

I Editorial

The invisible magnitude of violence against women

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In Brazil, the records on violence cases reveal, in general, a predominance of men, both as victims and as perpetrators. In 2013, the risk of death of men due to aggressions was 11.3 times higher than of women, and men accounted for 83.5% of the hospitalizations owing to aggression financed by the Brazilian National Health System (SUS).¹ Among the young population (20-29 years old), in which the aggressions are the main cause of death (54.6% in the period 2000-2012),² the differences between the sexes concerning the violence profile are quite clear. A study with data on the survey that makes part of the Surveillance System on Violence and Accidents (*Viva*), conducted by the Ministry of Health, in 2011, with youth victims of violence assisted at urgency and emergency SUS services, revealed that men were the main victims (75.1%) and aggressors (83.1% and 69.7% of violence cases perpetrated against victims of male and female sex, respectively). Among men, the most common aggressions were in public places, perpetrated by strangers, with higher proportion of severe injuries and deaths within 24 hours. On the other hand, among the female victims, most of the events took place at the household, perpetrated by a partner, ex-partner, relative or acquaintance.³

The truth is: men are the main victims of violence that result in a higher number of records on the information systems of the health, public security and justice sectors. In turn, violence against women is characterized by its invisibility, since it mainly occurs in private contexts and is, most of times, perpetrated by family and acquaintances.³⁻⁵ Due to these characteristics, most of those occurrences do not end in assistance and are not registered on the information systems, resulting in a subnotification of the events, which contributes to reinforce the invisibility of violence against women.

Unfortunately, this type of violence only gains visibility when extreme situations that demand a position from the State happen, such as the cases of collective rape in Piauí State and Rio de Janeiro city, in May and June 2016,^{6,7} and of feminicides, which are criminal offenses defined by the Law No. 13,104/2015.⁸ The repercussion that some cases have in the media and social networks, which contributes to bring numerous of similar cases to light, unveils the false sensation that the violence against women is a phenomena of lower magnitude than the violence perpetrated against men.

Statistics on rape are an example of underestimated magnitude of violence against women. According to the *Annual Report on Public Security*, in 2014, 47,646 cases of rape were registered in Brazil, with an estimated underreporting of 35%.⁹ In turn, the Information System for Notifiable Diseases (*Sinan*), of the Ministry of Health, recorded 17,781 health assistance cases of women victims of rape in 2015, corresponding to an average of 49 assistances/day, or more than two per hour. However, 40% of the Brazilian municipalities did not notify violence victims on *Sinan*. Besides that, in the municipalities where the notification is performed, not all the victims seek care in the health services, and there is also underreporting among the assisted cases.¹⁰ Supposing that the notified cases correspond to 10% of the occurrences, the estimate number of rapes per year in Brazil would be approximately 500/day, or more than 20 per hour. Indeed, the number of rape occurrences in Brazil is unknown, and, even being underestimated, its magnitude is overwhelming.

In Brazil, a survey requested by the Brazilian Summit on Public Security (2014), showed that 90% of the women said they were afraid of being victims of sexual assault.⁹ Such fear is not groundless. The risk of a woman to be raped in Rio de Janeiro during the 2016 Olympic Games was estimated in 3.5/10 thousand. This risk is similar to the risk of a man to be murdered by a fire gun (3.8/10 thousand), higher than the risk of dengue infection (5/10 thousand) and almost 12 times higher than the risk of Zika virus infection (3/100 thousand).¹¹⁻¹³

According to the World Health Organization (WHO),⁵ 35% of women worldwide have already suffered physical and/or sexual violence perpetrated by an intimate partner or sexual violence perpetrated by a non-partner. That is, more than one for every three women globally has already been victim of an episode of this kind of violence. There is a wide range of forms of violence against women, since verbal aggression and other forms of emotional abuse, passing through physical or sexual violence, and the most severe form of them all, the femicide.

It is clear that the statistics on violence against women in Brazil show only a small portion of the various forms of violence suffered by women every day. Therefore, we can notice the need for upgrading the information systems, in order to increase their coverage and improve their quality. Among the systems managed by the Ministry of Health, we can highlight the Mortality Information System (*SIM*), the Hospital Information System of the Brazilian National Health System (*SIH-SUS*) and the Viva System. The latter was implemented in 2006 and is based on two components: (i) the survey conducted in sentinel services of urgency and emergency care; and the (ii) continuous surveillance, added to *Sinan* in 2009.¹⁴ It is noteworthy that all the cases of violence against women are cases of mandatory notification on *Sinan*. Other information systems also deserve to be explored and integrated, such as those managed by the Ministry of Social Security; by the Ministry of Justice; by the Public Security Departments of the states and the Federal District; by the Public Prosecutor's Office; and by the Judicial System.

Regardless of the relevance of information systems data, they present limitations. Thus, surveys with primary data, collected using validated tools, are also necessary to understand the reality of violence against women.^{15,16}

The health services also have an essential role in the response to violence against women, because often, these are the first places where victims seek for assistance. It is essential that these services are available in the days and periods of greater occurrence of violence against women – weekends, night and late-night – and that the health professionals are trained to provide appropriate care to the victims and to notify the violence cases.^{4,17-19}

Violence against women is a public health issue of epidemic proportions in Brazil, although its magnitude is greatly invisible. This issue cannot be treated as restricted to some segments, once it is spread through all the Brazilian society. The prevention and combat of violence against women is necessarily related to the reduction of gender inequalities and requires the endeavor of different sectors of the society, in order to ensure that all the women and girls have access to the basic right to living without violence.

Leila Posenato Garcia¹

¹Instituto de Pesquisa Econômica Aplicada, Diretoria de Estudos e Políticas Sociais, Brasília-DF, Brasil

References

1. Mascarenhas MDM, Sinimbu RB, Silva MMA, Malta DC. Análise de situação das causas externas no Brasil. In: Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Departamento de Vigilância de Doenças e Agravos não Transmissíveis e Promoção da Saúde. Saúde Brasil 2014: uma análise da situação de saúde e das causas externas. Brasília: Ministério da Saúde;2014.
2. Neves ACM, Garcia LP. Mortalidade de jovens brasileiros: perfil e tendências no período 2000-2012. *Epidemiol Serv Saude*. 2015 out-dez;24(4):595-606.
3. Neves ACM, Garcia LP. Atendimentos de jovens vítimas de agressões em serviços públicos de urgência e emergência, 2011: diferenças entre sexos. *Cienc Saude Coletiva*. No prelo 2016.
4. 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 Saude Publica*. 2016 abr;32(4):e00011415.
5. World Health Organization. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence [Internet]. Geneva: World Health Organization; 2013 [cited 2016 Jun 21]. Available from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

6. Sena Y. Polícia apura terceiro estupro coletivo no Piauí em pouco mais de um ano [Internet]. São Paulo: Folha de São Paulo; 2016 [citado 2016 jun 21]. Disponível em: <http://www1.folha.uol.com.br/cotidiano/2016/06/1779541-policia-apura-terceiro-estupro-coletivo-no-piaui-em-pouco-mais-de-um-ano.shtml>
7. Paiva G. Garota presta depoimento à polícia após queixa de estupro coletivo no Rio [Internet]. São Paulo: Folha de São Paulo; 2016 [citado 2016 jun 21]. <http://www1.folha.uol.com.br/cotidiano/2016/05/1775312-garota-presta-depoimento-a-policia-apos-queixa-de-estupro-coletivo-no-rio.shtml>
8. Brasil. Lei 13.104, de 9 de março de 2015. Altera o art. 121 do Decreto-Lei nº 2.848, de 7 de dezembro de 1940 - Código Penal, para prever o feminicídio como circunstância qualificadora do crime de homicídio, e o art. 1º da Lei nº 8.072, de 25 de julho de 1990, para incluir o feminicídio no rol dos crimes hediondos. Diário Oficial da República Federativa do Brasil, Brasília (DF), 2015 mar 10; Seção 1:1.
9. Fórum Brasileiro de Segurança Pública. Anuário brasileiro de segurança pública 2015 [Internet]. São Paulo: Fórum Brasileiro de Segurança Pública; 2015 [citado 2016 jun 21]. Disponível em: http://www.forumseguranca.org.br/storage/download//anuario_2015.retificado_.pdf
10. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Departamento de Vigilância de Doenças e Agravos não Transmissíveis e Promoção da Saúde. Coordenação Geral de Doenças e Agravos não Transmissíveis e Promoção da Saúde. Nota: Estupros em mulheres. Brasília: Ministério da Saúde; 2016.
11. Ximenes R, Amaku M, Lopez LF, Coutinho FAB, Burattini MN, Greenhalgh D, et al. The risk of dengue for non-immune foreign visitors to the 2016 summer olympic games in Rio de Janeiro, Brazil. *BMC Infect Dis.* 2016 Apr;16:186
12. Bastos L, Villela DAM, Carvalho LM, Cruz OG, Gomes MFC, Durovni B, et al. Zika in Rio de Janeiro: assessment of basic reproductive number and its comparison with dengue. *BioRxiv.* 2016 May.
13. Escobar H. Risco de pegar zika nas Olimpíadas é menor que o de estupro, diz professor da USP [Internet]. São Paulo: Estadão; 2016 [citado 2016 jun 21]. Disponível em: <http://ciencia.estadao.com.br/blogs/herton-escobar/risco-de-pegar-zika-nas-olimpiadas-e-menor-que-o-de-estupro-diz-professor-da-usp/>
14. Ministério da Saúde (BR). Secretaria de Vigilância em Saúde. Departamento de Vigilância de Doenças e Agravos não Transmissíveis e Promoção da Saúde. Sistema de Vigilância de Violências e Acidentes (Viva): 2009, 2010 e 2011 [Internet]. Brasília: Ministério da Saúde; 2013 [citado 2016 jun 21]. Disponível em: http://bvsm.s.saude.gov.br/bvs/publicacoes/sistema_vigilancia_violencia_acidentes.pdf
15. Contreras JM, Bott S, Guedes A, Dartnall E. Sexual violence in Latin America and the Caribbean: a desk review [Internet]. Pretoria: Sexual Violence Research Initiative; 2010 [cited 2016 Jun 21]. Available from: <https://www.ciaonet.org/attachments/19595/uploads>
16. Rodrigo MLJ, Pérez IR. Medición de la violencia contra la mujer: catálogo de instrumentos. Granada: Escuela Andaluza de Salud Pública; 2008. 196 p.
17. Garbin CAS, Rovida TAS, Costa AA, Garbin AJI. Percepção e atitude do cirurgião-dentista servidor público frente à violência intrafamiliar em 24 municípios do interior do estado São Paulo, 2013-2014. *Epidemiol Serv Saude.* 2016 jan-mar;25(1):179-86.
18. Kury CMH, Kury MMH, Pereira CCR, Oliveira FA, Oliveira FC, Silva RMH, et al. Implantação de um centro na área das violências doméstica e sexual em Campos dos Goytacazes, Rio de Janeiro, 2009-2012. *Epidemiol Serv Saude.* 2015 out-dez;24(4):771-6.
19. Costa MS, Serafim MLE, Nascimento ARS. Violência contra a mulher: descrição das denúncias em um Centro de Referência de Atendimento à Mulher de Cajazeiras, Paraíba, 2010 a 2012. *Epidemiol Serv Saude.* 2015 jul-set;24(3):551-8.