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Health characteristics of female victims of domestic violence housed in a state care shelter

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Abstract *The promotion of care for female victims of violence implies action that is not limited to combatting the problem, but also to the dimension of care provided to the victims. This study seeks to understand the sociodemographic and health characteristics of female victims of violence who are/have been under the protective custody of the state, before and after the Maria da Penha Law (MPL), and the healthcare offered to them. It is a cross-sectional, exploratory-descriptive documentary study, with a qualitative/quantitative approach, conducted in the second semester of 2013 in a special unit for the protection of female victims of violence in the State of Ceará. The sample was composed of 197 medical records of women attended between 2001 and 2012. Few changes occurred in the health profile of female victims of domestic violence sheltered by the State after the enactment of the MPL. Significant changes occurred in the pattern of care provided, such as increased investigation, promotion, and registration of health-related activities. The identification of the aftereffects of aggression per se is still scarce. A suggested addition would be the inclusion of a health professional in the staff at the shelters to meet this demand.*

Key words *Domestic violence, Legislation, Women's health*

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Introduction

Violence is a social phenomenon that occurs in human relationships in which there are conflicts of interest and domination. Domestic violence is considered a type of gender violence and refers to violence that occurs within the households, defined as any act of physical, sexual, or emotional aggression perpetrated by an individual with whom one has or has had a relationship[1,2].

According to the World Health Organization (WHO), in a study conducted in ten countries, including Brazil, up to 71% of women aged 15 to 49 years have suffered some physical and/or sexual violence at some point in their lives[3]. In Latin America, domestic violence affects up to 50% of women, causing a 14.2% reduction in the Gross Domestic Product (GDP) because of the costs it gives rise to. In Brazil, 23% of women become victims of domestic violence, which means that a woman is assaulted every four minutes. The aggressors are their own partners in 85% of the cases[4].

Several legal measures have been adopted in Brazil as strategies for combating violence against women[4-6]. The creation of the Secretariat of Policy for Women in 2003 boosted the actions against violence, making it an intersectoral issue. Thus, promoting assistance to women victims of violence implies a qualified, humanized, multi- and interdisciplinary action, which presupposes a combative notion that is not limited to fighting the problem, but also to the dimension of the assistance provided to the victims[7].

Law 11340, known as Maria da Penha Law (MPL), was enacted in the latter part of year 2006 aiming to characterize gender violence as serious violation of the human rights and to ensure facing this problem by means of protection and humanized procedures for the victims, through transformations in the relationship between victims and perpetrators, changes in the way the crime is prosecuted, in the police service, and in the Prosecution Office assistance as well[8].

Although the scenario of violence against women demands an intersectoral action, debates and study of the MPL are still deeply rooted in the scope of legal and social sciences[9-15], with little production in the health area, whether concerning prevention or the healthcare offered to women victims of domestic violence[16,17].

Understanding the characteristics of women in situations of violence is one of the ways to improve the visibility of this subject, the society's perception of this situation, and the type and quality of care offered to this group in the services. Thus, recognizing the dimensions of the phenomenon of violence and elucidating the dynamics of its determinants provide subsidies to the formulation of public policies and encourages the reporting of cases in the individual and institutional levels[18]. It is, therefore, necessary to know the sociodemographic and health characteristics of women victims of violence who are/have been under the protective guardianship of the state, before and after the Maria da Penha Law, and the healthcare offered to them.

Materials and Methods

Cross-sectional, exploratory-descriptive, documentary study, with quantitative and qualitative approaches, performed during the second half of 2013 in a special shelter unit for women victims of violence in the state of Ceará. The said unit is linked to the Secretariat of Labor and Social Development, the Police Department Women's Rights Unit, and the Ceará Council of Women's Rights.

The sample was composed of the medical records of women who had been victims of any kind of domestic violence between 2001 and 2012. To set the sample size, we considered the total of women assisted per year, and an estimation of 30% was settled through stratified, proportional sampling per year. Therefore, of the 608 women seen between 2001 and 2012, 183 were selected for the sample and, considering a loss of 7% (14), the total sample comprised 197 medical records. To select the medical records, a list of random numbers without repetition was generated through Microsoft Office Excel® 2007. In case the selected record could not be found, the following record number was selected, considering their arrangement in order of admittance in the sheltering unit. The records of underage women were excluded, as well as those lacking consistent information (women with impaired cognitive function, that is, women presenting neurological disorders that could compromise the answers).

Data was collected by three blind researchers, previously trained, using a specially designed form containing: sociodemographic variables (age, race, religion, marital status, education, family income); experience with violence (triggering factor, type of relationship with the aggressor, means used for the assault); health status of the attacked woman (diseases history, gyneco-

logical history, physical and mental examination, lesions location on the body); and other observations that were relevant to the study, such as the women's history of life and details from the police report. The healthcare provided by the shelter unit was qualitatively evaluated, with the researchers' observations being recorded in a field diary, along with the health-related information that was available in the medical records.

The database was populated in duplicate using Microsoft Office Excel® 2007, and the analysis was performed using the Statistical Package for Social Sciences (SPSS®), version 20. For inferential analysis, it was decided to adopt a cut considering the promulgation period of MPL (prior to it, from 2001 to 2006, and after, post-2007), since this legislation changed the way domestic violence is confronted, by ensuring better assistance to the victims in Brazil. Inferential statistics was conducted to compare the variables using Pearson's chi-square test, adopting a significance level of 5% ($P < 0.05$). Data normality was tested by the Kolmogorov-Smirnov test.

The research project was approved by the Research Ethics Committee of the Federal University of Ceará, in accordance with resolution 466/12 of the National Board of Health[19].

Results

Most of the women in the sample (43.7%) were older than 31 years (29.76 ± 7.27 years; min. = 18 and max. = 58), brown (47.2%), literate (91.4 %), single (73%), and lived in the capital (84.8%). Almost one third of the sample (30.5%) reported having no income, 37.6% worked in domestic services, 31.5% were unemployed or had no profession, and 26.9% received social support (Table 1).

Table 1. Sociodemographic profile of the studied population.

Sociodemographic characteristics	n	%
Age		
15 ●—o 25 years	66	33.5
25 ●—o 30 years	44	22.3
Above 31 years	86	43.7
Not informed	1	0.5
Race		
White	42	21.3
Black	22	11.2
Brown	93	47.2
Indigenous	23	11.7
Education		
Illiterate	12	6.1
Literate	180	91.4
Not informed	5	2.5
Civil status		
Single	144	73.0
Married	52	26.4
Not informed	1	0.5
City of residence		
Capital	167	84.8
Metropolitan area	24	12.2
Not informed	6	3.0
Family income		
No income	60	30.5
Up to 1 minimum wage	54	27.4
1 to 3 minimum wages	18	9.1
Above 3 minimum wages	1	0.5
Not informed	64	32.5
Professional category		
No job/unemployed	62.0	31.5
Service provider and commerce worker	21.0	10.7
Housekeeper	74.0	37.6
Handcraft work (Production of goods and industrial services)	25.0	12.7
Others	7.0	3.5
Not informed	8.0	4.1
Enrolled in governmental programs (Support programs and social benefits)	53.0	26.9

The majority of the sheltered women had been assaulted in the period prior to MPL (73.0% *vs.* 27.0%). More than 2/3 of the sample (86.3%) was assaulted by a steady partner (husband or boyfriend), and the relationship with the perpetrator lasted up to 10 years (157.8 ± 241.1 months; min = 1 month and max. = 31 years) in 72.1% of cases. The triggering factor for aggression was jealousy (20.3%), and the most popular means of aggression was physical force (40.1%) (Table 2).

With regard to the women's reproductive health, most had 1 to 5 living children (93.8% *vs.* 86.8%, P = 0.108); were not pregnant at the time they were housed in the shelter (7.6% *vs.* 5.7%, P = 0.632); had received prenatal care during all pregnancies (51.7% *vs.* 62.3%, P = 0.000); had 1-3 births in life (43.1% *vs.* 56.6 %, P = 0.527); and had never undergone an abortion (50% *vs.* 58.5%, P = 0.640) (Table 3).

As regards the history of diseases, most women were healthy and a few had Diabetes Mellitus (0.7% *vs.* 3.8%, P = 0.187) or systemic arterial hypertension (4.2% *vs.* 3.8%, P = 0.532). The most reported previous disease was sexually

Table 2. Characteristics of the experience with violence in the studied population.

Characteristics of violence	n	%
Year of the aggression		
2001 - 2006	144	73.0
2007 - 2012	53	27.0
Relationship with the aggressor		
Steady Relationship*	170	86.3
Ex-partner	19	9.6
Others (Father, boss or relatives)	5	2.5
Not informed	3	1.5
Relationship duration with the aggressor		
Up to 120 months	142	72.1
120 months or more	41	20.7
Triggering factor		
Jealousy	40	20.3
No motive/banal reason	37	18.8
Use of mind-altering drugs	34	17.3
Children/relatives (Disagreement about children's education or relationship with other relatives)	23	11.7
Non-acceptance of separation	17	8.6
Financial/patrimonial	12	6.1
Jealousy/Use of mind-altering drugs	11	5.6
Betrayal	8	4.1
Forced sexual intercourse	7	3.6
Reported the aggressor	4	2.0
Not informed	4	2.0
Means employed		
Physical force	79	40.1
Verbal	31	15.7
Physical force and firearms	22	11.2
Not informed	21	10.7
Physical force and verbal	19	9.6
Firearms	15	7.6
Others	5	2.5
Verbal and knife or similars	4	2.0
There was no aggression	1	0.5

* Data not shown: husband 15.2%; boyfriend 71.1%.

transmitted disease (STD) (45.1% *vs.* 17%, p = 0.009) followed by mental disorders such as anxiety, tearfulness, and depression symptoms with or without medical diagnosis (9.7% *vs.* 1.9%, P = 0.009). As for health knowledge and practices, most women report having some knowledge of contraceptives (83.3% *vs.* 71.7%, P = 0.015), having smoking habits (27.8% *vs.* 49.1%, P = 0.005), consuming alcohol (9.7% *vs.* 20.8%, P = 0.041), and being users of illicit drugs (3.5% *vs.* 17.0%, P = 0.001). Most report making use of some medication continuously (70.8% *vs.* 71.7%, P = 0.127) and they were admitted to the shelter with no apparent injury resulting from assault (12.5% *vs.* 22.6%, P = 0.709) (Table 3).

The way records are done has changed after the promulgation of MPL. The admission form initially contained generic and broad data (history of diseases, medicine use, illicit drug use, and diseases of children), likewise the anamnesis form (menarche, first pregnancy, and violence during pregnancy). The record contained prescriptions and medical tests, a psychosocial support form and police report (Chart 1).

After the MPL, the admission form added information on the children who were not sheltered, the section "health information", gynecological monitoring, detailed drug abuse, and means used in the assault. The anamnesis form was also modified, including history of sexual violence, abortions, and STD detailing, besides self-evaluation of the emotional state with questions about self-esteem. A follow-up folder with information about the health actions was also added to the women's records, including a medications chart (type, dosage and time of administration), prescriptions and medical examinations, and other healthcare actions (consultations, arrangements, relevant observations). Besides the above, the record comprised the so-called individualized plan of care for women victims of domestic violence, consisting of reports of internal activities and workshops, information on health, multidisciplinary and therapeutic monitoring, with identification of health demands (skin or psychiatric conditions, disability, use of medication, substance addiction, STD); the multi-professional (consultations, exams, referrals) and monitoring services (psychology and occupational therapy) provided to the woman, and the delineation of strategies for family reintegration and community life after discharge (Chart 1).

Discussion

There was a decline in the number of sheltered women after the promulgation of MPL. The sheltered women are young, brown, at personal and social vulnerability, battered by long-time intimate partner, because of jealousy and by means of physical force. There was an increase in health-related practices (use of psychoactive substances and carrying out prenatal care), and improvement in the knowledge of contraceptives, although STDs remain quite prevalent. It is

Table 3. Health characteristics of the studied population.

Year of the aggression	2001 – 2006		2007 - 2012		P
	n	%	n	%	
Characteristics of the reproductive health					
Number of living children (n=195)					0.108
None	1	0.7	3	5.7	
1 ●—o 5	134	93.8	46	86.8	
6 or more	7	4.9	4	7.5	
Currently pregnant (n=13)	11	7.6	3	5.7	0.632
Prenatal care in all pregnancies (n=107)					0.000*
Yes	74	51.7	33	62.3	
No	16	11.2	10	18.9	
Number of births in life (n=147)					0.527
None	2	1.4	2	3.8	
1 ●—o 3	62	43.1	30	56.6	
4 or more	39	27.1	12	22.7	
Number of abortions in life (n=140)					0.640
None	72	50	31	58.5	
More than 1	23	16.0	14	26.4	
Violence during pregnancy (n=165)					0.580
Yes	85	59	28	52.8	
No	37	25.7	15	28.3	
Diseases history					
Diabetes Mellitus (n=134)	1	0.7	2	3.8	0.187
Systemic Arterial Hypertension (n=135)	6	4.2	2	3.8	0.532
Cardiac condition (n=134)	6	4.2	-	-	--
Cancer (n=135)	3	2.1	-	-	--
History of previous disease (n=141)					0.009*
STD	65	45.1	9	17.0	
Mental disorders	14	9.7	1	1.9	
Others	12	8.3	3	5.7	
Pain syndromes	7	4.9	4	7.5	
Respiratory diseases	6	4.2	2	3.8	
Blood diseases	5	3.5	4	7.5	
Gastrointestinal diseases	4	2.8	5	9.4	
Number of reported diseases (n=144)					0.204
Up to 1	120	83.3	48	90.6	
More than 1	24	16.7	5	9.4	
Health-related knowledge and practices					
Knowledge of birth control (n=166)	120	83.3	38	71.7	0.015*
Smoker (n=193)	40	27.8	26	49.1	0.005*
Alcohol consumer (n=192)	14	9.7	11	20.8	0.041*
Recognizes use of illicit drugs (n=177)	5	3.5	9	17.0	0.001*
Reports the continuous use of medication (n=188)	31	70.8	7	71.7	0.127
Physical consequences of the aggression					
Type of injury (n=58)					0.709
No injury	18	12.5	12	22.6	
Bruises	6	4.2	6	11.3	
Multiple	4	2.8	3	5.7	
Cuts	3	2.1	3	5.7	
Burns	1	0.7	-	-	
Hemorrhage	-	-	1	1.9	
Scars	-	-	1	1.9	

* $P < 0,05$; Pearson's chi-square test.

Chart 1. Healthcare provided to the women in the shelter.

Offered Actions/ Activities	Before MPL (2001 - 2006)	After MPL (2007-present time)
Admission file	History of diseases, disease history of sheltered children, drug addiction, use of medication, last menstrual period, health insurance and place of aggression.	Information about homeless children, section with health information (history of diseases, use of medication, gynecological monitoring, health insurance, and drug addiction).
Anamnesis	1st menstruation, violence during pregnancy, notions about pregnancy, self-evaluation of the emotional state, STD history, family history of the victim and the aggressor.	Violence during pregnancy, notions about pregnancy, birth control, history of sexual assault, STD history (type, treatment, date of the last preventive examination), history of abortions, relationship with the aggressor (beginning, behavior in violence situations), family history of the victim and the aggressor, self-evaluation of the emotional state (expectations for the future and plans to achieve them).
Physical evaluation	Information comprised in the violence report, location of the assault injuries.	Information comprised in the violence report, location of the assault injuries, means employed in the assault.
Health actions	Consultations, exams randomly attached in medical records, a few records of workshops, lectures, and health practices.	Consultations, exams, health monitoring file with control of the medicines in use, records of all the women's health demands, along with all actions performed (workshops, courses, group discussions, physiotherapy sessions, therapeutic follow-up) through an individualized plan of care to women victims of domestic violence, evaluation of the health procedures offered to the sheltered women, registry of recreational and educational activities provided to the children.

noteworthy that the registries and the healthcare offered in the sheltering unit were expanded after the MPL.

The decrease in the number of women housed in the shelter after the PML was enacted may be linked to the fact that the law rendered stricter the punishment of aggressors (Urgent protective measures – removal of the aggressor, suspension of visitation to children - and monetary penalties cannot be applied anymore, taking as a crime any form of aggression.), and limited the referral of women to shelters to the cases of extreme risk, when there is no alternative solution, and that referral often occurs after reporting a second or third violent event[20,21]. Thus, after the MPL, being housed in a shelter only occurs in situations where this is the only way to break the violent relationship[22].

In Ceará as in Brazil, the factors associated with domestic violence, particularly the psychological violence, are associated with age (above 30 years), low education, race (non-white), absence of paid employment, romantic relationship profile (steady and lasting), and history of violence (having suffered or lived with violence during childhood)[23-26].

In other countries, however, there is disagreement on these issues relating personnel and social vulnerability of battered women. A multi-country study showed that risk factors for domestic violence are associated with having had other romantic relationships, especially if there are children, having suffered other forms of violence, use of alcohol, and the women's attitude of acceptance of violence[27]. Sonego et al.[28] reported that the violence which this woman is subjected

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to influences her perception; for example, when a woman suffers psychological violence, she just does not interpret this as abuse/violence, but as something "normal"; only when it extrapolates to the physical aggression, it becomes abnormal.

Jealousy, trivial reasons and use of mind-altering substances are elements present in the violent daily life of the studied women. Dossi et al.[29] report that jealousy is the leading cause of intimate partner violence, which is due to the sense of ownership of man over woman. Those authors also reports that drug use is associated with episodes of violence (92%), and that banal and commonplace reasons are responsible for turning aggressiveness into aggression. The battered women's perception reflect these findings:

... he batters me because he's hotheaded, because he didn't receive any money, because he says he dreamed I was cheating on him... (sheltered in 2007).

Physical violence, prevalent in the study, causes numerous traumatic injuries that manifest themselves in the form of bruises, fractures, and organic disorders such as inaccurate pain and multiple complaints, but are rarely described in the records and seemingly little investigated during the initial care provided in the shelter[30,31].

The experience of physical violence sometimes resonates with the experiences in sexual and reproductive health of these women. Like in this study, Campbell et al.[32] demonstrated an association between domestic violence perpetrated by an intimate partner and urogynecological disorders (STD, urinary tract infections, pelvic pain, vaginal bleeding, vaginal infections, and fibrosis). This can be explained by the fact that most of these women are also victims of sexual abuse, being forced to keep sexual practices and/or relationship with the abuser partner. The reports show that the "marital rape" occurs both by fear of the aggression and as a consequence of the very aggression:

...he forces me to have sex with him ... I take it because I'm afraid...

(sheltered in 2006).

This study also reveals multiple and repeated violence, predominant among the sheltered women. Many women reported a history of sexual abuse since childhood or adolescence, like in the following speech:

...when I was a child, I had two brothers who abused me... (sheltered in 2006)

... I had no childhood... I was raped by an uncle at 8, and later by other uncle, when I was 12 years old... my father has already tried to abuse me... (sheltered in 2010)

Sexual abuse, fear of aggression, gender issues, among other elements of vulnerability of these woman also exposes them to undesired pregnancies. A study held in the northeast of Brazil found that 32.4% of the unintended pregnancies occur among women victims of gender violence. The factors associated with this are the inefficient use of contraceptives, partner's disapproval attitudes and partner's refusal to use contraceptives, also constituting a form of violence, since women in violent relationships have no control over the sexual intercourse she has[33], thus corroborating the present study, as can be seen in these statements:

...my husband didn't allow me to use any birth control measure... neither the condom, nor the pills... (sheltered in 2006)

...he forced me to take some medicine to cause the abortion... but I didn't lose the child... (sheltered in 2004)

Added to this scenario the multiple experiences of violence during pregnancy, which exposes the women and the child they are expecting to numerous risky situations. Ribeiro et al.[34] report that violence during pregnancy is more common than diseases routinely investigated in prenatal care (preeclampsia and diabetes) and that the most common form of violence is the psychological violence (41.6%). Moreover, violence triples the chance of pregnant women performing inadequate prenatal[35]. The women seen in the shelter reaffirm these findings:

...in one pregnancy I even lost the baby, and in the other he broke my arm... (sheltered in 2005)

...my son was born with epilepsy because he had battered me... in my last pregnancy, he didn't even allow me to go to the consultations... (sheltered in 2006)

...I was hospitalized more than 20 times in my last pregnancy because of the attacks ... he also would not let me go to the prenatal consultations (sheltered in 2006)

Thus, the occurrence of mental disorders as well as the use of legal or illegal mind-altering drugs (alcohol, tobacco and marijuana) is common among sheltered women, so that drugs use and post-traumatic stress disorder are prevalent among women who suffer sexual or psychological violence, or physical abuse[36,37]. Currently, among low-income urban women, a triad of co-occurrence of health conditions has been described, the SAVA syndemic, which refers to the use of hard drugs, the occurrence of intimate partner violence, and HIV/AIDS, being strongly associated with depression, even if the woman is provided social support[37].

The increased use of tobacco and alcohol, found in the study, has also been presented as a direct consequence of the situation of violence experienced by these women[10,28]. Women may consume alcohol and other drugs in an attempt to "self-medicate" the pain and discomfort arising from living with violent and traumatic situations[38].

Blasco-Ros et al.[39] report that women who suffer associated psychological and physics violence have greater potential to leave the situation of violence and are, consequently, more likely to recover mental health. Kernic et al. [40] added that the reduction in the symptoms of mental disorders is associated with the cessation of violence. Thus, sheltering seems to be an effective measure to improve the issues related to mental and physical suffering of women victims of violence.

Yet another school of thought about these women's sheltering and mental health states that, while the shelters protect them, by being locations of secretive address, they also generate many losses (home, property, family life, and employment), reinforce the ideation that the aggressor can take some attitude of revenge and retaliation against the woman who has denounced, and reveal the inefficiency of the government in providing answers to security, thus reaffirming the offender's "omnipotence" and exempting the State from the guarantee of the right to come and go[41,42].

This study indicates that major changes have occurred in the care for women sheltered in the state of Ceará, but there is still insufficient recorded information concerning the physical and psychological consequences of the assault(s). Thus, an specialized service and a well-trained, multidisciplinary, and inter-institutional team that guarantees care and proper arrangements are not enough[31,43]; it takes a reorganization of the services, with changes in the way assistance is provided, and greater involvement of the multidisciplinary team in the monitoring of women and in developing actions for violence prevention[20].

The lack of studies in the health area; losses of results due to changes that have occurred in women's admission forms in the shelter; the lack of standardization in filling the forms that contain numerous qualitative components; besides the absence of a healthcare professional during the initial assistance, and the very factors that attend the sectional studies are elements that contributed to the limitation of this study.

Conclusion

A few changes have occurred in the health profile of women victims of domestic violence assisted by the State after the MPL. Relevant changes have occurred in the standard of care offered, such as increased investigation, development and registration of activities related to health; however, there is still scarce research on the physical and psychological repercussions of the aggressions suffered by the women.

It is suggested the inclusion of professionals in the staff of the shelter unit, who are able to contribute to the women's assistance, bearing in mind the physical effects of the assault and the empowerment of women about their health through health education and citizenship practices.

Collaborations

RM Ferreira helped in the conception, collection of data, drafting and revising the manuscript; TB Vasconcelos contributed in the analysis and interpretation of data, and revising the manuscript; RE Moreira-Filho contributed in the interpretation of data and revising the manuscript; RHM Macena contributed in the conception, collection of data, design and revising the manuscript.

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