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ORIGINAL ARTICLE

Notification of self-inflicted and interpersonal violence among the LGBT population, state of Rio de Janeiro, 2015-2021

Notificação de violência autoprovocada e interpessoal da população LGBT, estado do Rio de Janeiro, 2015-2021

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ABSTRACT This study aims to compare the characteristics of violence notifications between the LGBT and other populations, which occurred in the state of Rio de Janeiro from 2015 to 2021. This is an observational epidemiological study of the repeated panels type, based on data of notification of violence, occurred in the age group of 18 to 59 years, made available by the state of Rio de Janeiro. 114,093 notifications were eligible, with only 2.8% referring to the LGBT population. However, there was an increase in the proportion of notifications in this population (β = 0.46; p < 0.001), reaching 4.5% in 2021. Most notifications of self-inflicted and interpersonal violence occurred among the youngest from 18 to 39 years and blacks, being proportionally higher among the LGBT population (p < 0.001). Physical violence was the most reported (90.5%). Notification of torture (2%) and sexual violence (8%) were proportionally higher in this population (p < 0.001), but torture showed a slight decline in the period (β = -0.19; p = 0.039). The expansion of notification filling, beyond the health institutions, could contribute to the reduction of underreporting and, consequently, give greater visibility to the violence experienced, in particular by the LGBT population.

KEYWORDS Violence. Health information systems. Vulnerable populations. LGBT persons. Human rights.

RESUMO *Este estudo teve como objetivo comparar as características das notificações de violência na população LGBT com as demais populações, ocorridas no estado do Rio de Janeiro no período de 2015 a 2021. Trata-se de uma pesquisa epidemiológica observacional do tipo painéis repetidos, com base em dados de notificação de violências ocorridas na faixa etária de 18 a 59 anos, disponibilizados pelo estado do Rio de Janeiro. Foram elegíveis 114.093 notificações, sendo apenas 2,8% referentes à população LGBT. Houve, entretanto, um aumento da proporção das notificações nessa população (β = 0,46; p < 0,001), atingindo 4,5% em 2021. A maioria das notificações de violência autoprovocada e interpessoal ocorreu nos mais jovens, de 18 a 39 anos, e nos(as) negros(as), sendo proporcionalmente maior entre a população LGBT (p < 0,001). A violência física foi a mais notificada (90,5%). A notificação de tortura (2%) e a violência sexual (8%) foram proporcionalmente maiores nessa população (p < 0,001), mas a tortura apresentou leve declínio no período (β = -0,19; p = 0,039). A ampliação do preenchimento da notificação, para além das instituições de saúde, poderia contribuir para redução da subnotificação e, consequentemente, dar maior visibilidade à violência vivenciada, em particular, pela população LGBT.*

PALAVRAS-CHAVE *Violência. Sistema de Informação de Agravos de Notificação. Populações vulneráveis. Pessoas LGBT. Direitos humanos.*

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Introduction

In Brazil, accident and violence surveillance was being carried out through the analysis of information from the Mortality Information System (SIM) and the Hospital Information System of the Unified Health System (SIH/SUS). Deaths represent a small portion of cases, because they generally result from extreme interpersonal violence that occurs in different contexts of social interrelationships, such as urban, rural or domestic spaces. Additionally, in domestic violence, episodes of mistreatment tend to be repetitive and, in the beginning, do not usually lead to death or even hospitalization[1]. The World Health Organization (WHO)[2], however, recognizes that there are still advantages in mortality information systems, as they are generally universal and of good quality; but it must be remembered that their data underestimate the true magnitude of the violence.

SIH/SUS, by only capturing cases that required hospitalization, also underestimates the magnitude of violence[3,4]. Furthermore, due to the care logic of this system, its scope is restricted to hospitalizations paid for by the SUS, its own or partner network[5]. Additionally, when filling out the Hospital Admission Authorization, a form that feeds the SIH/SUS, although there is a field for information on the cause of hospitalization (code from chapter XX of ICD-10), often, only the nature of the injury is reported (chapter IX of ICD-10), making it impossible to know what type of external cause led to hospitalization[6].

Another limitation in relation to the surveillance of external causes, inherent to the two systems mentioned above, is the fact that the information provided through them is restricted to the victim, and in a succinct way, with the description of the event restricted to the ICD-10 code. These systems do not provide detailed information about the occurrence, its consequences and the profile of the victim and the likely perpetrator in cases of violence[3].

For all the reasons mentioned, it is clear that considering only with the analysis of data from SIM and SIH/SUS, external causes are underestimated[3,4]. Consequently, the scope of measures to promote health and a culture of peace, and to prevent and control external causes also becomes smaller, especially in relation to domestic and sexual violence and other violence that remains with little visibility[7].

In this sense, the implementation of the Violence and Accident Surveillance System (VIVA) aimed at obtaining a more sensitive diagnosis of cases with external causes that require care in the health network, especially those not recognized and not incorporated into the SIM and SIH /SUS[3,4]. In 2006, the Ministry of Health implemented VIVA within the scope of the SUS, in two components: i) surveillance of domestic, sexual, and/or other interpersonal and self-inflicted violence (VIVA Continuous), and ii) surveillance of violence and accidents in hospital emergencies (VIVA Sentinel), with the aim of generating broader assessments of the impact and characterization of violence in all regions of the country. This surveillance strategy is configured as a tool for acquiring information that can be used to plan and execute measures to prevent so-called external causes and morbidity and mortality in Brazil.

VIVA aims to provide reliable information about external causes to support the formulation of intersectoral and integrated public policies that reduce morbidity and mortality from these conditions and that promote health and a culture of peace[7,8]. Gawryszewski and collaborators[4] add that the implementation of VIVA also aims to support the evaluation of implemented actions and better planning of resources and services. The implementation of this system, in its VIVA Continuous and VIVA Sentinel components, is the responsibility of the State Health Departments (SES) in partnership with the Municipal Health Departments (SMS). The recording of data in the Notifiable Diseases Information System

(SINAN) module is fed by SMS, mainly for the notification and investigation of cases of diseases and conditions that appear on the national list of compulsory notification diseases, which is the responsibility of Health/Epidemiological Surveillance of states and municipalities[8].

The systematization of data makes it possible to characterize the types and nature of the violence committed, the profile of the victims and the likely perpetrators of the violence. Another important aspect of the notification device is related to the need to record the data collected in the forms, as this information should support the public authorities and the three spheres of management of the SUS, at the federal, state and municipal levels, regarding the definition of priorities and public policies to prevent violence and promote health, coordinating the different members of the care networks that make up the SUS[8]. With VIVA Contínuo, the notification of violence must be understood beyond an instrument to obtain and produce epidemiological information, but as a subsidy to guarantee the rights to health and life, and, also, as an incentive to the formation of a social protection network and comprehensive health care, following the line of health care[8].

That said, the inclusion of the Lesbian, Gay, Bisexual, Transvestite, Transsexual or Transgender (LGBT) population in the notification of violence occurred from 2015 onwards, recognizing sexual orientation and gender identity as social determinants of health and the right to the use of a social name. In this panorama, one can observe the particularities, complexity and guarantee of public policies that permeate the issue of LGBT rights, since Brazil has the highest number of murders against this population[9].

The present study aims to compare the characteristics of the notifications of violence in the LGBT population with other populations, which occurred in the state of Rio de Janeiro from 2015 to 2021.

Methodology

An observational epidemiological research of the repeated panels type[10] was carried out to understand the interpersonal and self-inflicted violence that occurred in the LGBT population reported in the state of Rio de Janeiro in the period from 2015 to 2021. The data came from notifications of interpersonal and self-inflicted violence made available by the state of Rio de Janeiro. The research (CAAE: 54012221.2.0000.5240) was approved by the Research Ethics Committee (CEP) of the Sergio Arouca National School of Public Health of the Oswaldo Cruz Foundation, number 5.170.411, issued on December 16, 2021.

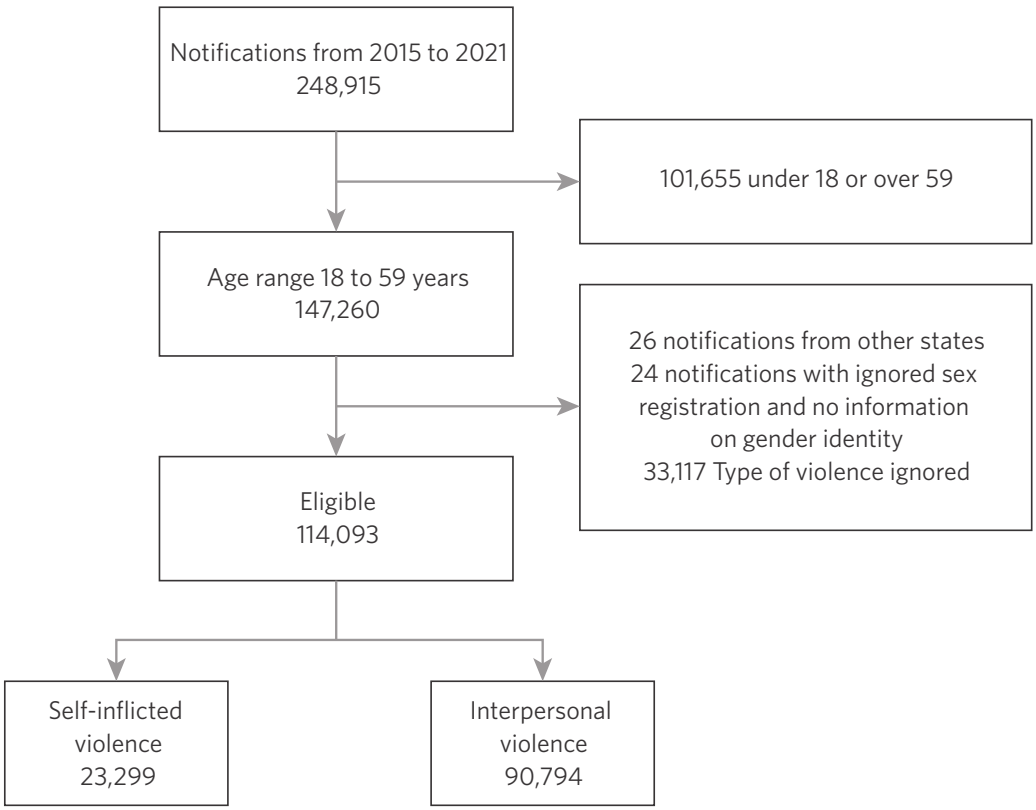
Variables related to the victim's socioeconomic and demographic characteristics were analyzed (sex, sexual orientation, gender identity, race/color, education, age group, municipality of notification), characteristics of the aggression (interpersonal or self-inflicted violence, type of aggression, motivation) and referrals made.

The percentage of each category of the studied variables was calculated, stratifying by LGBT population and others (non-LGBT population). Pearson's chi-square test was calculated to assess the existence of a statistically significant difference ($p \leq 0.05$) between the strata, with Yates correction when necessary. The temporal trend was described using the year of notification as the independent variable, and the proportion of the characteristics studied as the dependent variable. The evaluation was carried out by generalized linear regression, using the Prais-Winsten method, which is recommended for analyzing short series with autocorrelation or serial correlation, a common situation in time series of social phenomena[11]. The increase or decline in proportions was evaluated based on the regression coefficient (β) and respective statistical significance ($p \leq 0.05$). The data were analyzed using the R program.

Results

In the period from 2015 to 2021, 248,915 acts of violence were reported in the state of Rio de Janeiro. Of these, 114,093 were eligible, 70.6% of which corresponded to notifications of interpersonal violence (*figure 1*).

Figure 1. Diagram of the procedure for selecting violence notification records in the state of Rio de Janeiro, from 2015 to 2021[a]

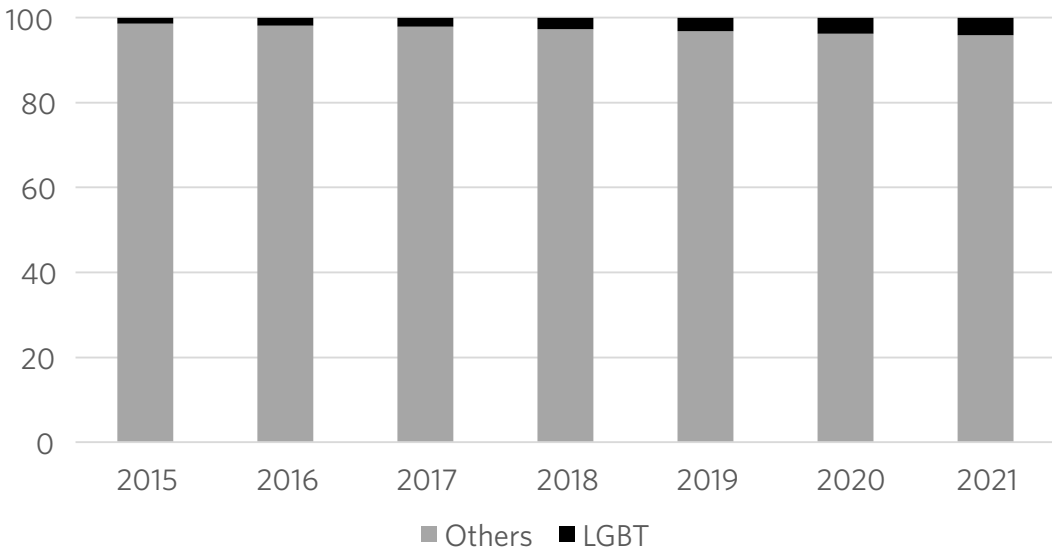


Source: Own elaboration.

[a] Data made available on 01/05/2022.

Only 2.8% of notifications of violence referred to the LGBT population. There was, however, an increase in the proportion of notifications in this population in the period ($\beta = 0.46$; $p < 0.001$), ranging from 1.4% in 2015 to 4.1% in 2021 (*graph 1*).

Graph 1. Proportional distribution of notifications of interpersonal and self-inflicted violence by type of population and year. Rio de Janeiro, 2015 to 2021[a]

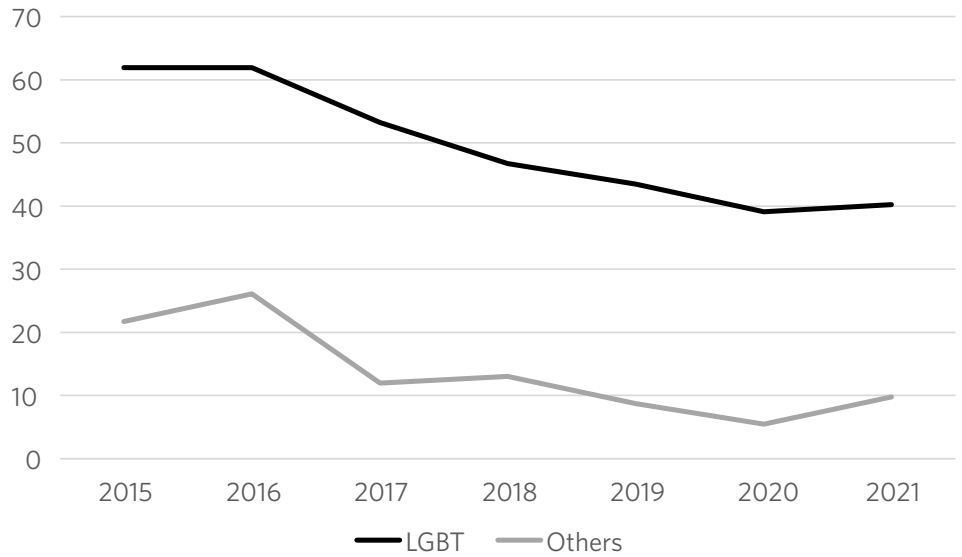


Source: Own elaboration.

[a] Data made available on 01/05/2022..

The municipality of Cardoso Moreira did not record any notifications of violence during the period. Another 18 municipalities did not report violence against the LGBT population: Angra dos Reis, Bom Jardim, Cambuci, Cantagalo, Conceição de Macabu, Cordeiro, Engenheiro Paulo de Frontin, Italva, Laje do Muriaé, Miracema, Paty do Alferes, Santa Maria Madalena, São Francisco de Itabapoana, São João da Barra, São José de Ubá, Sapucaia, Trajano de Moraes and Varre-Sai. There was a significant reduction in the percentage of municipalities without notifications of violence among the LGBT population, ranging from 62% in 2015 to 40.2% in 2021 ($\beta = -4.35$; $p < 0.001$); as well as of the other populations ($\beta = -3.25$; $p = 0.002$) (*graph 2*).

Graph 2. Proportional distribution of municipalities without reports of interpersonal and self-inflicted violence by type of population and year. Rio de Janeiro, 2015 to 2021[a]



Source: Own elaboration.

[a] Data made available on 01/05/2022.

Self-inflicted violence received 23,299 notifications, 3.6% of which corresponded to the LGBT population (*table 1*). The majority of notifications occurred among younger people, aged 18 to 39 (72.9%), being proportionally higher among the LGBT population (87.2%; $p < 0.001$), and with a tendency towards stability in the period ($p = 0.096$). The black population was also the majority (45.5%), but with a high percentage of ignored information (22.4%), in particular, for the non-LGBT population ($p < 0.001$), but with a drop in the period ($\beta = -1.92$; $p = 0.018$). Education level had high number of ignored records (68.7%), compromising the analysis and with a stable trend in the period evaluated ($p = 0.072$). The majority were referred to the health sector (64.3%), followed of social assistance (7.2%), being proportionally higher for the LGBT population (68.7% and 9.3% respectively; $p \leq 0.016$). The majority of referrals remained stable during the period ($p > 0.05$). In the LGBT population, however, there was a decline in referrals to women's police stations ($\beta = -0.53$; $p = 0.049$). In the others, there was an increase in referrals to the health area ($\beta = 4.2$; $p = 0.009$), social assistance ($\beta = 0.93$; $p < 0.001$) and women's police station ($\beta = 0.37$; $p = 0.025$); and decline for other police stations ($\beta = -0.92$; $p = 0.008$).

Table 1. Characteristics of notifications of self-inflicted violence and referrals made by type of population. Rio de Janeiro, 2015 to 2021[a]

	Total		LGBTQIA+		Others		
Characteristics	**N**	**%**	**N**	**%**	**N**	**%**	**p**
Age group							
18 to 39	16983	72.9	738	87.2	16245	72.4	< 0.001
40 to 59	6316	27.1	108	12.8	6208	27.6	
Race/skin color							
White	7310	31.4	306	36.2	7004	31.2	< 0.001
Black	10599	45.5	426	50.4	10173	45.3	
Yellow or indigenous	175	0.8	5	0.6	170	0.8	
Ignored or blank	5215	22.4	109	12.9	5106	22.7	
Education							
Incomplete Primary School	1626	7.0	54	6.4	1572	7.0	< 0.001
Complete Primary School or Superior Education	5656	24.3	394	46.6	5262	23.4	
Ignored or blank	16017	68.7	398	47.0	15619	69.6	
Referral							
Health	14989	64.3	581	68.7	14408	64.2	0.008
Social assistance	1671	7.2	79	9.3	1592	7.1	0.016
Education[b]	28	0.1	3	0.4	25	0.1	-
Women's Care Center	480	2.1	21	2.5	459	2.0	0.449
Reference Center for Human rights[b]	23	0.1	1	0.1	22	0.1	-
Public Ministry[b]	40	0.2	0	0.0	40	0.2	-
Women's Police Stations	395	1.7	14	1.7	381	1.7	1.000
Other police stations	1024	4.4	54	6.4	970	4.3	0.005
Public defender's office[b]	43	0.2	5	0.6	38	0.2	-
Total	**23299**	**100.0**	**846**	**100.0**	**22453**	**100.0**	**-**

Source: Own elaboration.

[a] Data made available on 01/05/2022.

[b] Insufficient data for comparison.

Among the LGBT population with notifications of self-inflicted violence, the majority were homosexual (76.5%). All those who declared to be heterosexual were transgender (6.6%). Regarding gender identity, 21.2% were transsexuals, in particular, transgender women (12.3%).

In relation to notifications of interpersonal violence, the characteristics of the population are presented in *table 2*. The majority of notifications also occurred among younger people, aged 18 to 39 (73.6%), and was proportionally higher in the LGBT population (81.2%; $p < 0.001$), and with an increasing trend in the period ($\beta = 0.87$; $p = 0.019$). There was also a predominance of the black population (51.9%), as well as a high percentage of ignored information (18.7%), mainly for the non-LGBT population (19%; $p < 0.001$), but with a stable trend in the period ($p = 0.112$). The education variable also showed a high percentage of ignored records (56.1%), being proportionally higher for the non-LGBT population ($p < 0.001$), but with a stable trend in the period ($p = 0.992$).

Physical violence was the most reported (90.5%), being proportionally higher among the non-LGBT population ($p < 0.001$) and with a tendency to increase in the period ($\beta = 0.99$; $p = 0.027$), but with the possibility of positive autocorrelation ($d = 1.35$). Reporting of negligence and police/legal violence was also higher in the non-LGBT population ($p < 0.001$), but with a stable trend in the period ($p \geq 0.055$). Notifications of torture and sexual violence was proportionally higher in the LGBT population ($p < 0.001$), but torture showed a slight decline in the period ($\beta = -0.19$; $p = 0.039$).

With regard to referrals, the majority also went to the health area (39.6%), followed of police stations (26.3%) (*table 1*). In the LGBT population, referrals to social assistance (7.8%), police stations (32%) and Human Rights Reference Center (0.6%) were proportionally higher ($p < 0.001$), while in the others, it was the police station of care for women (18.8%; $p = 0.002$).

In the LGBT population, referrals showed an increasing trend in the period to health areas ($\beta = 5.24$; $p = 0.006$), social assistance ($\beta = 1.20$; $p = 0.002$) and public defender's office ($\beta = 4.2$; $p = 0.003$); and decline for police stations ($\beta = -1.94$; $p = 0.004$). In the non-LGBT population, there was also a tendency towards an increase in referrals to the health sector ($\beta = 3.54$; $p = 0.003$), social assistance ($\beta = 0.88$; $p = 0.001$) and public defender's office ($\beta = 0.42$; $p = 0.002$); but also to the women's police station ($\beta = 1.05$; $p = 0.020$).

Table 2. Characteristics of notifications of interpersonal violence by type of population. Rio de Janeiro, 2015 to 2021[a]

	Total		LGBTQIA+		Others		
Characteristics	**N**	**%**	**N**	**%**	**N**	**%**	**p**
Age group							
18 to 39	66839	73.6	2489	81.2	64350	73.4	< 0.001
40 to 59	23955	26.4	576	18.8	23379	26.6	
Race/skin color							
White	25819	28.4	1003	32.7	24816	28.3	< 0.001
Black	47124	51.9	1674	54.6	45450	51.8	
Yellow or indigenous	859	0.9	32	1.0	827	0.9	
Ignored/Blank	16992	18.7	356	11.6	16636	19.0	
Education							
Incomplete Primary School	10051	11.1	372	12.1	9679	11.0	< 0.001
Complete Primary School or Superior Education	29791	32.8	1406	45.9	28385	32.4	
Ignored/Blank	50952	56.1	1287	42.0	49665	56.6	
Type of Violence[b]							
Physical	82141	90.5	2604	85.0	79537	90.7	< 0.001
Psychological	31855	35.1	1122	36.6	30733	35.0	0.076
Torture	1789	2.0	93	3.0	1696	1.9	< 0.001
Sexual	7271	8.0	571	18.6	6700	7.6	< 0.001
Traffic[c]	23	0.0	0	0.0	23	0.0	-
Financial	1793	2.0	74	2.4	1719	2.0	0.087
Negligence	726	0.8	8	0.3	718	0.8	< 0.001

Table 2. Characteristics of notifications of interpersonal violence by type of population. Rio de Janeiro, 2015 to 2021[a]

	Total		LGBTQIA+		Others		
Characteristics	**N**	**%**	**N**	**%**	**N**	**%**	**p**
Policial/Legal	572	0.6	3	0.1	569	0.6	< 0.001
Others	1152	1.3	22	0.7	1130	1.3	0.007
Refferal							
Health	35999	39.6	1263	41.2	34736	39.6	0.075
Social Assistance	5340	5.9	238	7.8	5102	5.8	< 0.001
Education	165	0.2	8	0.3	157	0.2	0.405
Woman's Care Center	13794	15.2	472	15.4	13322	15.2	0.765
Reference Center for Human rights	232	0.3	18	0.6	214	0.2	< 0.001
Public Ministry	465	0.5	20	0.7	445	0.5	0.328
Woman's Police Stations	17015	18.7	508	16.6	16507	18.8	0.002
Other police stations	23866	26.3	981	32.0	22885	26.1	< 0.001
Public defender's office	147	0.2	4	0.1	143	0.2	0.833
Total	**90794**	**100.0**	**3065**	**100.0**	**87729**	**100.0**	**-**

Source: Own elaboration.

a Data made available on 01/05/2022.

[b] Non-exclusive categories.

[c] Insufficient data for comparison.

The majority of notifications did not record the reason for the violence (73.9%). Among those that registered, sexism stood out, being 48.7% in the LGBT population and 68.9% in the others, followed by generational conflict, 12.5% and 22.9% respectively. In the LGBT population, violence for homophobic or transphobic reasons corresponded to 0.4% of notifications.

Among the LGBT population with notifications of interpersonal violence, the majority were homosexual (69.1%). Regarding gender identity, 26.5% were transsexuals, in particular, transgender women (18.1%).

Discussion

Notification of violence was implemented in Brazil more than ten years ago[12], however, the municipality of Cardoso Moreira did not show any records during the period studied. The inclusion of the LGBT population in the notification of violence occurred eight years ago[13], but 40.2% of municipalities in the state of Rio de Janeiro did not notify in 2021. There was, however, a significant reduction in the percentage of municipalities without notification of violence in this population in the evaluated period.

The percentage of notifications of violence involving the LGBT population has increased in recent years ($\beta = 0.46$; $p < 0.001$), reaching 4.5% in 2021, but is still very low; considering that, every 29 hours, one of these people is killed in Brazil[14]. A study carried out in the country, from 2015 to 2017, had already found an increase in notifications from this population in the period[15].

Although the inclusion of the sexual orientation and gender identity variables in the violence notification form is recent, there is greater investment, especially by the social movement, in disseminating information about this population, in addition to professionals

that are looking into better qualifications to understand and care for this social segment. However, there is still no legislation to combat violence based on sexual orientation and gender identity. In the Federal Chamber, a bill was submitted that provided for the criminalization of various forms of discrimination throughout the national territory, including LGBTphobic discrimination[16], but it is still being processed in committees before going to the Plenary. The Federal Supreme Court, however, intervened to include discrimination against the LGBT population and others[17] in the racism law[18] until Congress approves a specific law, aiming to minimize this problem.

It is still a challenge to sensitize professionals to introduce in their practice the act of notify, which is probably due to a lack of knowledge about how to proceed in these cases due to prejudices and difficulties in approaching these issues. Furthermore, the isolation of the health professional, who is faced with a complex case, without having anyone to share it with, without knowing how to proceed, favors the high percentage of inconsistencies identified. Discriminatory and exclusionary care, which still occurs, can also be a barrier to access for the LGBT population to health services, especially for transgender people[14,19-21].

There is a need for continued training of health professionals in order to activate sensitivity and perception for humanized care, as provided for in the National Policy for Comprehensive Health for Lesbians, Gays, Bisexuals, Transvestites and Transsexuals (PNSI-LGBT)[22], as well as to properly complete the notification form. However, work in health services often presents an overload for professionals, as experienced during the COVID-19 pandemic and in emergency care, and the requirement to fill out yet another extensive and detailed form can be considered excessive. Furthermore, it is also necessary to take into account that, generally, professionals receive little institutional support to carry out notification, as it is not considered a priority in assistance.

Professionals from other sectors, such as education, social assistance, Human Rights Reference Centers, indigenous health, guardianship councils, specialized women's care centers, among others, can also make the notification[13]. It is important to highlight that notification by sectors, in addition to health, contributes to expanding information for better formulation of public policies, strengthens care networks and keeps it from being restricted to the health area alone.

The majority of notifications of self-inflicted violence occurred in younger people, aged 18 to 39 (72.9%), and in black people (45.5%), being proportionally higher in the LGBT population ($p < 0.001$). Studies carried out in the country have also identified a predominance of the black population in violence occurring in the LGBT population, both in notifications[15] and in deaths[14].

Regarding notifications of self-inflicted violence among the LGBT population, the majority were homosexuals (76.5%), and among transsexuals, women were the most affected (12.3%). In the study carried out in the state of Paraná, a similar characteristic was identified, with 33.7% of notifications in lesbians, 24.9% in gays and 19% among transsexual women23. The study also found that 29% of notifications were of attempted suicide. The vulnerability of transsexual women has also been presented in the last three of the National Association of Transvestites and Transsexuals[24]. Furthermore, the survey based in newspaper reports published in the Brazilian media and on social networks found that, of the 300 violent deaths that occurred in Brazil in 2021, 8% were suicides[14].

Suicide is considered a global public health problem, as it already represents the second cause of death among young people aged 15 to 29[25]. This led the WHO to prioritize mortality reduction and include it as an indicator in the United Nations Sustainable Development Goals (SDGs) under target 3.4, as well as in

the 13th General Program of Work 2019-2023 and the Comprehensive Action Plan of Mental Health 2013-2030, both from WHO. As for the global suicide rate, although it decreased between 2010 and 2016, there was an increase of 6% on the American continent.

Suicide prevention ranges from offering the most appropriate conditions for effective care and treatment of people in psychological distress to environmental control of risk factors. Such violence increases the weight of social disapproval on the unconscious and self-esteem of people who are victims of this injury – and some of them have not been able to bear the pain caused by the gaze and criticism to the point of taking their own lives. In the LGBT population and others, it is revealed how painful and difficult it is to deal with sexuality outside the framework of heteronormativity, in a cissexist society[26]. Suffering, embarrassment, murders and suicides are often motivated by the lack of recognition of trans experiences[27], a group that is still little studied in Brazil, and which, in the present study, presented a low percentage of notifications of violence, both provoked and interpersonal.

The notification is part of a dimension of the care line, which also includes reception, care and reference to the assistance and social protection network. The reported cases of self-inflicted violence were mainly referred to health care (64.3%), followed of the social assistance (7.2%), being proportionally higher for the LGBT population (68.7% and 9.3% respectively). The trend of referrals for the LGBT population to these areas remained stable during the period ($p > 0.05$), however, there was a decline for women's police station. The impact on mental health and suicidal behavior is more likely in this population[26], and the availability of this information is essential to identify the magnitude of this problem, as well as improving the provision of care, involving more qualified teams in the territories to provide adequate reception, follow-up service and insertion in the intra and intersectoral network. On the other hand, for the non-LGBT population, there was an increase in referrals to health, social assistance and women's police stations, and a decline to other police stations.

In relation to notifications of interpersonal violence, there was also a predominance of younger and black people, and, similarly, proportionally greater in the LGBT population. This situation corroborates the structural racism that exists in society, in which black people are at imminent risk of suffering violence due to the color of their skin because of prejudice and discrimination[28].

Physical violence was the most reported (90.5%), mainly in the non-LGBT population, and with an increasing trend in the period. Notifications of torture (2%) and sexual violence (8%) were proportionally higher among the LGBT population, but torture showed a slight decline in the period. A study carried out in Brazil, from 2015 to 2017[15], also identified notifications of physical violence as the most frequent among the LGBT population (75%), followed by psychological (28.7%) and sexual violence (11.2%). The majority of notifications did not record the reason for the violence (73.9%). The absence of this record compromises care, protection of people and the formulation of public policies. Among those who registered, sexism stood out, with 48.7% in the LGBT population and 68.9% in the others, followed by generational conflict, with 12.5% and 22.9% respectively. In the LGBT population, violence for homophobic or transphobic reasons corresponded to 0.4% of notifications, mainly among transgender women. This population is very vulnerable to violence, given the difficulty of acceptance by society, generating prejudice, discrimination, prejudgment and rights violations. It was only in April 2022 that the 6th panel of the Superior Court of Justice recognized that the Maria da Penha Law applies to cases of domestic or family violence against transgender women[29].

In cases of interpersonal violence, the majority of referrals were also to the health area (39.6%), followed of the police stations (26.3%). In the LGBT population, there was

a proportional increase in referrals to social assistance (7.8%), police stations (32%) and Human Rights Reference Center (0.6%); while in the others, it was the women's police station (18.8%). The trend of referrals for the LGBT population showed growth in the period for the areas of health, social assistance and public defender's office, however, there was a decline for police stations. In the non-LGBT population, there was also a tendency towards an increase in referrals to health, social assistance and public defender's office, but also to services for women.

With regard to the notification of violence against the LGBT population, as it is recent on Sinan, health professionals may still be unaware of the specific equipment and respective flows to serve this population, as well as how to effectively mobilize resources triggered by compulsory notification. However, through monitoring in the municipalities, there is a timid formation of a network for priority referral of victims to the LGBTI+ Citizenship Center (Lesbians, Gays, Bisexuals, Transvestites, Transsexual Women, Trans and Intersexual Men and others) before the police station, so that these people receive more specialized assistance to their needs.

Another aspect that contributes to the existence of underreporting in municipalities is the privatization/outsourcing in the provision of this type of service. This causes fragmentation of health actions, high turnover of professionals, fragility of contractual bonds, especially in primary care. When professionals are replaced, there is generally no training for them, which prevents a good quality of services and compromises the construction of a continuing training program to face the problem.

Bearing in mind the objectives of contributing to the reduction of stigma and contributing to a better understanding of terms that are recurrent among the LGBT population, this instrument could also be filled by the sectors that serve this population, as well as by social movements, due to the fact that they are more close and know their needs and difficulties. This possibility is provided for in the form itself, which lists as notifying units: social assistance unit, educational establishment, Guardianship Council, indigenous health unit, Specialized Women's Care Center and others; but this is still little publicized and/or agreed with institutions. In this sense, the expansion of the completion of this instrument by other institutions could contribute to reducing underreporting and, consequently, give greater visibility to the violence experienced, in particular, by the LGBT population.

The need for research focusing on the LGBT population is highlighted, including queer, intersex, asexual, among others, which are still scarce, especially with epidemiological data, in order to contribute to subsidize public health policies aimed at this population[30].

Final considerations

The present study sought to analyze the notifications of interpersonal and self-inflicted violence, particularly among the LGBT population. Notification is the communication of the occurrence of a certain affliction or health problem made to the territory's health authority by health professionals, for the purpose of adopting the relevant intervention measures. From a surveillance point of view, the notification is the immediate trigger of information for the Epidemiological Surveillance or Non-Communicable Diseases and Conditions Surveillance area of the municipality, for data entry, consolidation and analysis. The objective is to understand its magnitude, with a view to planning and measures to combat the situation of violence. From the perspective of assistance, it triggers insertion into the comprehensive and humanized care and protection network, within the scope of social assistance policies and the human rights protection and guarantee system.

In this context, multidisciplinary teamwork is essential for adequate monitoring of cases. Notification can be carried out not only by health professionals, but also by other professionals, inserted in other policies, such as social assistance, education, Reference Centers for Human Rights, Justice, Guardianship Council, Specialized Women's Service Center and others, as recommended in the instruction. It is important to highlight that the notification made by these sectors, in addition to expanding information for better formulation of public policies, strengthens care networks, not just restricted to the health area. Furthermore, it ratifies the importance of this notification also being completed by social movements representing the LGBT population and others, avoiding the erasure of data, inequities and gaps in care that are recurrent in this population, but, above all, strengthening the specific protection network for this segment which, despite being small, is beginning to emerge in the territories. It is therefore necessary to value notification, as it is through it that this problem gains visibility so that it can support public policies, creating strategies to promote the culture of peace.

It is also considered essential to strengthen the representation of organized social movements of the LGBT population and others, in Health Councils, Committees, Conferences and other instances of social participation to expand access to health. The monitoring and evaluation of public policy that occurs at the state level, through the State Technical Committee for the Health of the LGBT Population, must unfold into actions to encourage the creation of municipal committees, taking into account what is recommended in the PNSI-LGBT.

Collaborators

Cordeiro GTL (0000-0002-7241-948X)* contributed to the conception, planning, analysis and interpretation of data, writing the first version and approving the final version of the manuscript. Girianelli VR (0000-0002-8690-9893)* contributed to data analysis and interpretation, critical review of the content and approval of the final version of the manuscript. ■

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