ORIGINAL ARTICLE

REVISTA ENFERMAGEM ATUAL IN DERME

CHILD SEXUAL ABUSE DURING WELL-CHILD VISITS: UNDERSTANDING CHALLENGES AND NURSING CARE

VIOLÊNCIA SEXUAL INFANTIL NAS CONSULTAS DE PUERICULTURA: UMA COMPREESÃO SOBRE DESAFIOS E CUIDADOS DE ENFERMAGEM

ABUSO SEXUAL INFANTIL DURANTE LAS CONSULTAS DE CONTROL PEDIÁTRICO: UNA COMPRENSIÓN SOBRE LOS DESAFÍOS Y LOS CUIDADOS DE ENFERMERÍA

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ABSTRACT
Objective: To analyze the dynamics of the approach to child victims of violence in well-child nursing consultations in primary health care, from the perspective of nurses. **Methods:** An analytical, exploratory study with a qualitative approach, developed with 15 nurses who conduct well-child consultations in Basic Health Units in the city of Campina Grande, Paraíba, between September and October 2023. For this purpose, a form with sociodemographic questions was applied, and interviews were conducted following a semi-structured script. For the preparation and analysis of the materials, the interviews were transcribed in full, and the IRAMUTEQ software was used in conjunction with Bardin's content analysis. The research took place after approval by the Research Ethics Committee. **Results:** The analysis allowed the creation of two categories: "Challenges in assisting children and adolescents who are victims of sexual violence" and "Nursing care". **Final thoughts:** nurses use various approaches when dealing with children who are victims of sexual violence, such as analyzing their medical history, investigating the family environment and who the child lives with, as well as observing their behavior and psychological aspects; however, they revealed significant difficulties in identifying these cases.
Keywords: Child Sexual Abuse; Primary Health Care; Nursing.

RESUMO
Objetivo: analisar a dinâmica da abordagem da criança vítima de violência na consulta de enfermagem de puericultura na atenção primária à saúde, na perspectiva de enfermeiros e enfermeiras. **Métodos:** estudo analítico, exploratório, com abordagem qualitativa, desenvolvido com 15 enfermeiros que realizam consultas de puericultura nas Unidades Básicas de Saúde da cidade de Campina Grande, Paraíba, entre setembro e outubro de 2023. Para isso, aplicou-se um formulário com questões sociodemográficas e realizou-se entrevistas seguindo roteiro semiestruturado. Para preparação e análise dos materiais, transcreveu-se as entrevistas na íntegra e utilizou-se o Software IRAMUTEQ associado a análise de conteúdo de Bardin. A pesquisa ocorreu após aprovação pelo Comitê de Ética em Pesquisa. **Resultados:** a análise oportunizou a criação de duas categorias: “Desafios da assistência à criança e ao adolescente vítima de violência sexual” e “Cuidados de enfermagem”. **Considerações finais:** os enfermeiros se valem de diversas abordagens frente às crianças vítimas de violência sexual, como a análise do histórico clínico, a investigação do ambiente familiar e de com quem a criança convive, além da observação de seu comportamento e aspectos psicológicos, todavia, revelaram dificuldades importantes na identificação desses casos.
Palavras-chave: Abuso Sexual na Infância; Atenção Primária à Saúde; Enfermagem.

RESUMEN
Objetivo: Analizar la dinámica del abordaje a niños víctimas de violencia en consultas de enfermería de salud infantil en atención primaria, desde la perspectiva de las enfermeras. **Métodos:** Estudio analítico, exploratorio con un enfoque cualitativo, desarrollado con 15 enfermeras que realizan consultas de salud infantil en Unidades Básicas de Salud en la ciudad de Campina Grande, Paraíba, entre septiembre y octubre de 2023. Para ello, se aplicó un formulario con preguntas sociodemográficas y se realizaron entrevistas siguiendo un guion semiestructurado. Para la preparación y el análisis de los materiales, las entrevistas se transcribieron íntegramente y se utilizó el software IRAMUTEQ junto con el análisis de contenido de Bardin. La investigación se llevó a cabo tras la aprobación del Comité de Ética en Investigación. **Resultados:** El análisis permitió la creación de dos categorías: "Retos en la asistencia a niños y adolescentes víctimas de violencia sexual" y "Cuidados de enfermería". **Consideraciones finales:** Las enfermeras emplean diversos enfoques al atender a niños víctimas de violencia sexual, como el análisis de su historial médico, la investigación del entorno familiar y las personas con quienes conviven, así como la observación de su comportamiento y aspectos psicológicos; sin embargo, revelaron dificultades significativas para identificar estos casos.
Palabras clave: Abuso sexual infantil; Atención primaria de salud; Enfermería.

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INTRODUCTION

Sexual violence can be characterized by any act of a sexual nature committed without the victim's consent, such as fondling, sexual insinuations, or coercing someone into a sexual act through words or physical contact[1]. In Brazil, between 2020 and 2023, approximately 164,199 crimes involving rape and the rape of a vulnerable person were recorded, involving victims aged 0 to 19. Among children aged 5 to 9, 92% of the victims were female and 8% were male[2].

Thus, a higher prevalence of this type of violence is observed among children, particularly within the family setting. According to UNICEF[2], the younger the victim, the greater the risk of domestic sexual violence. For children aged 0 to 9, approximately 72% of these crimes occur in the home. In most cases, the abused children are related to their abusers; however, they often fail to recognize that they are being abused due to factors stemming from threats and subordination.

It is well established that such violence entails various consequences, social, physical, psychological, and emotional, that significantly affect the victim's development. Consequently, increasing the number of reports and initiatives aimed at mitigating this issue improves the chances of alleviating the trauma and other adverse effects the act may cause the child[4].

This scenario has been treated as a priority by the Family Health Strategy (FHS), given the high prevalence of the issue and the involvement of the family in these situations. Nurses play a fundamental role in identifying and addressing this type of health complication[5] by taking a leading role in child health consultations. These consultations aim to assess the patient's growth and development through attentive listening, physical examination, and evaluations of nutritional status, breastfeeding, the introduction of solid foods, vaccination records, and the presence of childhood risk factors; through this process, the professional is able to investigate situations that deviate from the norm[5].

Child health nursing consultations provide a crucial opportunity to devise health promotion strategies, serving as a favorable moment for exchanging experiences and overcoming challenges. Thus, health promotion encompasses more than just a healthy lifestyle, aiming instead for overall well-being[6], and entails a commitment to providing care for the child. In light of this, the nursing team must adopt a comprehensive approach focused on identifying signs and evidence of violence, ensuring protection for the victim and developing strategies in collaboration with the multidisciplinary team to promote holistic care.

These consultations are guided by the National Primary Care Policy (PNAB), which directs comprehensive care based on needs, delivered in a welcoming and humanized manner. It is relevant to highlight Axis V of the National Policy for Comprehensive Child Health Care (PNAISC), linked to the Adolescent Health Program (PROSAD), which reinforces the need to identify signs of violence and ensure

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support and protection; this axis addresses care regarding exposure to violence, accident prevention, and the promotion of a culture of peace[7-8].

A study involving 31 Primary Health Care (PHC) nurses in a Northeastern state capital revealed that only one nurse demonstrated satisfactory performance during child health consultations, highlighting that a lack of systematization in the consultation process can weaken care delivery and undermine trust in the care provided by the nurse[9].

To effectively provide high-quality care in case identification, particularly regarding sexual violence, it is essential that professionals pay attention to the technical and scientific aspects characterizing violence. The need to focus on quality is justified by initiatives aimed at maximizing and optimizing care, expanding the information available regarding the care provided to children, and identifying their needs more rapidly[10].

Emphasizing the importance of mapping how nurses approach child victims of violence, this study aims to analyze the dynamics of the nursing approach to child victims of violence during child health consultations in primary health care, from the perspective of the nurses themselves.

METHODS

This is a descriptive, exploratory study with a qualitative approach, conducted with nurses from Basic Health Units in the municipality of Campina Grande, Paraíba, Brazil. It aimed to analyze the dynamics of how child victims of violence are addressed during child health consultations in primary health care, from the nurses' perspective.

Currently, the city has 88 Basic Health Units, distributed across districts and their respective neighborhoods, with approximately one to two nurses per unit. The study population consisted of 108 nurses working in family health within the municipality. The sample included nurses who had been working in Primary Health Care for over a year and conducted child health consultations at the Basic Health Units. Conversely, nurses who were on vacation, on leave, or off duty at the time the research team made contact were excluded.

Data collection involved the administration of a form containing sociodemographic questions and a semi-structured interview guide based on a literature review. These instruments were administered by a Nursing graduate student, trained by a doctoral researcher experienced in qualitative research, and covered topics such as the professional's tenure at the unit, their actions when dealing with potential victims, and their perception regarding their safety when intervening in cases of child abuse.

It should be noted that the researcher responsible for data collection established prior contact with the participating nurses to explain the study's objectives, schedule interviews, and present the research's purpose: serving as the undergraduate student's final course project.

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A stratified sample based on health districts was used, involving 15% of the total number of nurses, in accordance with the distribution shown in Table 1 below. The final sample size was determined by theoretical saturation—a point reached when neither the researcher nor the study participants provide further elements sufficient to substantiate or deepen the theorization[11].

The researcher responsible for data collection made prior personal contact with 25 nurses; however, 10 declined to participate in the study. Participants were informed of the study's objectives and the purpose of the research, which was to fulfill the course completion requirements for the researcher, who was an undergraduate nursing student at the time, and interviews were scheduled. No pilot test was conducted for data collection.

The informed consent form and the voice recording consent form were presented and signed in duplicate prior to the administration of the questionnaire and interview guide. Data collection took place between September 27 and October 26, 2023, with an estimated duration of ten minutes per session; interviews were conducted in the nursing office of the Basic Health Unit (BHU), a setting free from noise and interruptions, with only the interviewer and the nurse present. Repeated interviews were conducted with the study participants.

The interviews were recorded and transcribed verbatim for data preparation and analysis. Bardin's content analysis technique was employed to construct thematic categories; this technique comprises a set of methods used to examine communications with the aim of obtaining qualitative or quantitative indicators through systematic, objective procedures for describing messages[12]. It should be noted that the transcripts were not returned to the participants for review; however, the researchers' contact information was provided to address any needs or potential withdrawals, even after data collection, consequently, no feedback regarding the results was shared with the participants.

In conjunction with this, the *Interface de R pour les Analyses Multidimensionnelles de Textes et de Questionnaires* (IRAMUTEQ) software was used to conduct the lexical analysis and generate the classes. This software measures word frequency and enables various statistical analyses of textual data and matrices, including traditional textual statistics and the generation of word clouds, among others[13].

To preserve participant confidentiality, the participants were identified using "F" codes (e.g., F1, F2, F3, F4); consequently, the data were presented based on the construction of thematic categories, with participants assigned a coded identification system known only to the research team. The study was approved by the Research Ethics Committee (REC) and adhered to all recommendations set forth in Resolution No. 466/2016 of the National Health Council (CNS - *Conselho Nacional de Saúde* in Portuguese).

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RESULTS

The study involved 15 nurses, 13 (87%) female and 2 (13%) male, ranging in age from 25 to 58 years.

The majority (9; 60%) were originally from Paraíba and resided in the city of Campina Grande (PB); they had between 2 and 28 years of professional experience, specifically in Primary Health Care (PHC), and had worked at a Basic Health Unit (BHU) for periods ranging from 1 to 28 years. All participants (15; 100%) held postgraduate qualifications in related public health fields, specifically: family health, collective health, child health, and/or obstetrics.

Analysis using IRAMUTEQ software and the Descending Hierarchical Classification (DHC) method yielded 15 texts, 211 text segments, 7,495 occurrences, 764 active forms, and 71.09% equivalence. The content was distributed across four classes: Class 1 (27.3% of text segments), Class 2 (31.3% of text segments), Class 3 (25.3% of text segments), and Class 4 (16% of text segments).

Class 1, designated "Child Health Consultation," showed a prevalence of the following words: physician, consultation, year, child health/puericulture, month, follow, monthly, health record book, perform, growth, schedule, age, nursing, ministry, start/from, and pregnant woman. Class 2, titled "Need for Professional Training," revealed the following terms: understand, theme, people, thing, tell/count, alert, time/instance, own, attention, need, knowledge, exist, direct, training, and management. Class 3, named "Means of Reporting and Referral," was characterized by the predominance of the following words: *council*, *guardianship* (as in *Conselho Tutelar*), *only*, *report* (noun and verb), *initiate action*, *contact*, *CRAS*, *believe*, *depend*, *anonymous*, *responsible*, *case*, *clear*, *family*, and *personal*. Meanwhile, Class 4, named "Identifying Violence," showed a preponderance of the words: *girl*, *age*, *range*, *come*, *genital*, *mother*, *know*, *guide*, *region*, *year*, *father*, *assessment*, *right*, *start*, *discharge*, and *examine*.

In this context, two main categories were established: the first, comprising Classes 2 and 3, was named "Challenges in providing care to children and adolescents who are victims of sexual violence," as it included words emphasizing coping strategies for potential violence scenarios and suggestions regarding the need for better preparation on this topic; the second category, formed by Classes 1 and 4, was named "Nursing care for children and adolescents who are victims of violence," highlighting statements related to care provision and potential signs for identifying the phenomenon.

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Chart 1 - Classes generated from the Descending Hierarchical Classification (DHC).

Categories	***Classes***
Category 1 – Challenges in providing care to children and adolescents who are victims of sexual violence.	Class 2: Need for professional training Class 3: Channels for reporting and referral
Category 2 - Nursing care for children and adolescents who are victims of violence.	Class 1: Child Health Consultation Class 4: Identifying Violence

Source: created by the authors.

CATEGORY 1 - CHALLENGES IN PROVIDING CARE TO CHILDREN AND ADOLESCENTS WHO ARE VICTIMS OF SEXUAL VIOLENCE

One of the offshoots of the category "Challenges in providing care to children and adolescents who are victims of sexual violence" is Class 3—comprising 25.3% of the text segments—titled "Means of reporting and referral"; this class relates to the agencies, institutions, or channels that professionals or guardians turn to when seeking support and assistance for victims of violence.

Within this category, the following speech stood out:

> *I contacted CRAS and the Child Protective Services (*Conselho Tutelar*), but unfortunately, the Child Protective Services weren't very approachable; they didn't take the matter further because any follow-up required a written police report filed by either the mother or myself (Nurse 12, F, 26 years old).*
>
> *I couldn't file an anonymous report; I had to appear in person alongside the council staff. However, working here means I'm highly exposed, since it is my workplace (Nurse 12, F, 26 years old).*
>
> *I knew that if I did it, I would be taking a huge risk. For instance, I attended a meeting for a school project where there were people responsible for receiving reports, and the woman there said, "You really should report it; send the report to us." But we need some form of protection in situations like that (Nurse 5, F, 25 years old).*

Class 2, comprising 31.3% of the text segments, was labeled "Need for professional training"; it highlighted the self-identified need among nursing professionals for formal preparation to address the phenomenon of violence. The words that stood out in this class were: "understand," "topic," "training," "knowledge," and "direct."

> *I feel that way because, at times, we could have more discussions and access to information; while it's true that we often have to seek things out on our own—and that's certainly a professional approach—there isn't much*

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> *coming from management or in the way of training. That's what's been missing: all this time, I haven't had any guidance in this area—knowing how to identify the workflow, how to act, which protocols to follow, and what questions to ask (Nurse 3, F, 49 years old).*

Another relevant point identified in this discussion was the interest in receiving feedback on the results of the research conducted and the importance of studying this topic, as highlighted in the following statements:

> *one thing we sometimes ask for is to have the survey results brought back—and it's not just me; there are things I think are important to have fed back, even to health management, so that we could see the results (Nurse 3, F, 49 years old).*

> *I find this a very pertinent and important topic because I am speaking about my own community, a community that is highly vulnerable, and where we know there are very high rates of sexual violence (Nurse 12, F, 26 years old).*

These speeches reveal the participants' critical perception regarding the relevance of the topic and the need for scientific findings to feed back into the service, informing local care practices and policies. This dialogic exchange between research and clinical practice reinforces the social function of science and the role of the nurse as an agent of transformation within their community.

CATEGORY 2 - NURSING CARE

The second category, named "Nursing Care," comprised classes 1 and 4, which describe how child health consultations are conducted at Basic Health Units, as well as their frequency, objectives, and the aspects assessed. They are represented by words such as "Consultation," "Child health care," "Health record book," "Growth," and "Guidance," which highlight the importance of these visits for children based on their age groups. Within this category, certain accounts regarding how consultations are carried out at the unit stood out:

> *the check-ups are monthly up to one year of age, then every six months up to two years, and annually up to four years; there was just one instance where I actually had a patient who was a suspected case and was indeed diagnosed (Nurse 12, F, 26 years old).*

> *one monthly visit is with the nursing staff and the other with the unit's physician; we take the child's and family's history, perform a physical exam, and provide guidance based on the child's developmental stage and age (Nurse 15, F, 44 years old).*

Regarding class 1, which has 27.3% of ST, named "Childcare Consultation", the statements demonstrate how these nurses carry out childcare consultations in the Basic Health Unit in which they work.

Class 4, with 16% of ST, named "Identifying violence", concerns the identification of children victims of sexual

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violence during these consultations, in which five of the 15 nurses were able to identify signs that raised suspicions of some type of violence suffered by a child. These situations are represented by the following speeches:

> *no, what we reported is unusual; generally, when a child has discharge—and there are certain types of discharge that aren't typical for that age—you start to suspect something when the vagina looks a bit swollen (Nurse 2, F, 43 years old).*

> *I actually had a suspected case once; the mother brought the girl to the unit where I work and reported that she was experiencing pain upon urination. When I began the assessment, I noticed that the child's hymen had been ruptured (Nurse 8, F, 45 years old).*

In this scenario, some of the nurses' statements illustrate the type of behavior the child typically exhibits:

> *it was a girl, two years old, almost three, who was starting to become aggressive; she wouldn't let her mother change her diaper or allow anyone to touch her genital area. When the mother came in for the consultation, she said she had noticed a brownish discharge on the girl's panties (Nurse 12, F, 26 years old).*

> *it was a long time ago, I think about a year ago, really quite a while back, that she arrived in a very agitated state; the mother rushed into my office asking me to examine the child's vagina to see if she had been assaulted (Nurse 14, F, 48 years old).*

DISCUSSION

Nurses face numerous challenges when dealing with child victims of sexual violence, as identified in the results. These include issues regarding the continuity of care, specifically, that responsible agencies often fail to provide the necessary support to advance investigations; parents or guardians may be unreceptive to healthcare professionals or attempt to withhold crucial information; and there is a shared fear of reporting the abuse, felt by both the professional and the guardian. However, ensuring the safety of a child victim of sexual abuse requires following three fundamental steps: disclosure of the incident, notification of the authorities, and formal reporting of the abuse[14].

When examining professional practice, it became evident that nurses feel apprehensive about the steps following the identification of violence; many report fearing the reporting process and pursuing the case further, as they feel there is a lack of safety for professionals working in Basic Health Units. A literature review identified fear as one of the most recurring obstacles to the continuity of care, negatively influencing the filing of reports and the implementation of interventions, as professionals feel socially and institutionally vulnerable[15].

The nurse's role in primary health care is characterized by close ties to the community; while this facilitates the detection of violence, it also creates anxiety and uncertainty regarding the social and personal repercussions of reporting the abuse[16-17].

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The fear and difficulty involved in activating protection networks reveal a structural tension between the nurse's institutional role and their life within the community. By reporting abuse, the nurse is exposed both as a public official and as a community member, leaving them vulnerable to criticism and retaliation. This dual position highlights that the obstacles faced are not limited to individual fear but also stem from a lack of robust institutional structures providing legal and symbolic support and protection[18]. Another challenge is the lack of continuing education for nurses; a study conducted in an adolescent health ward in Rio de Janeiro identified a significant gap regarding the qualification and training of nursing professionals in the care of children and adolescents who are victims of violence, underscoring the importance of continuing education initiatives[19].

Corroborating this, a literature review indicates that the majority of professionals working within the Unified Health System (UHS) lack adequate training to handle cases of violence, remaining unfamiliar with care protocols and guidelines[20]. This represents a significant setback in addressing the issue, as it can compromise the entire continuum of care for the victim.

This training deficit involves technical limitations as well as educational and institutional barriers, stemming from a lack of knowledge that integrates clinical, ethical, and social dimensions in addressing child sexual violence. Effective preparation requires a hybrid training approach, integrating practical protocols and relational skills, combined with legal and psychological support to ensure professional protection and confidence, as demonstrated by recent studies[21-23].

Thus, the importance of using field research findings to inform health education initiatives becomes evident, fostering reflection on existing shortcomings and guiding professional development strategies to overcome them. In this context, educational efforts aimed at both professionals and mothers/guardians play a pivotal role in addressing sexual violence and its consequences[2].

It is crucial that these initiatives address warning signs observable during child health check-ups, guiding professionals on how to proceed when suspicions arise, how to communicate with guardians, and which agencies to contact. Beyond strengthening the protection network, these measures foster a culture of ethical vigilance and comprehensive child care[24].

Different patterns regarding child health check-ups were observed in the nurses' statements. It is evident that some follow the schedule recommended by the Ministry of Health, which entails a total of seven routine check-ups during the first two years of life: seven in the first year (at the 1st week, 1st month, 2nd month, 4th month, 6th month, 9th month, and 12th month) and two in the second year (at the 18th and 24th months).

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This information indicates that the child health consultation serves as a prime setting for attentive monitoring, particularly when nurses establish a longitudinal bond with the child and the family. For this to occur effectively, the professional must understand the phenomenon, including its origins, identification, and the necessary protective measures. Therefore, strategies for welcoming patients and active listening, especially in services that serve as the point of entry into the healthcare system, must invariably be adopted[18].

Child health consultations provide an opportunity for nurses to expand their scope of practice beyond the biometric monitoring of child growth, encompassing risk surveillance and the early identification of potential situations involving violence and vulnerability. To this end, it is essential for professionals to develop emotional, empathetic, and communication skills capable of detecting not only physical signs but also subtle cues manifested through behavior, withdrawal, or emotional distress[25].

Beyond the physical examination, other aspects must be considered when investigating child sexual abuse, namely: the child's behavior and psychological state—such as irritability, withdrawal, or episodes of crying without apparent cause. Consequently, investigations into potential abuse often begin by reviewing the patient's history, as this step proves effective for understanding the circumstances under which the violence occurred[18].

The participants' accounts underscore the importance of qualified nursing professionals, particularly in primary health care, where establishing community ties is more tangible and there is a greater opportunity to identify and intervene in the cycle of violence. In this setting, nursing consultations and home visits are crucial for professionals to understand the family context and identify early risk factors that could trigger violent acts[19,32].

A limitation of the study is its small sample size, consisting of 15 nurses working in Basic Health Units in a single municipality: Campina Grande (PB). Although sufficient to achieve theoretical saturation within a qualitative framework, this number limits the generalizability of the findings.

FINAL THOUGHTS

The study identified the approaches adopted by nurses during child health consultations involving victims of sexual violence, highlighting strategies such as welcoming the child and their guardians, analyzing clinical history, investigating the family environment and social network, and observing behaviors and psychological indicators of abuse.

Recurring obstacles were also identified, such as a lack of institutional support for continuing investigations, resistance or withholding of information by guardians, and fear of reporting the abuse, a fear shared by both health professionals and caregivers.

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Therefore, there is a need for continuous training for Primary Health Care professionals, combined with the implementation of community-oriented educational initiatives to raise awareness and prevent child sexual violence. Strengthening intersectoral and legal support networks is also recommended to ensure technical and emotional backing for the professionals and families involved.

Finally, the study underscores the vital need for further, more comprehensive research to understand diverse contexts and realities, thereby facilitating the generalization of findings and the development of more targeted, effective actions to combat child sexual violence.

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Yngrid Karoline dos Santos Amorim: contributed substantially to the conception and/or planning of the study; to the collection, analysis, and/or interpretation of data; and to the drafting and/or critical revision and final approval of the published version.

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