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HOMICIDE AS A PUBLIC HEALTH PROBLEM IN THE CITY OF CAMPO GRANDE, MATO GROSSO DO SUL, BRAZIL

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ABSTRACT: This is a case study of homicides carried out within the Second Section of the Justice Court, in Campo Grande, Mato Grosso do Sul, Brazil. It has been observed that: most homicides are carried out by males (95,7%), Afro-Brazilians (62,9%), between 15 and 25 years (45,7%), illiterate or with incomplete schooling (74,3%), and unemployed (18,6%). It was also observed that the victims' profiles are very similar. Most homicides take place on public streets (41,4%), in the city suburbs, between 20 and 24 o'clock, (51,4%). In 50,0% of the cases, the victim did not receive help from any public health service. In the cases where any family member helped (37,41%), the victims were taken to the Santa Casa de Misericórdia Hospital. Firearms were the prevailing weapons (70,0%) and motives for all crimes were futile, or banal; in most cases (57,0%), alcohol was involved.

KEYWORDS: violence; mortality; public health.

O HOMICÍDIO COMO PROBLEMA DE SAÚDE PÚBLICA NO MUNICÍPIO DE CAMPO GRANDE, MS

RESUMO: Este trabalho trata-se de um estudo de caso, realizado na Segunda Vara do Tribunal do Júri, de Campo Grande, MS. Verificou-se que: a maioria dos homicídios foi praticada por homens (95,7%), pardos e negros (62,9%), entre 15 e 25 anos (45,7%), analfabetos ou com primeiro grau incompleto (74,3%) e desempregados (18,6%). O perfil da vítima é semelhante ao do réu. A maioria dos homicídios ocorreu em via pública (41,4%), na periferia da cidade, entre as 20 e 24 horas (51,4%). Em 50,0% dos casos não houve socorro e encaminhamento para serviços de saúde. Nos casos socorridos por familiares (37,4%) as vítimas foram levadas à Santa Casa de Misericórdia. A arma de fogo foi o principal instrumento dos homicídios (70,0%). A motivação para o crime, em todos os casos, foi motivo fútil, ou banal. A maioria (57,0%), envolveu o uso de álcool.

PALAVRAS-CHAVE: violência; mortalidade; saúde coletiva.

Introduction

Interpersonal violence affects public health negatively by provoking alterations in corporeal, organic and emotional integrity. But it may well also cause death, robbing the victim of his life, in a negation of his maximum personal legal right (Agudelo, 1989). Interpersonal violence may be divided into two categories – family and intimate partner violence, and community violence. In either case, the broad definition of violence is that of the intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in – or has a high likelihood of resulting in – injury, death, psychological harm, interrupted development or deprivation. Latin America has the world's highest burden of community violence and homicides are double the world average. In 1990, injuries to males aged 15-45 totaled 55 million disability-adjusted life years (DALYS) lost – a third of the overall loss in this age group (Sclar, Garau, & Carolini, 2005).

In Brazil, violence is one of the principal public health problems: a complex of contributing factors has led to violence occupying the second place as a cause of death since 1989, being surpassed only by cardiovascular diseases (Minayo, 2000). During the 80's, no less than 850,307 per-

sons were killed (loc.cit); during 1993-1995, 325,300 lives were lost (Melo Jorge & Gotlieb, 2000). Generally speaking, the large majority of these victims can be characterized as precocious mortalities, being persons at the height of their productive and reproductive activities. The Centers for Disease Control and Prevention (CDC) report (2004) concluded that: "homicides among adolescents and young adults remain a substantial health problem in Brazil, and additional prevention strategies that target young persons are needed."

In the public health field, this generator of aggressions may be characterized as part of the so-called "epidemiological transition", to which the category of External Causes greatly contributes, as defined by the International Classification of Diseases – CID 10, including traffic accidents and violence, homicides, suicides, domestic and workplace violence, as well as accidents in general. In Brazil, the emphasis should be given to traffic accidents and homicides, since these compose the greater part of mortalities due to External Causes.

Homicides reflect a high level of social tension, and were responsible for the increase in the contribution of violence to the overall mortality rate from 2% in 1930, to 10.5% in 1980 and 15.3% in 1990 (Minayo, 2000).

Homicides in São Paulo, and Recife in the 90's, exceeded more than fifty times the mortality rates in the UK and Japan (Camargo, Ortiz, & Fonseca, 1995); the social costs of homicides in large cities, although difficult to calculate exactly, most certainly are high, due to the categories of the perpetrators and their victims.

The importance of homicidal deaths is also related to their tendency to increase from 19% of deaths due to External Causes in the 80's to more than 30% in the middle of the 90's. Otherwise, the proportion of deaths due to traffic accidents decreased from 23.4% in 1997 to 17.5% in 2002 in the category of External Causes. During the decades 1980 and 1990, the Midwest of Brazil had the second highest rate of homicides in the country, being exceeded only the Southeast Region (Brasil – Ministério da Saúde, 2004).

These regional differences can be related to the fact that the binomial disease-poverty, generally seen as inseparable, does not apply to homicides, since some of the poorest regions in Brazil do not show elevated mortality. Melo Jorge (2000) observes that there exists a false impression that the poor generate crime and that delinquency is an attribute of the lower classes, while in fact these social groups are the major victims of violence.

In the state of Mato Grosso do Sul, in 1998, 67.9% of all homicides were due to firearms, increasing to 70% in 2000 (Nachif, 2000), percentages greater than those for the Mid-West region as a whole and for Brazil in general. In 2002, the homicide mortality rate in Mato Grosso do Sul State was 61.9/100,000, higher than that for Brazil, with a rate of 59.3/100,000 inhabitants. In this state, in the year 2000, 6.2% of all deaths were due to firearms, the second ranking in Brazil, with the state of Pernambuco in first place (6.8%), confirming the gravity of the situation (Brasil – Ministério da Saúde, 2000).

In the municipality of Campo Grande, the subject of this study, the analysis of proportional mortality during the five years of 1997 to 2001, showed that External Causes of mortality alternate with cancers in the second and third position among the principal causes of death, following the pattern of the state and Brazil, as far as urban conglomerations are concerned. Within the group of deaths classified as External Causes, the proportion of homicides was dominant, varying from 34.5 to 43.0% (Nachif, 2002).

A preliminary analysis of more recent data shows that from 2002 to 2005, homicidal death due to firearms was the second cause of mortality in the municipality, representing 3.98% in 2002, rising gradually to 6.45% in 2005 (Mato Grosso do Sul, 2006).

Methods

This study was carried out from February to June 2004 and included criminal cases referred as homicides, by the

Public Ministry, to the Jury Tribunal of the Juridicature of Campo Grande, Mato Grosso do Sul state. The exploratory analysis was conducted as a descriptive series of case studies, using a data collection form developed for this purpose, permitting the verification of a series of variables and not just point data (Yin, 2001).

The following variables were selected for study:

- The category of the crime, according to the Brazilian Penal Code, and the treatment given by the judges due to the violations committed;
- The circumstances of the crime, locality, time, instrument used, the scenario of the crime and its motivation, the cause of death; whether the victim received medical treatment and where;
- The demographic characteristics of both victim and perpetrator, such as sex, age, educational level, occupation and marital status.

At the start of the study period, 354 cases were being processed and of these 70 were selected for analysis – a convenience sample, case selection being dependent on the stage of legal processing, i.e. cases where sufficient information had been accumulated and registered, permitting the identification of all the variables mentioned above, and available for analysis. The victims, perpetrators and witnesses were identified by case numbers only, and the data was tabulated and analyzed descriptively. The Ethics Committee of the Federal University of Mato Grosso do Sul (UFMS) approved the study protocol.

Results

In 50 of the 70 cases in the sample (71.4%) the perpetrator was accused of simple homicide, according to Article 121 of the Brazilian Penal Code (BPC). Four cases (8.0%) were considered atrocities, since the homicide was committed during activities typical of gangs or execution squads, even though the homicide was carried out by an individual.

Homicides were characterized as qualified in 16 (22.9%) of the cases, 7 (43.8%) being characterized as despicable motivation (BPC, Article 121, section 2º) and 6 (37.5%), as futile motivation (BPC, Article 121, Section 1º). The remaining three cases (18.7%) were classified differently, (BPC, Article 121, Section 4º) being due to treason by ambush, a motive complicating the defense of the perpetrator.

In 3 cases (4.3%) the perpetrator was charged with qualified homicide, for despicable motivation, (BPC, Article 121, section 2º, II), combined with Article 29, as a person that, in some way, was involved in the crime. In only one case (1.4%), the perpetrator was charged with infanticide (Article 123), i.e. homicide involving her own child, under the influence of postnatal stress.

The situation of perpetrators awaiting judgment was mixed, with 54.3% in liberty, 28.6% under arrest and 17.1% in an unknown locality.

It was ascertained that 65% of the cases had been subjected to processing for more than three years since the initial police investigation, and that in 47%, this processing exceeded five years.

Despite the large number of atrocity, despicable or futile crimes, and the fact that 21.4% of the perpetrators were also charged with other crimes such as homicides, theft and extortion while awaiting judgment, the majority (54.5%) remained at liberty, 17.1% evaded detention, and only 28.6% were incarcerated. The penalties imposed on the perpetrators judged guilty were detention in open prison systems (33%) or semi-open (22%). Of those condemned to incarceration, 22% received terms of less than four years.

Most crimes (41.4%) occurred in public places, close to the residence or workplace of the victim and or perpetrator, near bars or in public events. No less than 35.7% of the homicides were carried out in the residence of one or other party to the crime. The majority of the homicides (51.4%) took place between 8 pm and midnight; in 50% of the cases the victim received no help. When help was given, 60% involved family or neighbors, and in 25.7% of these cases the fire brigade was responsible for treating the victim. Most of these (85.7%) were moved to the Santa Casa Hospital or to the University Hospital of the Mato Grosso do Sul State Federal University.

In these crimes, the principal weapon used was the firearm, responsible for 70% of the deaths. Postmortem examinations therefore identified acute hemorrhages caused by the perforation of the thorax or abdomen as the principal cause of death (35.7%), or perforation of the cranium and brain, in 24.3% of the cases.

The demographic characteristics of the victim and perpetrator were found to be very similar, since both were usually male (95.7%), aged 15 to 25 years (45.7%) and with little, or no formal education – 74.3% with an incomplete primary year schooling, or none at all.

Several were unemployed (18.6%) or employed as a manual worker, e.g. as a bricklayers mate (about 10%); no less than 57% of the cases involved the use of alcohol by the victim or perpetrator, or both. In none of the cases examined there was evidence of the use of narcotics – Campo Grande is part of the transfer route for these drugs, but the local consumption would appear to be relatively low.

Sixty percent of the perpetrators and 47.1% of the victims were classified as African-Brazilians, in a society where the proportion of this category is 49%, according to the IBGE (2006).

Finally, it is important to record that the principal motives for the crimes committed were related to money

debts including gambling, intimate and family relationships, gang or group conflicts, or traffic aggressions.

Discussion

In Campo Grande, as in the majority of cities, the presence of groups or gangs, organized into criminal networks, can readily be observed. These gangs satisfy the necessity of their members to belong, to create an identity, and to attain a certain status. The relationship between such gangs and violent behavior indicate a complex interaction of factors leading to the option of joining such an organization. Among these factors the lack of opportunity for social mobility or economic progress is certainly important, while, at the same time, society itself is aggressively consumist (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2000).

The large number of homicides provoked for trivial and banal reasons characterizes a desperate situation – when a man, a woman or a child is assassinated for banal reasons, those who die are individuals, but judgement should be passed on society, that deserves to be tried and condemned (Odalía, 1985).

The United States Federal Bureau of Investigation (US Department of Justice, 2005) drew up its annual profile of criminal victimization by intentional homicides (excluding accidents, suicides and justifiable homicides) based on 16,500 occurrences in the year 2003 for the entire United States. In this profile, most of the victims were male (78%), firearms were employed in 71% of the homicides, 78% of the victims knew the perpetrators personally, while about 50% were Afro-Americans. About 90% of the perpetrators were adult males, and interpersonal arguments were responsible for 29% of the homicides. The FBI observes that this pattern is relatively fixed, varying little from year to year, noting that persons aged 12-19 years of age experience more violence than those who are over 25 years of age.

The spatial distribution of homicides and perpetrators is similar – the phenomenon occurs above all in peripheral urban areas, where – not by chance – there are major deficits in public services and infrastructure. Expelling the poorer dwellers to the periphery, as a result of housing prices, urban areas expand to regions without welfare services. Thus, while a greater part of the population is left to fend for itself, a small portion benefits from city modernization programs. Davis (2006) expresses this trend in the following way: “Instead of cities of light soaring toward heaven, much of the twenty-first-century urban world squats in squalor”.

Minayo (2000) emphasized that the conventional Brazilian urbanization model scarcely contemplates workers rights and those of the poorer segments of society are moving to the urban periphery, so that these populations

were never guaranteed minimum social rights. This is an apparent throwback to the classic Social Disorganization Theory of Shaw and McKay (1942), who did not see poverty per se as the cause of crime – poverty simply facilitates crime through the deprivation of adequate social resources to fight it. They saw social disorganization as the inability of communities to attain the common values of the population or to solve fundamental community problems satisfactorily.

It is in this scenario that the sensation of inconformity grows, with the lack of employment, safety and opportunities in general, including wide social inequalities, especially for the younger section of the population. It is this historical aspect that shows that Brazilian adolescents, poor and from the urban peripheries, are those that die by, and commit, violence (Minayo, 2000).

In this way, urban violence, expressed as the criminality of the cities, according to Pires (1985):

involves our smallest steps, from the opening of the door to the first walk in the street, to the bus stop to work, the route followed in the car, the threat waits from the first traffic-light to the garage door (...) the Brazilian awoke to a reality that is part of his day (...) an economic disaster, in benefit of the few, left an army of the disinherited (...) transforming every citizen in a potential victim.

One observes, therefore, that these homicides involve principally young males, adolescents, often boys, with little education and therefore without any professional qualification in peripheral communities, unemployed and with access to firearms – a combination of conditions that favors criminal activities. Concern with these social aspects of the phenomenon of violence has been a constant component in public health studies. Nevertheless, recently it has become clear that there are methodological limitations to the instruments used to study this phenomenon, unable to cope with the articulations that exist between the characteristics and social processes that typify homicides (Barros, 1986). For this reason, it is essential that, in analyzing these characteristics, the analysis itself must be as global and integrated as possible, conferring a central role to the social determination of these deaths. Long ago, Shaw and McKay (1942) suggested treating the environment first and then the delinquent.

Efficiency legitimizes the judicial process, but more and more frequently this efficiency is being questioned, especially in the sense of producing satisfactory results within a reasonable period. In fact, the drawn-out case processing observed contributes to the absconding of the perpetrator, or to his permanence in liberty for long periods. This is quite clear to members of society, and leads to a dissatisfaction with the judicial process, contributing to

the impunity of perpetrators; not only does it favor the fugitive, but also exceeds the temporal lapse legally permitted for judgment. In our material this occurred in three cases (one natural death of the perpetrator, one suicide and one homicide). These facts demand a profound reflection: the codes and formal constructs for the guarantee of civil rights are not, under the present circumstances, legitimizing credibility in the democratic functioning of the system; these are replaced by informal, hierarchic mechanisms, which may – or may not – be legal (Grynszpan, 1999). Combating violence must be therefore subjected to the inversion of these tendencies, necessitating a radical change in attitude by operators within the legal system, such as judges, lawyers, prosecutors and police.

An epidemiology that intends to study the behavior and distribution of health-related events at population levels and their causes inevitably becomes involved in socially dimensioned problems. For this reason it is necessary that the description of diseases and mortalities, with their geographical, temporal or personal characteristics, takes into account the role, and interference, of social factors.

The data collected in this study underline the availability of weapons, and the necessity for effective programs of prevention. Despite the fact that State provides protection programs, more and more the normal citizens try to make the resolution of their conflicts by their own, increasing the use of firearms – showing the lack of confidence in the State. In the words of Buoro, Schilling, Singer, and Soares (1999) "(...) this is a society where anything goes, each for himself and God take care of all, what counts is individual survival".

About 11% of the Brazilian population consumes alcoholic beverages in excess, with explicit dependence. The importance of alcohol use in interpersonal violence is well-documented (Thompson & Kingree, 2006) but, in Brazil, public health policies have not dealt adequately with this relatively high percentage of the population, so that there is no inter-sector policy for the problem. An anti-alcoholic ("dry") policy would be undesirable and ineffective, but some action aimed at reducing the damage caused by the excessive drinking should be contemplated, developing actions facilitating articulations between various sectors of society (Brasil – Câmara dos Deputados, 2004).

It is noteworthy that 60% of the perpetrators and 47.1% of the victims were mulattos, as in other reports mentioned above. The proportion of perpetrators is considerably higher than their proportion in society, although that of the victims does not deviate significantly. This leads to questioning whether these numbers really reflect a racial mix characteristic of Brazilian society, or whether they reveal a certain attitude of prejudice,

simplifying the distinction between African-Brazilians and whites. A study in São Paulo (São Paulo, 2005) showed that firearms are the principal cause of violent death for Negro victims – 7.5% compared to 2.8% of white victims; additionally, according to this study, Negro victims die sooner. Pedroso (2002) sees in such figures a reflection of racism and the perverse aspect of the inferior conditions to which the Negro population is subjected. Misery generates violence and the Negro population is concentrated in the poorest localities.

Finally, it should be noted that the perpetrators and/or witnesses identify the motivation for homicide in the majority of cases as being related to the non-payment of debts, gambling, family conflicts and “love affairs”, group or gang conflicts or traffic arguments – in other words – evidences of the banalization of daily existence. In many societies, assassination in the defense of honor, no matter what or whose, is not regarded as violence or a crime, but practically quasi-moral, in defense of values regarded as being superior to human life (Odalía, 1985). In this fashion, habits, traditions and implicit laws cover up certain acts and normalize violence. This normalization can be seen as a mere excuse which disguises societies with authoritarian conduct and the unequal distribution of goods and services, factors provoking privation and social exclusion.

“Without a solution for violence in daily life, the remedy is to integrate violence as a ‘normal’ component of daily life” (Buoro et al., 1999).

One alternative to this would be the famous “broken windows” theory, launched by Wilson and Kelling (1982) and vigorously defended recently by Bratton and Kelling (2006) – creating community pride, avoiding signs of decay and neglect, the – “broken windows” – involving the whole community in the affairs of the community, encouraging valid household income strategies, avoiding repressive police actions, which will not work, and have not worked in the past, as a solitary answer to community violence.

Violence affects health because it is a risk to the vital human processes; however, the majority of violent events and injuries is not accidental, or due to bad luck, it is a problem of public health which must be confronted and prevented (Minayo & Souza et al., 1995). Violence affects public health through the costs of treatment, the loss of members of society in (what should be) their most productive age-group, and by increasing social tensions and deviant social behavior. Society must be mobilized to transform traditional, but outdated, social structures in a search for social justice and peace.

As far as the activities of health services are concerned,

the results of this study underline the fact that several challenges reported or re-emphasized here show the necessity for a clear policy for the reduction of morbidity and mortality, due to violence. This policy should be implanted in the public health service sector with a view to:

- the active promotion of the adoption of safe, healthy behavior;
- the surveillance of the occurrence of violence, permitting the configuration of a database for planning and adjustment;
- the promotion of the reorganization, or relocation, of health services;
- the strengthening of mobile, pre-hospital, treatment and services for recuperation and rehabilitation;
- the promotion of the training of human resources with the introduction of this particular theme, leading to the formation of health teams with increased sensibility, eliminating prejudices in the attending of victims.

However, above all else, it is necessary to centralize the human being in the political actions of the State. It is necessary to eliminate the logic of untrammelled accumulation, for social values, an ethical sense of life, and the reason for human liberty can no longer continue subordinated to this accumulation (Buarque, 2003).

Whatever the preoccupation of the governing class is, it is necessary to mobilize society itself for the transformation of ancient and archaic social structures, in the search for social justice and peace. To this end, it is necessary that every member of society knows his rights, knows how to invoke them, leaving his isolation behind, strengthening solidarity and participation (Garcia, 2001).

Referências

- Agudelo, S.F. (1989). *Violência y/o salud: elementos preliminares para pensarlas e actuar*. Geneve: PAHO/OMS.
- Barros, M.B.A. (1986). A utilização do conceito de classes sociais nos estudos de perfis epidemiológicos: uma proposta. *Revista de Saúde Pública*, 20(4), 269-273.
- Bratton, W. & Kelling, G.L. (2006). No Cracks in “Broken Windows” Strategy. *National Review Online*, Feb. 28, 2006. Acessado em 04/03/2006 de www.nationalreview.com/
- Buarque, C. (2003). Desenvolvimento Integral para o bem comum. Em V. Vivart (Ed.), *Que país é este?: Pobreza, desigualdade e desenvolvimento humano & social no foco da imprensa brasileira* (Série mídia e mobilização social, Vol. IV, pp.43-49). São Paulo: Cortez.
- Buoro, A.; Schilling, F.; Singer, H. & Soares, M. (1999). Analisando a violência hoje. Em Loconte, W., *Violência urbana: dilemas e desafios*. São Paulo: Editora Atual, p. 30-44.
- Brasil – Câmara dos Deputados (2004). *Seminário: Alcoolismo e violência* (Série Ação Parlamentar, nº 255). Brasília: Coordenação de Publicações.
- Brasil – Ministério da Saúde (2000). *Rede Interagencial de Infor-*

- mações para a Saúde/RIPSA. IDB 2000 – Indicadores e Dados Básicos para a Saúde. Brasília: Ministério da Saúde.
- Brasil – Ministério da Saúde (2004). *Informações de saúde*. Acessado em 08/03/2004 de <http://www.datasus.gov.br>
- Camargo, A.B.M.; Ortiz, L.P.; & Fonseca, L.A.M. (In press). *Transição epidemiológica no Brasil: evolução e novos fatos*. São Paulo: Fundação SEADE.
- Camargo, A.B.M.; Ortiz, L.P. & Fonseca, L.A.M. (1995). Evolução da mortalidade por acidentes e violências em áreas metropolitanas. Em C.A. Monteiro (Ed.), *Velhos e novos males da saúde no Brasil: a evolução do país e de suas doenças* (pp.256-267). São Paulo: HUCITEC.
- Centers for Disease Control and Prevention (2004). Homicide trends and characteristics – Brazil, 1980–2002. *MMWR*, 53(8), 169-171.
- Davis, M. (2006). *Planet of Slums*. London: Verso.
- Deslandes, S.F., Neto, C., Gomes, R. & Minayo, C. (Eds.) (1994). *Pesquisa social: teoria, método e criatividade*. Petrópolis, RJ: Vozes.
- Folha de São Paulo (2005). São Paulo – Coordenadoria de Análise e Planejamento (CAP) da Secretaria da Segurança Pública de São Paulo. *Folha de São Paulo*, 10 de outubro de 2005, C1.
- Garcia, E.G. (2001). *As caras da violência: e alguns modos de construir a paz*. São Paulo: TFD.
- Grynspan, M. (1999). Acesso e recurso à justiça no Brasil: algumas questões. Em D.C. Pandolfi (Ed.), *Cidadania, justiça e violência* (pp.99-113). Rio de Janeiro: Fundação Getúlio Vargas.
- Instituto Brasileiro de Geografia e Estatística (2006). Banco de dados, população. Acessado em 10/03/2006 de www.ibge.com.br
- Krug, E.G.; Dahlberg, L.L.; Mercy, J.A.; Zwi, A.B. & Lozano, R. (2002). *World report on violence and health*. Geneve: World Health Organization.
- Mato Grosso do Sul – Secretaria de Estado de Saúde (2006). *Informações in Saúde*. Acessado em 09/03/2006 de <http://www.saude.ms.gov.br>
- Mello Jorge, M.H.P. & Gotlieb, S.L.D. (2000). *As condições de saúde no Brasil*. Rio de Janeiro: FIOCRUZ.
- Minayo, M.C.S. & Souza, E.R.S. (1995). O impacto da violência social na saúde pública do Brasil: década de 80. Em M.C.S. Minayo (Ed.), *Os muitos Brasis: saúde e população na década de 80*. São Paulo (pp.87-116). Rio de Janeiro: HUCITEC – ABRASCO.
- Nachif, M.C.A (2002). O impacto das mortes por homicídio em Campo Grande, MS, 2000 (Resumo). Em *V Congresso Brasileiro de Epidemiologia*, 2002, Curitiba, Paraná. Rio de Janeiro: ABRASCO.
- Odalía, N. (1985). *O que é violência*. São Paulo: Brasiliense.
- Pedroso, C.P. (2002). *Violência e cidadania no Brasil – 500 anos de exclusão*. São Paulo: Ática.
- Pires, C.A. (1985). *A violência no Brasil*. São Paulo: Morena.
- Revista de Saúde (2002). Entrevista com Maria Cecília de Souza Minayo. Conselho Nacional de Saúde. *Revista de Saúde*, III(3), 18-21.
- Sclar, E.D., Garaup, P. & Carolini, G. (2005). The 21st century health challenge of slums and cities. *The Lancet*, 365(March 5), 901-903.
- Shaw, C. & McKay, H. (1942). *Juvenile Delinquency and Urban Areas*. Chicago: University Press.
- Thompson, M.P. & Kingree, J.B. (2006). The roles of Victim and Perpetrator Alcohol use in Intimate Partner Violence Outcomes. *Journal of Interpersonal Violence*, 21(2), 163-177.
- US – US Department of Justice, (2005). *Bureau of Justice Statistics, Criminal Victimization, 2004*. Washington: US Justice Department.
- Wilson, J.Q. & Kelling, G.L. (1982). Broken Windows. *The Atlantic Monthly*, 249(3), 29-38.
- Yin, R.K. (2001). *Estudo de caso: planejamento e métodos*. Porto Alegre: Bookman.
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