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Aggressions in urgency and emergency care in Brazilian capitals: perspectives of 2011, 2014 and 2017 VIVA Survey

Agressões nos atendimentos de urgência e emergência em capitais do Brasil: perspectivas do VIVA Inquérito 2011, 2014 e 2017

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ABSTRACT: ***Objectives:*** To describe the profile of care provided by aggressions in emergency units from the VIVA Survey 2011, 2014 and 2017 data, and to compare the evolution of six indicators over four (2011 to 2014) and seven years (2011 to 2017). ***Methods:*** Cross-sectional study, using data from the last three editions of the VIVA Survey carried out in the Federal District and in 19 Brazilian capitals. The types of occurrence were selected: aggression/mistreatment and intervention by a public agent. The weighted frequencies of the characteristics of the people assisted, of the aggressions, injuries and evolution of the cases were calculated, according to sex. Differences between proportions were compared using the χ^2 Test. Six indicators were also selected and their evolution over the years was evaluated by means of the percentage variation and the 95% confidence interval. ***Results:*** In most cases of aggression, the individuals were black, young and adult, of both sexes. The main nature of the assaults was physical, reaching over 85% in all investigations, followed by negligence. In the comparison between 2011 and 2017, "neglect" aggressions had a significant increase in both sexes and in children and the elderly; aggressions of a "sexual" nature had a significant increase only in children. ***Conclusions:*** The VIVA Survey is an important tool for Brazil's Violence and Accident Surveillance System, providing evidence for public health decision-making and for coping with and preventing violence.

Keywords: Violence. Health surveys. Emergency care. Wounds and injuries.

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RESUMO: ***Objetivos:*** Descrever o perfil dos atendimentos por agressões em unidades de urgência e emergência com base nos dados do Inquérito de Violências e Acidentes em Serviços Sentinela de Urgência e Emergência (VIVA Inquérito) 2011, 2014 e 2017 e comparar a evolução de seis indicadores ao longo de quatro (2011 a 2014) e sete anos (2011 a 2017). ***Métodos:*** Estudo transversal, com dados das três últimas edições do VIVA Inquérito realizadas no Distrito Federal e em 19 capitais do Brasil. Foram selecionados os tipos de ocorrência: agressão/maus-tratos e intervenção por agente público. Calcularam-se as frequências ponderadas das características das pessoas atendidas, das agressões, das lesões e da evolução dos casos, segundo o sexo. As diferenças entre as proporções foram comparadas pelo teste χ^2. Também foram selecionados seis indicadores, e avaliou-se sua evolução ao longo dos anos por meio da variação percentual e do intervalo de confiança a 95%. ***Resultados:*** Em grande parte dos atendimentos por agressão, os indivíduos eram negros, jovens e adultos, em ambos os sexos. A principal natureza das agressões foi física, alcançando mais de 85% em todos os inquéritos, seguida da negligência. Na comparação entre 2011 e 2017, as agressões de natureza negligência tiveram aumento significativo em ambos os sexos e em crianças e idosos; já as agressões de natureza sexual tiveram aumento significativo apenas em crianças. *Conclusões:* O VIVA Inquérito é uma importante ferramenta para o Sistema de Vigilância de Violências e Acidentes do Brasil, proporcionando evidências para a tomada de decisões em Saúde Coletiva e para o enfrentamento e a prevenção das violências.

Palavras-chave: Violência. Inquéritos epidemiológicos. Serviços médicos de emergência. Ferimentos e lesões.

INTRODUCTION

Violence is considered as a social problem that has been part of humanity since its early days. In the public health field, violence causes important impacts regarding morbidity and mortality, affecting people in different stages of life. It is a major cause of death, injuries, complications and disability, mainly among young people[1-3].

According to estimations from the World Health Organization, violence leads to more than 1.5 million deaths every year, besides causing non-fatal wounds. In general, violence is among the main causes of death for people aged between 15 to 44 years[4].

In terms of magnitude, in Brazil, only in 2017, 65,602 deaths by murder were registered, corresponding to the rate of 31.6 deaths/100,000 residents, and representing a 21% increase in relation to the rate in 2007[5]. Younger men were the main victims (59.1% of the homicides targeted men aged between 15 and 19 years), with relevant emphasis on specific populations, such as black, lesbian, gay, bisexual, transvestite and transgender populations, and women[5].

According to estimations from the Institute for Health Metrics and Evaluation[6], and its own method for correcting the data from the Mortality Information System, in Brazil, external causes were responsible for 14.2% of the deaths in 2000, and for 12.3% in 2017; the first reason was violence, with 6.5% in 2000, and 5.8% in 2017. In the same period, the loss of years of life due to premature death and disability caused by violence increased from 6.8% (2000) to 7.1% (2017)[6].

When not leading to death, aggressions can cause severe injuries that require health care. In Brazil, only in 2017, 52,359 hospital admissions were registered caused by violence in the hospitals of the Unified Health System (SUS), and most of them among men (84.8%), and people aged between 20 and 29 years (53.5%)[7]. In this sense, urgency and emergency services are the main gateway for victims of aggression in the public health system. As stated by Deslandes[8], the emergency room is the destination of victims with injuries, or even in the imminence of death; care provided by these services is an undeniable indicator of violence in a city.

Internationally, all Member States of the United Nations have committed to the Sustainable Development Goals (SDG), which compose the 2030 Agenda and reflect, especially in goals 5 and 16, the concern about gender equality and the construction of peaceful societies. In this sense, the SDGs propose to eliminate gender-based violence and significantly reduce all forms of violence[9].

In 2006, Brazil implemented the Violence and Accidents Survey (VIVA), in the survey and continuous surveillance modalities, whose objective is to analyze the violence and accidents' tendencies and describe the profile of care in health services[10]. The Violence and Accidents Survey Conducted in Brazilian Sentinel Emergency Departments (VIVA Survey) aims at identifying the epidemiological profile and the risk factors related to violence and accidents in the emergency units participating in the study[11,12], in order to enlighten the circumstances of these events, the assisted people and the aggressors.

So, The VIVA Survey can contribute, throughout the survey years, with the control of indicators related to the notification of violence, considering the indicators proposed to monitor the SDGs, supporting the planning of public policies of health prevention and promotion[12].

The objective of this study was to describe the profile of people assisted for aggressions in emergency units in 2011, 2014 and 2017, as well as the notifications, injuries and evolution of care. Additionally, it compared the evolution of six indicators throughout four (2011 to 2014) and seven years (2011 to 2017) of the surveys.

METHODS

Cross-sectional study using data from the VIVA Survey, carried out by the Municipal Secretariats of Health in the selected capitals and cities, supported by the State Secretariats and the Ministry of Health (MH)[10,11]. The VIVA Survey is a sentinel surveillance instrument in the scope of VIVA.

The population of the VIVA Survey[11,12] was composed of people assisted for violence and accidents (external causes) who looked for urgency and emergency services selected in the scope of SUS. The data were collected through a form that was standardized by the MH, which included sociodemographic data of the patients, data about the event (characteristics of the aggression and injuries), and evolution of care. The study lasted for 30 consecutive days, in randomly selected shifts.

For this article, we consider the types of aggression/mistreatments (codes X85 to Y09 in the 10th edition of the International Statistical Classification of Diseases and Related Health Problems) and intervention by a public agent (codes X35 to Y36) in the surveys of 2011 and 2014[11,12]. In the 2017 survey, these two categories were aggregated in a single type of notification: aggression/mistreatments/intervention by a public agent (codes X85 to Y09 and X35 to Y36). The surveys carried out in these three years were selected because the variable nature of aggression allows the comparison. The data included the Federal District (DF) and 19 capitals that participated in the three editions of the study: Aracaju (SE), Belém (PA), Belo Horizonte (MG), Boa Vista (RR), Campo Grande (MS), Curitiba (PR), Fortaleza (CE), Goiânia (GO), João Pessoa (PB), Maceió (AL), Natal (RN), Palmas (TO), Porto Velho (RO), Rio Branco (AC), Rio de Janeiro (RJ), Salvador (BA), São Luís (MA), Teresina (PI) e Vitória (ES).

Since the data come from complex sampling plans, the use of sample weights is necessary to analyze the capitals as a group. Therefore, for the three editions of VIVA Survey, we calculated the weighted frequencies for the following variables, according to sex (female and male):

- Characteristics of the assisted people: ethnicity/color, age group, schooling, alcohol consumption, vulnerability (gypsy, quilombola, villager, homless people, people deprived of liberty, population from the countryside, forest, and water and others)a nd disabilities;
- Characteristics of the aggression: nature of the aggression, means of aggression and relation to the possible aggressor;
- Injuries and evolution of cases: nature of the injury, affected body part and evolution.

The differences between the proportions, according to sex, were compared using the χ^2 test, considering 0.05 as significant.

For controlling the notifications of aggression in the three editions of the Viva Survey, the following indicators were selected:

- Sexual violence: percentage of care caused by sexual violence in relation to the total number of care services due to aggression;
- Physical violence: percentage of care caused by physical violence in the total number of care services due to aggression;
- Negligence: percentage of care caused by negligence in the total number of care services due to aggression;
- Intrafamily violence: percentage of care whose probable author of the aggression was the father/mother and other relative in the total number of care services due to aggression;
- Intimate partner violence: percentage of care whose probable author of the aggression was the partner/ex in the total number of care services due to aggression;
- Violence by na unknown person: perentage of care whose probable author of the aggression was unknown in the total number of care services due to aggression.

The evolution of these indicators was assessed using the percentage variation in the period of four (2011 to 2014) and seven years (2011 to 2017), with 95% confidence interval.

The VIVA Survey was approved by the National Ethics Research Commission in the Ministry of Health, Opinions n. 2.234.509,23/8/2017 — Certificate of Presentation for Ethical Consideration: 67709417.0.0000.0008 (2017), n. 735.933/2014 (2014) and n. 006/2011 (2011).

RESULTS

In 2011, 2014 and 2017, in the Federal District and in the 19 capitals that adopted the VIVA Survey, 3,363, 3,489 and 2,902 people were assisted with the type of notification of aggression/mistreatments/legal intervention, respectively. The male gender was the most frequent, representing 74.09, 71.41 and 71.65% of the care services in 2011, 2014 and 2017, respectively. Ethnicity/color black (black and brown) was prevalent among individuals of both genders, in all editions of the study, corresponding, in 2017, to 77.5% of the men and 72.6% of the women. The main age group of the affected people was young (15 to 29 years), in the surveys of 2011 and 2014, and adults (30 to 59 years) in the 2017 edition. The percentage of care caused by aggression in the extreme life cycles were lower; however, among children, girls underwent aggressions more often in all analyzed years, reaching the double of the percentage among boys in 2017 (Table 1). A small part of the assisted people had a university degree (maximum of 8.2% in 2017, among women; maximum of 5.7% in 2014, among men), and the assisted women presented higher schooling levels in comparison to men, especially after high school (lower percentage in 2014, being 35.6% among women, and 30.0% among men). In all editions, the percentage of referred consumption of alcohol by the victim was higher among men (minimum of 39.1% in 2017) in comparison to women (minimum of 20.9% in 2014). In 2017, the percentage levels of vulnerable populations and people with disabilities were higher among men (7.9% and 5.1%, respectively); and among women, 3.3 and 3.9%, respectively.

The main nature of the aggressions was physical, reaching more than 85% among female individuals, and more than 95% among male individuals, in all surveys. Among women, negligence also stood out, whose percentage levels reached 7.0%, in 2014, and 6.6%, in 2017. For both genders, the main mean of aggression was physical strength and beating, with higher percentage levels among women, followed by sharp objects. Among men, firearms represented the third most expressive mean of violence perpetration, and, among women, blunt objects held this position. In aggressions against men, the main authors were unknown people, followed by friends, in all editions of the survey; among women, the main authors were current or previous intimate partners, followed by unknown people in the surveys of 2011 and 2014, and friends in 2017 (Table 1).

Cuts and lacerations were the most common injuries found in care services caused by aggression in both genders in the three editions of the survey (minimum of 36.8%

Table 1. Number and percentage of care services due to aggression according to the profile of the assisted people, of the events and the evolution of care in the three editions of the VIVA Survey. Federal District and 19 capitals, 2011, 2014 and 2017.

Variables	2011					2014					2017				
	Male		Female		p	Male		Female		p	Male		Female		p
	n	%*	n	%*		n	%*	n	%*		n	%*	n	%*	
Ethnicity/color															
White	442	19.37	212	26.41	< 0.01	460	21.31	232	29.25	< 0.01	356	20.38	156	24.89	0.01
Black	449	17.19	144	16.81		527	21.47	159	16.60		426	22.78	124	16.37	
Brown	1,534	61.35	504	54.58		1,513	55.11	528	51.70		1,205	54.70	450	56.25	
Yellow/Indigenous	58	2.09	23	2.20		64	2.10	30	2.45		55	2.14	19	2.49	
Age															
0 to 14	193	7.61	110	12.71	< 0.01	285	11.58	175	17.79	< 0.01	194	9.11	140	18.70	< 0.01
15 to 29	1,210	49.88	388	42.00		1,180	45.11	389	40.79		913	43.42	284	35.26	
30 to 59	997	39.92	352	41.89		1,031	40.58	352	37.86		936	44.01	320	41.61	
60+	61	2.59	30	3.41		64	2.73	35	3.56		67	3.46	38	4.43	
Nature of the aggression															
Physical	2,460	98.99	836	96.34	< 0.01	2,402	95.18	801	85.61	< 0.01	2,016	96.19	690	88.39	< 0.01
Negligence	12	0.23	12	1.09		100	4.16	66	7.02		59	2.64	52	6.58	
Other**	18	0.78	35	2.57		19	0.66	57	7.37		32	1.17	37	5.03	
Mean of aggression															
Physical/beating	981	39.61	501	59.28	< 0.01	906	38.98	518	57.87	< 0.01	832	43.42	436	60.53	< 0.01

Continue...

Table 1. Continuation.

Variables	2011					2014					2017				
	Male		Female		p	Male		Female		p	Male		Female		p
	n	%*	n	%*		n	%*	n	%*		n	%*	n	%*	
Firearm	433	19.29	55	7.69	< 0.01	572	21.27	63	6.81	< 0.01	414	17.66	40	3.85	< 0.01
Sharp object	699	26.65	174	17.58		636	21.81	146	11.88		492	21.01	120	13.13	
Blunt object	313	12.74	97	10.61		293	11.58	98	10.56		233	12.30	69	9.87	
Other***	55	1.71	53	4.84		158	6.36	114	12.88		124	5.61	105	12.62	
Aggressor															
Relative	245	9.56	162	18.17	< 0.01	302	12.51	198	20.80	< 0.01	230	11.05	159	19.62	< 0.01
Current/ex partner	112	3.96	271	30.58		125	5.55	277	28.83		133	6.98	234	32.28	
Friend	772	32.75	212	23.67		663	27.35	196	19.44		524	26.40	184	26.29	
Unknown person	1,117	48.32	194	24.55		1,200	48.31	223	25.84		916	47.85	151	19.52	
Other****	123	5.41	22	3.04		154	6.27	40	5.09		152	7.71	19	2.28	
Evolution															
Discharge	1,469	59.50	619	70.35	<0.01	1,467	57.73	659	73.22	< 0.01	1.179	60.95	557	76.07	< 0.01
Hospitalization	598	25.91	96	12.86		630	26.18	124	13.14		591	26.15	88	10.41	
Referral to another service	301	11.23	124	13.48		323	12.35	126	12.11		197	8.51	81	8.27	
Evasion or Death	80	3.35	29	3.31		83	3.73	16	1.53		79	4.40	29	5.25	

Source: Health Surveillance Secretariat/Ministry of Health.
*Weighted frequency; **this category included: psychological, sexual and other types of violence; ***this category included: poisoning, threat, hot substance/object and other means of aggression; ****this category included: legal agent and other connections.

among women, and 49.3% among men, in 2017). In second came trauma, among men, and bruises, sprains and dislocations among women. The mostly affected body parts were head/neck and upper limbs in both genders (59.1% or more among women; 55.6% or more among men). In the evolution of cases, for both genders, discharge was the main outcome, and hospitalization, the second; among men, the percentage levels of hospitalization were always higher than those of women, reaching 26.2% of the cases n 2017 (Table 1).

In the analysis of the indicators related to the nature of aggression, it was observed that (Table 2):

- Physical violence was the most frequent in the three editions of the survey. These cases decreased for both genders in the period of 2011 to 2017, mainly among women (8.0%). All age groups showed reduction in these cases from 2011 to 2014. The comparison between 2011 and 2017 showed significant reduction in physical violence, from 29.2% among children, and 13.2% among the elderly;
- Negligence was the second most prevalent nature of aggression in the care services shown in the three editions of the survey, higher among female individuals. In both periods (2011-2014 and 2011-2017), there was positive and significant percentage variation in services provided due to negligence among men, women, children and the elderly, emphasizing the increment of 23.8% in care addressed to women, and 7.5% to the elderly from 2011 to 2017;
- The care services directed at cases of sexula violence in the three editions of the study were more common among female individuals, with significant increase of 3.1% between 2011 and 2014. Between 2011 and 2017, there was a significant increase of 5.7% in cases of sexual violence in the age group of 0 to 14 years.

The analysis of indicators related to the connection between the aggressor and the victim showed that (data not shown in tables):

- The aggressions perpetrated by relatives were more common among female individuals in the three editions of the study, reaching 19.6% in 2017. Among male individuals, there was significant increase, of 2.9%, between 2011 and 2014. The highest percentage levels of these cases occurred among children and the elderly in the three analyzed years; the comparison between 2011 and 2014, and 2011-2017 shows expressive increase, of more than 20%, among children;
- The care services addressed to aggressions perpetrated by intimate partners were more common among female individuals in the three editions of the study, reaching 31.6% in 2017. Among male individuals, there was significant increase od 2.8% between 2011 and 2017. The highest percentage levels of these services were found among young people and adults in the three studied years, and in the comparison between 2011 and 2017 there was an expressive increase of 3.9% among young people;
- The care services addressed to aggressions perpetrated by unknown people affected mainly male individuals in the three editions of the study, reaching 47.9% in 2017.

However, for both genders, the percentage remained stable. The highest percentage levels of these services occurred among young people and adults in the three analyzed years, and in comparison to 2011 and 2017, there was significant reduction of 6.3% among children.

Table 2. Indicators related to the nature of aggression, according to sex and age group, in the three editions of the VIVA Survey. Federal District and 19 capitals, 2011, 2014 and 2017*.

Indicator	Variable	Year			2011–2014		2011–2017	
		2011	2014	2017				
		%	%	%	Variation (%)	95%CI	Variation (%)	95%CI
Sexual violence	Sex							
	Male	0.23	0.33	0.45	0.10	(-0.24; 0.44)	0.22	(-0.11; 0.55)
	Female	1.36	4.47	2.81	3.11	(1.13; 5.08)	1.45	(-0.57; 3.47)
	Age group							
	0 to 14	2.37	5.38	8.02	3.01	(-0.08; 6.10)	5.65	(0.95; 10.35)
Physical violence	Sex							
	Male	98.99	95.18	96.19	-3.81	(-5.10; -2.52)	-2.80	(-3.90; -1.70)
	Female	96.34	85.61	88.39	-10.73	(-13.86; 7.60)	-7.95	(-12.04; -3.87)
	Age group							
	0 to 14	91.90	58.63	62.73	-33.27	(-40.63; -25.91)	-29.17	(-37.82; -20.53)
	15 to 29	98.55	98.13	98.89	-0.41	(-2.33; -0.29)	0.34	(-0.57; 1.26)
	30 to 59	99.31	98.05	98.67	-1.26	(-2.23; -0.29)	-0.64	(-1.43; 0.07)
	60+	97.17	85.08	83.95	-12.09	(-20.76; -3.42)	-13.22	(-20.94; -5.52)
Negligence	Sex							
	Male	0.23	4.16	2.64	3.93	(2.81; 5.06)	2.41	(1.52; 3.30)
	Female	1.09	7.02	6.58	5.93	(3.69; 8.17)	5.49	(2.46; 8.52)
	Age group							
	0 to 14	4.71	34.30	28.46	29.60	(22.52; 36.67)	23.75	(15.98; 31.52)
	60+	1.33	13.45	8.84	12.12	(3.93; 20.30)	7.51	(0.94; 14.08)

Source: Health Surveillance Secretariat/Ministry of Health.
*The sum of the percentage values, considering the three indicators, will not account for 100% because the indicators of other natures of aggression were not shown. We only presented the age groups whose variation in one of the surveys was statistically significant.

DISCUSSION

The study showed the evolution of the profile of care addressed to cases of violence in the three last editions of the VIVA Survey, in which the most common nature of aggression was physical, and the most used mean for perpetrating it was physical abuse/beating. The male gender was more frequent, and the age groups mostly assisted were young people and adults (15 to 29 and 30 to 59 years). Regarding the aggressors, the results corroborate with other studies: among the elderly[13], children[14] and women[15] the authors of the violence are, in most cases, relatives or intimate partners; among men[10], most of the authors are unknown. These results show a situation that has been demonstrated[16-18] regarding the interpersonal violence that takes place in public spaces, involving men, in locations such as pubs and streets, and not rarely, alcohol consumption. Conflicts in these spaces, mostly attended by men, reveal the affirmation of social roles that manufacture masculine socialization, determining an unequal and oppressive relationship among people[18]. The results of this analysis identified, in the three editions of the survey, the most frequent consumption of alcohol among men (about 40%) in relation to women (about 20%). Alcohol consumption, especially when abusive, has been associated with higher occurrence of injuries caused by violence among young adults[19], besides accidents and violence in traffic[20].

Although drug consumption and violence present a complex relationship, alcohol can be analyzed as an enhancer for aggressive actions. On the one hand, consumption causes physical changes related to absence of sleep, neurochemical changes and changes in perception and awareness, which, together with the social and cultural contingencies in which drug abuse is encouraged, and the culture of violence is banalized, create an easier relationship between abuse of psychoactive substances and use of violence as a response to relational dilemmas[21].

Intimate partner violence mostly affected female individuals, in the three editions of the study, reaching about one third of care services in 2017. This gender-based violence profile that affects women has been demonstrated in several studies that consider cases of fatal violence to less severe types of violence, but which gain a potential of lethality because of its recurrence. In this context, the immediate consequences of violence are observed, such as injuries that lead people to emergency services, but also long-term ones, which generate pain and indirect effects, such as chronic pain, gastrointestinal problems, fibromyalgia, sexually transmitted diseases, sexual dysfunction and mental health dysfunctions, such as depression or anxiety[22].

It is possible to state that gender-based violence is associated to a masculinity that is built through processes of subjectivation, which still invite men to show demonstrations of strength, sexual power and several forms of domination, resulting in aggression among men — including more severe outcomes, such as hospitalization and death — and victimization among women and female children.

Despite the progress resulting from the implementation of Law Maria da Penha[23] and the Feminicide Law[24], describing and punishing relational crimes based on gender, the absence

of educational policies addressed to men is still a matter of concern. These could help them confront hegemonic masculinity related to the use of force through an educational and supporting process, beyond the legal and police devices that we can easily use in cases of men perpetrating violence and the consequences of their relational forms.

The brown ethnicity/race was the most reported one in the analyzed services. The association between black ethnicity/color and mortality has been pointed out in studies[25] and in other editions of the VIVA Survey[10]. Social inequalities, expressed by the differences of ethnicity/color, schooling, income and access to services and goods, and amplified by the intersectionality of these categories, besides prejudice and discrimination present in society, help to explain the much higher notifications involving the black population and the higher exposure to risks of violence[26,27].

The analysis of the three editions of the VIVA Survey shows that negligence had a major positive variation, between 2011 and 2017, in the extreme life cycles. Additionally, violence perpetrated by people known by the victim significantly affects children and the elderly. These results lead to intriguing reflections about the spaces of coexistence and exposure to the risk of negligence: the household and the institutions providing care to children and the elderly. Even after many years of legislations, such as the Child and Adolescent[28] and the Statute of the Elderly[29], and studies showing their vulnerabilities and possibilities of action to protect these groups, violence that takes place in the household environment reveals the unfavorable conditions in which Brazilian families live and develop. Negligence, which is a controversial concept, carries a complexity that makes it difficult to define, in real life, which situations are negligent, so the families may reproduce, practice or suffer negligence[30]. Such a complexity may affect the record, but also the possibilities of action regarding this form of violence.

One limitation of this study was the fact that data were collected in 71 selected emergency units, which are part of the public health system in 19 capitals of the country and the Federal District. The sampling of the VIVA Survey is representative of the population assisted in the health units that are part of the study, however, it does not represent the city or state. Besides, even though units such as these correspond to reference emergency services used by most of the population in Brazilian capitals, they do not contemplate users of the private sector, therefore not representing the population of the cities.

Violence is recognized as a public health problem, and contributes with the high rates of morbidity and mortality. The prevention of violent events represents a major challenge due to the need to establish intersectoral dialogues, through the constitution of a care network whose format is open to a combined, continuous and intersectoral follow-up. This would provide room for listening and care, thus opposing to the relational logic based on the secret and secrecy in which violence, specially the intrafamily and intimate partner types, gains strength. The 2030 Agenda for Sustainable Development represents an opportunity for the country to prioritize public policies that approach topics such as peace, disarmament, protection and life[31]. In this sense, the discussion about the age of penal majority and the attacks to the Disarming Statute[5,32] directly confront the present

and future of young people. The higher the access to weapons, the higher the number of violent deaths, especially among the more vulnerable audience, young people, black and poor[32], besides increasing and intensifying aggression against women. This can also result in fatal outcomes and feminicide, since such a tendency has been registered by recent studies[5].

The implementation, expansion and improvement of health surveillance policies

are currently an essential strategy so that intrafamily violence be revealed, and followed-up by public care services in different fields, such as health, social assistance, public safety, judiciary and education.

It is important to mention that the VIVA Survey not only registers care services provided due to violence, including that of adult men; it also contemplates other events of external causes, such as traffic accidents, falls, burns and other incidents. For these events, notification is not mandatory in the Notifiable Diseases Information System (Sinan). Therefore, it is important to highlight the importance of surveillance in the survey modality, which produces information that is not part of the continuous violence surveillance, thus collaborating with the production of more comprehensive data about events with external causes.

The results point to the importance of innovating the current surveillance model. Considering the severity of aggression by firearms, the monitoring through continuous surveillance in sentinel units (emergency units) is suggested for men and women of all ages. Besides, it is relevant to revise the inclusion criteria of adult men as a target-population for the notification of interpersonal/self-provoked violence in Sinan.

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