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FACTORS ASSOCIATED WITH VIOLENCE AGAINST WOMEN IN PRIMARY HEALTH CARE

Fatores associados à violência contra as mulheres na atenção primária de saúde

Factores asociados con la violencia contra las mujeres en la atención primaria de salud

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ABSTRACT

Objective: To assess the factors associated with violence against women in primary health care based on the Chronic Illness Care Model (Modelo de Atenção às Condições Crônicas – MACC). **Methods:** Retrospective cross-sectional study conducted in a municipality of the Zona da Mata in Pernambuco with medical records of 512 women subjected to violence from 2008 to 2012 made available by the Women's Executive Secretariat. The Chi-square test was used with a significance level of $p \leq 0.05$) to determine the relationship between reporting data, sociodemographic characteristics of the victim and perpetrator (age, marital status, level of education, occupation, income, housing), type of violence, perpetrator-victim relationship, length of relationship, cause of the violence and use of alcohol and drugs. **Results:** There was a predominance of physical violence (65%) perpetrated by marital partners ($p<0.001$) against young women ($p<0.001$) with low levels of education ($p<0.001$) in a common-law marriage ($p<0.001$) and poor economic conditions ($p=0.013$). Alcohol use by perpetrators ($p<0.001$) was the main risk behavior. **Conclusion:** Violence against women was associated with the victims' age, level of education, income, alcohol abuse by perpetrators, and marital relationships.

Descriptors: Violence Against Women; Primary Health Care; Health Promotion.

RESUMO

Objetivo: *Investigar os fatores associados à violência contra as mulheres na atenção primária à saúde baseando-se no Modelo de Atenção às Condições Crônicas (MACC).* ***Métodos:*** *Estudo retrospectivo e transversal, realizado em município da Zona da Mata Pernambucana, em que se analisaram 512 fichas de atendimento à mulheres em situação de violência, relativas ao período de 2008 a 2012, disponibilizadas pela Secretaria Executiva da Mulher. Para averiguar a relação entre as variáveis data da notificação, características sociodemográficas da vítima e do agressor (idade, estado civil, escolaridade, ocupação, renda, situação de moradia), tipo de violência sofrida, relação entre os envolvidos, tempo de relacionamento, causa atribuída à violência e uso de álcool e de droga, aplicou-se o teste Qui-Quadrado, com* $p \leq 0,05$*.* ***Resultados:*** *Verificou-se a predominância da violência física (65%) praticada por companheiro conjugal* ($p<0,001$) *em mulheres jovens* ($p<0,001$)*, com baixa escolaridade* ($p<0,001$)*, em união estável* ($p<0,001$) *e com condições econômicas precárias* ($p=0,013$)*. O consumo de álcool pelo agressor* ($p<0,001$) *apareceu como principal comportamento de risco.* ***Conclusão:*** *A violência contra as mulheres obteve associação com a idade, com a escolaridade, com a renda da vítima, com o uso abusivo de álcool pelo agressor e com a relação conjugal.*

Descritores: *Violência Contra a Mulher; Atenção Primária à Saúde; Promoção da Saúde.*

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RESUMEN

Objetivo: *Investigar los factores asociados con la violencia contra las mujeres en la atención primaria de salud basado en el Modelo de Atención de las Condiciones Crónicas (MACC).* ***Métodos:*** *Estudio retrospectivo y transversal realizado en un municipio de la Zona de la Mata de Pernambuco en el cual se analizaron 512 fichas de asistencia a las mujeres en situación de violencia relativas al período entre 2008 y 2012 disponibles en la Secretaria Ejecutiva de la Mujer. Para verificar la relación entre las variables fecha de notificación, características sociodemográficas de la víctima y del agresor (edad, estado civil, escolaridad, ocupación, renta, situación de vivienda), tipo de violencia sufrida, relación entre los involucrados, tiempo de relacionamiento, causa de la violencia y uso de alcohol y droga se aplicó la prueba Chi-Cuadrado con el p≤0,05.* ***Resultados:*** *Se verificó la predominancia de la violencia física (65%) practicada por el compañero conyugal (p<0,001) en mujeres jóvenes (p<0,001), de baja escolaridad (p<0,001), en unión estable (p<0,001) y con condiciones económicas precarias (p=0,013). El consumo de alcohol por el agresor (p<0,001) fue la principal conducta de riesgo.* ***Conclusión:*** *La violencia contra las mujeres estuvo asociada con la edad, la escolaridad, la renta de la víctima, el uso abusivo del alcohol por el agresor y la relación conyugal.*

Descriptores: *Violencia contra la Mujer; Atención Primaria de Salud; Promoción de la Salud.*

INTRODUCTION

Violence against women is frequently observed in several cultures and settings and is widely recognized as a major public health problem. It reproduces power relations between men and women in society and represents one of the main forms of violation of human rights. It can be defined as any gender-based action or omission that results in a woman's death, injury, physical, sexual or psychological suffering and moral or patrimonial damage[1].

In Brazil, the objectives of the National Women's Comprehensive Health Care Policy (*Política Nacional de Atenção Integral à Saúde da Mulher – PNAISM*) includes the incorporation of the gender perspective in comprehensive care to set promotion and humanization of health as guiding principles[2]. Such policy prioritized the organization of integrated networks for the empowerment of women subjected to domestic and sexual violence and the implementation of health promotion policies[3].

Health care networks should operate intersectorally, linking primary health care services to other levels of health care through joint actions aimed at offering continuous, quality, humanized, equitable and safe care to the population. These networks operate based on constitutive elements, such as population, operational structure and health care models for the treatment of acute or chronic conditions[4,5].

The role of health care models is to organize the operation of networks and articulate the relationships between their components and health interventions defined based on the prevailing concept of health, demographic and epidemiological situations, and the social determinants of health in force in a certain time and society[4].

In this context, the Chronic Illness Care Model (*Modelo de Atenção às Condições Crônicas – MACC*) is proposed as a feasible alternative for tackling violence against women from a more comprehensive perspective. The MACC's conceptual foundation adapts to the requirements of Brazil's public health system. It is the combination of three other models of health care: the chronic care model (CCM), the risk pyramid model and the social determinants of health model. It is subdivided into five levels of care according to the populations stratified by the model[5].

Level 1 provides health promotion interventions and focuses on the intermediate social determinants related to the living and working conditions of the population. Level 2 provides interventions to prevent health conditions taking into account supported self-care and proximal determinants in subpopulations with risk factors associated with behaviors and lifestyles. At these first two levels, health teams act before chronic conditions are established. Health changes are identified from level 3. MACC levels 3, 4 and 5 are aimed at individuals with complex chronic conditions who require predominantly clinical interventions[5].

Violence has become a chronic condition as its interfaces have caused serious repercussions that result in physical and/or psychological suffering, including depression, post-traumatic stress, suicidal tendencies and abuse of licit and illicit substances. It is a risk factor for the development of several health problems and it has a financial impact on economic production[6-8].

It is essential to measure the occurrence of this phenomenon more accurately, given its complexity and multi-causal genesis, by conducting research to increase the visibility of the subject. Thus, the research question of the present study is: What is the prevalence of factors associated with violence against women who use primary health care services? This study is an important contribution to the health field as it allows to rethink the way of caring for women subjected to violence based on the MACC.

Given that, the present study to assess the factors associated with violence against women in primary health care based on the MACC.

METHODS

This is a retrospective cross-sectional study carried out in the city of Vitória de Santo Antão, Pernambuco, Brazil, located in the Zona da Mata Sul in Pernambuco, Northeastern Brazil.

A census survey of the entire population of cases treated for violence against women from June 2008 to December 2012 at the Special Secretariat of Policies for Women. This secretariat was linked to the City Hall (*https://mulheresdavitoria.wordpress.com/2008/03/*) and was a place for the care of women subjected to violence in the municipality, an aspect that justifies the publishing of the findings given the historical importance of knowing the local reality in a region with a strong patriarchal legacy in the gender division and that lacks studies on domestic violence due to underreporting. The Women's Police Station and the Specialized Reference Center for the Care of Women Subjected to Violence began to operate in the municipality only in 2013.

The data were collected from January to April 2013 in a private room under the supervision of employees of the service due to the secrecy that involves cases of this nature. The data were collected using records developed by the service to collect information from women subjected to violence. The records contained the following variables: reporting date, sociodemographic characteristics of the victim and offender (age, marital status, education, occupation, income, housing), type of violence, cause of violence, use of alcohol and drugs.

It should be noted that each record was assessed manually. Records filling was incomplete and, therefore, some variables were missing; however, no records were discarded. Therefore, the study covered 100% of the cases in the selected period, totaling 512 cases. In the presentation of the results, the values of the variables differ from the total of analyzed cases due to missing information.

A database was built in Epi Info 2000 and was later exported to SPSS version 20.0. For the analysis, prevalence rates, percentage frequencies and frequency distributions of the analyzed variables were estimated. The Chi-squared test was used to compare proportions and then the factors associated with violence and the profile of the victims were analyzed with a statistical significance set at 5%.

The discussion of the results was based on the theoretical assumptions contained in levels 1 and 2 of the MACC[5] as they address the management of gender violence as a chronic condition in primary care and focus on health promotion.

The present study complied with the guidelines regulating research involving human beings and was approved by the Research Ethics Committee of the Federal University of Pernambuco (*Universidade Federal de Pernambuco*) under Approval No. 495/11.

RESULTS

Among the 512 cases analyzed, the highest prevalence rates were found in women aged 19 to 30 years ($p<0.001$), in a stable union ($p<0.001$), with primary education ($p<0.001$), living un urban areas ($p<0.001$), with an income of less than one minimum wage ($p=0.013$), and living in their own house ($p<0.001$), as shown in Table I. The proportion comparison test was significant in all factors analyzed.

Table I - Sociodemographic characterization of women subjected to violence. Vitória de Santo Antão, Pernambuco, 2013.

Analyzed factor	n	%	p-value[1]
Age (years) *(n=439)			
< 18	45	10.3	
19 to 30	177	40.3	
31 to 40	106	24.1	<0.001
41 to 50	71	16.2	
51 to 60	25	5.7	
> 60	15	3.4	
Marital status *(n=231)			
Married	67	29.0	
Divorced/separated	20	8.7	<0.001
Single	71	30.7	
Stable union	73	31.6	
Education *(n=139)			
Illiterate	14	10.1	
Primary Education	69	49.6	<0.001
Secondary Education	44	31.7	
Higher Education	12	8.6	

Area *(n=400)			
Rural	27	6.7	<0.001
Urban	373	93.3	
Income *(n=117)			
Yes	72	61.5	0.013
No	45	38.5	
Housing *(n=84)			
Own house	38	45.2	<0.001
Rented house	34	40.5	
Handed over house	3	3.6	
Other	9	10.7	

[1]p-value of the Chi-squared test for comparison of proportions. *Total values differ due to record with missing information on the variables.

Regarding the prevalence of the type of violence, physical violence was the most frequent in the study population (65.0%, 333 cases), followed by psychological violence (60.4%, 309 cases), moral violence (17%, 87 cases), patrimonial violence (10.4%, 53 cases) and sexual violence (6.1%, 31 cases).

Table II depicts the prevalence of violence according to the type and factors associated with the victim's profile. Physical violence (p<0.001) and sexual violence (p=0.002) occurred more frequently in women under the age of 18 years, while psychological violence (p<0.001) predominated in women aged 31 to 40 years. Women older than 60 years suffered more moral violence (p<0.001) and patrimonial violence (p<0.001). The proportion comparison test yielded significant finding in all types of violence analyzed, thus demonstrating that the prevalence differed according to age group.

As for marital status, women living in a stable union suffered more physical violence (p<0.001). Married women experienced more psychological violence (p=0.002) and moral violence (p<0.001). With regard to education, women who completed primary education suffered more sexual violence (p=0.028) and those who completed secondary education experienced more physical violence (p<0.001). The highest prevalence rate of psychological violence occurred in women who held a high education degree (p<0.001).

Psychological violence was prevalent in women living in rural areas (p<0.001) and other types of violence were more common in women living in urban areas. Women with no income exhibited higher prevalence rates of physical, sexual and patrimonial violence, and those with income experienced more psychological (p=0.010) and moral (p=0.041) violence. Despite these differences in the prevalence of types of violence according to income, the proportion comparison test yielded significant results only in psychological and moral violence, thus indicating that occurrence in these groups differed statistically. As for housing, women who owned their house experienced more physical violence (p<0.001).

Table II - Prevalence of violence according to type and factors associated with the victim. Vitória de Santo Antão, Pernambuco, 2013.

Analyzed factor	**Type of violence**				
	Physical	**Sexual**	**Psychological**	**Moral**	**Patrimonial**
Age (years)					
< 18	35(77.8)	9(20.0)	19(42.2)	4(8.9)	1(2.2)
19 to 30	117(66.1)	5(2.8)	108(61.0)	27(15.3)	25(14.1)
31 to 40	66(62.3)	12(11.3)	76(71.7)	22(20.8)	18(17.0)
41 to 50	48(67.6)	3(4.2)	47(66.2)	10(14.1)	0(0.0)
51 to 60	14(56.0)	1(4.0)	17(68.0)	5(20.0)	1(4.0)
> 60	8(53.3)	1(6.7)	9(60.0)	7(46.7)	5(33.3)
p-value[1]	<0.001	0.002	<0.001	<0.001	<0.001
Marital status					
Married	40(59.7)	7(10.4)	47(71.1)	18(26.9)	7(10.4)
Divorced/separated	8(40.0)	1(5.0)	14(70.0)	1(5.0)	3(15.0)
Single	41(57.7)	7(9.9)	48(67.6)	15(21.1)	7(9.9)
Stable union	58(79.5)	8(11.0)	51(69.9)	10(13.7)	7(9.6)
p-value[1]	<0.001	0.148	<0.001	0.002	0.572
Education					
Illiterate	10(71.4)	0(0.0)	8(57.1)	5(35.7)	1(7.1)
Primary education	49(71.0)	12(17.4)	55(79.7)	9(13.0)	6(8.7)
Secondary education	32(72.7)	7(15.9)	35(79.5)	5(11.4)	8(18.2)
Higher education	6(50.0)	2(16.7)	11(91.7)	3(25.0)	2(16.7)
p-value[1]	<0.001	0.028	<0.001	0.327	0.052

Area					
Rural	15(55.6)	1(3.7)	19(70.4)	4(14.8)	2(7.4)
Urban	245(65.7)	25(6.7)	232(62.2)	70(18.8)	45(12.1)
p-value[1]	<0.001	<0.001	<0.001	<0.001	<0.001
Income					
Yes	42(58.3)	9(12.5)	60(83.3)	17(23.6)	4(5.6)
No	32(71.1)	10(22.2)	35(77.8)	7(15.6)	7(15.6)
p-value[1]	0.245	0.819	0.010	0.041	0.366
Housing					
Own house	28(73.7)	11(28.9)	37(97.4)	5(13.2)	3(7.9)
Rented house	19(55.9)	7(20.6)	30(88.2)	4(11.8)	4(11.8)
Handed over house	2(66.7)	1(33.3)	3(100.0)	0(0.0)	1(33.3)
Other	5(55.6)	0(0.0)	7(77.8)	0(0.0)	1(11.1)
p-value[1]	<0.001	0.018	<0.001	0.739	0.392

[1]p-value of the Chi-squared test for comparison of proportions.

Most of the women reported marital partners as offenders (53.4%, 198 cases). Women who were in a relationship for more than 10 years (37.2%, 54 cases) experienced more violent episodes than those in shorter relationships. Women reported being offended frequently (67.9%, 76 cases) and related violent acts to alcohol abuse (38.4%, 53 cases). They pointed out that the offender regularly used alcohol and/or other drugs (86.2%, 125 cases). The proportion comparison test yielded significant findings in all the factors analyzed, thus indicating a high frequency of cases of violence, as shown in Table III.

Table III - Characteristics of the offender. Vitória de Santo Antão, Pernambuco, 2013.

Analyzed factor	n	%	p-valor
Relationship with the offender *(n=371)			
1st and 2nd degree relatives	47	12.7	
Marital partner	198	53.4	<0.001
Ex-partner	115	31.0	
Someone known to the victim	11	2.9	
Duration of relationship (years) *****(n=145)			
1 to 4	51	35.2	
5 to 7	24	16.6	<0.001
8 to 10	16	11.0	
10 or more	54	37.2	
Frequency *(n=112)			
Sporadic	16	14.2	
Often	76	67.9	<0.001
Seldom	20	17.9	
Cause of the aggresion *(n=138)			
Alcohol abuse	53	38.4	
Jealousy	43	31.2	<0.001
Agressive temper	31	22.5	
Other	11	7.9	
Alcohol/drug abuse *(n=145)			
Yes	125	86.2	<0.001
No	20	13.8	

[1]p-value of Chi-squared test for comparison of proportions; * Total values differ due to record with missing information on the variables.

DISCUSSION

Violence against women is a complex and multifactorial phenomenon based on gender issues and hierarchy of power and is related to the condition of inequality between women and men, which has been historically constructed and naturalized[9]. Therefore, it is important to identify the factors associated with violence against women as sociodemographic, behavioral and cultural aspects can intensify the violence perpetrated by the partner.

The findings of the present study reveal the predominance of young people with low levels of education living in a stable union with precarious economic conditions. These findings corroborate other studies that have associated these characteristics with women's greater vulnerability to different types of violence[8,10-12].

The results of the bivariate analysis differ from other studies in which psychological violence predominated, followed by physical and sexual violence[6,11,13]. Marital conflicts tend to start with verbal aggressions and evolves into physical violence[6]. In addition, psychological violence is the most neglected type of violence and is rarely recognized[13].

Women are more vulnerable to episodes of violence regardless of level of education and socioeconomic status[12]. However, few years of study and financial dependence on the partner intensify the frequency of conflicts between the couples as less educated women are found to have greater difficulty to break the cycles of aggressions[6,14,15]. Higher levels of education seem to be associated with women's personal empowerment, which leads to a reduction in tolerance to violence[16]. The more women study, the more chances they have of finding paid work, thus improving self-esteem and independence[17]. Therefore, there is a need for actions to enable health professionals to grant conditions for embracing and listening to women with a view to raising awareness and empowering women to discontinue destructive relationships.

The marital partner was listed as the most important perpetrator of violence against women in the present research. This finding is consistent with the findings of other studies on the subject[11,15] which have related this fact to rights inequality, which imposes on women obedience and submission to men in a situation of inferiority and male domination.

In most cases, women choose not to report the aggression perpetrated by the partner. Therefore, many cases of violence are not reported to health services[18]. As a result, studies[16,19-21] have pointed out that health professionals, especially in primary health care, face difficulties in approaching women who seek care but remain silent regarding the violence experienced for shame or fear.

The failure to identify violence in health services is linked to professionals' difficulty to engage in intimate and complex issues involving situations of violence[13]. In this regard, attention should be paid to the training of primary health care professionals to work in these situations because violence intervention measures are still not very effective.

Violent acts against women are invisible in the service and this invisibility of violence contributes significantly to fragile care practices. Some of the main reasons for not identifying domestic violence in health care centers are women's secrecy, fear of intervening in marital affairs, lack of identification of apparent physical injuries and lack of time[22].

Studies[11,23] emphasize that violence against women takes place mainly within the home due to the privacy and little interference of other individuals. Additionally, the occurrence of violent episodes increases throughout the course of the relationship, especially psychological violence, which is naturalized and often socially accepted[14,16,24]. Given this context, the results of the present study reinforce the importance of health professionals' knowledge about the life of women who attend health services to better understand and deal with situations of violence.

The development of strategies to combat domestic violence needs to take into account some considerable features. Most violent acts do not consist of a single episode, but a series of events that may last for decades, increasing the risk for common disorders, post-traumatic stress disorders, chronic pain syndrome, socialization difficulties, reproductive health problems, and other comorbidities[16].

However, it should be noted that when abuse occurs in the first years of union and the woman seeks help for the conflictive relationship, this attitude prevents aggressions from becoming chronic[14]. Thus, the health team should be trained to serve women beyond physical injuries or organic problems, incorporating in their practice the approach in different sectors, such as justice, public safety, health and education[16].

Alcohol use by offenders has been shown in some studies[15,25,26] as a risk behavior associated with violence against women. Women report the use of alcohol as a trigger for marital violence. Considering that one of the characteristics of the offender indicated by the victims in the present study is the predominance of use of alcohol and other drugs, primary health care services should be prepared to include the offender in strategies for tackling violence so as to facilitate family restructuring and improve family relationships[25].

Alcohol, for being socially accepted, is highly consumed, especially among men, making it the drug that mostly damages family dynamics[17,27]. Women state that the marital relationship becomes healthier when there is no drinking[25]. Drinking is a modifiable risk factor that needs to be addressed in the community analyzed through preventive strategies in primary health care as its use exacerbates the magnitude of violence, making women even more vulnerable.

According to the definitions in the Ottawa Charter, health promotion initiatives represent an interdisciplinary and intersectoral effort to overcome the gaps in technical and medical approaches to health problems[28]. Community engagement is therefore a crucial component as it favors the mapping of their real needs and motivations, collaboration between multiple partners, and collective accountability for outcomes.

The incorporation of health promotion practices in primary health care services aims to engage the whole society in improving the quality of life of individuals. This process is permeated by challenges, and evidence of success in the field of health promotion can guide its replication in different settings[29].

In this context, the proposal to combat violence against women through health promotion practices and stratification of the population focused on the local scope of action of the health care centers, as proposed by the MACC, seeks to articulate the actions of the Family Health Strategy (*Estratégia Saúde da Família – ESF*) team with other governmental and non-governmental sectors, social movements, churches, schools, companies, and others[4,5].

Community support networks are essential for increasing capital and social cohesion, fostering trust, solidarity, lack of conflict, a culture of peace and health promotion. Intersectoriality comprises the relationships of the health sector with the others in order to develop more effective and sustainable strategies of action which would not be developed in isolation. Based on this approach, MACC level 1 proposes to implement projects that go beyond health interventions and are capable of promoting improvements in general living conditions through the generation of jobs for victimized women, actions to tackle drug addiction, organization of support networks and adequate housing(5).

With a view to strengthening intersectoral actions, the Brazilian government proposed the guidelines of the National Pact for Combating Violence against Women for the implementation of network services for the identification, embracement and comprehensive care of women subjected to violence. These networks are subdivided into a combating network and a care network(3,30).

The combating network refers to joint actions carried out by governmental and non-governmental institutions and the community aimed at the development of prevention policies that guarantee the empowerment and the construction of the autonomy of women and their human rights. The network of care for women subjected to violence must be organized through collaboration between different sectors, especially social welfare, justice, public safety and health(3).

The proposal to establish care networks is based on the assumption that although violence against women has a strong impact on women's health it represents a bigger problem of a social nature. Therefore, its approach requires resources in the health field and in several other fields(19). Despite advances in combating violence against women, it is still necessary to develop effective programs with more inclusive and comprehensive prevention and care measures(6).

Health professionals understand the care network as something that permeates the health sector and the municipal responsibility. They see the network in a positive way, i.e., they see it as resulting from the integration of areas and services; however, their lack of articulation hinders its functioning. With regard to strategies carried out in primary health care, user embracement, guidelines, referrals and reporting should be highlighted(31).

Thus, the development of actions in health services to recognize the health-disease process in the social context of women subjected to violence and to provide quality listening and guidelines to users can strengthen comprehensive care and foster women's empowerment(22).

MACC level 2 suggests prevention interventions based on modifiable behavioral and lifestyle changes promoted through health education, access to information, actions to tackle alcohol/drug abuse, and the creation of healthy environments(5).

To that end, modifiable risk factors need to involve macrostructural goals with the development of specific legislation, such as: tax increase for the alcohol and tobacco industries and restriction of retail alcohol sales. At the mesostructural level, it should encompass preventive interventions in the community, in schools and in work environments. At the microstructural level, educational actions should be incorporated into the daily relationships between the users and the teams of the ESF centers(5).

However, behavior change is a complex and challenging task. Based on the MACC proposals, the ESF teams should approach the user using soft technologies, such as motivational interviewing, operative groups and evidence-based educational interventions(5).

That being said, the MACC can contribute to providing comprehensive care to victims and minimizing the prevalent factors found by proposing the use of community resources to improve the organization of health services and the use of new technologies to address health conditions(5).

One of the limitations of the present study that should be highlighted is the lack of information that should be filled by health professionals. This aspect interfered with the selection of variables but did not hinder the research. However, it should be noted that the lack of standardization in the reporting of cases contributes to the invisibility of the violence perpetrated as it underestimates its magnitude, severity, typology, location of occurrence and profile of the people involved.

CONCLUSION

Violence against women has been associated with the age, education and income of the victim, alcohol abuse by the offender and the marital relationship. In addition, the set of interventions supported by the MACC to combat violence can promote comprehensive care to victims by encompassing the complexity of the factors involved, supported self-care and the promotion of healthy environments.

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