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Violence against adolescents: analysis of health sector notifications, Brazil, 2011-2017

Violências contra adolescentes: análise das notificações realizadas no setor saúde, Brasil, 2011–2017

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ABSTRACT: ***Introduction:*** Violence experienced in adolescence results in serious damage and suffering to society. This study aims to characterize the profile of violence victims and likely perpetrators of violence against adolescents, as well as to describe the percentage of notifying municipalities according to the federation unit. ***Methods:*** Cross-sectional study conducted with data on notification of violence against adolescents from the Information System for Notifiable Diseases, from 2011 to 2017. The chi-square test was used to assess the statistical significance of the differences between the proportions in the comparison between genders. Proportion ratios for the most frequent types of violence were estimated according to selected variables. ***Results:*** The notifications came from 75.4% of all the Brazilian municipalities. Physical violence predominated among males, aged 15-19 years. Psychological violence was predominant among females, between 10 and 14 years old, when perpetrated repeatedly at home by family aggressors. Sexual violence prevailed among females, aged 10 to 14 years old, in the indigenous, black and yellow races/colors, when perpetrated repeatedly at home. Negligence was more common among males, between 10 and 14 years old, when perpetrated repeatedly by family aggressors. ***Conclusions:*** Sexual violence occurred predominantly against females and generated significant negative impacts on mental, physical, sexual and reproductive health. Community violence, perpetrated with sharp objects and firearms, were prominent among males and are important risk factors for male over-mortality. Because the problems are complex, addressing them requires intersectoral actions.

Keywords: Violence. Adolescent health. Aggression. Violence against women. Mandatory reporting.

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RESUMO: ***Introdução:*** A violência sofrida na adolescência resulta em sérios prejuízos e sofrimento para a sociedade. Este estudo objetivou caracterizar o perfil das violências, das vítimas e dos prováveis autores das violências perpetradas contra adolescentes, bem como descrever o percentual de municípios notificantes por unidade da Federação. ***Métodos:*** Estudo transversal, realizado com dados de notificação de violência contra adolescentes do Sistema de Informação de Agravos de Notificação referentes ao período de 2011 a 2017. A significância estatística das diferenças entre as proporções na comparação entre sexos foi testada com o qui-quadrado. Estimaram-se razões de proporção para os tipos de violência mais frequentes segundo variáveis selecionadas. ***Resultados:*** As notificações foram procedentes de 75,4% dos municípios brasileiros. A violência física predominou no sexo masculino, na idade de 15 a 19 anos. A violência psicológica predominou no sexo feminino, entre 10 e 14 anos, quando praticada de forma repetitiva, no domicílio, por agressores familiares. A violência sexual prevaleceu no sexo feminino, entre 10 e 14 anos, nas raças/cores indígena, negra e amarela, quando perpetrada de forma repetitiva, no domicílio. A negligência predominou no sexo masculino, entre 10 e 14 anos, quando praticada de forma repetitiva, por agressores familiares. ***Conclusões:*** Violências sexuais ocorreram preponderantemente no sexo feminino e geram consideráveis impactos negativos à saúde mental, física, sexual e reprodutiva. Violências comunitárias perpetradas com objetos perfurocortantes e arma de fogo tiveram destaque no sexo masculino e são fatores de risco significativos para a sobremortalidade masculina. Como os problemas são complexos, demandam atuação intersetorial para seu enfrentamento.

Palavras-chave: Violência. Saúde do adolescente. Agressão. Violência contra a mulher. Notificação de abuso.

INTRODUCTION

Adolescence is a unique formative stage of human development that requires special attention in national development policies, programs and plans[1]. During this period, individuals have new experiences, and many protective or risky behaviors begin or consolidate, with more exposure to accidents and violence[1-5].

The violence experienced in adolescence can result in serious physical and psychosocial consequences for individuals and directly affect quality of life[6], with disabilities, psychological disorders[7,8] and suffering for both families and the society[6,9]. Interpersonal violence that occurs in this phase is associated with risky sexual behaviors, poor school performance and alcohol and other drugs abuse, which in turn are risk factors for several health problems throughout life[6,9-11]. The earlier the exposure to violence and the more intense it is, the greater the problems arising from it and the greater the probability of the victim's involvement in future violent behaviors[10]. It is noteworthy that violence is associated with an increased risk of depression from adolescence, especially among women, considering that in their case, some types of violence, including sexual victimization, increase markedly in early adolescence[8].

Interpersonal violence is the third leading cause of death among adolescents worldwide, although its prominence varies by region of the world. This violence causes almost a third of all male adolescent deaths in low- and middle-income countries in the Americas[1,12]. In Brazil, homicide is the main cause of death of adolescents and

young people between 15 and 24 years of age and affects mainly black youth living in the peripheries and metropolitan areas of urban centers[5,13]. Overall, it is estimated that one in three female adolescents aged 15 to 19 years old has suffered emotional, physical, psychological and/or sexual violence by their husband or partner[12]. The Sustainable Development Goals contain the goals of global action by 2030, including indicators to tackling violence[14].

In Brazil, the reporting of violence against adolescents was established as mandatory through the Child and Adolescent Statute (ECA, in the Portuguese acronym)[15], in 1990. Within the health sector, from 2011 onwards, notification of violence became part of the national list of compulsory notification, universalizing notification to all health services in the country[16-18]. In this context, notification is an important protection instrument and one of the dimensions of the line of care for adolescents in situations of violence, which also provides for reception, care and follow-up in the care and social protection network[19].

In view of the social and epidemiological severity of violence against adolescents, studies on aggressions notified to the Notifiable Diseases Information System (Sinan, in the Portuguese acronym) may contribute to broaden the knowledge about violence practiced against this group and guide the creation of public policies for its prevention.

The objective of this study was to characterize the violence, the victims and the probable perpetrators notified to Sinan, in the period from 2011 to 2017, as well as to describe the percentage of municipalities notifying violence by Federation unit.

METHODS

STUDY DESIGN AND POPULATION

Cross-sectional study, conducted with data from notifications of violence against adolescents in the period from 2011 to 2017, in Brazil. Adolescents were defined as individuals aged between 10 and 19 years old, according to the convention prepared by the World Health Organization[3] and adopted by the Brazilian Ministry of Health[20].

SOURCE OF DATA

The data used were extracted from Sinan, which is fed by the Individual Notification Form of Interpersonal/Self-harm.

The notification of violence against adolescents is mandatory for both sexes and for all public and private health establishments in the country since 2011[16]. It is noteworthy that in situations of suspicion or identification of violence against adolescents, health professionals

must report the case and communicate the competent bodies, supported by ECA[16,19], regardless of the acceptance of family members[19].

STUDY VARIABLES

Cases of violence were described according to the victims' sociodemographic characteristics: sex (female, male), age group (10 to 14 and 15 to 19 years old), ethnicity/skin color (white, black [black + brown], yellow, indigenous), education (0 to 8 years of study, 9 or more years of study), presence of disability/disorder (yes, no). Physical, intellectual, visual and hearing disabilities, mental disorders, behavioral disorders, as well as other disabilities and other disorders were considered. Characteristics of violence: history of recurrent violence (yes, no), place where the violence occurred (home, street, school, other places), self-harm (yes, no), type of violence (physical, sexual, psychological, negligence, others), means of aggression (corporal force/beating, threat, poisoning/intoxication, sharp objects, firearm, blunt object, hanging, hot object/substance, other means). Characteristics of the likely perpetrator of violence: number of people involved (one, two or more), sex (female, male), bond with the victim (family, friend/acquaintance, stranger, intimate partner, other bonds), suspected alcohol abuse by the aggressor (yes, no). The variables "type of violence" and "bond with the victim" allowed multiple responses.

DATA ANALYSIS

The chi-square test was used to assess the statistical significance of the differences between the proportions in the comparison between genders, with significance level of 5%. Proportion ratios (PR) and respective 95% confidence intervals (95%CI) were estimated for the most frequent types of violence according to selected variables. The percentage of municipalities notifying violence per federation unit in 2011 through 2017 was also calculated.

ETHICAL ASPECTS

The national database that supported this study was accessed through the portal of the Unified Health System's Informatics Department[21]. The definitive data corresponding to each Brazilian federation unit from 2011 to 2017 were accessed. As this is a study with secondary data without identification, the research project was exempted from any considerations by the Research Ethics Committee, in accordance with guidelines of the National Health Council Resolution nº 510 of 2016.

RESULTS

From 2011 to 2017, 1,429,931 cases of interpersonal or self-violence were reported. Of this total, 374,673 (26.2%) corresponded to notifications of violence against adolescents.

In 2011, 28,792 cases of violence against adolescents were reported and, in 2017, 79,914 cases, which represents an increase of 177.6% in the number of notifications. These came from 4,202 notifying municipalities, equivalent to 75.4% of Brazilian municipalities.

In 2011, only two federal units (Rio de Janeiro and Mato Grosso do Sul) had a more than 50% notifying municipalities, that is, municipalities that had at least one notification of violence against adolescents in the year. In 2017, 17 federation units had more than 50% notifying municipalities, and among these, Roraima, Acre, Minas Gerais, Amazonas and Rio de Janeiro had a percentage greater than 80%. Among the 10 federation units with notifying municipalities below 50% 2017, eight of them (Paraíba, Sergipe, Piauí, Rio Grande do Norte, Maranhão, Bahia, Alagoas, Ceará) are located in the Northeast Region.

Table 1. Sociodemographic characteristics of adolescents who are victim of violence reported in the Information System for Notifiable Diseases by sex, Brazil, 2011–2017.

Characteristics	Female		Male		Total		p
	(N = 244,249; 65.2%)		(N = 130,398; 34.8%)		(N = 374,647; 100%)		
	N*	%	N*	%	N*	%	
Age group							
10-14	103,626	42.4	45,177	34.6	148,803	39.7	0.00
15 -19	140,623	57.6	85,221	65.4	225,844	60.3	
Skin color/ethnicity							
White	93,435	44.4	42,904	40.9	136,339	43.3	0,00
Black**	113,110	53.8	59,831	57.1	172,941	54.9	
Yellow	1,677	0.8	769	0.7	2,446	0.8	
Indigenous	2,187	1.0	1,280	1.2	3,467	1.1	
Schooling							
0-8 years	110,212	66.8	54,490	72.6	164,702	68.6	0.00
9 years or more	54,715	33.2	20,548	27.4	75,263	31.4	
Disability							
Yes	14,870	7.4	8,591	9.0	23,461	7.9	0.00

Source: Notifiable Diseases Information System/Ministry of Health[21].
*The sum of records referring to each variable differ due to missing data (blank/ignored); **In the variable skin color/ethnicity, the categories black and brown were added as black.

The sociodemographic characteristics of adolescents in situations of violence are detailed in Table 1. Of the total of notified cases, 65.2% involved females. The average age was 15.2 years. Most victims (60.3%) were between 15 and 19 years old, 54.9% were black, 68.6% had completed up to eight years of study and 7.9% had some disability or disorder.

We could see that 39.9% of the events had the characteristic of being repetitive and 56.9% occurred at the victims' household. Females were victims of repetitive violence and violence at home in a greater proportion than males. Self-inflicted injuries accounted for 18.5% of notifications and occurred in a greater proportion among females. The most reported types of violence were: physical (64.7%), sexual (24.7%), psychological (24.5%) and negligence/abandonment (12.2%). Sexual and psychological violence were more

Table 2. Characteristics of violence against adolescents reported in the Information System for Notifiable Diseases by sex, Brazil, 2011–2017.

Characteristics	Female (N = 244,249; 65.2%)		Male (N = 130,398; 34.8%)		Total (N = 374,647; 100%)		p
	N*	%	N*	%	N*	%	
Repetitive violence							
Yes	82,122	44.2	25,830	30.5	107,952	39.9	0.00
Where violence took place							
Household	143,605	65.9	42,352	38.9	185,957	56.9	0.00
Public road	38,228	17.6	41,782	38.3	80,010	24.5	
Other**	35,971	16.5	24,826	22.8	60,797	18.6	
School	8,758	4.0	7,399	6.8	6,157	4.9	
Self-inflicted injury							
Yes	44,660	20.6	16,397	14.5	61,057	18.5	0.00
Type of violence***							
Physical	136,131	58.1	97,769	77.0	233,900	64.7	0.00
Sexual	78,937	34.6	6,530	5.6	85,467	24.7	0.00
Psychological	64,595	28.7	19,310	16.5	83,905	24.5	0.00
Negligence	22,069	9.8	19,867	16.9	41,936	12.2	0.00
Other	36,166	16.4	14,505	12.5	50,671	15.0	0.00

Source: Notifiable Diseases Information System/Ministry of Health[21].
*The sum of records referring to each variable differ due to missing data (blank/ignored); **Other locations include: collective housing, sports venue, bar or similar, trade/services, industry/construction and other unspecified locations; ***does not total 100%, as it is a variable with multiple responses.

frequent among females, while physical violence and negligence/abandonment were more frequent among males (Table 2). The most used means of violence were body force (45.4%) and threat (15.5%), with a higher proportional distribution among females. Sharp objects (10.3%), firearms (9.0%) were also reported as means of aggression, with higher frequency among males, and poisoning, more frequent among females (results not shown in table).

The evaluation of the characteristics of the probable author of violence showed that in 73.1% of the notifications there was involvement of an author and that, among females, the proportion of these aggressions perpetrated by only one aggressor was higher. In 66.5% of the cases, the aggressor was a male and, as to the bond with the victim, they were family

Table 3. Characteristics of probable perpetrators of violence against adolescents reported in the Information System on Notifiable Diseases by sex of the victims, Brazil, 2011–2017.

Characteristics	Female		Male		Total		p
	(N = 244,249; 65.2%)		(N = 130,398; 34.8%)		(N = 374,647; 100%)		
	N*	%	N*	%	N*	%	
Number of people involved							
One	174,652	78.8	61,961	60.7	236,613	73.1	0.00
Two or more	46.945	21.2	40.168	39.3	87.113	26.9	
Sex of aggressor							
Male	136.602	62,1	76.358	76,1	212.960	66,5	0.00
Female	69,045	31.4	12,473	12.4	81,518	25.5	
Both	14,317	6.5	11,458	11.4	25,775	8.0	
Bond with probable aggressor**							
Relatives***	48,757	27.9	27,677	30.2	76,434	28.7	0.00
Friends/ acquaintances****	40,773	23.3	22,976	25.1	63,749	23.9	0.00
Strangers	26,672	15.4	23,709	27.3	50,381	19.4	0.00
Intimate partners*****	42,277	24.2	1,378	1.5	43,655	16.4	0.00
Other types of bond	17,376	10.0	10,768	11.8	28,144	10.6	0.00
Alcohol abuse by probable aggressor							
Yes	44,162	28.2	20,151	29.3	64,313	28.5	0.00

Source: Notifiable Diseases Information System/Ministry of Health[21].
*The sum of records referring to each variable differ due to missing data (blank/ignored); ** does not total 100%, as it is a variable with multiple answers; *** family members included father, mother, stepfather, stepmother, brother and son; **** friends/acquaintances included friends/acquaintances, caregivers, boss; ***** Intimate partners included spouse, ex-spouse, boyfriend and ex-boyfriend

members (28.7%), friends/acquaintances (23.9%), a stranger (19.4%), intimate partners (16.4%). There was a difference in the distribution of aggressors according to the victim's sex: females were more frequently raped by intimate partners than males, who in turn were victims of family members, friends/acquaintances and strangers in greater proportion than females. The suspicion that the abuser had consumed alcohol was mentioned by 28.5% of the victims (Table 3).

Table 4 shows the proportion and PR of the types of violence mostly reported according to selected characteristics. Physical violence was significantly higher among indigenous people (PR = 1.15), black (PR = 1.03) and yellow people (PR = 1.03), and when the aggressor was suspected of abusing alcohol (PR = 1.21). It was significantly lower among females (PR = 0.75), at the age of 10 to 14 years (PR = 0.65), with the characteristic of being repetitive (PR = 0.83), when occurring at home (PR = 0.73), and when practiced by family members (PR = 0.70).

Psychological violence was significantly higher among females (PR = 1.73) in the group aged 10 to 14 years (PR = 1.19), being repetitive (PR = 1.68), at home (PR = 1.40), by family members (PR = 1.16), and with suspected alcohol abuse by the aggressor (PR = 1.33). It was significantly lower in the black-skin people group (PR = 0.96) compared to the white-skin people group.

Sexual violence was six times more frequent for females (PR = 6.20), three times higher in the group aged 10 to 14 years (PR = 3.11), more common among indigenous people (PR = 1 , 40), black people (PR = 1.38) and yellow people (PR = 1.28), perpetrated repeatedly (PR = 1.39), at home (PR = 1.34) and in suspicion of alcohol abuse by the aggressor (PR = 1.08). It was perpetrated by family members in a significantly lower proportion compared to non-family members (PR = 0.63).

Negligence was predominant in the age group from 10 to 14 years (PR = 2.23), perpetrated repeatedly (PR = 1.47), at home (PR = 1.12), by family members (PR = 14.48). It was significantly lower among females (PR = 0.58), in the black-skin group (PR = 0.84), yellow-skin group (PR = 0.78), indigenous group (PR = 0.36), and when there was suspicion of use of alcohol by the aggressor (PR = 0.89).

DISCUSSION

Notifications of violence in the health sector contribute to the epidemiological analysis of cases and provide support for the organization of services and the creation of public health policies. Furthermore, communicating cases to the Guardianship Councils serves the purpose of activating the social protection network for adolescents[16,22]. In this context, the increase in the number of notifications and the number of notifying municipalities in the period from 2011 to 2017 is in line with the strategies to fight violence against adolescents in Brazil.

Table 4. Proportion (%) and proportion rate of the main types of violence against adolescents according to selected characteristics, Brazil, 2011–2017.

Characteristics	Physical		Psychological		Sexual		Negligence/ abandonment	
	%	PR (95%CI)	%	PR (95%CI)	%	PR (95%CI)	%	PR (95%CI)
Sex								
Female	58.1	0.75 (0.75 – 0.76)	28.7	1.73 (1.71 – 1.76)	34.6	6.19 (6.05 – 6.35)	9.8	0.58 (0.57 – 0.59)
Male	77.0	1	16.5	1	5.6	1	16.9	1
Age group (years)								
10-14	48.6	0.65 (0.64 – 0.65)	27.1	1.19 (1.17 – 1.20)	41.5	3.11 (3.07 – 3.15)	18.3	2.23 (2.19 – 2.27)
15-19	75.1	1	22.8	1	13.4	1	8.2	1
Skin color/ethnicity*								
Black	64.3	1.03 (1.03 – 1.04)	25.0	0.96 (0.94 – 0.97)	29.4	1.38 (1.36 – 1.40)	11.0	0.84 (0.83 – 0.86)
Yellow	64.2	1.03 (1.00 – 1.06)	26.6	1.02 (0.95 – 1.09)	27.3	1.28 (1.20 – 1.37)	10.2	0.78 (0.69 – 0.88)
Indigenous	71.8	1.15 (1.13 – 1.18)	25.7	0.98 (0.93 – 1.04)	29.8	1.40 (1.32 – 1.48)	4.7	0.36 (0.31 – 0.42)
White	62.3	1	26.1	1	21.3	1	13.0	1
Repetitive violence								
Yes	56.3	0.83 (0.83 – 0.84)	36.6	1.68 (1.66 – 1.70)	33.0	1.39 (1.38 – 1.41)	13.1	1.47 (1.44 – 1.50)
No	67.5	1	21.8	1	23.7	1	8.9	1
Occurrence in household								
Yes	54.4	0.73 (0.72 – 0.73)	28.5	1.40 (1.38 – 1.42)	28.3	1.34 (1.32 – 1.36)	12.9	1.12 (1.10 – 1.15)
No	74.9	1	20.4	1	21.1	1	11.5	1
Family members as aggressors**								
Yes	49.4	0.70 (0.69 – 0.70)	30.3	1.16 (1.15 – 1.18)	20.6	0.63 (0.62 – 0.64)	39.0	14.48 (14.07 – 14.90)
No	70.7	1	26.1	1	32.5	1	2.7	1
Alcohol abuse by probable aggressor								
Yes	72.3	1.21 – (1.20 – 1.21)	33.4	1.33 (1.31 – 1.34)	26.5	1.08 (1.06 – 1.10)	10.1	0.89 (0.87 – 0.92)
No	59.9	1	25.2	1	24.5	1	11.3	1

Source: Notifiable Diseases Information System/Ministry of Health[21].
PR: prevalence ratio; 95%CI: 95% confidence interval; * in the variable skin color/ethnicity, the categories black and brown were added as black; ** Family category included father, mother, stepfather, stepmother, brother and son.

Despite the increase in the number of notifying municipalities, the increase was uneven between federation units and regions. This indicates the need to design public policies and specific strategies to expand the coverage of notifications in different Brazilian territories, in view of the different regional realities.

In this context, underreporting in health services is a limitation of this study. Notifications cannot be considered as the set of violence perpetrated against adolescents, but rather an approach to the problem or a diagnosis based on the cases of people in situations of violence who sought the health service and had access to it, and whose cases were notified by professionals working in the notifying services[17]. It is known that these professionals find it difficult to register notifications due to the difficulty of diagnosing situations of violence in diffuse complaints, the refusal to deal with violence as a health problem, the accumulation of activities and lack of time in the work process, embarrassment that can be caused by the approach to these cases, due to fear of retaliation and exposure of professional performance, and lack of training[23,24]. It should be noted that not every case of violence results in injuries that can be cared for in health services[25]. In addition, different federation units and municipalities may have different levels of coverage of the violence surveillance system, resulting in differences in the capacity to register violence[17].

The larger number of reports of violence among females, in addition to the more frequent victimization of women, especially when it comes to sexual violence[26-28], psychological and perpetrated by intimate partners in home environment[6,29], may be related to factors such as greater search for health care by females than by men[30] and, consequently, more acknowledgment of violence among them.

Regarding the higher proportion of victims in the black skin group, it is relevant to highlight that black adolescents and young people are more subjected to social inequalities and situations of insecurity, as well as more exposed to violence compared to white people[5,13,31-33].

Females were victims of repetitive violence in greater proportion than males. Studies describe that episodes of violence against women are chronic and tend to become progressively more serious[34]. This repetitive violence has significant repercussions on women's health or mental suffering and contributes to a greater demand for health services compared to men[34,35].

The household and the public road stood out as places where violence occurs, as observed in other studies[6,11,31,36,37]. The violence practiced in the victims' homes reveals that the aggressors are family members or have free access to the household[11,29,37]. This situation is opposed to the concept of home as a safe place, the source of development for children and adolescents[37].

Females were victims of violence at home in a greater proportion than males. The violence they suffer has their parents, boyfriend or mothers' partner as main authors[6,29], and commonly in the domestic environment. Among males, violence on public roads occurred in practically the same proportion as domestic violence. The high proportion of violence

among males on the public road by strangers is related to greater exposure to risks in public spaces than women[6,38].

Self-inflicted injuries accounted for 18.5% of notifications and occurred in a greater proportion among females. This result is in line with a study carried out in urgency and emergency sentinel services in Brazilian capitals, which showed a greater chance of assisting females for this cause[39]. The vulnerability of Brazilian adolescents and young people to suicide occurs in an increasing, sustained and high-impact manner, a fact that requires new public policies and strategies aimed at facing the problem in this population group[40].

Physical violence was predominant among males, in the group aged 15 to 19 years, when perpetrated outside the home and when the aggressors were not family members, results that are in line with the findings of a survey carried out in emergency services in Brazilian capitals[6]. Injuries resulting from community violence, an important public health problem, especially among adolescents and young male adults, are identified in the literature as risk factors for male over-mortality[6,38,41,42].

The high level of notifications of physical violence observed in this and other studies can be justified by the presence of visible bruises or marks that facilitate identification, which may not occur in other forms of violence, thus requiring more detailed investigation for identification[1,11,43].

Sexual violence was more frequent among females and in the group aged 10 to 14 years, which is in accordance with the literature[26-28]. The greater victimization among women reinforces the evidence of inequalities expressed in the gender relations of a sexist society, which legitimizes the preservation of a supposed male supremacy and places women at risk for victimization by violence[27,28,44]. In addition, it is worth noting that the younger the victim, the greater the consequences of this type of violence, which causes considerable psychological and physical damage that will accompany them throughout life[27,28,45].

Furthermore, it is known that the real prevalence of sexual abuse is little known and it is believed that the underreporting rate is very high[11,46] due to factors such as the victim's embarrassment, fear of humiliation and of lack of understanding by family members, friends and authorities[11].

Psychological violence was more frequent among women and when perpetrated in a chronic way. Due to its subjectivity and different expressions, this type of violence is difficult to register. In general, it is part of the context of other forms of violence, it is inflicted in a chronic way, and can lead to serious damages to the cognitive and psychosocial development of children and adolescents, compromising emotional health[11,43,47].

Negligence and abandonment were more frequent when practiced in a chronic way, in the home environment and when the aggressors were family members, which is in accordance with a work published with data from the Violence and Accident Surveillance System with the child and adolescent population[43], and the highest proportion was observed among males[43,48]. This type of violence is difficult to define and needs fundamental elements for identification, such as the contexts of poverty, isolation, social deprivation and other deficiencies

present in the life history of parents and victims[37,43]. These factors, related to structural violence perpetrated historically against millions of Brazilian families, make it more difficult to judge more precisely between abusive practice and impossibility of providing what it takes to the development of children and adolescents[49].

The higher proportion of poisoning observed among adolescents may be related to the fact that among women, especially adolescents and young adults[50], suicide attempts are carried out using the most easily accessible method, such as toxic agents[39,50].

Firearms and sharp objects were the most used means of aggression against male adolescents and corroborate the national literature[51-54], which points out the predominance of these aggressions in young adults and adolescents. It is important to highlight that, globally, 48% of homicides are committed with firearms and 27% with sharp objects, such as knives. In low- and middle-income countries in the Americas region, firearm deaths account for 75% of all homicides, while cases perpetrated by sharp objects account for 16%[55]. Absence of firearms in the household and community environments is the most reliable and effective measure to prevent suicide, homicide and unintentional injuries by firearms in children and adolescents[12,56].

Most cases of violence had males as aggressors. It is important to highlight that the constitution of male identity, which is hegemonically characterized by strength, competition and sexism, enhances the association between "masculine" and "violence"[51,57] and imprisons men as victims and perpetrators[57]. Overcoming this problem requires the implementation and strengthening of initiatives that promote deep reflection on values, forms of socialization and the construction of male and female identities in current societies, based on the establishment of more equitable relations among men, with their peers and with the opposite sex[51].

Regarding the use of alcohol by the aggressor, it is necessary to highlight that, in Brazil, part of the violence has been associated, in addition to social and cultural determinants, to alcohol abuse, use of illicit drugs and the vast availability of firearms[38]. Alcohol consumption is a significant promoter of violent situations[12,58,59], from the point of view of both the aggressor and the victim[58].

The findings of this study point out the predominance of intrafamily and community violence in the reports of violence against adolescents, with a strong chronic, repetitive character. As the problem is complex and requires several sectors to face it, the health field needs to act in a network, in an articulated way, so that effective intra and intersectoral referrals are offered.

It is concerning that sexual violence is the second most prevalent type in notifications among female adolescents. Due to its negative impacts on mental, physical, sexual and reproductive health, special attention should be offered to professionals and services qualified for this assistance, as to guarantee humanized and comprehensive care.

Furthermore, a support and protection structure for professionals who report violence is relevant, as well as continuous training on the topic. Finally, the viability of tools that facilitate and qualify the notification process, such as an online system, can be relevant to improve notification as an important dimension of the line of care.

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