

Epidemiological Profile of Women Victims of Violence

ORIGINAL

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Abstract

Introduction: Currently, the violence against women occupies a prominent place in Brazil, which places it as one of the priority issues in public health. Thus, it is aimed to analyze the profile of women victims of violence treated in Mossoro health services.

Method: It is a descriptive study, documentary type. Data were extracted from the notification records of 2013-2014 and processed using Excel 2007 software. Data were grouped in tables and charts and the distribution analyzed by simple descriptive statistics.

Results: The profile of women victims of violence in the notifications of Epidemiological Surveillance of Mossoró in 2013-2014 period are brown women, young people with low educational level and looking for the Emergency Care Units, referring to the type of violence suffered, physical violence as present in most cases, followed by psychological torture caused by people who love or are close to them.

Discussion: This study points out the need for health professionals to have a differentiated view on abused women, giving moral, psychological support, do not be silent on this issue and therefore not be omitted nor hear the case.

Conclusion: An ethical and humanitarian assistance to comfort the suffering of women is needed, avoiding revictimization and further damage and identifying new cases and report the problem to gain visibility.

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Introduction

The violence against woman is a multi-casual, multi-dimension, multi-faceted and intransparent phenomenon [1]. It is a recurrent phenomenon shocking the victim's autonomy, destroying the self-esteem and decreasing the quality of life, bringing consequences to the personal, familiar and social organization. It contributes to the loss of quality of life, increasing the costs with health assistance, and the absenteeism at school and work [2].

Although the advances in the legislation towards women protection, millions of Brazilian women continue suffering physical, sexual, psychological and economic violence. The policies in this area emphasize the extreme importance of proper treatment, especially, in the health services [3].

In Brazil, the Law 11.340/2006 also known as Maria da Penha Law, emerges as a legal possibility to cover the women's right, which touts that domestic and familiar violence against women consists in the way of human right's violation [4].

Up to the first semester of 2012, there were 47,555 attendance records in the Women Attendance Center in Brazil. During the entire year of 2011, there were 74,984 records, lower quantity than 108,491 recorded in 2010. The kind of record that appears the most is to report physical against the woman, which may vary from mild, severe or very severe body injuries, the attempt of homicide and consummate homicide. There were 63,838 in 2010, 45,953 in 2011 and 26,939 until July of 2012 [5].

According to the Women Attendance Center, the kinds of violence in the first semester of 2012 in Brazil shows that physical violence had 26,939 reported cases. Psychological violence, classified as a threat, emotional damage, pursuits and bullying at work had 12,941 reported cases. Moral violence, classified as defamation, slander and injury had 5,797 reported cases. The patrimonial violence had 750 reported cases. The sexual violence, classified as rape, sexual exploitation and harassment at work had 915 reported cases [5].

The violent practices against women happened more frequently in the home environment, the fact that reduces its visibility and record. Among the countless consequences of this events, the mortal effects, such as murder, suicide, maternal mortality and HIV/AIDS and the non-mortal effects, but affecting the physical health, such as injuries, functional alterations, permanently disabling and chronic disorders can be highlighted. Concerning the mental health, the post-traumatic stress, depression, anguish, phobia, panic attacks, eating disorders, sexual dysfunction, low self-esteem and abuse of psychoactive substances were identified [2].

In Brazil, the violence against women occupies a featured spot, placed as a priority problem for the public health. Hence, the execution of studies to investigate the magnitude of this problem and amplify the knowledge of its causes may provide subsidies to the public policies that cover the women's health in its integrality. Furthermore, the transgenerational transmission has been pointed as one of the important factors for the increase in violence [2].

In this way, the goal of this study was to analyze the profile of the women that were victims of violence attended in the health services in the city of Mossoró – RN. It is considered that knowing these women profiles, the manager of the Health Secretary may draw strategies that allow a better assistance and integration among the different sectors that are involved, for a good development and resolution of the violence situations.

Methods

This paper is a descriptive study, documental kind. It was developed in the epidemiological surveillance in Mossoró – RN because it is an institution of notification of the women violence cases.

The research sample was constituted by 270 notification records of victims of violence; that arrived at the health assistance in Mossoró. The notification records that presented violence against women in

the period from 2013 to 2014 were included in the study. The unreadable and/or misfiled documents were excluded.

The data collection was held in the period of August-September of 2015, and they were extracted from the notification records, in the health unit, through an instrument. For the beginning of the data collection, the "Declaration for the use of Files/Records" was delivered to the director of the sector to allow access to the members. The information collected was: age, ethnicity, education, marital status, kind of suffered violence, the attacker and by which service was attended.

After the analytical reading of the selected research and the fulfillment of the created instrument for this finality, the obtained data was gathered in tables and charts and the distribution was analyzed through simple descriptive statistic. For the data processing, the software Microsoft Excel 2007 was used.

For the accomplishment of this study, the guidance provided in the resolution 466/2012 was respected, the research was approved by the Ethic Committee of the Universidade Potiguar under the number 1225805, CAAE: 48501515.6.0000.5296.

Results

Of 270 investigated records, with notification of women being victims of violence, there were 138 cases notified in 2013 and 132 in 2014, as shown in **Table 1**. Also, the number of victims according to their age and education was shown in **Table 1**.

Table 2 shows the relation between violence, race/ethnicity, and marital status.

Regarding the kinds of violence suffered by these women, 84.8% suffered physical violence, 38.1% psychological/moral violence, 6.3% torture violence, 8.1% sexual violence, 1.1% financial violence, 1.8% neglected violence, 17.4% other kinds of violence. It is important to point out that women may suffer more than one kind of violence, hence, the

Table 1. Distribution of women victim of violence according to age and education.

Variables	N	%
Victims of Violence	270	
Age		
<9	10	3.7
10 to 19	54	20
20 to 34	128	47.4
35 to 49	56	20.7
50 to 79	19	7.0
80>	3	1.1
Education		
Complete Elementary school	8	2.9
Incomplete Elementary school	61.47	62.50
Complete High school	15	5.5
Incomplete High school	14	5.1
Complete College Degree	7	2.5
Incomplete College Degree	7	2.5
Illiterate	1	0.37
Not Declared	169	62.5
Not applied	8	3.0

Table 2. Distribution of women victims of violence according to race/ethnicity and Marital Status.

Variables	N	%
Race/Ethnicity		
White	63	15,5
Black	15	5,5
Yellow	5	1,8
Brown	145	53,7
Not Declared	63	23,3
Marital Status		
Single	92	34,0
Married/Stable Relationship	86	31,8
Widow	7	2,5
Divorced	14	5,1
Not Declared	59	21,8
Not applied	12	4,4

higher number of notifications than the number of files. **Figure 1** shows the kinds of violence that have been notified.

In **Figure 2**, Kinship of the victim with the attacker.

In **Figure 3**, the services where these women were attended were found, 0.74% looked for Basic Units, 38.8% General Hospital, 2.2% Specialized Hospital, 0.37% Specialty Center/Clinic, 3.7% Hospital/Isolated Day and 54% Emergency Unit.

Figure 1: Notifications of women victims of violence in 2013 and 2014.

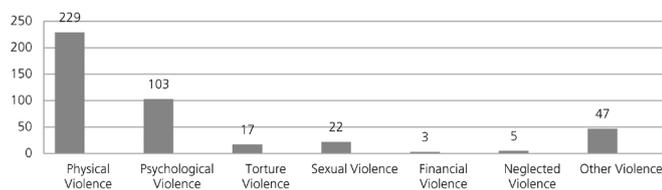


Figure 2: Kinship of the Attacker.

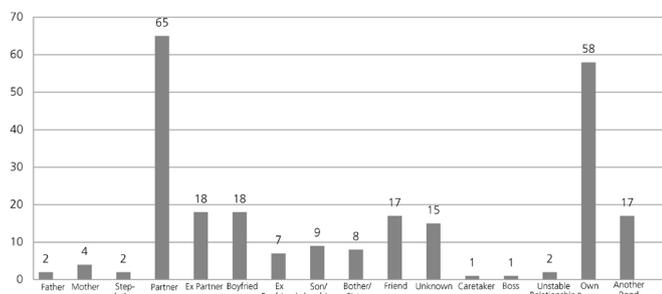
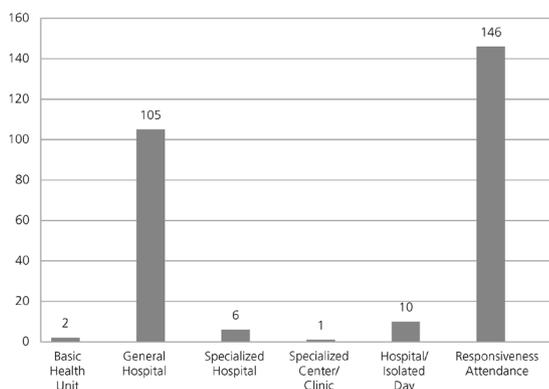


Figure 3: Services that women victims of violence were attended in 2013 and 2014.



Discussion

It is perceived that violence against woman is a complex phenomenon and involves questions of gender, generations, education, ethnicity-racial, with major consequences for the women's health, and for the public health in Brazil and the World.

It was identified a huge amount of information not filled and under notified during the research, where the race/ethnicity and the kind of education were not declared. This may be related to the poor filling of the file report or omission by the woman. It is important for the problem to gain the notoriety that all information are properly filled, so an approach with reality become possible.

It is highlighted that the notification of domestic, sexual and/or other violence was implanted in the Information System of Notification Grievances (SINAN: *Sistema de Informação de Agravos de Notificação, in Portuguese*) in 2009. The notification must be performed in a universal, continuous and compulsory way, for the situations of suspect or confirmation of violence involving children, adolescents, women and elders, according to the Law 8,069 (Children and Adolescent), 10,741 (Elders) and 10,778 (Compulsory notifications of violence against women) [6].

However, there is a lack of training for the professional to detect situations of violence in the complaints presented by the women. Besides, most of the times, the professionals only pay attention to physical symptoms, disregarding psychosocial aspects with a high tendency to medicalization [7]. When, in times, the woman does not suffer the physical violence, but when asked about a verbal violence, it is possible to identify as a victim, not referring to this fact in a spontaneous way [8], which increase the need of a health professional to investigate with the woman this aspect of her relationship.

There is also the difficulty of the professionals to report, due to a fear of involvement in this cases, of being threatened by the attacker, generating a

confusion between reporting and pressing charges. It is observed that there is the urgency of a welcoming and ethical approach by them. Another factor is that the victim feels ashamed to report the source of the injury, the fear of vengeful attitudes by the attacker, and the lack of family support regarding the problem, or even the disbelief in professional secrecy, hindering the identification and, consequently, the report [7].

The ethical question of secrecy must be reinforced, mainly when treating about a small city (population under 50 thousand). Beyond this, the professionals must be prepared to give the proper routing to the other sectors about the violence, such as Police Department, social assistance education, welcoming homes and NGO's [7].

The age of the victims is concentrated in the young population, with ages between 20 and 34 years old (47.4%). However, this phenomenon is characterized by being concentrated in the age from 20 to 39 and with low education. Furthermore, the lack of occupation exposes another aspect of the victim, the economic dependency, associated with the repression and neglect history, constituting the basis for perpetuating the violence [9].

Regarding the education, the higher number of victims are women with Incomplete Elementary School, 41 (15.1%). It is believed that the lower the education, the lower the professional qualification and, the higher the chance that the women are economically dependent on the partner. On the other hand, it is supposed that women with higher education have alternatives to escape from violent acts, that comes from lower incomes, beyond presenting higher clarification about their rights, which makes them less tolerant to violence [10].

Although data about incomes do not appear in the file report, it is important to be investigated and to have a social-economical profile of this woman, because the financial dependency may be one of the facts that contributes to this situation of violence to perpetuate.

Among the women victims of violence, 10 (3.7%) are children under 9 years old. Currently, the domestic violence against children constitute the higher cause of death of youngsters between 5 and 19 years old, and most of this violence happens in the familiar core [11].

From the victims of violence, the violence against elder women was found, where 19 cases were reported with age between 50 and 79 years old and 3 cases with women older than 80 years old. It is highlighted that living with the attacker may not only affect the health of the elderly, as it is one of the biggest issues for the victim to report [12].

Regarding the race/ethnicity, the yellow women (race/color) are the most victimized by violence with 145 (53.7%) cases, in the geographic region where this study took place. Findings collaborating with the research, also held in Brazilian northeast region, identified the black/yellow women as the main victims of violence by the partners [8].

However, there are difficulties to find sources of national information about these events, above all, that are likely of desegregation by race/color and inform the context of this violence – kind of attackers, local, environment and reason. Furthermore, the black/yellow women are more exposed to violence that comes from a patriarchal structure and racism, that stereotype them as suffers and warriors [13].

Regarding the marital situation, it is perceived that 92 (34%) of women victim of violence are single and 86 (31.8%) are married. This kind of violence is based on the violence of gender, also structured in a patriarchal system, that sees as natural the male supremacy, attributing socially to the women a submission paper, objectifying and belonging towards the man [14].

Between the health services that are most searched by these women are the General Hospital, 105 (38.8%) and the Emergency Units, 146 (54%). Understanding the primary care as a privileged space for health actions, where should be the entrance door for these women, the Basic Health Units, ap-

pears in only 2 cases (0.74%). The primary care is the main space to confront the violence against women because there is a multi-professional team that works on different levels and programs by strategic ways of health education, home visits, community, and singularity monitoring [15].

In the context of integral health care, the assistance for a woman in a situation of violence in any age must be organized according to specific knowledge updated, sustainable epidemiologic basis and proper technique. The actions of health care must be accessible to the entire population, city or regional, and the responsibility to assure each step of the care is from the institutions, including emergency measures, the monitoring, rehabilitation and treatment for eventual impacts of the violence in the physical and mental health of the woman [16].

It is fundamental that mechanisms fairly defined exist to detect the kinds of violence, the medical procedures that are regulated and viable and the destination of the women victims of violence. The efficiency of this mechanisms collaborates for the health care to be available as soon as possible, according to the demands of each woman. For such action, it is necessary that the health services, law authorities, emergency sector, schools and civil society have knowledge about which health services perform each kind of treatment. In turn, the assistance for the health services requires the observation of certain conditions and measures to guarantee the different steps of the treatment. However, there is not an obligation to the organization of a specific service to this end, and the assistance may be included and integrated into the other current actions that are taken [16].

It is highlighted that women in a situation of violence tend to use the health services in higher frequency, and the assistance has low-resolution power, having high costs to SUS (Unified health service, *Sistema Único de Saúde – in Portuguese*) as a consequence of its ineffective and repetitive use. Furthermore, due to the suffering caused by

the violence, the women tend to neglect self-care and care for the others. The most common are the late beginning of prenatal care, low adherence for cervical-uterine prevention exam, insecure sex act, alcohol and other drugs abuse. These aspects show that the teams are not prepared to identify the women in a situation of violence, what aggravate when they do not express the violence verbally [17].

As for the attacker, it was observed in the notifications report, that the partners are the most reported, responsible for 65 (24%) cases, followed by boyfriends with 18 (6.6%) reports.

The violence by intimate partners (*VPI – Violence por Parceiro Íntimo, in Portuguese*) describes physical, sexual and psychological damages by a current or ex-partner. It is not only basic human survival rights that are committed, but also the physical and sexual attacker may result in direct damage, such as physical, STDs, or pregnancy, and all of them may result in physical and mental long term damages⁸.

While the VPI happens in heterosexual and homosexual couples, most of them are perpetrated by the male partners against female partners, around the world. An analysis by the WHO (World Health Organization) [18] combining data from 77 studies in 56 countries estimated that in Africa, 37% of women have already been a physical or sexual victim of violence by an Intimate Partner. These data were like the eastern Mediterranean (37%) and the Southeast of Asia (38%), and higher than in the Americas (30%), Europe (25%) and West Pacific (25%) [19].

With a global prevalence estimated in 30% (23.2% in high income), and a global female homicide percentage committed by Intimate Partners of 38.6% (41.2% in Western Countries), the violence by Intimate Partner is considered the most common way of violence suffered by women [18,20,21].

Tolerance and accepting attitudes of violence by an intimate partner against women by their male partners are still common and have an important question to understand the individuals and social

facts that contribute to its prevalence in society, representing one of the main targets for intervention and efforts in public health [22].

Data that is warning is that many women suffer violence by themselves, 58 (21.4%) cases caused by the own person. However, this fact makes thinking that women may relate that physical injuries are caused by themselves because of fear of admitting that she is a victim of violence, or showing that this is an aggravating fact that threatens the mental health of the woman causing her to injury herself. Although, the somatization of such living may be associated with isolation, fear, anxiety, low self-esteem, depression, post-traumatic stress, suicidal ideation and the attempt of suicide. Such frame reassures the necessity of a treatment targeting the mental health of the women victim of violence [13].

The physical violence is the most prevalent in the results of the research with 229 cases (84.8%), but it is necessary to be aware of the others kinds of violence, especially the psychological, that may bring serious damages, normally, invisible to the health care.

The studies that mainly concentrate about the individuals and immediate determinants of violence exclude the wider and inequalities contexts in the source of multiple forms of violence in the life of women. The Interpersonal violence refers to the everyday violence, such as abuse or physical or sexual violence, that may occur among family members, close friends, and close people or strangers. One emphasis in individual determinants may ignore the structural violence, that, in some way, it shapes the interpersonal violence, omitting economic, legal and political aspects; which all of them have important roles in assuring the women's health [23].

Therefore, there are many forms of violence involving the context of women's life, turning more complex the acting of health professionals who should trace strategies of prevention and promotion of a peace culture and gender equality. It is clear that

analyzing the profile of these women; it is possible to know the problem and trace more effective and close strategies to the reality.

Conclusion

The profile of women victims of violence presented in the reports of Epidemiologic Surveillance of Mossoró City in the period of 2013-2014 are yellow, young women, with low education level and that search in the beginning the Emergency Units, which the physical violence appeared in most cases, followed by physical torture, provoked by people that they love or are close to them, as partners or ex-partners.

It is noted that the services that are most searched by these victims are the Emergency Units and General Hospitals when they already have physical damage. This result must allow reflections about the Primary care, which in its territorial basis, acting as a multi-disciplinary team, structured by the bond with this patient should be a space to confront this violence.

The results show the negligence of the information when referring to filling the report file, being a limitation to this study, which directly interferes with the construction of a profile of the victim, with a high percentage of in blank or ignored information, such as income wage that does not appear in the notifications. Because of that, it is necessary to train the professionals to show them the importance of act correctly when filling the file and obtain complete and trustworthy data that present the real situation of the city.

Beyond that, it is pointed out the urgency to break the male chauvinist culture, through discussion of gender, above all in spaces of health care and other sectors, so the women feel confident and safe in reporting any kind of violence suffered, including, that does not naturalize this living.

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