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Prevalence of violence against women users of health care services

ABSTRACT

OBJECTIVE: Intimate partner abuse is a complex phenomenon and a public health problem and health care services are one of the places sought by women in this situation. The objective of this study was to assess the prevalence of violence against women attending a health care center.

METHODS: This study was carried out in a municipality of Southeastern Brazil, in 2003. A sample of 265 women, aged 18 to 49 years old, was interviewed using a questionnaire administered face-to-face. Violence was classified as psychological, physical, sexual and general. Statistical analyses utilized were exact logistic regression and Fisher's exact test.

RESULTS: Psychological violence, at least once in life, was reported by 41.5%, physical violence by 26.4%, and 9.8% reported sexual violence. "General violence", which refers to anyone of the above mentioned types of violence, was reported by 45.3% of the women, and, in 20.3% of the cases, they stated it had occurred during the last 12 months before the interview. However, when asked whether they had suffered any kind of violence in life, only 22.3% answered affirmatively. The multivariate analysis indicated that the risk factors for each type of violence were: drug use by the partner, socioeconomic status and family history of violence for both psychological and general violence; drug use by the partner, schooling and family history of violence for physical violence; and, socioeconomic status and family history of violence for sexual violence.

CONCLUSIONS: This study indicates that the prevalence of violence among women attending the health care center is high and consistent with the results of other investigations. It also suggests that most of the violence is invisible to the health care center.

KEYWORDS: Violence, classification. Battered women. Spouse abuse. Risk factors. Prevalence, statistics & numerical data.

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INTRODUCTION

Violence against women is known as gender violence because it is associated to women's condition of subordination within society. It includes physical, sexual, psychological and economic violence.[2] The unequal power among genders would be at the genesis of situations involving dispute and violence.

Several authors affirm that gender violence is influenced by social factors such as schooling, unemployment, the use of alcohol or of drugs.[1,2,8,14]

Violence against women takes on several forms, such as rape, murder, war crimes, forced prostitution, sexual abuse of girls, trafficking women, genital mutilation and others. Despite that when violence occurs in the domestic sphere, it presents certain specific characteristics. Most of the time it is perpetrated by partners, ex-partners, relatives and acquaintances and it tends to recur in cycles (Heise apud Schraiber et al[10]).

Violence against women committed by intimate partners is a complex phenomenon, that is considered a public health issue not only because of its consequences in terms of women's health, but also because the health care services are one of the locations most frequently sought by women in this situation.[9] However, gender violence has become an even more complex problem and one that is difficult to approach due to factors such as the insensibility of health care professionals, their lack of specific training in dealing with it, the tendency to medicalize cases and the weak articulation among different sectors of society with respect to this issue.

Throughout the world, from 10 to 50% of the female population have suffered some form of physical violence perpetrated by their intimate partners in some moment of their lives.[2] Comparatively, the risk of a woman being attacked by her partner at home is almost nine times greater than the risk of being a victim of violence on the streets.[5] Studies[4] indicate the high prevalence of gender violence among women attending health care services. MacCauley et al (apud Schraiber et al[10]), for example, indicate that 21.4% of the women aged 18 years or older reported they had been victims of domestic violence. In emergency departments, occurrences of domestic violence throughout a woman's life varied from 22 to 35%.[10]

A study[11] of the prevalence of violence against women in the metropolitan area of São Paulo indicates that 40% of the women attending 19 health care centers reported the occurrence of some form of violence against them at least once in their lives.

Despite its frequency, presenting higher prevalence than many pathologies, gender violence suffers from an invisibility that is social in origin. The widespread notion that violence among intimate partners is a private matter that can only be resolved by those directly involved stands out among the factors that contribute to this invisibility. Until recently, the norms and laws in our society permitted rather than punished gender violence. This occurred, for example, when courts of law upheld that defense of one's honor was a legitimate motive for men to assassinate women. Furthermore, health care professionals' education does not prepare them to manage cases of violence, which might contribute to the fact that it is not detected.

The need for care in consequence of physical violence, its psychological sequels, as well as vague symptoms and inexplicable pains leads women to seek for care at the health care services.[4] Often, women are not willing to report the episodes of violence to which they have been submitted, and so the problem remais occult, making it more difficult to diagnose it. In addition, the fact that health care professionals lack proper training and instruments for dealing with this issue also leads them to contribute to its invisibility.[13]

In Ribeirão Preto, a municipality within the State of São Paulo, there are no studies concerning the prevalence of violence against women. However a study (Santos, 2003*) based on the medical files of women attending a health care service registered 3.3% cases of violence. In that study, nine cases of violence were registered in the medical files of a sample consisting of 273 women.

Considering the aforementioned results, the objective of this investigation was to determine the prevalence of violence against women attending a health care service. Some characteristics of these women were identified so as to study factors associated with situations of gender violence. The present article focuses specifically on violence against women committed by an intimate partner.

METHODS

This is a quantitative, cross-sectional study. A questionnaire was administered to a group of women chosen randomly among those attending the clinical or gynecological services of a district health care center of Ribeirão Preto in the year 2002.

*Santos LL. A invisibilidade da violência de gênero em dois serviços de atenção primária à saúde [dissertação de mestrado]. Ribeirão Preto: Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo; 2003.

Among the list of women who attended the service in 2002 (N=808) a sample of 265 women was calculated, taking into consideration a 95% confidence interval and a sample error of 5%, so as to determine the prevalence of violence.

In order to obtain this sample size, 564 women were visited at the addresses declared on their medical files at the health care center. Within this total, losses comprised 299 women: 278 (49%) did not live at the declared address, 19 (3.3%) refused to participate in the study and 2 (0.3%) had deceased before the study began.

The questionnaire was administered during face-to-face interviews conducted between May 1st and June 30th, 2003. After an initial contact with an interviewer that was specifically selected and trained for this purpose, an individual interview was conducted, preferentially at the woman's home or otherwise in a place that was considered safe for the latter. The inclusion criteria for this study were: women aged 18 to 49 years old at the time of the medical consultation and who agreed to participate in this study, signing a form of informed consent. Preceeding the data collection, a pre-test of the questionnaire was conducted in order to verify the language employed and women's comprehension of the questions.

The questionnaire consisted of 52 questions, being an adaptation of other instruments.[8,11,*] Straus's[12] Conflict Tactics Scale (CTS), and the Abuse Assessment Screening[6] (AAS). The instrument defines three distinct types of violence:

- Physical violence - shoving, slapping, punching, kicking or beating, choking or using a weapon such as a gun, a knife or others.
- Psychological violence - insult, humiliation, intimidation or threat.
- Sexual violence - being physically forced to practice sexual intercourse, practicing sexual intercourse due to fear or intimidation, or practicing sex in a degrading manner.

For analytical purposes, a variable denominated "general violence" was created that took into consideration any one of these three manifestations of violence.

Since the subjects of this research may be involved in situations of vulnerabilty, certain special precautions were taken when conducting the interviews. These were: the interview was conducted in a safe place for both interviewee and interviewer, support was availble for both the interviewee and interviewer in cases of acute violence or in situations involving risks, communication with the health care units within the area in which the field work was being conducted concerning the study that was underway so that they could receive the women identified as victims of violence or as persons living in vulnerable situations, the researchers were available to lend their support to interviewers in case of need. In addition to these measures, the privacy of interviewees was preserved and their identity was not revealed. There was no case that demanded attention or support during the study, although the research team was prepared to handle such situations.

The variables studied included the sociodemographic characterization of the women such as age, schooliing, color (self-referred), religion, socioeconomic classification,** marital status, number of children, age at first sexual intercourse and characterization of violence, use of alcohol and drugs and precedents of violence in the family of origin. The variable antecedents of violence in the family was created by agregating two categories: having abandoned the family of origin due to violence or having suffered violence from the mother, father and/or brothers and or sisters.

Exact logistic regression and the Fisher's exact test were utilized in conducting statistical analysis. The variables selected were based on factors that could be associated to violence as suggested by other studies.[14,15] The factors studied were grouped in categories: age of the interviewee (18 to 29 years, 30 to 39 years, 40 to 49 years), socioeconomic classification (categories A and B, category C and category D and E), schooling of the interviewee (has not completed junior high school or has completed junior high school and/or has more years of schooling), color (white or non-white), partner consumes drugs or does not do so and whether or not there are precedents of violence in the family. The variable marital status was also collected, but it was disregarded as a risk factor because it referred to the interviewee's status at the time the study was conducted and not during the period when violence occurred.

This study was approved by the Ethics in Research Committee of the Health Care Center of the Faculdade

*The study *"Saúde da Mulher, Relações Familiares e Serviços de Saúde"* [Women's Health, Family Relations and Health Services], conducted in São Paulo City by Prof. Lilia Blima Schraiber of the *Departamento de Medicina Preventiva da Faculdade de Medicina da Universidade de São Paulo* [Department of Preventive Medicine of the University of Sao Paulo's School of Medicine at Sao Paulo. [Unedited data].

**_Associação Brasileira de Empresas de Pesquisas (ABEP). Critério de Classificação Econômica Brasil_. Brazilian Association of Research Enterprises (ABEP). Available from http://www.abep.org/codigosguias/ABEP_CCEB.pdf [access in 200 Jun 26]

de Medicina da Universidade de São Paulo at Ribeirão Preto. It contemplates all ethical aspects discussed in the 196/96 resolution of the National Council of Health of the Brazilian Ministry of Health.

RESULTS

The average age of the subjects of the study was 34.6 years old and the majority were literate (96.2%). A little over half of these had completed junior high school (51.9%), referred to themselves as being white (58.5%), were catholic (55.8%), were legally married (45.4%) or lived with a partner at the time of the interview (59.2%), were unemployed or referred to themselves as housewives (41.9%). More than half of them lived in their own houses (58.5%) and 40% belonged to the social category C. The majority (57.1%) of the women interviewed had their first sexual intercourse between the ages of 15 and 19 years and 71.7% have children. The majority did not drink alcoholic beverages or did so only occasionally (75.9%).

Physical violence had occurred at least once in the life of 26.4% of the interviewees, and, among these, 40% reported that violence had occurred during the last 12 months. At least one incident of psychological violence throughout their lives was reported by 41.5% of the interviewees, being that upto 44.2% of these incidents ocurred during the last 12 months before the interview. As to sexual violence, 9.8% of the women interviewed stated this had occurred at least once during their lives, being that 72.7% of the episodes occurred during the last 12 months before the interview.

"General violence" occurred among 45.3% of the women, being that 20.3% reported that it had occurred during the 12 months previous to the interview.

When asked explicitly if they had suffered any kind of violence at any time during their lives, 59 (22.3%) women replied affirmatively.

Table 1 indicates the percentages of each type of violence according to each of the variables and Table 2 indicates the estimated odds ratios and their corresponding confidence intervals obtained by means of multivariate analysis.

The results of the univariate analyses, referring to the factors that may be associated to each type of violence and to general violence, are presented in Table 1. In these analyses, the variables that presented a value of $p<0.20$ were included in the model of exact multivariate logistic regression. According to this criteria, age was discarded as a risk factor for any type of violence.

The variables schooling, socioeconomic classification and violence in the family were included in the four multivariate models for violence. In addition, the following factors were included: partner's use of drugs (excuding the model for sexual violence) and color (excluding the model for psychological violence).

Color was not a significant risk factor in any of the multivariate models and, in practically all of them, family violence, which estimated odds ratio oscilated at approximately 2.6, was significant. The estimated odds of a woman with precedents of violence in the family suffering any type of violence is 2.6 times

Table 1 - Number of women (n) in each level of the explanatory variable, frequency (f), percentage of the occurrence of violence against women and p-values of each test (logistic regression and Fisher's exact test). Ribeirão Preto, Southeastern Brazil, 2003.

Variable		Psychological violence			Physical violence			Sexual violence			General violence		
	n	f	%	p	f	%	p	f	%	p	f	%	p
Schooling													
> Junior high	126	44	34.9		25	19.8		7	5.6		48	38.1	
≥ Junior high	136	64	47.1	0.06	44	32.4	0.03	19	14.0	0.02	70	51.5	0.04
Partner's uf of drugs													
No	251	102	40.6		63	25.1		25	10		112	44.6	
Yes	10	8	80.0	0.02	7	70.0	0.05	1	10	1.00	8	80.0	0.05
Color													
White	155	62	40.0		35	22.6		11	7.1		65	41.9	
Non white	110	48	43.6	0.61	35	31.8	0.12	15	13.6	0.09	55	50.0	0.21
Age (years)													
18-29	88	38	43.2	0.60	27	30.7	0.47	6	6.8		42	47.7	0.54
30-39	73	31	42.5	0.69	16	21.9	0.54	9	12.3		33	45.2	0.80
40-49	104	41	39.4		27	26.0		11	10.6	0.46	45	43.3	
Socioeconomic classification													
Categories D/E	121	61	50.4	0.01	40	33.1	0.05	19	15.7	0.01	66	54.6	<0.01
Category C	103	33	32.0		22	21.4		5	4.9		36	35.0	
Categories A/B	41	16	39.0	0.43	8	19.5	0.81	2	2.0		18	43.9	0.32
Family violence													
No	222	84	37.8	0.01	51	23.0	0.01	18	8.1	0.05	92	41.4	0.01
Yes	43	26	60.5		19	44.2		8	18.6		28	65.1	
Total	265	110	41.5		70	26.4		26	9.8		120	45.3	

Table 2 - Estimates of the odds ratio and corresponding confidence intervals and p-values obtained in the exact multivariate logistic regression. Ribeirão Preto, Southeastern Brazil, 2003.

Variable	Violence			
	Psychological	Physical	Sexual	General
Partner's use of drugs				
OR	7.8	9.9	-	6.4
95% CI	1.6-38.7	2.4-41.3		1.2-65.4
p	0.01	<0.01		0.03
Socioeconomic condition				
OR	2.3	-	3.4	2.3
95% CI	1.3-4.0		1.2-9.6	1.3-4.2
p	0.01		0.02	<0.01
Schooling				
OR	-	2.2	-	-
95% CI		1.2-3.9		
p		0.01		
Family violence				
OR	2.6	2.8	2.4	2.7
95% CI	1.3-5.3	1.4-5.7	0.95-6.1	1.3-6.0
p	0.01	<0.01	0.06	0.01

OR: Odds ratio

greater than that of a woman with no antecedents of violence in the family (Table 2). It can be noted that 65.1% of the women with antecedents of violence in the family suffered some form of violence (general violence), against 41.4% of the women with no precedents (Table 1).

The partner's use of drugs was not a significant factor only in the model for sexual violence; for psychological, physical, and general violence, the odds ratios were 7.8, 9.9 and 6.4, respectively. Among the women whose partners used drugs, 80% were victims of some form of violence, whereas only 44.6% of the women whose partners did not use drugs were victims of violence.

The woman's socioeconomic classification was not significant in the model for physical violence; the odds ratios were estimated in 2.3, 3.4 and 2.3, respectively. Among the women in socioeconomic categories D and E, 54.6% suffered some kind of violence, while 35.0% of the women in category C did likewise.

Schooling was a significant factor for physical violence, substituting the socioeconomic category in this model in which it had an estimated odds ratio of 2.2. Women with less schooling (up to junior high school) suffered physical violence more frequently (32.4%) than women with more schooling (19.8%).

Risk factors detected for each type of violence are: partner's use of drugs, socioeconomic condition and violence in the family (psychological violence); partner's use of drugs, schooling and violence in the family (physical violence); socioeconomic condition and violence in the family (sexual violence); partner's use of drugs, socioeconomic condition and violence in the family (general violence).

DISCUSSION

The present study indicated that the prevalence of violence among women attending the investigated health care service was high, being compatible with the prevalence of gender violence found in other studies,[3,7,10,14] indicating similarities with the results found in the latter.

In a study conducted with South African women, interviewed at their homes, from 19.1 to 28.4% reported some incident of physical violence committed by their partners or ex-partners at least once in their lives.[3] A study carried out in a neighborhood of the city of Barranquilla, Colombia, that interviewed 275 women of reproductive age at their homes, found that 22.9% reported domestic violence at least once during their lives.[14] Another study, carried out in Guadalajara, Mexico, indicated that 46% of the interviewees reported some kind of violence committed by their partners or ex-partners; 33% referred having suffered some type of psychological violence, 19% physical violence and 12% some episode of sexual violence.[7] In the municipality of São Paulo,[10] an investigation with women aged 15 to 49 years old, attending primary health care units, found that 44.4% of the women reported the ocurrence of an incident of physical violence and 11.5% of them reported an incident of sexual violence at some time during their lives. These results were similar to those of the present study, which found, respectively 45.3% and 9.8% for the same categories of violence.

It may be affirmed that violence is indeed invisible, to a large extent. In another study* based on data collected in the medical files of a population living in the same municipality in which the present study was conducted, the ocurrence of violence registered in the files (3.3%) contrasts greatly with the preva-

*Santos LL. A invisibilidade da violência de gênero em dois serviços de Atenção Primária à Saúde [dissertação de mestrado]. Ribeirão Preto: Faculdade de Medicina de Ribeirão Preto da Universidade de São Paulo; 2003.

lence indicated in this study (45.3%). This finding suggests that only a small portion of the women attending health care services identifies themselves or are identified as living in a violent situation.

Only a portion of the women recognize violence as such. Although 45.3% have reported the ocurrence of violence at least once in their lives, only half of them (22.3%) recognize this incident as violence.

As to the factors associated to the occurrence of violence, associations were verified between some types of violence and less favorable socioeconomic conditions, less schooling, the partner's use of drugs and antecedents of violence in the family. Less schooling presents itself as a risk factor for physical violence and not for other types of violence. According to a review of the literature carried out by the World Health Organization (WHO)[4] there are no conclusive indications of an association between socioeconomic conditions or schooling and gender violence, suggesting that some studies present this association whereas others do not. However, the authors of that paper affirm that there is evidence of a greater risk of physical violence in the presence of poverty or inequality. As to the antecedents of violence in the family, studies throughout the world have indicated that abuse is more evident among women whose husbands were beaten or who saw their mothers being battered. However, the present study did not formulate a question with respect to this theme. On the other hand, women's precedent of family violence may lead them to have greater tolerance towards violence.

An observation should be made with respect to the association between marital status and violence. Studies[4] report that such an association exists, however, this was not investigated, for, in principal, divorced women and widows would be more exposed to violence than married women and even more than single women, for they have already been both married and single. It is suggested that in future studies the investigators should register the marital status of the women at the moment when the incident of violence occurred rather than when the study was being carried out.

Although violence is a complex problem, as is its resolution, it is beleived that the first step to be taken in order to deal with it is to make it visible. Some measures have been proposed to diminish its invisibility in the health care services. Acknowledging that gender violence is a public health issue, WHO[16] proposes that health care professionals be trained to recognize it and to approach it by being receptive; by recognizing women's integrity ad their entitlement to human rights; by informing them of society's resources in such cases, such as women's police stations and shelters; by recognizing those situations that represent a risk to women's lives and protecting them, working in conjunction with other sectors of society.

As to the limitations of the present study, the size of the sample was not large enough to make it feasible to explore the association between partner's use of drugs and the occurrence of violence in depth. Furthermore, because it was restricted to the population of women attending a single health care center, the prevalence of violence found cannot be generalized to the entire municipality. Even so, it may motivate the development of similar studies in the city, so that, once gender violence is better characterized, local policies may be created to combat it.

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