Global Journal of Medical Research - Section K
GJMR

Recognizing and Responding to Suspected Child Physical Abuse: Knowledge, Attitudes, and Practices of Primary Health Care Professionals

Waleska Fernanda Souto Nóbrega[§ *], Sarah Fernandes Assis Gadelha Botelho Leonel[‡ ϑ], Paula Falcão Carvalho Porto de Freitas[‡ ϑ], Maria Jeanette de Oliveira Silveira[‡ ϑ], Heitor Leonel de Paiva Lima[‡ ϑ], Ana Beatriz Dantas Nogueira[¶ ξ], and Danilo Vieira Barbosa[‖ θ]

Affiliations

§ Department of Social and Preventive Dentistry, School of Dentistry, Universidade Federal de Minas Gerais, Belo Horizonte, Brazil (OA)
‡ Municipal Government of Campina Grande, Campina Grande, Brazil
¶ Universidade Federal de Campina Grande (OA)
‖ Universidade Estadual da Paraíba (OA)

Qualifications / Designations

ϑ Residency in Family and Community Medicine
ξ Multiprofessional Residency in Mental Health
θ Postgraduate degree in Dentistry

Abstract

Background: To investigate the knowledge, attitudes, and practices of physicians and nurses when faced with suspected cases of physical abuse and child maltreatment.

Methods: This was a cross-sectional, quantitative, analytical study involving 155 physicians and nurses working in Primary Health Care (PHC). A previously validated questionnaire was administered. Statistical analyses were performed using IBM SPSS Statistics, version 21.0. Pearson's chi-square test was used to identify associations between variables, and a decision tree analysis was performed to assess the influence of independent variables on the dependent variable, "number of reported cases." Outcomes: Most participants were female (77.4%), with a mean age of 35.6 years. Approximately 58.1% had postgraduate degrees, 38.7% of whom had specialized in public health. In the previous year, 20.6% of participants had identified suspected cases of abuse, but only 7.1% had reported them. The variables with the greatest influence on reporting were training in maternal and child health ($p < 0.001$), being a physician ($p = 0.044$), and 21–30 years of experience in PHC ($p < 0.001$).

Conclusion: Physicians with longer professional experience and training in maternal and child health were more likely to report suspected cases of child abuse. However, reporting decisions were also influenced by barriers such as fear, uncertainty regarding confidentiality, and lack of knowledge of reporting protocols.

Keywords: *Child Abuse, Child Care, Liability, Mandatory Reporting*

*** Corresponding Author**
Waleska Fernanda Souto Nóbrega

1. Introduction

Violence against children and adolescents is defined as any form of emotional and/or physical mistreatment, sexual abuse, neglect, commercial exploitation, or other forms of exploitation that may cause actual or potential harm to their health, survival, development, or dignity [1]. Child abuse can occur both in their home environment and in institutions, schools, or communities with which they have contact [2].

In this article, child abuse is defined according to the World Health Organization [3] as interpersonal acts of violence against individuals under 18 years of age, including any form of maltreatment inflicted by a parent or caregiver at home (whether physical, emotional, or sexual abuse, neglect, or exposure to domestic violence), intimate partner (or dating) violence during childhood and adolescence, as well as community violence occurring between individuals who are not connected as family members, such as peers, acquaintances, or strangers [3, 4].

Child abuse represents a significant public health challenge with severe impacts. Despite advances in scientific production and awareness-raising in society over the past ten years, infant mortality rates associated with reported cases of abuse have increased [5]. The study by Hillis et al. [6] points out that, in just one year, more than 1 billion children aged 2 to 17 experienced some form of violence.

In Brazil, the fight against child abuse began in the 1980s, with a focus on preventing risk factors and providing specialized treatment [7]. However, a report published by the United Nations Children's Fund (Unicef) identified 34,918 intentional violent deaths of children and adolescents in the country between 2016 and 2020, an average of 6,970 deaths per year. Among the victims, at least 1,070 were children up to 9 years of age [8].

Cases of child abuse reported in Brazil revealed higher prevalence in children aged 0-4 years (63.5%) compared to those aged 5-9 years (36.5%). Reporting rates for different forms of violence, such as physical, psychological, neglect, and sexual, varied between

boys and girls in different age groups [9]. The largest number of notifications occurs among girls, most of whom are black or brown, and in most cases the abuser is identified among friends, acquaintances or family members [10].

Under current health policies, primary health care teams play a crucial role in identifying and responding to violence against children and adolescents. As they are close to families and involved in individual and collective health actions, they are more likely to detect cases of violence and offer support, diagnosis, treatment, care and reporting, referring cases to the social protection network.

In addition, collaboration among professionals, services, and sectors is essential to ensure the comprehensive protection of children and adolescents, with health services playing a crucial role in this practice and participation in protection networks [11].

Despite their strategic position, many professionals working in the Family Health Strategy (FHS) have not received adequate training to identify and support victims of domestic violence. The predominance of practices based on the biomedical model tends to hinder the appropriate management of cases involving children and adolescents who have experienced violence. International studies emphasize the importance of investing in training programs that develop the pedagogical competencies needed to address domestic violence. These studies highlight collective reflection, team communication, and the sharing of beliefs and experiences as essential components of group learning [12].

Furthermore, in cases of intrafamilial violence against children, it is necessary to consider the dynamic relationship of power and affection, in which subordination and domination are present. In these relationships, parents and children, across different generations, occupy opposite and asymmetrical positions. In this context, violence represents an abuse of power that objectifies children and adolescents and violates their fundamental rights [13].

However, challenges in addressing violence remain rooted in cultural beliefs and practices that hinder changes in the way child maltreatment is perceived and addressed, for example, by accepting corporal punishment as a legitimate form of education and discipline [14].

Therefore, this study aimed to investigate the knowledge, attitudes, and practices of physicians and nurses working in primary health care in Campina Grande, Paraíba, Brazil, regarding suspected cases of child physical abuse and maltreatment.

2. Material and methods

2.1. Study Characterization and Setting

This was a cross-sectional, quantitative, analytical study of knowledge, attitudes, and practices (KAP). KAP studies assess a specific population's knowledge, beliefs, and behaviors regarding a particular topic, thereby identifying potential gaps, cultural influences, and behavioral patterns that may affect how the topic is understood and addressed [15].

The study was conducted in Campina Grande, Paraíba, Brazil, the state's second-largest city in terms of population. The Human Development Index (HDI) of Campina Grande is among the highest in Paraíba, with education being the dimension that evolved the most from 2000 to 2010, followed by longevity and income. Furthermore, the state of Paraíba has the tenth largest economy in Brazil, with Campina Grande being one of the municipalities that stands out in this topic based on livestock, tourism, agriculture, among others [16].

According to the Human Development Atlas of Brazil [17], social inequality in Campina Grande changed over the period, with the Gini index increasing from 0.61 in 1991 to 0.62 in 2000 before decreasing to 0.58 in 2010.

2.2. Study population and Sampling

The study included physicians and nurses working in primary health care (PHC) services within the Family Health Strategy in Campina Grande, Paraíba, Brazil. According to information from the Municipal Health Department, the municipality currently has 204 family health teams, which accounts for a total of 408 physicians and nurses. In addition, nurses working in Basic Health Units enrolled in multidisciplinary residency (five) were included, totaling a population of 413 individuals [18].

The sample size was calculated using Epi Info for Windows, considering a 95% confidence level and a 5% margin of error. The resulting sample consisted of 155 professionals. The sample was divided into two groups, comprising 78 physicians and 77 nurses.

2.3. Eligibility criteria

All physicians and nurses working in the Primary Health Care (PHC) within the scope of the family health strategy during the research period were included.

Professionals who refused to sign the Free and Informed Consent Form (FICF) or were absent from work due to leave or medical reasons during data collection were excluded. Those who could not be reached after three attempts on different days and at different times were considered losses.

2.4. Questionnaire and data Collection

The data collection instrument was based on a questionnaire previously developed and tested by Silva-Oliveira et al. [19]. The questionnaire underwent cross-cultural adaptation into Brazilian Portuguese and demonstrated excellent reproducibility. Response stability was assessed using simple and weighted kappa coefficients, which were predominantly above 0.80, indicating excellent test–retest agreement. The authors concluded that the Brazilian version of the instrument is a reliable tool for assessing the knowledge and attitudes of primary healthcare professionals regarding child physical abuse [19].

The seven health districts were divided between two researchers, who visited the Basic Health Units on different days and at different times to locate the professionals. To avoid potential embarrassment while completing the self-administered questionnaire, printed copies were distributed to the participants and collected at a later date. The health units to be visited in search of the professionals were chosen for the researchers' convenience, with no randomness in the selection process.

Collection was carried out between September and December 2024.

2.5. Data analysis

Two researchers independently entered the data into the database, and the entries were checked for inconsistencies. Statistical analyses were performed using IBM SPSS Statistics for Windows, version 21.0. First, descriptive analysis was performed, followed by Pearson's chi-square test to verify associations between dependent and independent variables. Finally, the influence of independent variables on the dependent variable "number of reported cases" was investigated using a decision tree.

2.6. Ethical Clearance

The study followed the guidelines established in National Health Council Resolution No. 466/2012 for research involving human

EARLY VIEW

participants. The study was submitted for ethical review through Plataforma Brasil and approved by the Research Ethics Committee of HUAC/UFCG (approval number 7.110.427).

Participants were invited to sign the Free and Informed Consent Form (FICF), which explained that their participation was voluntary. In addition, institutional approval was obtained to conduct the research.

3. Outcomes

Most participants were physicians (50.3%) and female (77.4%). The mean age was 35.65 years, ranging from 24 to 68 years. Most participants had 1–10 years since graduation (62.6%), 1–10 years of professional experience (57.4%), 1–10 years of experience in PHC (47.7%), and 1–10 years of experience in their current unit (45.2%). The majority had graduate degrees (58.1%), in the area of collective/public health or family health (38.7%).

Table 1 presents issues on the recognition and reporting of suspected cases of child abuse in professional life. Most participants reported that they had never encountered suspected cases of physical abuse among their pediatric patients during their professional experience (59.4%). However, 20.6% had identified suspected cases in the previous year, whereas only 7.1% had reported suspected or confirmed cases to the authorities during that period.

Most participants considered themselves capable of recognizing signs and symptoms of child physical abuse and of making an appropriate diagnosis. When asked where suspected cases should be reported, 71.0% identified the Child Protection Council. However, when asked if they had the telephone number for the reporting department, the majority responded that they did not (55.5%) (Table 1).

Most participants identified confidentiality (72.3%), safety (70.3%), and training (72.3%) as factors that could facilitate or encourage the reporting of suspected cases. When asked about the main barriers to reporting, the main responses were fear (82.6%), insufficient knowledge (81.3%) and lack of confidentiality (60.0%) (Table 2).

Most participants expressed interest in receiving training on identifying suspected cases of child abuse (97.4%). In addition, 89.7% reported being willing to become involved in detecting physical abuse against children. Regarding the knowledge acquired during their undergraduate studies on the subject, the majority considered it sufficient (50.3%) and finally, when asked about their interest and preparation for child care, the majority responded that they were interested (93.5%) and claimed to be sufficiently prepared (90.3%) (Table 3).

Table 4 presents the bivariate analysis of the dependent and independent variables. Sex was associated with identifying fear as a barrier to reporting suspected cases and with participants' perceived preparedness to report such cases. In addition, it can be observed that age group, time since graduation, time working in PHC, time working in the unit, type of professional and graduate area influenced the number of cases observed (suspected and confirmed) by the professionals participating in the research.

Figure 1 presents the decision tree illustrating the association between the number of reported child abuse cases and the study variables. The variables most strongly associated with reporting were specialization in maternal and child health ($p<0.001$), being a physician ($p = 0.044$), and having 21–30 years of experience in primary health care ($p<0.001$).

EARLY VIEW

Table 1. Questions regarding suspected/confirmed cases of child abuse identified and reported in professional experience, Campina Grande – PB, 2025.

Variable	N	%
In your professional experience, have you ever encountered a suspected case of physical abuse among your pediatric patients?		
No	92	59,4
Yes	63	40,6
If yes, please indicate the number of cases. If you are not sure, provide an approximate number		
Up to 5 cases	59	38,1
Between 6 and 10 cases	3	1,9
From 11 to 20 cases	1	0,6
Not applicable	92	59,4
Have you ever reported a suspected case of physical abuse in a child among your patients?		
No	127	81,9
Yes	28	18,1
If yes, please indicate the number of reported cases		
Up to 5 cases	26	16,8
Between 6 and 10 cases	1	0,6
From 11 to 20 cases	1	0,6
Not applicable	127	81,9
Have you seen any case of pediatric orofacial trauma related to physical abuse in the past year?		
No	153	98,7
Yes	2	1,3
If yes, please indicate the number of trauma cases		
Up to 5 cases	2	1,3
Not applicable	153	98,7
Have you seen any suspected cases of physical abuse in a child in the past year?		
No	123	79,4
Yes	32	20,6
If yes, please indicate the number of cases seen		
Up to 5 cases	30	19,4
Between 6 and 10 cases	2	1,3
Not applicable	123	79,4
Have you seen any confirmed cases of physical abuse in a child in the past year?		
No	146	94,2
Yes	9	5,8
If yes, please indicate the number of cases seen		
Up to 5 cases	8	5,2
Between 6 and 10 cases	1	0,6
Not applicable	146	94,2
Have you reported any suspected or confirmed cases of physical abuse in a child to the authorities in the past year?		
No	144	92,9
Yes	11	7,1
If yes, please indicate the number of cases reported		
Up to 5 cases	11	7,1
Not applicable	144	92,9
Using a scale from zero to ten, how capable are you of recognizing signs and symptoms of physical abuse in a child?		
1 to 5 - Not very capable	21	13,5
6 to 10 - Very capable	134	86,5
Using a scale from zero to ten, how capable are you of effectively diagnosing physical abuse in a child?		
1 to 5 - Not very capable	35	22,6
6 to 10 - Very capable	120	77,4
Do you know who to contact to report a suspected or confirmed case of physical abuse in a child?		
No	18	11,6
Yes	137	88,4
If yes, please specify the agency, institution, or professional you would contact		
Guardianship Council	110	71,0
Civil Police	4	2,6
Social Worker / Social Service	10	6,5
CPAI (Child Protection and Assistance Center)	5	3,2
Health Department	4	2,6
Children's Hospital	1	0,6
Public Prosecutor's Office	1	0,6
SINAN (National System for Notifiable Diseases)	1	0,6
Community Health Worker (CHW)	1	0,6
Not applicable	18	11,6
Do you have any phone number or contact address for the agency, institution, or professional responsible for receiving reports of physical abuse in children?		
No	86	55,5
Yes	69	44,5
Total	**155**	**100**

Source: Research author, 2025

EARLY VIEW

Table 2. Factors that facilitate and hinder the reporting of suspected cases of child abuse, interest in training on reporting abuse and willingness to get involved in suspected cases, Campina Grande – PB, 2025.

Variable		N	%
In your opinion, why are some cases of physical abuse in children not reported?			
Fear	No	79	51,0
	Yes	76	49,0
Insufficient knowledge	No	89	57,4
	Yes	66	42,6
Negligence	No	133	85,8
	Yes	22	14,2
Mark three factors that you believe may facilitate or encourage healthcare professionals to report suspected cases of physical abuse in children			
Confidentiality	No	43	27,7
	Yes	112	72,3
Safety	No	46	29,7
	Yes	109	70,3
Training	No	43	27,7
	Yes	112	72,3
Simplifying the reporting process	No	78	50,3
	Yes	77	49,7
Interdisciplinarity and intersectorality	No	108	69,7
	Yes	47	30,3
In your opinion, what are the three main barriers preventing healthcare professionals from reporting physical abuse in children?			
Fear	No	27	17,4
	Yes	128	82,6
Insufficient knowledge	No	29	18,7
	Yes	126	81,3
Lack of confidentiality	No	62	40,0
	Yes	93	60,0
Negligence	No	105	67,7
	Yes	50	32,3
Excessive workload	No	112	72,3
	Yes	43	27,7

Source: Research author, 2025

Table 3. Questions regarding interest in training on reporting abuse and willingness to get involved in suspected cases, Campina Grande – PB, 2025.

Variable	N	%
Would you like to receive training on how to identify and the reporting mechanisms for suspected cases of physical abuse in children? (e.g., courses, workshops)		
No	4	2,6
Yes	151	97,4
Do you think that the mechanisms for identifying and reporting possible cases of physical abuse in children should be part of professional training courses?		
Yes	155	100
Using a scale from zero to ten, how willing do you feel to get involved in detecting physical abuse against children?		
0 - Not willing at all	1	0,6
1 to 5 - Slightly willing	15	9,7
6 to 10 - Very willing	139	89,7
Using a scale from zero to ten, how sufficient do you think your undergraduate education was in preparing you to care for children?		
0 – Insufficient	1	0,6
1 to 5 - Slightly sufficient	76	49,0
6 to 10 – Sufficient	78	50,3
Using a scale from zero to ten, how interested do you feel in caring for children?		
1 to 5 - Slightly interested	10	6,5
6 to 10 - Very interested	145	93,5
On a scale from zero to ten, how prepared do you feel to care for children?		
1 to 5 - Slightly prepared	15	9,7
6 to 10 - Very prepared	140	90,3
On a scale from zero to ten, how interested are you in continuing education courses and training to improve care for children?		
1 to 5 - Slightly interested	4	2,6
6 to 10 - Very interested	151	97,4

Source: Research author, 2025

EARLY VIEW

Table 4. Bivariate analysis between dependent and independent variables of the study, Campina Grande – PB, 2025.

Independent variable	Dependent variable	p*
Sex	In your opinion, what are the three main barriers preventing healthcare professionals from reporting physical abuse in children? – Fear	0,048
	Using a scale from zero to ten, how willing do you feel to get involved in detecting physical abuse against children?	0,039
Age group	Using a scale from zero to ten, how interested are you in providing care for children?	0,003
	Number of suspected or confirmed cases (seen) during professional experience	0,039
Time since graduation	Number of reported cases during professional experience	0,003
	Number of suspected or confirmed cases (observed) during professional experience	0,044
Work experience	Number of reported cases during professional experience	0,004
	Number of suspected or confirmed cases (observed) during professional experience	0,013
Time working in PHC	Mark three factors that you believe may facilitate or encourage healthcare professionals to report suspected cases of physical abuse in children - Interdisciplinarity and intersectorality	0,029
Time working in the current unit	Number of suspected or confirmed cases (observed) during professional experience	0,047
	Do you have any phone number or contact address for the agency, institution, or professional responsible for receiving reports of physical abuse in children?	0,016
Type of professional	In your opinion, why are some cases of physical abuse in children not reported? - Insufficient knowledge	0,046
	In your professional experience, have you seen any suspected cases of physical abuse among your pediatric patients?	0,007
	Number of suspected or confirmed cases (observed) during professional experience	0,048
	Have you reported any suspected cases of physical abuse in a child among your patients?	0,014
	Number of suspected cases in the past year	0,024
	Do you have any phone number or contact address for the agency, institution, or professional responsible for receiving reports of physical abuse in children?	0,001
	Mark three factors that you believe may facilitate or encourage healthcare professionals to report suspected cases of physical abuse in children – Confidentiality	0,022
Postgraduate degree	In your opinion, what are the three main barriers preventing healthcare professionals from reporting physical abuse in children? – Excessive workload	0,022
	Number of suspected cases in the past year	0,025
	In your opinion, what are the three main barriers preventing healthcare professionals from reporting physical abuse in children? – Negligence	0,036
Field of postgraduate degree	Number of suspected or confirmed cases (observed) during professional experience	0,001
	Have you reported any suspected cases of physical abuse in a child among your patients?	0,022
	Number of reported cases during professional experience	0,001
	Using a scale from zero to ten, how capable do you consider yourself in recognizing signs and symptoms of physical abuse in children?	0,026

**Pearson's chi-square test (p<0.05). Source: Research author, 2025.*

EARLY VIEW

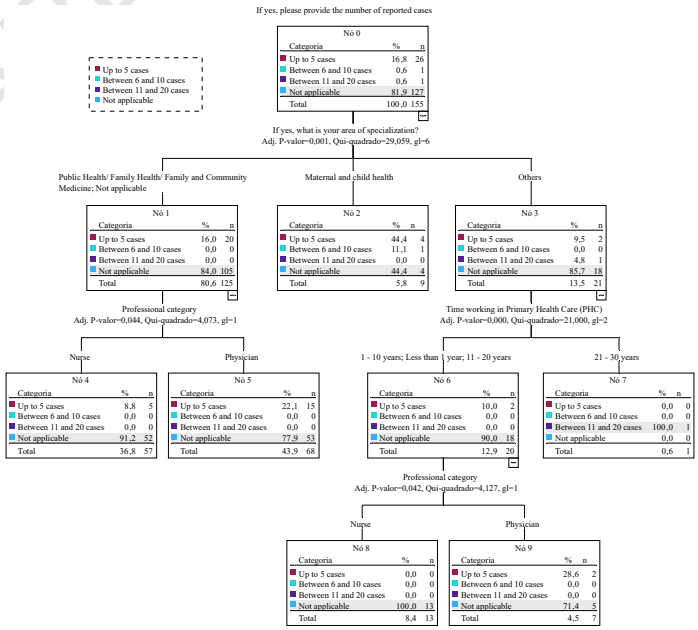

Figure 1. Decision tree demonstrating the association between number of reported cases of child abuse and the dependent variables of the study

4. Dialogue

Articles 13 and 245 of the Statute of Children and Adolescents (ECA) [20], together with Ministry of Health Ordinances No. 1968/2001 [21] and No. 104/2001 [22], established the requirement for professionals to report violence against children, which constitutes an action of utmost importance for measuring the epidemiological dimension of these injuries and the formulation of policies aimed at their prevention [19].

The Notifiable Diseases Information System (SINAN) is responsible for consolidating reports of violence cases submitted by health

units. It should be noted that the Ministry of Health provides training that covers everything from the proper completion of forms, data processing, and analysis, to the dissemination of information. However, it is observed that many municipalities and states still do not properly maintain the system [23].

The identification and documentation of child abuse remain major challenges in pediatric practice, resulting in cases that go unnoticed and are not formally reported [24]. The acceptance of physical punishment as a culturally accepted form of discipline hinders the identification and prevention of cases of violence [14]. Furthermore, the lack of sufficient knowledge and sensitization among professionals, whose practices are still guided by the biomedical model, compromises the proper management of children who have experienced violence and the measures to address it [12].

The results showed that physicians, particularly those with training in maternal and child health and longer professional experience, reported more cases of child abuse. This finding corroborates the study by Martins-Júnior et al. [25], who demonstrated that, among physicians, nurses and dentists, physicians make the most reports.

In addition, Silva-Oliveira et al. [19] stated that older professionals with longer time in the public service are those who are most likely to notice and report cases of child abuse. A recent study conducted by Mandadi et al. [5] identified that physicians trained in pediatric emergency medicine have high confidence and knowledge about the treatment of child abuse.

A concerning finding was that not all professionals who had encountered suspected cases in the previous year reported them. Most respondents identified the Child Protection Council as the preferred reporting destination, corroborating the results found by Silva-Oliveira [19].

Limited knowledge and uncertainty about recognizing signs and symptoms of child abuse are among the main barriers to reporting suspected maltreatment [24]. Other barriers include insufficient knowledge of reporting procedures [26], previous negative experiences after reporting [27], and the absence of strong legal consequences for failure to report [28].

According to Lima [26], even when training is provided, health systems continue to face challenges in ensuring that violence remains a sustained priority on the public health policy agenda. The decrease in reporting rates since 2020 may be related to pandemic-related restrictions and concerns about COVID-19 transmission, which may have led to underreporting [29].

One of the initiatives that can assist in the identification of signs and factors associated with child abuse is the dissemination of screening, identification, and assessment tools for the different forms of violence experienced in childhood and adolescence. A study by Oliveira (2016) identified eight instruments with this purpose, five of which are intended for identifying violence in domestic settings. The author believes that the proper use of these tools can contribute to the accurate identification and reporting of cases.

Nevertheless, it is necessary to analyze whether it is prudent or fair to require reporting of cases in a scenario where, often, there is no policy to support, protect and assist these professionals responsible for reporting violence against children [30].

The convenience-based selection of health units constitutes a limitation of this study, as it may introduce selection bias and restrict the generalizability of the findings to all Family Health Strategy teams in the municipality. Although the participating units encompassed different healthcare contexts, a systematic comparison of their demographic and geographic characteristics with those of non-selected units was not performed. Therefore, the findings should be interpreted in light of the specific context of the participating units. Furthermore, the presence of small terminal subgroups in the CHAID decision tree may introduce instability in lower-level splits; therefore, these results should be interpreted with caution.

5. Conclusion

Reporting suspected cases of child abuse is a complex challenge involving not only health professionals' technical knowledge but also personal, institutional, and ethical factors.

Physicians with longer professional experience and training in maternal and child health were more likely to report suspected cases. However, reporting decisions were also associated with multiple barriers, including fear, uncertainty about confidentiality and lack of information about the reporting process.

These findings highlight the importance of strategies that strengthen training and support for health professionals, ensuring that they have the confidence and clear, adequate information needed to act ethically and effectively. Measures such as implementing protocols, offering psychological and legal support, and promoting an institutional culture that values child protection can contribute to increase the reporting of suspected cases.

Therefore, this study reinforces the need for a multidisciplinary and intersectoral approach, where the commitment to child safety is shared among health professionals, managers and regulatory bodies, aiming not only at complying with legislation, but, above all, at guaranteeing the fundamental rights of children.

REFERENCES

[1] Krug EG, Mercy JA, Dahlberg LL, Zwi AB. The world report on violence and health. Lancet. 2002;360(9339):1083-8.

[2] Alsaleem SA, Alsaleem MA, Asiri AM, Alkhidhran SS, Alqahtani WSS, Alzahrani MS, et al. Knowledge and attitude regarding child abuse among primary health care physicians in Abha, Saudi Arabia, 2018. J Family Med Prim Care. 2019;8(2):706-10. doi:10.4103/jfmpc.jfmpc_442_18

[3] World Health Organisation (WHO). Violence against children. 2022. Available from: https://www.who.int/news-room/fact-sheets/detail/violence-against-children. Accessed 28 Oct 2025.

[4] Nation A, et al. Prevalence of violence against children in the United Kingdom: a systematic review and meta-analysis. Child Abuse Negl. 2023;146:106518.

[5] Mandadi AR, Dully K, Brailsford J, Wylie T, Morrissey TK, Hendry P, et al. A national survey of pediatric emergency medicine physicians on improving education in child maltreatment recognition and reporting. Child Abuse Negl. 2021;122:105324. doi:10.1016/j.chiabu.2021.105324

[6] Hillis S, et al. Global prevalence of past-year violence against children: a systematic review and minimum estimates. Pediatrics. 2016;137(3):e20154079.

[7] Sanchez RN, Minayo MCS, Souza ER. Violência contra crianças e adolescentes: questão histórica, social e de saúde. In: Minayo MCS, organizer. Violência faz mal à saúde. Rio de Janeiro: Editora Fiocruz; 2004. p.23-8.

[8] United Nations Children's Fund (UNICEF). Panorama of lethal and sexual violence against children and adolescents in Brazil. 2021. Available from: panorama-lethal-sexual-violence-against-children-adolescents-in-brazil.pdf. Accessed 28 Oct 2025.

[9] De Paula Correia JV, Pimentel Diniz CM, Oliveira MFB, Mendes IRT, Lacerda JT. Violência infantil: o perfil epidemiológico no Brasil a

EARLY VIEW

partir de dados do Sistema de Informação de Agravos de Notificação (SINAN). 2023.

[10] Brasil. Ministério da Saúde (BR). Boletim epidemiológico: volume 54, nº 08 [Internet]. Brasília: Ministério da Saúde; 2023 [cited 2025 May 1]. Available from: https://www.gov.br/saude/pt-br/centrais-de-conteudo/publicacoes/boletins/epidemiologicos/edicoes/2023/boletim-epidemiologico-volume-54-no-08

[11] Deslandes SF. Redes de proteção social e redes sociais: uma práxis integradora. In: Minayo MCS, organizer. Violência faz mal à saúde. Rio de Janeiro: Editora Fiocruz; 2006. p.135-41.

[12] Leite JCS, et al. Percepções de agentes comunitários de saúde acerca da violência doméstica contra crianças e adolescentes. Enferm Foco (Brasília). 2024;1-9.

[13] Moreira MIC, Sousa SMG. Violência intrafamiliar contra crianças e adolescentes: do espaço privado à cena pública. O Soc Quest. 2012;28:13-25.

[14] Theodoro R. A violência oculta na sola do chinelo: punição corporal, violência intrafamiliar e os modelos de autoridade em São Paulo, Brasil. Cad Saúde Pública. 2025;41:e00110324.

[15] Soares MTF, Low ST, da Silva Bastos ME, Nascimento AJF, Beserra MA, de Lima Cantarutti LM, et al. Validação de um instrumento de avaliação do conhecimento, atitude e prática de puérperas sobre os sinais gerais de perigo do recém-nascido. Aracê. 2024;6(4):11104-25.

[16] Instituto Brasileiro de Geografia e Estatística (IBGE). Cidades e Estados: Campina Grande – PB [Internet]. Rio de Janeiro: IBGE; [cited 2025 May 1]. Available from: https://www.ibge.gov.br/cidades-e-estados/pb/campina-grande.html

[17] Brasil. Ministério da Saúde. Secretaria de Vigilância em Saúde. Departamento de Vigilância de Doenças e Agravos não Transmissíveis e Promoção da Saúde. Sistema de Vigilância de Violências e Acidentes (Viva): 2009, 2010 e 2011. Brasília: Ministério da Saúde; 2013. 164 p.

[18] Campina Grande (PB). Secretaria de Saúde. Quantitativo de equipes de saúde da família no município no ano de 2024 [informações cedidas]; 2024 Sep.

[19] Silva-Oliveira F, Diniz NM, Alves MDS, Pimentel Diniz CM, Gama CAP. Adaptação transcultural e reprodutibilidade de questionário para avaliação de conhecimento e atitude de profissionais de saúde frente a casos de abuso físico infantil. Cien Saude Colet. 2014;19(3):917-29.

[20] Brasil. Lei nº 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. Diário Oficial da União. 1990 Jul 13.

[21] Brasil. Ministério da Saúde. Portaria nº 1968, de 25 de outubro de 2001. Dispõe sobre a notificação às autoridades competentes de casos de suspeita ou de confirmação de maus-tratos contra crianças e adolescentes atendidos nas entidades do Sistema Único de Saúde. Diário Oficial da República Federativa do Brasil. 2001 Oct 25.

[22] Brasil. Ministério da Saúde. Portaria nº 104, de 29 de janeiro de 2001. Dispõe sobre as Normas de Execução do Sistema de Vigilância Epidemiológica Hospitalar. Diário Oficial da União. 2001 Jan 30.

[23] Alves JM, et al. Notificação da violência contra crianças e adolescentes por profissionais de saúde. Rev Fac Ciênc Méd Sorocaba. 2017;19(1):26-32.

[24] Berchtold MB, Wüthrich C, Garcia D, Berger S, Löllgen RM. Nurses' and physicians' reported difficulties and enablers to recognising and reporting child abuse in Swiss paediatric emergency and paediatric surgery departments—an observational study. Swiss Med Wkly. 2023;153:40017. doi:10.57187/smw.2023.40017

[25] Martins-Júnior PA, Macedo JP, Silva-Oliveira F, Lacerda JT. Abuso físico de crianças e adolescentes: os profissionais de saúde percebem e denunciam? Cien Saude Colet. 2019;24(7):2609-16.

[26] Lima JS, Deslandes SF. Olhar da gestão sobre a implantação da ficha de notificação da violência doméstica, sexual e/ou outras violências em uma metrópole do Brasil. Saude Soc. 2015;24(2):661-73.

[27] Elarousy W, Abed S. Barriers that inhibit reporting suspected cases of child abuse and neglect among nurses in a public hospital, Jeddah, Saudi Arabia. East Mediterr Health J. 2019;25(6):413-21. doi:10.26719/emhj.18.055

[28] Owaidah SF, Alharaz RI, Aljubran SH, Almuhanna ZY, Menezes RG. Factors affecting reporting of suspected child maltreatment in Saudi Arabia. J Forensic Leg Med. 2022;89:102371. doi:10.1016/j.jflm.2022.102371

[29] Platt VB, Guedert JM, Coelho EBS. Violência contra crianças e adolescentes: notificações e alerta em tempos de pandemia. Rev Paul Pediatr. 2021;39:e2020267. Available from: https://www.scielo.br/j/rpp/a/Ghh9Sq55dJsrg6tsJsHCfTG/?format=pdf&lang=pt. Accessed 31 Jan 2025.

[30] Oliveira DGR. Instrumentos de rastreio, identificação e avaliação das diferentes formas de violência sofridas na infância e na adolescência: uma revisão de literatura. Trabalho de Conclusão de Curso. Universidade de Brasília, Brasília – DF; 2016.

EARLY VIEW