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Care for Elderly Victims of Violence in Primary Detention

Thaynara Ludvig[1], Sávia Denise Silva Carlotto Herrera[1], Neilton Araujo de Oliveira[2], Marcos Gontijo da Silva[3], Rodrigo Disconzi Nunes[1], Júlio Cézar Castro de Souza Júnior[1], Caio Willer Brito Gonçalves[1], Yuniel Martinez Hermández[1], Warly Neves de Araújo[4*], Rafaela de Carvalho Alves[1], Marcela de Souza Sotto Mayor[1] and Rafael Vilela Borges[1]

[1]Gurupi University (UnirG), Gurupi-TO, Brazil.
[2]Federal University of Tocantins (UFT), Palmas-TO, Brazil.
[3]Federal University of Tocantins (UFT) Gurupi-TO, Brazil.
[4]Faculty of Applied Social Sciences, Marabá-FACIMAB, Gurupi-TO, Brazil.

Authors' contributions

This work was carried out in collaboration among all authors. Authors TL, SDSCH, NAO and MGS designed the study, performed the statistical analysis, wrote the protocol and wrote the first draft of the manuscript. Authors RDN, JCCSJ, CWBG, YMH and RCA managed the analyses of the study. Authors WNA, MSSM and RVB managed the literature searches. All authors read and approved the final manuscript.

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ABSTRACT

Aims: The present study aimed to evaluate the quality of care provided to elderly victims of violence, comparing the basic health units (BHU) of the municipality of Gurupi-TO with and without the medical residency program in family and community health.
Study Design: This is a descriptive, cross-sectional and retrospective study.
Place and Duration of Study: Study from December 2017 to March 2018. Performed in 12 basic health units (BHU) in the municipality of Gurupi-TO, with a total of 21 family health teams, 10 (ten)

**Corresponding author: E-mail: warlynevesaraujo@gmail.com;*

have the Family Medical Medical Residency Program (FMMRP) and are distributed in six BHU, totaling approximately 210 individuals, divided into 21 teams.
Methodology: Study conducted in 12 BHU, in which health workers responded to the QualiAB assessment and monitoring instrument and the data were tested by the chi-square test to verify if there is a difference in care, considering p≤5% through the EPI INFO 3.2.2 program.
Results: We interviewed 107 health workers who found that of the 16 items analyzed, eight had better levels in BHU with MRPFCM.
Conclusion: The presence of MRPFCM programs contributes and improves the quality of service in basic health units, regarding the care of the elderly victims of violence and, as a public policy, should receive support for its expansion and effective incorporation in basic care to SUS users.

Keywords: Residence medical; primary care; health management; violence, elderly.

1. INTRODUCTION

Demographic aging is a worldwide, current, and growing phenomenon in the population. According to the World Health Organization (WHO), the world population of individuals aged 60 years or older will increase from 900 million to 2 billion between 2015 and 2050 [1].

The process of population aging in Brazil is a current phenomenon as a result of the demographic dynamics that significantly affected the age composition of the Brazilian population. Still, in development, the demographic transition provides a profound reduction in the country's fertility and birth rates and a progressive increase in the life expectancy of Brazilians [2].

The theme of violence against the elderly in the family context has drawn the attention of many scholars, either because it is a population that has been growing significantly or because research has revealed that the family environment is the main place where abuses are committed. Thus, primary care occupies a prominent position in the identification, prevention, and segment of cases of family violence against the elderly,[3] this arouses the need to impose new practical strategies to ensure the quality of life for the elderly population [4].

In most cases, the elderly need someone to assist them in activities that were previously simple to perform, but who now need third parties to perform, [5] and thus the greater the dependence, the greater the degree of vulnerability of the elderly [6].

The Basic Health Units (BHU) work directly with the elderly in their daily lives and are faced with a serious problem that is the violence suffered by them. Violence against the elderly is a universal phenomenon and represents an important public health problem and whose interest has become evident only in recent decades. No society, however developed, is immune to the occurrence of violence and ill-treatment of older people. Unfortunately, the numerous abuses committed are underreported, not revealing the magnitude of this phenomenon [7-8].

In this context, the Medical Residency Programs in Family and Community Medicine (MRPFCM) was created with the aim of improving the training of physicians who wish to work in primary care, this program is considered the gold standard in the training of medical specialists [4].

Primary Care (PC) in Gurupi consists of a network of 12 (twelve) Primary Health Care (PHC) units, located in the urban area, covering more than 50.000 people, and are directly installed in the communities. The implementation of the program in Gurupi-TO occurred in March 2016, with the objective of qualifying physicians in the clinical area for primary care, practicing the person-centered, evidence-based and longitudinal medicine for patients inserted in each community [9].

Thus, based on this conjuncture, the present study was proposed with the purpose of evaluating, through the Quali AB questionnaire, the quality of the service performed in front of elderly who demand health care and by health professionals who care for elderly people in situations of violence, comparing BHU who have the MRPFCM to those who do not have this program [10].

It is intended, through this study, to evaluate the influence that the MRPFCM presented on the quality of care provided in the BHU of Gurupi-TO to elderly victims of violence, to generate bases

for the better qualification of professionals in listening to this theme.

2. MATERIALS AND METHODS

This is a descriptive, cross-sectional, and retrospective study from December 2017 to March 2018. Performed in 12 basic health units (BHU) in the municipality of Gurupi-TO, with a total of 21 family health teams, 10 (ten) have the Family Medical Medical Residency Program (FMMRP) and are distributed in six BHU, totaling approximately 210 individuals, divided into 21 teams.

The sample calculation was made according to Andrade (ANDRADE, 1998) and determined an n of 107 employees. Heterogeneity of 50%, the margin of error of 5% and a confidence level of 95% were used. All participants were approached directly in the unit itself to which it is crowded.

The collection was made in a room (office/auditorium) in the 12 basic units of the municipality, where they were given the instrument for evaluation and monitoring of quali AB primary care services and asked to answer questions 86, 88 and 89 that dealt with the evaluation of violence against the elderly.

After applying the questions, the data were inserted into a computer spreadsheet of the Excel 2016 program. Subsequently, the chi-square test was applied to verify possible differences in the degree of quality of services between the BHU groups with and without MRPFCM. The significance level of $p<0,05$ or 5%, through the EPI INFO 3.2.2 program. The result of the quality of the services found was analyzed in contrast to the indicators recommended in the National Health Survey (NHS) Policy related to the Gold Standard of Quality of the SUS as well as other specialized literature on the theme.

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3. RESULTS AND DISCUSSION

The sample consisted of 107 health team employees, 61 from the BHU with Medical Residency (MR), and 46 from Medical Residency. Physicians, nurses, nursing technicians, and Community Health Agents (CHA) participated (Table 1).

It is possible to observe a greater number of CHA who participated in the research both in the BHU with MR and in the BHU without MR, probably due to the greater number of these servers in the primary health care network, when compared to the other professionals of the multidisciplinary team of the primary care networks being them, general practitioner or specialist in family and community health, generalist nurse or family health specialist, nursing technician or auxiliary and community health agents [11].

Another situation associated with this higher number of CHA in the participation of the research was about their appreciation for providing opportunities for their integration into the research, informing their routine in the units. CHA play an essential role in the integration between the health team and the community, thus putting into practice the effectiveness of the expanded concept of health [12].

Table 1. Distribution of the number and types of servers surveyed in the BHU teams

Professional category	BHU With MR*		BHU Without MR**		n. total by category	% total by category
	n.	%	n.	%		
Community Health Agent	45	73.77%	25	54.35%	70	65,42%
Nurse	7	11.47%	8	17.39%	15	14.02%
Nursing Technician	3	4.91%	6	13.04%	9	8.41%
Doctor	6	9.85%	7	15.22%	13	12.15%
Total	61		46		107	100%

Basic Health Unit With Medical Residency Basic Health Unit Without Medical Residency*

It is understood that the impact exerted by the BHU on the community is fundamental to improve the country's health indicators, acting through the guidelines and principles recommended by the unified health system (SUS), with an impact on the morbidity and mortality of the population. Thus, the MRPFCM through its commitment to health education and education has become a means of obtaining improvements in meeting the varied needs of the population by presenting itself as an alternative to localities with a high demand for care [13].

Question 86 of the QualiAB questionnaire deals with 18 (eighteen) items about the actions regularly developed in the BHU aimed at caring for the elderly, but only one item deals specifically with the actions scheduled for care to the elderly addressing the health problem in the identification and monitoring of "Situations of Violence against the Elderly", in this regard the perception of the interviewees was that there is a difference in care in units with and without MRPFCM (Table 2).

According to Table 2, the research showed that 63.04% of the BHU employees with MR reported that the unit in which they work offers actions aimed at identifying and monitoring cases of violence against the elderly. On the other hand, only 39,34% of health workers working in BHU without MR had the same perception.

This situation is addressed by the fact of the better qualification of health education that the MRPFCM brings to professionals for primary care, valuing care to hidden demand, which is very frequent in cases of violence. It is understood by hidden demand the delay or retention of information by the patient during the consultation, it is up to the doctor and the health team to perceive a situation that is often not expressed through words by the victim.19, a situation of eventual difficulty because most of these crimes come from very close family members and represent the point of support for the elderly [3].

It was demonstrated in a previous study conducted in Primary Care (PC), from a perspective and assistance to cases of violence against the elderly and other groups, that the difficulty involved in this context is due to the complexity of the problem since, in addition to the empowerment of local health teams for the proper execution of these cases, there is also the need for partnership with other institutions and the effective execution of intersectoral work such as social assistance [3].

According to Mascarenhas, [14] among the reasons described for underreporting, there is the difficulty of reporting domestic violence against the elderly; the unpreparedness of health professionals to better investigate cases, lack of training and knowledge of research protocols; the deficiency of infrastructure in care; and the fragility of support networks.

This difficulty in detecting violence against the elderly makes this phenomenon remain, most often hidden and neglected by society. Thus, health professionals must be increasingly prepared and trained to care for and face this problem in their work environment [15] .

Question 88 of the QualiAB questionnaire deals with seven items about the strategies used by the UBS to detect violence against the elderly, according to Table 3, in questions 1, 5 and 6, the perception of the interviewees was that they are better in the units with the MRPFCM.

According to Table 3 when evaluating the strategies used to detect violence against the elderly, it is observed in item 1 of the present study that 97,83% of the BHU with MR provide care with greater attention to this problem, using some type of protocol, to detect cases of violence, while only 22,95% of the BHU without MR offer this type of service with information in the format of well-defined protocols, which makes it difficult to detect cases of violence as well as their follow-up, problem-solving capacity, and prevention.

Table 2. Perception of health workers about the actions regularly developed in the BHU aimed at violence against the elderly in BHU with and without MRPFCM in Gurupi, Tocantins, Brazil, 2019

Item		BHU With MR*		BHU Without MR**		χ^2	*P*
		n	%	n	%		
Violence against the elderly	Yes	29	63.04%	24	39.34%	5.892	0.0152
	No	17	36.96%	37	60.66%		

Basic Health Unit With Medical Residency Basic Health Unit Without Medical Residency*

According to the Action Plan to Combat Violence Against the Elderly (APCVAE), to avoid the trivialization of the various forms of violence against the elderly in society, it is necessary to trigger an information process that contains the rights of the segment in the face of a case of this, and the development of simple actions with well-defined protocols that commit communities and the State to face and prevent any type of violence committed against people of this age group [16].

In item 2, the identification of physical and psychological symptoms/complaints was addressed, the present study demonstrated that 73,91% of the employees working in the BHU with MR and 73,77% of those working in BHU without MR use this strategy to identify cases of violence, and the numbers were similar for the item "listening to reports of other users and checking the case" with 73,91% of the professionals in the BHU with MR at 72,13% without MR. The elderly become more vulnerable to violence as they need greater care, mainly when they present physical or mental dependence, this causes a greater problem in the detection of violence, since the elderly may not be able to report it. Therefore, the health team must be aware of the signs of this problem [17].

According to Placideli, [18] the subdomain "Strategies and Actions in Situations of Violence against the Elderly", it can be affirmed that most services perform actions to detect violence through the declaration of the elderly (70,7%); listening to reports from other users (69,4%); identification of symptoms (68,1%); and home visits (59,8%) [18].

In item 4, it was showed that most professionals use the free declaration of the elderly as a strategy for detecting violence, with 73,91% in the BHU with MR and 63,93% of the employees working in the BHU without MR, a situation that can lead to underreporting of cases.

Violence against elderly people is present in several homes, is often hidden, not being revealed either by the victim himself, for various reasons, among them the embarrassment of the situation, the fear of punishment, the fear of being admitted to an asylum, the feeling of guilt in denouncing the aggressor, who most often is some member of his own family or the elderly not consider the phenomenon suffered as a form of violence, thus being difficult to detect the problem through the victim's free statement [19].

In item 5, it was observed that in the BHU with MR 71,74% of the surveyed servers use the discussion of the case as a team as a strategy for detecting violence against the elderly, which reminds us to think how important the MRPFCM is within the BHU for better integration of professionals, since in the BHU without MR only 49,18% of the servers use this strategy of interaction with the team for problem resolution. According to research conducted by Rocha et al. [20] the cases of abused elderly people, identified by PC professionals, required these strategies, such as home visits, dialogues and referrals as a way of coping and solving the problem.

In item 6 of this study, only 36,07% (n=22) of the employees working in the BHU without MR answered that they seek awareness and training to identify cases of violence against the elderly, on the other hand, 60,87% of the employees working in BHU with MR use this strategy as an ally, probably because with the implementation of the MRPFCM, training on various subjects becomes more frequent, resulting in professionals increasingly able to work with certain problems. The unpreparedness to deal with situations of family violence is related to the feeling of helplessness, which arises when the professional is faced with the issue and does not feel sufficiently qualified to approach and conduct it [21].

Among the attributions of the health team and PHC services, there is home care to people who need care at home, and the elderly are among the portion of the population that benefits most from this resource. Home care should involve health promotion, prevention, treatment of diseases, and rehabilitation that are provided at home [22]. The present study can verify through item 7 that both in BHU with or without MRPFCM, professionals recognize the importance of using the home visit strategy to detect new or suspected cases of violence in the elderly. The figures show 76,09% of the employees in BHU with MR and 77,05% of the servers working in BHU without MR use this strategy.

Table 4 presents the procedures performed in case of detection of violence against the elderly, and there were eight items, and in 3, 5, 6, and 8 the perception of the interviewees was that they are better in units with MRPFCM.

Table 3. Perception of health workers about the strategies used by the unit to detect violence against the elderly in UBS with and without MRPFCM in Gurupi, Tocantins, Brazil, 2019

Item		BHU With MR*		BHU Without MR**		χ^2	*p*
		n.	%	n.	%		
1. Service protocol	Yes	45	97.83%	14	22.95%	9.304	0.002
	No	1	2.17%	47	77.05%		
2. Identification of physical and psychological symptoms/complaints	Yes	34	73.91%	45	73.77%	0.0003	0.987
	No	12	26.09%	16	26.23%		
3. Listening to other users' reports and checking the case	Yes	34	73.91%	44	72.13%	0.0421	0.837
	No	12	26.09%	17	27.87%		
4. Free declaration of the elderly	Yes	34	73.91%	39	63.93%	1.2045	0.272
	No	12	26.09%	22	36.07%		
5. Team case discussion	Yes	33	71.74%	30	49.18%	5.5120	0.019
	No	13	28.26%	31	50.82%		
6. Awareness and training of the team to identify cases	Yes	28	60.87%	22	36.07%	6.4814	0.011
	No	18	39.13%	39	63.93%		
7. Home visit	Yes	35	76.09%	47	77.05%	0.0136	0.907
	No	11	23.91%	14	22.95%		

**Basic Health Unit With Medical Residency **Basic Health Unit Without Medical Residency*

Table 4. Perception of health workers about the procedures performed in case of detection of violence against the elderly in BHU with and without MRPFCM in Gurupi, Tocantins, Brazil, 2019

Item		BHU With MR *		BHU Without MR**		χ^2	*p*
		n.	%	n.	%		
1. Complaint to RCSA and SRCSA	Yes	32	69.57%	34	55.74%	2.1214	0.145
	No	14	30.43%	27	44.26%		
2. Report to DISQUE 100	Yes	5	10.87%	13	21.31%	2.0435	0.153
	No	41	89.13%	48	78.69%		
3. Care and follow-up of caregivers	Yes	28	60.87%	23	37.70%	5.6411	0,017
	No	18	39.13%	38	62.30%		
4. Complaint to the police authority	Yes	5	10.87%	10	16.39%	0.6639	0,415
	No	41	89.13%	51	83.61%		
5. Compulsory notification	Yes	28	60.87%	25	40.98%	4.1485	0,046
	No	18	39.13%	36	59.02%		
6. Interdisciplinary care with unit professionals	Yes	27	58.70%	20	32.79%	7.1469	0,007
	No	19	41.30%	41	67.21%		
7. Discussion with FHSC /support team	Yes	31	67.39%	39	63.93%	0.1385	0,710
	No	15	32.61%	22	36.07%		
8. Proposal for intersectoral follow-up	Yes	27	58.70%	19	31.15%	8.1202	0.004
	No	19	41.30%	42	68.85%		

**Basic Health Unit With Medical Residency **Basic Health Unit Without Medical Residency*

4. CONCLUSION

The Reference Center for Social Assistance (RCSA) is a basic social protection unit of the Unified Social Assistance System (USAS), which aims to avoid situations of vulnerability and social risks, through the expansion of access to citizenship rights and strengthening of bonds between family members and the community. It is characterized as the main gateway of USAS and facilitates the access of a large number of families to the social protection network of social assistance [23]. On the indicators of this area, the present work sought to interpret the perception of the appropriate procedures performed by health workers in case of detection of violence against the elderly, showed that in item 1 of Table 4, presented 69,57% of the

employees working in BHU with MR use the RCSA or SRCSA (Specialized Reference Center for Social Assistance) to denounce these acts and 55,74% of the BHU employees without MR also use them.

Dial 100 is a telephone number for reporting various types of crimes and human rights offenses, such as violence, neglect, prejudice against children, adolescents, the elderly, LGBT, people with disabilities, and other groups [24]. According to item 2, a small portion of the servers use this tool, only 10,87% in the BHU with MR and 21,31% in the BHU without MRPFCM.

This study questioned the perception of the servants regarding the care and follow-up of caregivers of elderly victims of violence. It was observed that in item 3, 60,87% of the employees working in the BHU with MR provide the care and accompany the caregivers of these patients to seek information about the aggressions, while in the BHU without MR only 37,70%. Caregivers should receive adequate guidance regarding the various forms of violence against the elderly and the ethical and legal implications linked to this problem and must be prepared psychologically and emotionally to deal with this part of the population that tends to grow and needs attention [25].

Regarding item 4, which refers to complaints made to law enforcement authorities, the data collected brought alarming numbers where only 10,87% of BHU employees with MR and 16,39% of the employees of the BHU without MR seek to report cases of violence against elderly patients to police officers. The monitoring of accidents and violence suffered by the elderly is provided for in Article 19 of the Statute of the elderly, which deals with the obligation of communication by health professionals, the police authority, the Public Prosecutor's Office and the Municipal, State and National Councils of the Elderly, of suspected or confirmed cases of ill-treatment against the elderly [26].

Violence against the elderly became the object of epidemiological surveillance in Brazil since 2006 through the implementation of the Surveillance and Accident System (SAS) [27]. Thus, in item 5, it presented data regarding compulsory notification of these types of cases, wherein the BHU with MR presented 60,87% makes the proper notification, in contrast in the BHU without MR only 40,98% make the immediate notification of cases of violence against the elderly.

In a study conducted by Wanderbroocke and Moré [3], with the professionals of a BHU, to describe the approach on family violence against the elderly, it was evidenced that the routine established for medical consultations favored the execution of interdisciplinary work, since the physician acts alone during their consultations, making it difficult both to detect and monitor these cases. According to Gusso [4], teamwork is a strategic organizational resource that contributes to achieving better results in tasks performed.

With the coming from the MRPFCM for some BHU in the municipality of Gurupi also improved the interdisciplinary service and the concern to work with a team where professionals from different health areas are located. Through this research, it was noted in item 6 that the BHU with MR offers interdisciplinary care to victims of violence over 60 years more frequent, about 58,70% responded positively, while in BHU without MR only 32,79% of the employees practice this type of care in these situations.

Similarly, in addition to interdisciplinary care, it is also important to interact with the FHSC (Family Health Support Center) for better progress of the case, it was observed in item 7 that 67,39% of the BHU employees with MR and 63,93% in the BHU without MR, present with this type of procedure when faced with cases of violence against the elderly. We highlight the need to establish an adequate articulation of the intersectoral network to meet both the practical aspects of coping with violence, such as attention to physical damage and the guarantee of rights and safety, as well as to offer support to the resulting suffering [28]. Item 8 presented data referring to this intersectoral follow-up, where it was positively presented in 58,70% of the BHU employees with MR and 31,15% of the BHU without MR.

CONSENT AND ETHICAL APPROVAL

The project was approved by the Research Ethics Committee of the University of Gurupi with opinion 2.255.519. The participants signed the Free and Informed Consent Form (FICF), strictly complying with Resolution Nº 466/2012 and 196/96 of the National Health Council.

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COMPETING INTERESTS

Authors have declared that no competing interests exist.

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