate that one should work with the team as a whole in order to reduce the disparity of knowledge of health professionals from the same institution. We could see that this was indeed possible and that it strengthened the bonds amongst teams.

Another point observed was the influence of health professionals own personal history of abuse as in the example of one team staff who said that: "*the last meeting (about different types of violence) made me reflect on the way I was raised, always with slaps and screams and that this was not necessary*" (PA12). Another participant disclosed to the team that when she was young, the aunt who raised her used to bang her head against the wall, if the child did not do house chores properly, and in addition, her cousins had attempted to rape her. It was agreed that these disclosures reflected confidence in the group as a team, and should remain confidential. A third participant disclosed privately to the researcher that she had been sexually abused as a child by an uncle, and a fourth professional told the researcher privately about what it was like to grow in a home with domestic violence, and how much she strived to provide a different environment to her children.

Yoshihama and Mills [37] examined the personal history of professionals and their influence on the professional responses to allegations of family violence. They found that about half of professionals (n = 303) reported having suffered physical and/or sexual violence by an intimate partner; one-third of respondents reported physical abuse in their childhood, and 22% had suffered sexual abuse as a child. Professionals who had an abuse history identified more with abused cases encountered, and offered greater support to victims, making more protective decisions. This aspect was not explored in the present questionnaires, but participants' accounts in each group with a history of corporal punishment, sexual and psychological violence indicate that there were indeed previous abuse histories. In future research it would be interesting to investigate this variable and match them to their respective opinions about the role of health professionals.

The emphasis given to the need of a training program rather than a single lecture [22] seems to be valid. The training in the present study lasted five months, enabling reflection among participants and a change of verbalizations, beliefs and attitudes about child abuse, which would have been difficult to observe in a shorter period of time. In addition, the inclusion of the training course in the work routine encouraged discussion of several potential or real child abuse cases.



Lane and Dubowitz [27] stated that clinical experience is essential for the development of skills and comfort level regarding assessments of child abuse. Thus, a brief training may not be suitable to create the knowledge needed to assess and treat children suspected of abuse. Additionally, Lane and Dubowitz [27] verified the need for expert assistance, which is also relevant to this study, as after the training, the team pointed out that an interdisciplinary group would be ideal in terms of assessment of child sexual abuse and neglect cases.

Another possibility of course expansion would be to include in-depth encounters for each type of violence, as was proposed by the second author [25] after giving a specific training course on sexual sexual abuse, as each violence modality leads to specific demands. The training program recommendation on the ecological context of child abuse to understand risk and protective factors [22] was well suited to the context of the Family Health Program, which aims to meet individuals and family needs fully and continuously, developing actions to promote and restore health [38].

In conclusion, the training of health professionals to identify and report to competent authorities cases of child abuse, may be instrumental to Brazil's Family Health Program. It would be important to incorporate this approach, once tested in large scale, as public policy aimed at training professionals to improve the general care of the population, and especially to prevent violence.

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