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Characterization of reported cases of interpersonal and self-inflicted violence

Caracterização dos casos notificados de violência interpessoal e autoprovocada

Caracterización de los casos notificados de violencia interpersonal y auto provocada

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This article aimed to characterize the reported cases of violence. This is a descriptive, cross-sectional study with a quantitative approach, carried out with data from the Information System of Health Problem Notifications, considering data from 2015, from the city of São José do Rio Preto, SP, Brazil. Tables were formulated considering as significant results of p <0.05, with a confidence level of 95%. There were 1,698 cases, from which 71.2% of the victims were female. Physical violence affected 54.4% and negligence 34.3%. People from 0 to 9 years of age were the victims in 81.9% of negligence cases, and 69% of them occurred at home. The mother, followed by the father, were the main aggressors in victims who were 0-9 years (68.8% and 31.4%) and 10-19 years (28.4% and 15%). A high incidence of self- inflicted violence was found (67.9%), (20-39-40) years or more. 84.2% and 61.8% of the 0-9 and of 10-19 age groups were sent to the Child Protection Agency, respectively. Between the ages of 20 and 39, the number of women attending a specialized service and the Women's Police Station was 44% and 52%, respectively. The research showed the articulation and organization that must exist between the support networks and other researches that highlight the issues of violence in each age group, for the elaboration of preventive and control actions.
Descriptors: Notification; Domestic violence; Child abuse; Violence against women; Elder abuse.

O artigo teve como objetivo caracterizar casos de notificações de violência. Este é um estudo quantitativo, com delineamento descritivo, de corte transversal, realizado com dados do Sistema de Informações de Agravos de Notificação, considerando dados do ano de 2015 da cidade de São José do Rio Preto, SP. Foram elaboradas tabelas considerando-se padrão de análise de significância de p<0,05, com nível de confiança de 95%. Houve registros de 1.698 casos, dos quais 71,2% das vítimas eram do sexo feminino. A violência física acometeu 54,4% e a negligência, 34,3%. A idade de 0-9 anos representou 81,9% da negligência, com maior ocorrência, 69%, na residência. A mãe, seguida do pai, foram os principais agressores nas idades de 0-9 anos (68,8% e 31,4%) e de 10-19 anos (28,4% e 15%). Alto grau de incidência da própria pessoa - autoprovocada (67,9%), (20-39-40) anos ou mais. Foram encaminhados para o Conselho Tutelar nas faixas etárias de 0-9 anos 84,2%, e na de 10-19 anos, 61,8%. Entre 20-39 anos, o foram para atendimento à mulher e Delegacia da Mulher em 44% e 52%, respectivamente. A pesquisa mostrou a necessária articulação e organização entre as redes de apoio e mais pesquisas destacando as questões das violências por ciclos de vida para elaboração de ações de prevenção e controle.
Descritores: Notificação; Violência doméstica; Maus-tratos Infantis; Violência contra a mulher; Maus-tratos ao idoso**.**

El artículo tuvo como objetivo caracterizar casos de notificaciones de violencia. Este es un estudio cuantitativo, con delineamiento descriptivo, de corte transversal, realizado con datos del Sistema de Informaciones de Agravamientos de Notificación, considerando datos del año 2015 de la ciudad de São José do Rio Preto, SP, Brasil. Fueron elaboradas tablas considerándose estándar de análisis de significancia de p<0,05 con nivel de confianza de 95%. Hubo registros de 1.698 casos, de los cuales 71,2% eran del sexo femenino. La violencia física afectó 54,4% y la de descuido 34,3%. La edad de 0-9 años representó 81,9% de la violencia de descuido, con mayor aparición en 69% en la residencia. La madre, seguida del padre fueron los principales agresores en las edades de 0-9 años (68,8%) y (31,4%) y, de 10-19 años (28,4%) y (15%). Alto grado de incidencia de la propia persona – auto provocada 67,9%), (20-39-40) años o más. Derivados al Consejo Tutelar en los grupos etarios de 0-9 años (84,2%), y 10-19 años (61,8%), y entre 20-39 años al atendimiento a la mujer y Comisaría de la Mujer en 44% y 52% respectivamente. La investigación mostró la necesaria articulación y organización entre las redes de apoyo y más investigaciones destacando las cuestiones de las violencias por ciclos de vida para la elaboración de acciones de prevención y control.
Descriptores: Notificación; Violencia doméstica; Maltrato a los niños; Violencia contra la mujer; Maltrato al anciano.

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INTRODUCTION

Violence has been identified as a relevant public health problem, and exists in any social environment[1]. Although its essence is obscure, one of the concepts used considers it as the use of physical force or authority, to act or put one under duress, and can be self-inflicted or directed at another person or social group, resulting or not in injury, death, moral damage, impaired development or privation of something[2].

Internationally, violence is one of the main causes of death in the 15 to 44 age group, and the rates of domestic violence are notorious, as it is considered to be the largest cause of injuries and deaths of women between 14 and 44 years[1]. In 2012, in Brazil, there was a total of 152,013 deaths from external causes, representing 12.9% of all causes of death in the country. A significant portion of these deaths are characterized by violence, 37% resulting from aggressions, that added to self-inflicted injuries and legal interventions include 44.3% of all deaths due to external causes, demonstrating a high frequency and making the Brazilian population vulnerable[3].

Analyzing the large social and economic impact generated by violence, mainly in the health sector, and considering that strategies based on the surveillance, prevention and health promotion are essential for the attempt to solve this issue, in 2006 the Ministry of Health, through its Department of Health Surveillance (SVS), established the Continuous Surveillance System of domestic, sexual and other types of violence, a branch of the Information System of Health Problem Notifications (VIVA/SINAN)[1,3,4].

Through the Information System of Health Problem Notifications (SINAN), the notification of cases of violence related to children, adolescents, women, elderly, and LGBT population is compulsory[4]. The obligation to notify complies with what is established by Laws n. 8.069/1990[5], the Statute of the Child and Adolescent, n. 10.778/2003, which establishes the Notification of Violence against Women[6], n. 10.741/2003[7], the Statute of the Elderly, and decree no. 2.836/2011, which establishes the mandatory notification of violence against the LGBT population [8].

The epidemiological surveillance of violence, in addition to collecting data that allows to describe these situations, can help to give support to actions, to create support networks for people who suffer from violence, and to ensure integral care, health promotion, and a culture of peace[4].

Although there are laws to fight against violence in Brazil, there are major gaps in the victim support network. Therefore, characterizing the cases of violence and showing the influencing variables can assist discussions for the improvement of public policies and can help organize the support network, as well as sensitize society's opinion about the importance of fighting violence.

There are countless cases of violence in the daily news, and with the political and economic crisis in the country, the vulnerability to these cases increases. There is no association between being assaulted and a specific class or age, neither is there a relation of these factors to those who practice self-inflicted violence.

In this context, and considering the relevance of the topic, this study proposes to characterize the cases violence notifications to corroborate actions of health surveillance and to elaborate strategic plans for promotion, prevention and control of cases of violence, in association to the support networks. Thus, this study aimed to characterize the reported cases of violence.

METHOD

This is a descriptive and cross-sectional study with a quantitative approach, using secondary data from the SINAN database from the Municipal Health Department (SMS) of São José do Rio Preto – SP, from January to December 2015, trough the reports of domestic, sexual and other interpersonal violence.

The variables studied were classified in relation to the victim, the types of violence, the possible aggressor and the referral of victims to support services. The collection considered the record made by the health professional who attended the suspected or confirmed the

case of violence. The following variables were analyzed:

(a) Victim characterization: gender (male and female); age (0 to 9, 10 to 19, 20 to 39, 40 years or more); skin color or race (white, black, others). Education (illiterate, incomplete elementary education, complete elementary education, others) place of occurrence (residence, others) and how many times the victim has suffered from violence (if only once or more);

(b) Types of violence: suspected or confirmed cases of self-harm; physical, psychological and sexual domestic violence, negligence; child violence and other types;

(c) Victim's relationship with the probable aggressor: father, mother, partner, own person, other;

(d) Referrals: if the victims of violence were sent to the support services of the municipality: Health Network, Social Assistance Network, Women's Care network, Child services and Women's police station.

From the data collected, a database was created with 1,698 records, subdivided into 74 variables that address clinical and socio-demographic data. Then, the variables relevant to this work (described above) were selected and age groups were created respecting the classification: 0-9 years, 10 to 19 years, 20 to 39 years, 40 years or more.

After this step, the information was submitted to two types of analysis: descriptive and inferential. In the descriptive step, the data collected was analyzed using absolute values (N) and their respective proportions (%). This data was subdivided into tables elaborated in Microsoft Excel® and edited in Microsoft Word® (2.016).

In the inferential step, a linear regression test was applied, which analyzes the existence of significant statistical dependence among the analyzed variables. This significance is calculated by analyzing the value of (p). If $p < 0.05$, there is evidence of statistical dependence among the variables. A 95% confidence level was considered for all cases.

This research followed the standards of the National Health Council 466/12, and all ethical aspects were respected. The data was used in secret and without individualization or identification of participants. The Ethics and Research Committee of the Faculty of Medicine of São José do Rio Preto approved the research under protocol number 1.723.984.

RESULTS

There were 1,698 reports of violence, from which 71% had female victims and 29%, male ones. Most cases took place among young adults (20 to 39 years), with different distributions when analyzed between the male and the female populations. For men, the most affected age group was 0 to 9 years in 52% of cases, followed by 10 to 19 years, with 29.4%. Among women, the highest proportion of violence was observed in the age group from 20 to 39 years with 84.7%, and in those aged 10 to 19 years, with 70.6%.

Violence against women occurred in 71% of cases, while in 29% of cases it was against men. The inferential analysis, considering the linear regression model, found a value of (p=0,00), to the left of the alpha-standard value, showing a tendency to statistical dependence between the age and gender variables.

Regarding race/color, those who claimed to be white represented 71%, followed by others with 17.4%. As for the educational levels, others (here representing complete and incomplete Secondary Education) were 60.9%, followed by incomplete elementary school with 39.1% in the 10 to 19 years of age group.

The residence was the place where violence occurred the most, with 68.9% of the cases, and 36.8% of the individuals suffered violence more than once. For both variables analyzed (race/color and educational level) the behavior of the p-value was identical, p=0,00, also proving the statistical dependency when considering the variable age group, according to Table 1.

Table 1. Sociodemographic characterization, place of occurrence and number of violence suffered. São José do Rio Preto, SP, 2015.

Information	0 to 9 years		10 to 19 years		20 to 39 years		40 years or more		Total		P-value
Gender	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Female	209	47.3	231	70.6	460	84.7	306	79.3	1206	71.0	
Male	233	52.7	96	29.4	83	15.3	80	20.7	492	29.0	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Race	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
White	288	65.2	215	65.7	403	74.2	298	77.2	1204	70.9	
Black	20	4.5	16	4.9	45	8.3	27	7.0	108	6.4	
Others	81	18.3	80	24.5	86	15.8	48	12.4	295	17.4	
Ignored	53	12.0	16	4.9	9	1.7	13	3.4	91	5.4	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Educational level	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Illiterate	1	0.2	1	0.3	1	0.2	5	1.3	8	0.5	
Elementary School Incomp.	3	0.7	128	39.1	71	13.1	54	14.0	256	15.1	
Elementary School Comp.	0	0.0	7	2.1	33	6.1	19	4.9	59	3.5	
Others	419	94.8	120	36.7	322	59.3	173	44.8	1034	60.9	
Ignored	19	4.3	71	21.7	116	21.4	135	35.0	341	20.1	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Place of occurrence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Residence	241	54.5	189	57.8	423	77.9	317	82.1	1170	68.9	
Ignored	18	4.1	16	4.9	22	4.1	8	2.1	64	3.8	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.049**
Other Times	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	83	18.8	95	29.1	259	47.7	188	48.7	625	36.8	
No	177	40.0	153	46.8	222	40.9	115	29.8	667	39.3	
Ignored	182	41.2	79	24.2	62	11.4	83	21.5	406	23.9	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.001**

The most reported form of violence was physical, with 54.4%, followed by negligence, with 34.3%, 24.6% of psychological violence cases, and the same, 24.6%, of self-inflicted violence cases. These types of violence were more frequent in the 20 to 39 age group, except for negligence, that was more prevalent in the 0 to 9 age group (81.9%), followed by physical violence (18.6%). These results show that children and adolescents are still being neglected and abandoned by their parents and/or caregivers (p=0.00). (Table 2).

As for the aggressors, the mother, followed by the father, were the main responsible in the age groups 0-9 (68.8% and 31.4% respectively) and 10-19 years (28.4% and 15% respectively).

Table 2. Violence by age group and type. São José do Rio Preto, SP, 2015.

Information	0 to 9 years		10 to 19 years		20 to 39 years		40 years or more		Total		P-Value
Injury Self-inflicted	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	2	0.5	95	29.1	199	36.6	121	31.3	417	24.6	
No	409	92.5	198	60.6	324	59.7	240	62.2	1171	69.0	
Ignored	31	7.0	34	10.4	20	3.7	25	6.5	110	6.5	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.817**
Physical Violence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	82	18.6	162	49.5	443	81.6	237	61.4	924	54.4	
No	349	79.0	160	48.9	100	18.4	141	36.5	750	44.2	
Ignored	11	2.5	5	1.5	0	0.0	8	2.1	24	1.4	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Psychological Violence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	41	9.3	61	18.7	205	37.8	110	28.5	417	24.6	
No	391	88.5	258	78.9	338	62.2	264	68.4	1251	73.7	
Ignored	10	2.3	8	2.4	0	0.0	12	3.1	30	1.8	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.227**
Sexual Violence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	52	11.8	63	19.3	43	7.9	10	2.6	168	9.9	
No	380	86.0	255	78.0	497	91.5	369	95.6	1501	88.4	
Ignored	10	2.3	9	2.8	3	0.6	7	1.8	29	1.7	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.550**
Violence by negligence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	362	81.9	113	34.6	7	1.3	100	25.9	582	34.3	
No	78	17.6	206	63.0	533	98.2	280	72.5	1097	64.6	
Ignored	2	0.5	8	2.4	3	0.6	6	1.6	19	1.1	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Child Violence	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	2	0.5	2	0.6	0	0.0	0	0.0	4	0.2	
No	430	97.3	316	96.6	540	99.4	379	98.2	1665	98.1	
Ignored	10	2.3	9	2.8	3	0.6	7	1.8	29	1.7	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.006**
Other Violences	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	25	5.7	37	11.3	102	18.8	53	13.7	217	12.8	
No	403	91.2	275	84.1	435	80.1	323	83.7	1436	84.6	
Ignored	14	3.2	15	4.6	6	1.1	10	2.6	45	2.7	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.047**

There was a high incidence of self-inflicted violence in the age groups 20 to 39 years (37.8%) and 40 years or more (32.9%), and in the age group 10 to 19 years of age (27.2%).

In the age groups 20 to 39 (25.4%) and 40 years or more (14.8%), a relative was the likely perpetrator of violence, with the mother appearing in first, followed by the father, and then the partner. In this context, considering the records of violence committed by a partner and the variable age group, there was evidence of statistic dependency (p=0,00), which was not true for cases of violence perpetrated by the father (p=0.16) (Table 3).

Table 3. Violence by age group and likely aggressor. São José do Rio Preto, SP, 2015.

Information	0 to 9 years		10 to 19 years		20 to 39 years		40 years or more		Total		Value p
Father	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	139	31.4	49	15.0	5	0.9	0	0.0	193	11.4	
No	286	64.7	268	82.0	530	97.6	374	96.9	1458	85.9	
Not applicable	17	3.8	10	3.1	8	1.5	12	3.1	47	2.8	
Ignored	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.160**
Mother	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	304	68.8	93	28.4	3	0.6	4	1.0	404	23.8	
No	130	29.4	227	69.4	532	98.0	371	96.1	1260	74.2	
Not applicable	8	1.8	7	2.1	8	1.5	11	2.8	34	2.0	
Ignored	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Partner	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	2	0.5	9	2.8	138	25.4	57	14.8	206	12.1	
No	429	97.1	310	94.8	398	73.3	316	81.9	1453	85.6	
Ignored	11	2.5	8	2.4	7	1.3	13	3.4	39	2.3	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Own Person	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	6	1.4	89	27.2	205	37.8	127	32.9	427	25.1	
No	425	96.2	232	70.9	334	61.5	250	64.8	1241	73.1	
Ignored	11	2.5	6	1.8	4	0.7	9	2.3	30	1.8	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.007**
Others	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	62	14.0	37	11.3	27	5.0	50	13.0	176	10.4	
No	368	83.3	280	85.6	505	93.0	324	83.9	1477	87.0	
Ignored	12	2.7	10	3.1	11	2.0	12	3.1	45	2.7	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.942**

A case can be referred to more than one service. The result was calculated, considering the 1,698 notifications. Source: SINAN/Epidemiological surveillance/SMS SJRP/SP.

84.2%, from 0 to 9 years old and 61.8% from 10 to 19 years old (children and adolescents), were sent mainly to the Child Protection Agency. As for the women, 44% from 20 to 39 years were referred to Women Care Services and, considering the age groups of 20 to 39 years and 40 years or more, 52% went to a Women's Police Station. In the inferential analyses, it was found that the reference to the Child Protection Agency was closely related to age group (p=0.00), according to the results shown in Table 4.

Table 4. Reported cases of violence, according to referenced service and age group. São José do Rio Preto, SP, 2015.

Information	0 to 9 years		10 to 19 years		20 to 39 years		40 years or more		Total		Value P
Health Network	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	28	6.3	56	17.1	74	13.6	33	8.5	191	11.2	
No	405	91.6	267	81.7	458	84.3	340	88.1	1470	86.6	
Ignored	9	2.0	4	1.2	11	2.0	13	3.4	37	2.2	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.143**
Social Assistance	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	10	2.3	18	5.5	44	8.1	59	15.3	131	7.7	
No	421	95.2	306	93.6	487	89.7	315	81.6	1529	90.0	
Ignored	11	2.5	3	0.9	12	2.2	12	3.1	38	2.2	
TOTAL	**442**	**100.0**	**327**	100.0	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Women's Service	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	5	1.1	29	8.9	239	44.0	140	36.3	413	24.3	
No	426	96.4	294	89.9	293	54.0	234	60.6	1247	73.4	
Ignored	11	2.5	4	1.2	11	2.0	12	3.1	38	2.2	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Child Protection Agency	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	372	84.2	202	61.8	8	1.5	5	1.3	587	34.6	
No	62	14.0	121	37.0	528	97.2	370	95.9	1081	63.7	
Ignored	8	1.8	4	1.2	7	1.3	11	2.8	30	1.8	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**
Women's police station	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**	
Yes	4	0.9	32	9.8	171	31.5	81	21.0	288	17.0	
No	427	96.6	291	89.0	366	67.4	294	76.2	1378	81.2	
Ignored	11	2.5	4	1.2	6	1.1	11	2.8	32	1.9	
TOTAL	**442**	**100.0**	**327**	**100.0**	**543**	**100.0**	**386**	**100.0**	**1698**	**100.0**	**0.000**

DISCUSSION

Violence against women is a subject that has attracted the attention of politicians, researchers, as well as the general society, due to the increasing number of cases. To improve this situation, initiatives and actions, performed around the world, demonstrate a growing trend in the recognition of the relevance of this form of violence as a problem and object of interventions of Public Health. The construction of the domestic violence is historically linked to the position that men and women should take in society. According to an androcentric culture legitimized by society, men assume the place of maximum authority, whether in the position of father or husband [9-11].

The post-traumatic syndrome, pointed out as a consequence of various forms of violence against women, is characterized as an acute phase of disorganization in the lifestyle of the injured person and her family, demanding a prolonged process of behavioral reorganization. The signs and symptoms camouflage a silence that demonstrates feelings of humiliation, shame and anger[12].

After the Maria da Penha National Law was sanctioned, the number of cases of women with demands for medical examination in the Medical-Legal Institute (IML) decreased considerably, raising

questions about whether the Law was strong enough to stop aggressors, or if it had contributed to silence women. Another hypothesis would be linked to the fact that many women have been taught to endure the oppression silently, in an attempt to keep an idealized concept of relationship or to ensure the balance, support and maintenance of the family[12,13].

Many victims seek alternatives to a formal report, such as the help of relatives, friends, and the church, and do nothing about the aggression they suffered, the main reason being the fear of the aggressor, followed by financial dependence and concern about raising children. However, the magnitude of the problem is much greater, since the silence of a high number of victims means that numerous cases are not reported, masking the epidemiological data[14-15].

Violence against women has been perpetuated throughout history. It has its origin in a family unit mediated and governed by the patriarch, in which men are granted the authority over women, giving them, in some cases, the possibility of being violent. The Maria da Penha Law restrains the incidence of domestic and family violence against women, but despite this legal tool, the number of female victims is growing[16-18].

In most cases, the woman is economically dependent on the aggressor, so it is common for them not to notify the aggression. The main reasons for the victims to silence themselves in the face of violence is the risk of punishment, economic dependence, loneliness, the idea that staying with the aggressor will be better for the children, family, gender or cultural prejudices and stereotypes[19].

The family is the basis of society, but in the context of violence, instead of offering support and security, it moves away from this responsibility and deprives children and adolescents of their rights, harming their development in the physical, social, behavioral, emotional, and cognitive dimensions. The main reasons for this type of violence are low family income, low level of education, poverty and lack of family planning[20].

In relation to adolescents, the physical violence practiced by parents is often related to behavioral changes of the children and to the weakness of affective bonds, which in these cases are fragile since childhood, generating apathy among parents and children in adolescence. The aggressor, in an attempt to discipline, uses physical force, making the child and adolescent the object of abuse[21].

In this study, the mother was the most frequent responsible for cases of negligence, physical violence, and abandonment. This may be related to the situation of postmodern society, in which there has been a significant increase in the number of women responsible for the family, generating a decrease in the quality of life and an increase in poverty.

In this context, it is expected that a bad life condition would translate, in addition to the neglect against children, into neglect and social violence experienced by women (mothers) whose personal and structural conditions do not allow to have a decent life for themselves and, consequently, cannot offer one to their children. Historically, women have been assigned the role of caretakers. Even when they take on work, domestic and child care are still their responsibility[22,23].

In Brazil, violence against children and adolescents is a relevant and still seldom researched problem. To understand this phenomenon on the various aspects associated, and allow appropriate prevention and intervention actions, researches on the theme of child violence are unanimous in highlighting the magnitude of the problem and the need for this reality to be known and recognized in its different nuances. Thus, it would be possible to obtain subsidies to make a comprehensive diagnoses about this social problem and to develop, propose and implement strategies for intervention and prevention of its occurrence and of their consequences[24].

It is of the utmost importance for strategies aimed at the family to be discussed and idealized as focus of interventions. International studies emphasize the relevance of the implementation of programs to combat

violence in childhood, focusing on activities that provide the improvement of skills for adulthood, such as strategies that promote the strengthening of the family relationship, excluding violence from relations[25,26].

Such factors may result in a reduction of the incidence of violence in adult life, mainly preventing future cycles of reproduction of violence against children, once a violent intra-family relation increases the likelihood of violent actions in childhood and in adult life[25, 26].

A study[27] that analyzed the perception of various professionals revealed a lack of training to deal with cases of violence against children and adolescents. In addition, the study also proved that the nurses of the paediatric units should assume a technical, scientific, social, political, and moral commitment in the care of children and adolescents who are victims of violence, in addition to fulfilling their role in training nursing auxiliaries and technicians regarding how to care for an affected children or young adult in a situation of physical abuse. Legislation knowledge and effective assistance make it possible to minimize underreporting, which masks the real situation of violence[27].

In this study, the person himself (70.7%), in the age group 20 to 39 years and 40 years or more, was the main perpetrator of the aggression. Analyzing the danger of self-inflicted violence tends to be a complex task, since they are planned actions that were not successful, and some attempts may not aim to successful. However, no case should be neglected, because of those who attempt against their own lives, from 20% to 30% try again, and from these, 10% result in death[15, 18].

Not all suicide cases can be prevented, but many lives would be saved if all those who attempt suicide were adequately addressed and treated. The impact of violence by a partner represents a three times higher risk of suicide among women who have suffered moderate physical violence, and an eight times higher risk among those who have experienced severe physical violence, compared to those who have not experienced physical violence[19, 28].

The importance of implementing public policies that fill in the gaps of the support networks for the reference of the victims of violence is remarkable, with a focus on qualification and better working conditions for the professionals, as well as for the users, in addition to strengthening the prospects of the network to ensure the follow-up of risk groups. The many types of aggression taint human rights, and confirm the importance of an efficient support network, with a focus on interdisciplinary and multidisciplinary teams, adding qualified professionals to recognize cases of violence, and to conduct the situation and/or refer the case, contributing significantly to the health-disease process of victims of violence[23,24].

Health professionals are identified as key components for the recognition of cases of violence, since the victims who experience it tend to seek the services due to the physical and psychological consequences. In addition to the recognition of cases, the professional should be empowered to work on gender issues and in the construction of autonomy, helping in the prevention of new cases. The increase in scientific productions can contribute to the recognition of strategies, limitations and potentials, aiming to reduce gender inequalities and the number of victims[15,29,30].

The intersectorality of actions and the formation of networks to assist people in situations of violence are indispensable for the conduction of actions to promote health and prevent injuries.

This characterization of cases of violence in the region researched is expected to encourage the notification and contribute to a wider dissemination of information, in addition to continuing with the process of articulation and organization among all the networks of support in the municipality, so that they can subsidize the elaboration of integrated and cross-sectoral public policies, addressing care guidelines by type of violence and age group, to effectively promote the health and quality of life of these victims.

CONCLUSION

The conclusion is that although reports of violence are being carried out in the surveyed region, they are fragmented. Only health networks, child care services and women's Health Reference Centers make notifications.

It is up to the government, together with the municipality, to propose that all support services participate in the notification of violence, and to propose measures, actions and ways to control these notifications, so that the epidemiological data of the municipality does not go underreported.

The results presented point to the need to continue the process of collaboration and organization between support networks, in addition to carrying out more researches on the problem, highlighting the issue of violence by age groups, for the elaboration of strategic plans, such as the care guideline, aimed at the prevention and control actions to improve the notification, the clarification, and the reception of the victims of interpersonal/self-inflicted violence.

REFERENCES

1. Dahlberg LL, Krug EG. Violência: um problema global de saúde pública. Ciênc Saúde Colet. [internet] 2007; [cited in 10 jul 2016]; 11(Suppl):1163-78. DOI: http://dx.doi.org/10.1590/S1413-81232006000500007

2. Krug EG, Dahlberg LL, Mercy JA, Zwi AB, Lozano R, editors. World report on violence and health [Internet]. Geneva: WHO; 2002 [cited in 10 jul 2016]. Available from: http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

3. Ministério da Saúde (Br). Saúde Brasil 2013: uma análise da situação de saúde e das doenças transmissíveis relacionadas à pobreza. Brasília, DF: Ministério da Saúde; 2014. 386p.

4. Ministério da Saúde (Br), Secretaria de Vigilância em Saúde. Viva: instrutivo notificação de violência interpessoal e autoprovocada. 2 ed. Brasília, DF: Ministério da Saúde; 2016. 92p.

5. Presidência da República (Brasil). Lei n. 8.069, de 13 de julho de 1990. Dispõe sobre o Estatuto da Criança e do Adolescente e dá outras providências. D.O.U., 16 jul 1990. Seção 1:1356.

6. Câmara dos Deputados (Brasil). Projeto de Lei 4.552-A, de 25 de fevereiro de 2016. Complementa a Lei n° 10.778, de 24 de novembro de 2003, que estabelece a notificação compulsória, no território nacional, do caso de violência contra a mulher que for atendida em serviços de saúde públicos ou privados [Internet]. Brasília, DF: Câmara dos Deputados; 2017 [cited in 20 may 2018]. Available from: http://www.camara.gov.br/proposicoesWeb/prop_mostrarintegra;jsessionid=907EC33223C7769CBCDED1326B0E3424.proposicoesWebExterno1?codteor=1580989&filename=Avulso+-PL+4552/2016

7. Presidência da República (Brasil). Lei nº 10.741, de 1º de outubro de 2003. Dispõe sobre o Estatuto do Idoso e dá outras providências [Internet]. D.O.U., Brasília, DF, 3 out 2003 [cited in 3 nov 2016]. Available from: http://www.planalto.gov.br/CCivil_03/leis/2003/L10.741.htm

8. Ministério da Saúde (Br). Portaria n. 2.836, de 1º de dezembro de 2011. Institui, no âmbito do Sistema Único de Saúde (SUS), a Política Nacional de Saúde Integral de Lésbicas, Gays, Bissexuais, Travestis e Transexuais [Internet]. Brasília, DF: Ministério da Saúde; 2011 [cited in 10 jul 2016]. Available from: http://bvsms.saude.gov.br/bvs/saudelegis/gm/2011/prt2836_01_12_2011.html

9. Vieira EM, Perdona GSC, Santos MA. Fatores associados à violência física por parceiro íntimo em usuárias de serviços de saúde. Rev Saúde Pública [Internet]. 2011 [cited in 04 may 2018]; 45(4):730-7. DOI: http://dx.doi.org/10.1590/S0034-89102011005000034

10. Duarte MC, Fonseca RMGS, Souza V, Pena ED. Gênero e violência contra a mulher na literatura de enfermagem: uma revisão. Rev Bras Enferm. [Internet]. 2015 [cited in 04 may 2018]; 68(2):325-32. DOI: http://dx.doi.org/10.1590/0034-7167.2015680220i

11. Lindner SR, Coelho EBS, Bolsoni CC, Rojas PF, Boing AF. Prevalência de violência física por parceiro íntimo em homens e mulheres de Florianópolis, Santa Catarina, Brasil: estudo de base populacional. Cad Saúde Pública [Internet]. 2015 [cited in 04 may 2018]; 31(4):815-26. DOI: http://dx.doi.org/10.1590/0102-311X00159913

12. Martín-Baena D, Montero-Piñar I, Escribà-Agüir V, Vives-Cases C. Violence against young women attending primary care services in Spain: prevalence and health consequences.

Fam Pract. [Internet]. 2015 [cited in 10 jul 2018]; 32(4):381-6. DOI: https://doi.org/10.1093/fampra/cmv017
13. Acosta DF, Gomes VLO, Fonseca AD, Gomes GC. Violência contra a mulher por parceiro íntimo: (in)visibilidade do problema. Texto & Contexto Enferm. [Internet] 2015 [cited in 10 sep 2016]; 24(1):121-7. DOI: http://dx.doi.org/10.1590/0104-07072015001770013
14. Garcia LP, Duarte EC, Freitas LRS, Silva GDM. Violência doméstica e familiar contra a mulher: estudo de casos e controles com vítimas atendidas em serviços de urgência e emergência. Cad Saúde Pública [Internet]. 2016 [cited in 10 sep 2016]; 32(4): e00011415. DOI: http://dx.doi.org/10.1590/0102-311X00011415
15. Souza MJ, Silva JP, Barros LA, France AMB, Moura MRW. Caracterização dos casos de violência sexual contra a mulher em uma unidade de referência. Ciênc Biol Saúde [Internet]. 2014 [cited in 10 sep 2016]; 2(1):177-92. Available from: https://periodicos.set.edu.br/index.php/fitsbiosaude/article/view/1367/773
16. Presidência da República (Brasil). Lei nº 11.340, de 7 de Agosto de 2006. Cria mecanismos para coibir a violência doméstica e familiar contra a mulher, nos termos do § 8º do art. 226 da Constituição Federal, da Convenção sobre a Eliminação de Todas as Formas de Discriminação contra as Mulheres e da Convenção Interamericana para Prevenir, Punir e Erradicar a Violência contra a Mulher; dispõe sobre a criação dos Juizados de Violência Doméstica e Familiar contra a Mulher; altera o Código de Processo Penal, o Código Penal e a Lei de Execução Penal; e dá outras providências [Internet]. D.O.U., Brasília, DF, 8 ago 2006 [cited in 10 sep 2016]. Available from: www.planalto.gov.br/ccivil_03/_ato2004-2006/2006/lei/l11340.htm
17. Adeodato VG, Carvalho RR, Siqueira VR, Souza FGM. Qualidade de vida e depressão em mulheres vítimas de seus parceiros. Rev Saúde Publica [Internet]. 2005 [cited in 19 sep 2016]; 39(1):108-13. doi: http://dx.doi.org/10.1590/S0034-89102005000100014
18. Sinimbu RB, Mascarenhas MDM, Silva MMA, Carvalho MGO, Santos MR, Freitas MG. Caracterização das vítimas de violência doméstica, sexual e/ou outras violências no Brasil 2014. Saúde Foco [Internet]. 2016 [cited in 10 set 2016]; 1(1):[1-14]. Available from: https://smsrio.org/revista/index.php/revsf/article/view/199/178
19. Silva LEL, Oliveira MLC. Características epidemiológicas da violência contra a mulher no Distrito Federal, 2009 a 2012. Epidemiol Serv Saúde [Internet]. 2016 [cited in 19 sep 2016]; 25(2):331-42. Available from: http://www.scielo.br/pdf/ress/v25n2/2237-9622-ress-25-02-00331.pdf
20. Zanelatto PF, Medeiros M, Santos WS, Bouttelet MD. Violência contra crianças e adolescentes: significados e atitudes por equipes da estratégia saúde da família. Ciênc Enferm. [Internet]. 2012 [cited in 10 jul 2016]; 18(2):41-9. DOI: http: / / dx.it hurts.org / 10.4067 / S0717-95532012000200005
21. Trabbold VLM, Caleiro RCL, Cunha CF, Guerra AMC. Concepções sobre adolescentes em situação de violência sexual. Psicol Soc. [Internet]. 2016 [cited in 10 sep 2016]; 28(1):74-83. DOI: http: / / dx.it hurts.org/10.1590/1807-03102015v28n1p074
22. Oliveira EM, Felix TA, Mendonça CBL, Lima PSF, Freire AS, Moreira RMM. Aspectos epidemiológicos e o cuidado de enfermagem na tentativa de suicídio. Rev Enferm Contemp. [Internet]. 2016 [cited in 10 sep 2016]; 5(2):184-92. DOI: http://dx.doi.org/10.17267/2317-3378rec.v5i2.967
23. Almeida SA, Guedes PMM, Nogueira JA, França UM, Silva ACO. Investigação de risco para tentativa de suicídio em hospital de João Pessoa - PB. Rev Eletrônica Enferm. [Internet]. 2009 [cited in 10 sep 2016]; 11(2):383-9. Available from: http://www.fen.ufg.br/revista/v11/n2/v11n2a20.htm
24. Ferreira DLM, Soler ZASG. O que tem sido divulgado em periódicos científicos online no Brasil sobre violência contra crianças e adolescentes. Enferm Brasil. 2013; 12(2):112-9.
25. Freitas RJM, Moura NA, Monteiro ARM. Violência contra crianças/adolescentes em sofrimento psíquico e cuidado de enfermagem: reflexões da fenomenologia social. Rev Gaúch Enferm. [Internet]. 2016 [cited in 19 sep 2016]; 37(1):e52887. DOI: http://dx.doi.org/10.1590/1983-1447.2016.01.52887

26. Apostólico MR, Nóbrega CR, Guedes RN, Fonseca RMGS, Egry EY. Characteristics of violence against children in a Brazilian Capital. Rev Latinoam Enferm. [Internet]. 2012 [cited in 10 jul 2016]; 20(2):266-73. DOI: http://dx.doi.org/10.1590/S0104-11692012000200008

27. Pinto EC, Ferreira DLM, Soler ZASG. Physical abuse against children and teens: perception of pediatric nursing team. Rev Enferm UFPE on line. [Internet]. 2013 [cited in 04 may 2018]; 7(6):4411-20. Available from: https://periodicos.ufpe.br/revistas/revistaenfermagem/article/view/11681

28. Almeida LCG, Diniz NMMF. Violência sexual: desvelando a realidade que acomete as mulheres. Rev Enferm UERJ. [Internet]. 2004 [cited in 04 may 2018]; 12(1):88-94. Available from: http://www.facenf.uerj.br/v12n1/v12n1a15.pdf

29. Garcia LP, Freitas LRS, Höfelmann DA. Avaliação do impacto da Lei Maria da Penha sobre a mortalidade de mulheres por agressões no Brasil, 2001-2011. Epidemiol Serv Saúde [Internet]. 2013 [cited in 04 may 2018]; 22(3):383-94. Available from: http://scielo.iec.gov.br/pdf/ess/v22n3/v22n3a03.pdf

30. Signorelli MC, Taft A, Pereira PPG. Intimate partner violence against women and healthcare in Australia: charting the scene. Ciênc Saúde Colet. [Internet]. 2012 [cited in 04 may 2018]; 17(4):1037-48. DOI: http://dx.doi.org/10.1590/S1413-81232012000400025

CONTRIBUTIONS

Ana Lígia Fernandes Reis and **Gabriela Martins Espolador** carried out the data and reference collection. **Sônia Aparecida da Cruz Oliveira** collaborated in the design and revision of the study, in the interpretation of the data and discussion. **Alexander Lins Werneck** participated in the discussion and critical review.

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