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Intimate partner violence against pregnant women: sociodemographic profile and characteristics of the aggressions

Violência por parceiro íntimo à gestante: perfil sociodemográfico e características das agressões

Violencia de pareja íntima en gestante: perfil sociodemográfico y características de las agressiones

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RESUMO

Objetivo: Identificar o perfil sociodemográfico e as principais características da violência por parceiros íntimos em gestantes de São Paulo, Brasil.

Método: Estudo transversal realizado por meio das notificações de casos suspeitos ou confirmados de violência interpessoal do Sistema de Informação de Agravos de Notificação realizadas entre 2016 e 2019. A coleta foi feita entre março e junho de 2020. Realizado teste qui-quadrado ou exato de Fischer na análise estatística.

Resultados: Foram obtidas 4.269 notificações e o perfil prevalente foi de mulheres entre 20 e 34 anos (62,5%), pardas ou negras (51,3%), com ensino médio completo (22,5%) no primeiro trimestre da gestação (44,2%). A violência física foi a mais frequente (48,3%), ocorrida em domicílio (59,1%), motivada por sexismo (22,29%). Na violência sexual, o estupro foi o mais frequente (85,4%) com aborto nos casos previstos na lei (39%).

Conclusão: Mulheres adultas, pardas ou negras, no primeiro trimestre gestacional apresentaram maior frequência de violência física.

Palavras-chave: Violência por parceiro íntimo. Gravidez. Saúde da mulher. Vigilância em saúde pública. Enfermagem.

ABSTRACT

Objective: To identify the sociodemographic profile and the main characteristics of violence by intimate partners in pregnant women in São Paulo, Brazil.

Method: Cross-sectional study based on notifications for suspected or confirmed cases of inter-police violence from the National Disease Notification System (SINAN) carried out in the 2016-2019 period. Collection was performed between March and June 2020. Chi-squared test or Fisher's Exact test were used in statistical analysis.

Results: A total of 4,269 notifications were obtained and the prevalent profile was women between 20 and 34 years old (62.5%), brown or black (51.3%), who have completed high school (22.5%) in the first trimester of pregnancy (44.2%). Physical violence was more frequent (48.3%), occurred at home (59.1%), motivated by sexism (22.29%). Sexual violence or rape was more frequent (85.4%) with abortion in cases provided for by law (39%).

Conclusion: Adult brown or black women in the first gestational trimester experienced physical violence more frequently.

Keywords: Intimate partner violence. Pregnancy. Women's health. Public health surveillance. Nursing.

RESUMEN

Objetivo: Identificar el perfil sociodemográfico y las principales características de la violencia por parte de la pareja en mujeres embarazadas en São Paulo, Brasil.

Método: Estudio transversal realizado a través de notificaciones de casos sospechosos o confirmados de violencia interpersonal del Sistema de Información de Enfermedades Notificables realizadas entre 2016 y 2019. La recolección se realizó entre marzo y junio de 2020. Hecho prueba Chi-cuadrado o exacto de Fischer en análisis estadístico.

Resultados: Se obtuvieron 4.269 notificaciones, El perfil prevalente fue de mujeres entre 20 y 34 años (62,5%), morenas o negras (51,3%), con bachillerato completo (22,5%) en el primer trimestre de gestación (44,2%). La violencia física fue la más frecuente (48,3%), ocurrida en el hogar (59,1%), motivada por el sexismo (22,29%). En violencia sexual, la violación fue la más frecuente (85,4%) con aborto en los casos previstos por la ley (39%).

Conclusión: Las mujeres adultas, morenas o negras, en el primer trimestre gestacional tuvieron una mayor frecuencia de violencia física.

Palabras clave: Violencia de pareja. Embarazo. Salud de la mujer. Vigilancia en salud pública. Enfermería.

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INTRODUCTION

The term Intimate partner violence (IPV) is defined as domestic violence by a current or former spouse or partner in an intimate relationship[1]. IPV concerns any behavior that causes death, injury, physical, sexual or psychological suffering and moral or financial harm to the victim[2]. It is one of the factors that affect the lives of many women[3–4]. According to researchers, IPV should be widely discussed and identified early by health professionals, as it can cause harm to pregnant women and their infants, in addition to aggravating gender inequality[3].

Violence against women, at any stage of their life, is recognized as a public health problem that requires attention[4]. In Brazil, after the enactment of Law no 11.340/2006, known as the "Maria da Penha Law", violence against women has gained greater visibility, and is perceived as one of the biggest problems to be tackled by public health and human rights organizations[5].

Unfortunately, pregnant women can also be part of these sad statistics. Research indicates a high prevalence of IPV during pregnancy[2–3]. Studies conducted in Jamaica show that 36% of pregnant women are abused by their intimate partners. According to information provided by the WHO, there is a prevalence of violence during pregnancy of 8% in Japan, 32% in Brazil and 44% in Peru. In other words, violence against women is a multifaceted and global phenomenon[4–7]. Furthermore, when violence against women occurs during pregnancy, it requires greater care from health services, as it is a time when women go through many changes, which can be a more vulnerable phase due to psychological conditions, physical and emotional changes[4,6].

It should also be noted that violence against pregnant women impacts both the mother and the fetus and then the newborn, resulting in premature labor, hemorrhages, headaches, spontaneous abortions, depression, urinary tract infection, fetal trauma, early weaning and increased risk of perinatal and neonatal mortality[4–5]. However, recent searches in databases in the healthcare area revealed the lack of publications on the profile of victims and the most common forms of violence against them in this sensitive period of their lives. The absence of studies results in gaps in areas such as women's health nursing, which may reflect directly on the care provided to the mother-fetus binomial and on strategies for coping with intimate partner violence, as some researchers point out[5–6]. The few studies identified were carried out in cities or states in the South or Northeast regions of Brazil[3,5], and no broad epidemiological studies were found in highly populated and multicultural states, such as São Paulo, whose results could support the implementation of health or inter-sector policies and expand the measures to protect pregnant women.

Thus, the authors of this study proposed the following question: What are the most common characteristics of intimate partner violence (IPV) against pregnant women in the State of São Paulo? It is believed that the results found can help in planning actions to prevent violence against pregnant women, in addition to promoting public and care policies to help the victims.

Therefore, the present study aims to identify the sociodemographic profile and the main characteristics of intimate partner violence against pregnant women in the State of São Paulo, Brazil.

METHOD

Exploratory, descriptive study with a cross-sectional design[8] guided by the tool Strengthening the Reporting of Observational Studies in Epidemiology (STROBE).

Notification Forms for Suspected or Confirmed Cases of Interpersonal Violence of the National Disease Notification System (SINAN). Variables such as type of violence that occurred, profile of victim and aggressor, characterization of the occurrence and the major injury (when applicable) were analyzed. Information was also collected on patient's progress (outcome) and the referrals made by the health professionals who assisted the victims.

All information has been entered into the National Disease Notification System (SINAN) by the notifying units of the SUS network, such as Epidemiological Surveillance, Hospitals, Outpatient Medical Assistance Units (AMA) and the other public services of primary, secondary or tertiary care. Subsequently, the data were made available by the National Health Surveillance Department (SNVS) through TabNet, a software developed by the Information Technology Department of the Unified National Health System (DATASUS) and made available on the internet without access restrictions.

Inclusion criteria were notifications of suspected or confirmed cases of interpersonal violence against women at any time of pregnancy, assisted at public or private health units in the State of São Paulo, Brazil. Reports of violence whose gender and/or pregnancy were described as 'ignored' were excluded, as well as reports of suspected or confirmed cases of self-inflicted violence and suicide attempt. Separation of suspected from confirmed cases of interpersonal violence was not possible, because the same notification form is used for both cases. Such separation is also not possible with the TabNet system.

The study period was the period of notifications of events of violence and accidents that occurred between 2016 and

2019. Data for the year 2020 is not yet available at the SNVS (National Health Surveillance System). Data from compulsory notifications prior to 2016 were not used because of the possible inconsistence of such information, since violence has only been included in the SINAN as a notifiable event from 2016 onwards. Data was collected between January and March 2020 and tabulation was performed with the Excel 2007 software.

Univariate statistical analysis was performed using the following programs: Statistical Package for Social Sciences (SPSS), version 21.0 and R, version 4.0.2. As the data set is composed of categorical variables, a descriptive analysis of the data was carried out based on the calculation of simple absolute and percentage frequency. To verify the associations between the type of violence and other variables (motivation of violence, means of aggression, the possible occurrence of sexual violence, place of occurrence, gender of the perpetrator, aggressor's life cycle, referral, age group, race, education, marital status, disability and gestational age) chi-square or Fisher's exact tests were performed. A significance level of 5% ($\alpha = 0.05$) was considered. To assess perpetration of physical violence, a hypothesis test for equality of proportions was performed for cases of significance, multiple test (Bonferroni-Holm procedure) was used to verify in which pair of categories of any variable assessed there was a different in proportions. The same was done for the assessment of sexual and psychological violence. In the cases of low frequency of physical violence in any category of any variable, the category was disregarded in the comparisons of proportions. The same was done for the assessment of sexual and psychological violence.

In line with national and international standards, the project was submitted to the Research Ethics Committee of Universidade Federal de São Paulo and obtained a favorable opinion (no 7759210519/2019).

RESULTS

A total 4,269 cases of pregnant women who suffered some type of violence were reported in the 2016-2019 period in the State of São Paulo. Table 1 shows that 62.6% (2,669) of the women were aged 20-34 years at the time of the aggression, and 18% (766) were aged between 15-19 years.

According to the notifications, 39.7% (1,696) of the women declared themselves white and 38.5% brown (1,647), data that stands out when compared to the 12.8% who declared themselves black and 1.29% (55) indigenous. Regarding education, 22.5% of the pregnant women had completed high school. A small minority of the women, 0.5% (20), said they were illiterate. Most victims, 43% (1,835), said they were single and 33.8% (1,443) were married or living in a consensual union.

As it can be seen in Table 2, depending on the characteristics of some records, notifications could have more than one answer, such as types of violence and means of aggression. The most common type of violence was physical violence, with 48.3% (3,101), followed by psychological/moral violence with 23.6% (1,514) and sexual violence with 16.2% (1,044). The means of aggression most commonly used was physical force or beating, with 56.1% (2,768), followed by threat, with 16.6% (820).

As for the referrals (which could be more than one), it was found that 44.8% (2,561) of the pregnant women were referred to the Health Network (Basic Health Unit, specialized hospital, among others), 16.4% (939) to the Women's Assistance Network and 15% (862) to the Women's Police Station (Table 3).

The proportion of physical and sexual violence suffered by pregnant women aged between 20 and 34 years exceeds that of other age groups (p-value <0.001) with a significance level of 5%. On the other hand, there was greater compliance of psychological violence among pregnant women aged 15-19 years. Brown and black pregnant women suffered more sexual violence than women of other ethnicities (p-value=0.02). As for education, pregnant women with incomplete secondary education had a greater association with physical violence (p-value<0.032). Sexual violence was more common among women with incomplete higher education (p-value<0.001).

As for marital status, there was no difference in the proportions of psychological violence between marital classifications (p-value=0.402). However, regarding sexual and physical violence, married women had a higher proportion than the others (p-value<0.001). The gestational period with the highest statistical compliance in relation to all forms of violence was the first trimester (p-value<0.05).

As for the total value of IPV motivation due to sexism and generational conflict, the proportion of physical violence due to generational conflict (65.4%) was higher than sexism (34.4%). Multiple test (Bonferroni-Holm procedure) showed a difference in the proportion of physical violence between sexism and generational conflict (p-value<0.001). There was a difference in the proportion of psychological violence between the motivations: sexism and disability (p-value<0.001) and between generational conflict and disability (p-value<0.001).

The proportions of physical violence between the means of aggression differed: body strength/beating and all other categories of means of aggression (p-value<0.001). The test of equality of proportions showed difference between the proportions of sexual violence in the comparison of sexual harassment, rape and sexual exploitation (p-value<0.001). Multiple comparisons showed differences between sexual harassment and rape (p-value=0.001).

Table 1 – Socioepidemiological characteristics of pregnant women victims of intimate partner violence, São Paulo, Brazil, 2020.

Socioepidemiological characteristics	Notifications (N= 4,269)	
	N	%
Age range		
10-14	202	4.7
15-19	766	18
20-34	2,669	62.6
35-49	547	12.8
Ignored	85	2.0
Ethnicity/color		
Ignored/No answer	283	6.6
White	1,696	39.7
Black	548	12.8
Yellow	40	0.94
Brown	1,647	38.5
Indigenous	55	1.2
Education		
Ignored/No answer	1,121	26.3
Illiterate	20	0.5
Incomplete PE (1st to 4th grades)	134	3.1
Completed the 4th grade of PE	147	3.4
Incomplete PE (5th to 8th grades)	587	13.7
Complete primary education	344	8.1
Incomplete secondary education	567	13.3
Complete secondary education	962	22.5
Incomplete higher education	208	4.9
Complete higher education	179	4.2

Table 1 – Cont.

Socioepidemiological characteristics	Notifications (N= 4,269)	
	N	%
Marital Status		
No answer	43	1.0
Single	1,835	43
Married/Consensual union	1,443	33.8
Widowed	18	0.4
Separated	267	6.3
Not applicable	52	1.2
Ignored	611	14.3
Disability of any kind		
No answer	15	0.4
Yes	219	5.1
No	3,319	77.7
Ignored	716	16.8
Gestational age		
First trimester	1,889	44.3
Second trimester	1,308	30.6
Third trimester	767	18
Ignored	305	7.1

Source: SINAN (system of information on notifiable diseases and events), 2020.

There was a difference in the proportions of occurrence of physical and sexual violence between the different sites of occurrence (p-value<0.001). Regarding the gender of the perpetrator of physical aggression, there was a difference in the proportion between men and women (p-value<0.001), as well as in sexual violence (p-value<0.05).

There was a difference in the proportions of physical violence between the referrals: health network and almost all other referrals (p-value<0.05) except for social assistance network, women's police station and other police stations (p-value <0.001). Regarding sexual violence, the referrals also had the same trend (p-value<0.05).

Table 2 – Main characteristics of intimate partner violence against pregnant women. São Paulo, Brazil, 2020

Characteristics	Notifications (N= 4269)	
	N	%
Motivation of violence		
Sexism	952	22.3
Homophobia/Lesbophobia/Transphobia/Racism	21	0.5
Religious intolerance	3	0.1
Xenophobia	2	0.1
Generational conflict	279	6.5
Homelessness	31	0.7
Disability	36	0.8
Others	951	22.2
Ignored	1,994	46.7
Type of violence		
Physical Violence	3,101	48.3
Psychological/Moral Violence	1,514	23.6
Torture	128	2.0
Sexual Violence	1,044	16.2
Human Trafficking	4	0.1
Financial/Economic	82	1.3
Neglect/Abandonment	234	3.6
Other types of violence	315	4.9
Means of aggression		
Body strength/Beating	2,768	56.1
Hanging	196	4.0
Blunt instrument	137	2.8
Sharp Object	282	5.7

Table 2 – Cont.

Characteristics	Notifications (N= 4269)	
	N	%
Hot Substance/Object	41	0.8
Poisoning/intoxication	267	5.4
Firearm	101	2.0
Threat	820	16.6
Other Means	323	6.6
In the case of sexual violence		
Sexual Harassment	113	10.4
Rape	928	85.4
Child Pornography	4	0.3
Sexual Exploitation	16	1.5
Other Sexual Violence	26	2.4
Procedure performed in cases of sexual violence		
STI prophylaxis*	62	7.5
HIV prophylaxis	61	7.4
Hepatitis B Prophylaxis	47	5.7
Blood collection	125	15.2
Semen Collection	15	1.8
Collection of vaginal secretion	25	3.0
emergency contraception	167	20.3
Legal abortion	322	39.1
Site of the occurrence		
No answer	3	0.1
Residence	2,524	59.1
Collective Housing	87	2.0

Table 2 – Cont.

Characteristics	Notifications (N= 4269)	
	N	%
School	20	0.5
Sports practice venue	7	0.2
Bar or Similar	90	2.1
Public highway	689	16.1
Trade/Services	67	1.6
Industries/construction	7	0.2
Others	249	5.8
Ignored	526	12.3
Gender of the perpetrator of the aggression		
No answer	11	0,3
Ignored	282	6.6
Male	2,960	69.3
Female	898	21.0
Both genders	118	2.8
Aggressor's life cycle		
No answer	1	0.0
Child (0- 9 years)	16	0.4
Adolescent (10-19 years)	382	9.0
Young person (20-24 years)	757	17.7
Adult (25-59 years)	2,307	54.0
Elderly (60 years of older)	32	0.8
Ignored	774	18.1

Source: SINAN (system of information on notifiable diseases and events), 2020.
*STI: Sexually Transmitted Infections. **HIV: Human Immunodeficiency Virus.

Table 3 – Referrals of pregnant women victims of intimate partner violence, São Paulo, Brazil, 2020

Referrals	Notifications (N = 5717)	
	N	%
Health Network (Basic Health Unit, hospital, others)	2,561	44.8
Social Assistance Network	385	6.7
Education Network	24	0.4
Women's Assistance Network	939	16.4
Guardian Council	268	4.7
Human Rights Reference Center	8	0.1
Prosecutor's Office	15	0.3
Police Department for the Protection of Children and Adolescents	29	0.5
Women's Police Station	862	15.1
Other police stations	572	10
Infant and Juvenile Court	11	0.2
Public Defender's Office	43	0.8

Source: SINAN (system of information on notifiable diseases and events), 2020.

DISCUSSION

Analyzes of the records of notifications of violence against pregnant women perpetrated by intimate partners in São Paulo show that the educational profiles of women range from illiteracy to complete higher education, though with a predominance of secondary education. Another relevant piece of information in the referred data survey was marital status. Single pregnant women were victims of violence more often than married pregnant women, which can lead to infer that the absence of a stable partnership increased the chances of aggression. This finding cannot be correlated with national studies when compared to other states in Brazil, due to the scarcity of publications on the subject. A partial comparison of marital status can be made with studies carried out in Athens (Greece)[9] and Andalusia (Spain)[10], where most pregnant women raped by intimate partners in these regions were single (34.3% and 52.2%), respectively.

Regarding marital status and education analyzed in other studies, the information contrasts with the results of the present study, and even with those obtained in the aforementioned regions. A study carried out in Nepal[11] found that all pregnant women who suffered violence were married. Regarding education, other studies[9–10,12] contradict this scenario, and samples with individuals that had higher education, including complete higher education, were obtained in these studies.

Most pregnant women who suffered violence committed by their partners were between 20 and 34 years old, 62.5% (2,669). That is, they were young adults. This information is consistent with international research[9–11] that showed that the pregnant women victims of violence were over 25 years old. The age ranges of the women who participated in the studies are consistent with the findings of the present study and they are statistically similar in the other age ranges found.

The ethnicity/color of the pregnant women deserve mention. Around 51.3% of the total victims were brown and

black. This characteristic shows the greater vulnerability of non-white women. Although Brazil is a country with a great racial mixing and significantly influenced by African culture, women who identify themselves as black or brown often suffer more violence than women of other colors. Therefore, it can be seen that even hidden, racism and discrimination based on skin color are frequent in the Brazilian society and should be widely discussed and fought, especially when women are targeted[13].

Another important variable was the pregnant woman's gestational trimester at the time of the violence. The data obtained showed that most victims were in the first trimester of pregnancy, especially those who suffered physical violence (p-value <0.001), a period of high risk of complications to the fetuses and pregnant women caused by the various forms of violence. Studies show that experiences of violence, especially in the first trimester of pregnancy, can affect the safety of fetal formation, risks of placental abruption, bleeding, increased risk of spontaneous abortion, fetal death and morbidity and mortality of the pregnant woman[4–5]. Thus, it can be assumed that pregnant women and fetuses were at risk of life because they were attacked in this particular period.

International studies[14–15] also point out that there is a significant association between exposure to physical violence during pregnancy and premature birth or low birth weight in newborns. One of the authors' findings was that women exposed to intimate partner violence during pregnancy were three times more likely to give birth to low birth weight babies and to have premature births. However, these data cannot be associated with the present study, given the lack of follow-up data for pregnant women and fetuses in the compulsory notification forms. In addition, victims of IPV in the first gestational trimester are more likely to develop depression, anxiety, alcohol and drug abuse and suicidal ideation[9–11].

As for the types of violence perpetrated, it was evident that physical violence was the most frequent, with 48.3% (3,101), followed by psychological violence, 23.6% (1,514) of the reports and sexual violence,16, 2% (1,044), and these pregnant women may even have been victims of other types of aggression. As for the means of aggression used, 56.1% (2,768) of the women reported the use of physical force and/or beating. Physical aggression with the use of body strength was also identified in a study[9] as the most frequent among pregnant women, and the intimate partners were the aggressors. In the aforementioned study, the authors pointed out that the most affected parts of the body of the women were the face (51%), the lower limbs (15%) and the head (12%).

However, in 1,514 (23.6%) of the notifications analyzed, there was also psychological or moral violence against pregnant women, a remarkable fact given the possible repercussions for the mental health and dignity of these women. A study published in 2019[14] pointed to a convergent prevalence with this finding, with a high frequency of forms of violence against the psychological and moral integrity of pregnant women, in which the perpetrator of violence exercised moral and social control over the victims. According to the study authors, 25.7% of pregnant women had regular partners with abusive behavior or who exercise social control, such as restricting the victims' contact with their families or visits from friends. Other studies[12,15] corroborate that there are high rates of psychological violence caused by insults, humiliation, intimidation, threats of injury to the victim or someone in their family. Reports of accusations of sexual relationships or love affairs between the pregnant women and other partners were also mentioned[15–16].

Of the 1,087 notifications of sexual violence carried out, 85.4% were characterized as rape and sexual harassment (p-value<0.001). As this is a study of data contained in an information system, it was not possible to establish how many of these victims acquired Sexually Transmitted Infections or became pregnant because of violence. However, only 20.3% of these women received emergency contraception, a fact that increases the risk of unwanted pregnancy. Perhaps for this reason, there was a high number of cases of abortion as an outcome (39.1%). Although the number of rape notifications has grown in Brazil, about 590% from 2009 to 2013, which has given greater visibility to the problem and contributed to the adoption of measures to deal with the situation, it is still frightening to find high levels of this health issue in epidemiological studies[17]. The perpetration of this violence by intimate partners can be even greater, because when it comes to a stable affective relationship, women do not always feel safe to report what happened or even tend to trivialize the fact.

In addition to the strengthening and empowering of women, improvement of public health policies and prompt reporting of cases, health services must be prepared to provide humanized and efficient care, including the provision of emergency contraception in accordance with the recommendations of lines of care for victims of sexual violence. Value judgments, beliefs and moral standards are still barriers to be faced even in health units and that result in a lower supply of emergency contraception[18].

Analysis of the motivation for violence against pregnant women showed that sexism was the most frequent reason, accounting for 22.3% of the cases. This means that the intimate partners viewed their companions, the pregnant

women, as subordinate and inferior to them, as someone who must fulfill their wishes and/or who deserve to suffer discrimination or prejudice simply because of their sex or gender. Of all the motivations for violence against women, this is perhaps the most common and the most regrettable, since assaulting someone because of their biological condition (sex) or social identity (gender) is an outrage to the human condition, to the subject itself[19]. Sexism can be both a motivation and a manifestation of violence, as it translates into prejudice and discrimination, in addition to a stereotype about these victims as being inferior.

The attitude of discrimination based on sex or gender is presented by the authors[11] as one of the possible causes of sexual abuse during pregnancy, as they point out that most pregnant women claim that their partners insist on having sex, as a way of domination, or unilateral satisfaction. They also report that many pregnant women recognize the sexual act as violence when their partners insist on having sex in conditions that seemed to be degrading or humiliating.

Regarding the life cycle of the perpetrators of violence, it was found that most of them (54%) were aged between 25 and 59 years, being therefore much older than their victims. Studies on power relations between male offenders and female victims of violence reveal that the feelings of superiority of perpetrators of violence can have different origins, such as the fact that they are older than the victims and think that younger people must be subject to their whims[9,15].

Regarding the actions taken to assist these women, it was found that 44.8% (2,561) of the victims were referred to the health network (Basic Health Unit, hospital or similar), 16.4% (939) for the Women's Assistance Network and 15% (862) for the Women's Police Station. Specialists on this subject claim that prompt referral to the health network is one of the main ways to prevent risks secondary to violence, as well as ensuring full health rights to these women, including their reproductive health rights[18–20]. Professionals who perform their duties in basic health units, general or specialized hospitals and other equipment directly or indirectly linked to the Unified Health System must be trained to welcome pregnant women victims of violence, for follow-up appointments, to conduct clinical and laboratory tests and for the prevention and control of possible complications or other injuries. In the case of sexual violence, immediate provision of emergency contraception, testing for HIV and Sexually Transmitted Infections, and guidance on termination of pregnancy should also be ensured in cases provided for by law[20].

It should be noted that there are frequent disparities between data on notifications of violence made by health services and registration of complaints of domestic violence in police departments[14]. Some of the justifications pointed out in research are the fear of the intimate partner, the maintenance of a relationship of affection with the aggressor, fear (embarrassment) of public exposure and police assistance, and even trivialization of violence[15–17].

Although the information listed in the notification form contributes considerably to the recognition of the profile and epidemiological characteristics of the situation of violence suffered by pregnant women in São Paulo, this study has some limitations, such as the interpretation of information extracted from the notification form of suspected or confirmed cases of violence, as this instrument that does not provide data on the end of the woman's gestational period, for example, or about any possible complications during childbirth, whether with the baby or with the victim, aspects that would be relevant for the analysis. Another limitation is the possibility of inclusion of notifications after the data collection period for this study, considering the dynamics of the platform and the late closure of cases. Finally, another limitation concerns the size of the sample: our findings were obtained in only one Brazilian state and may differ in other regions of the country.

CONCLUSION

The results obtained in this study show that most victims were single, had incomplete high school or lower, and aged 20-34 years. As for the types of violence, it was found that physical violence is the aggression that most affects pregnant women. As for the means of aggression used, the victims reported mostly the use of physical force and/or beating. The main perpetrator of violence, according to the results, is the spouse and most aggressors were aged 25 -59 years. As for the actions taken to assist the pregnant women victims of violence, it was found that most victims were referred to the health network, but few were referred to specialized police stations.

It is believed that the results of this study can significantly contribute to nursing and other healthcare professions, since the identification of the profile of victims and the characteristics of interpersonal violence can foster discussions on public policies for the prevention of this event and the creation of safer ways to care for pregnant women victims of violence. Obviously, new similar studies in other Brazilian states and deeper correlational statistical analyzes are needed to understand the phenomenon. However, this study triggers a reflection about an important topic.

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