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RESEARCH

Profile of intimate partner violence in Family Health Units

Perfil das violências por parceiro íntimo em Unidades de Saúde da Família

Perfil de las violencias por pareja íntima en Unidades de Salud de la Familia

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ABSTRACT

Objective: To estimate the profile of intimate partner violence involving women in a scenario of Family Health Strategy in the municipality of Nova Iguaçu (Rio de Janeiro). **Method:** A transversal study was conducted in four units with a sample of 640 women between the ages of 25 to 64. The phenomena of violence was determined using the tool Revised Conflict Tactics Scales, validated for Brazil. Statistical analysis took into consideration an estimation of prevalence in the calculation of the *p* values. **Results:** The situations of violence and the sociodemographic profiles demonstrated a statistically significant relationship with the variables of educational level and housing conditions. Age, ethnicity and economic class demonstrated an association with certain types of violence, varying in type and severity. **Conclusion:** The study investigated the profile of these situations of violence and enabled reflection regarding the approaches adopted by the Family Health Strategy teams.
Descriptors: Violence; Domestic Violence; Violence Against Women; Intimate Partner Violence; Family Health.

RESUMO

Objetivo: Estimar o perfil das situações de violência por parceiros íntimos que envolvem mulheres no âmbito da Estratégia Saúde da Família do município de Nova Iguaçu (Rio de Janeiro). **Método:** Trata-se de um estudo transversal realizado em quatro unidades com amostra de 640 mulheres entre 25 e 64 anos de idade. Apreendeu-se o fenômeno das violências com auxílio do instrumento Revised Conflict Tactics Scales, validado para o Brasil. A análise estatística levou em consideração a estimação das prevalências e o cálculo dos p-valores. **Resultados:** a associação entre as situações de violências e o perfil sociodemográfico demostrou significação estatística principalmente para as variáveis tempo de estudo e condições de moradia. Idade, etnia e classe econômica demonstraram associação com alguns tipos de violência, variando em forma e gravidade. **Conclusão:** O estudo investigou o perfil das situações de violências e possibilitou reflexões quanto às abordagens adotadas pelas equipes da Estratégia Saúde da Família.
Descritores: Violência; Violência Doméstica; Violência Contra a Mulher; Violência por Parceiro Íntimo; Saúde da Família.

RESUMEN

Objetivo: Estimar el perfil de las situaciones de violencia por parejas íntimas que involucran mujeres en el ámbito de la Estrategia Salud de la Familia de la provincia de Nova Iguaçu (Rio de Janeiro). **Método:** Se trata de un estudio transversal realizado en cuatro unidades con muestra de 640 mujeres entre 25 y 64 años de edad. Se aprehendió el fenómeno de las violencias con auxilio del instrumento Revised Conflict Tactics Scales, validado para Brasil. El análisis estadístico llevó en consideración la estimación de las prevalencias y el cálculo de los p-valores. **Resultados:** la asociación entre las situaciones de violencias y el perfil sociodemográfico demostró significación estadística principalmente para las variables tiempo de estudio y condiciones de vivienda. Edad, etnia y clase económica demostraron asociación con algunos tipos de violencia, variando en forma y gravedad. **Conclusión:** El estudio investigó el perfil de las situaciones de violencias y posibilitó reflexiones cuanto a los enfoques adoptados por los equipos de la Estrategia Salud de la Familia.
Descriptores: Violencia; Violencia Doméstica; Violencia Contra la Mujer; Violencia por Pareja Íntima; Salud de la Familia.

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INTRODUCTION

Violent events have been occupying an ever-increasing space in society's agendas for debate. These discussions involve considerable media time and even polemical arguments regarding the formulation of policies in the country, including therefore, aspects which permeate the day-to-day lives of people who are directly experiencing these phenomena. Certainly, one of the obstacles experienced and which drives this growth is the very (in)comprehension of how these events, with all their various socio-historic variations, modify the habits and customs, the values and judgments, and society's understanding of itself[1]. Despite the divergences and the complexity of adopting a single concept which contemplates the diverse forms of violence, it is possible to point to a consensus which resides in the application of physical force or in the use and abuse of power, and which translates into an attitude that generates bio-psychological, socioeconomic and cultural consequences for one or more people[2].

In virtue of the multifaceted characteristics, the practices and expressions of violence are diverse, they can be present in an explicit way in the urban and institutional spaces, or in a subtle and veiled form in people's homes, as in the cases of domestic violence which occurs principally – but not exclusively – to children, the elderly and women[2]. In the family environment, many studies have addressed the relationships of conflict and violence between intimate partners, perhaps due to the innumerous variables in the causal links, or due to the varying daily and mutual consequences – for both the victim and perpetrator[3-4].

Specifically with respect to violence perpetrated against women, which reaches in the order of 90% of this public, much wisdom has been accumulated, above all regarding the impact and triggering factors of abusive acts – that cause from physical and psychological consequences to difficulties in using the health services[2,5]. Although there is no consensus, some events linked to abuse committed against women have already been mapped, these are frequently associated to attempts at punishment for acts which the partner judges to be transgressions of the traditional rules imposed on the family, and which many times are backed by financial and emotional dependence as well as the fragile social support for some victims[2].

Based on this information, the country has presented a set of strategies that have enabled a constant (re)formulation of public policy and intersectoral approach, as envisaged by the National Policy for Combating Violence Against Women. According to this document, at least four major priorities should govern the handling of abusive situations in the country: prevention; assistance; confronting and combat; and access to and guarantee of fundamental rights. In this manner, programs should include educational and cultural interventions that combat the sexist standards and traditional vision of gender, guarantee autonomy and generation of freedom for women, as well as effective enforcement of the punishment defined by the "Maria da Penha" law (Law 11.340, August 7, 2006). This in conjunction with a strengthening and broadening of a care and protection network – involving the health sectors, social welfare, education and judicial system, among others – should be encouraged and amplified ever increasingly in society[6]. Such action should directly include the three levels of public health in permanent programs for these women.

In this context, a special importance has been conferred upon the community-based instruments, as is the case of the Family Health Strategy, whether due to its functional dynamics characterized by the principles of the *Vigilância em Saúde* [Public Health Surveillance] – and the production of information for action – whether for the possibility of programs *in loco*, considering the micro, meso and macro-social levels involved in the phenomena of violence. Nonetheless, it has been seen that despite the broadened coverage of these services, it is still necessary to advance the detection and handling of such cases. This inference is based on the already acknowledged underestimation and underreporting of the cases of abuse, the victims of which sometimes attend the health services without due professional recognition, which generates a chasm and barrier in their attendance; these facts are present in the daily work of the health teams[7].

To broaden the vision beyond the position of a victim also appears to be indispensable to advance the programs to control these phenomena. Some studies have already pointed in this direction, principally by inferring the possibility of losses in the family care process in face of the disregarding of violence as a cyclical and bidirectional entity, and also by the recognition of those who also suffer in these situations: the victim, the perpetrator and all the other actors which comprise the family nucleus[8-9]. In this sense, a profound reflection on the profile of women involved in situations of violence appears to be ever more necessary, in order to aggregate new perspectives on the existing knowledge.

OBJECTIVE

To estimate the profile of violence committed by intimate partners which involve women in the framework of Family Health Strategy in the municipality of Nova Iguaçu (Rio de Janeiro).

METHOD

Ethical aspects

The ethical guidelines for research involving human subjects were respected, as determined by the National Health Council Resolution number 466/2012. The project was evaluated and approved by the Research Ethics Committee of the Hospital Universitário Pedro Ernesto, in the Universidade do Estado do Rio de Janeiro. All participants signed a Free and Informed Consent Form and were clarified regarding the objectives, risks, and benefits of the study and were guaranteed anonymity, privacy and the possibility of withdrawing from the study at any moment and without detriment. Considering the specific nature of the subject in this manuscript, the work also integrally respected the ethical recommendations for studies involving situations of violence[10].

Study design, location and period

An observational, transversal type study was conducted based on data collected from the project "Barriers in efforts for the screening of precursor lesions of cervical cancer: a study into the relations of domestic violence in Family Health".

The location chosen for the realization the study was the municipality of Nova Iguaçu, in the metropolitan region of Rio de Janeiro state, which presents an average Human Development Index and a population of approximately 800 thousand inhabitants. The scenario which is an important political and economic center for the State, both for its notable development over recent years and for presenting an economically active population in the region, expresses a similar demographic profile to the greater part of the municipalities in the region; a fact which strengthens the external validity of this study.

The municipality was chosen because it is known for presenting an elevated incidence of intimate violence which involves the families and especially women, as is frequently covered in the social media. Considering the principle that central regions of cities enjoy better access to information and social equipment, the study was developed in the main planning sector: the center, or more specifically in four health units, counting on nine family health teams and attending a population of 26,000 inhabitants.

Sample and inclusion criteria

Based on the understanding that the study population is finite, in that it is a population attended by the health teams, the sample was calculated using a sampling error of 5% and the 95% Confidence Interval, reaching a sample size of 640 women. Using non-probability sampling, the women present in the waiting rooms of the health units were opportunely recruited, an eligibility sheet was applied with the following inclusion criteria: age between 25 to 64 years, to be a resident and registered by the family health teams and to have maintained an intimate relationship for at least one year.

Study protocol

A pilot study was performed with the object of evaluating the methodological design and to guide the interviewers regarding the application of the study instruments and approach to the respondents. This phase was realized in the region close to the area being studied, with a total of 120 interviews (approximately 20% of the total sample). In addition to this, the interviewers were given instruction manuals for the study tool to standardize the techniques used in the face-to-face interviews. Data collection took place over eight months, in private rooms within the health units, this phase ended in June 2013. The study counted on the help of four female nursing professionals from the municipal network, however, in order to maintain the privacy of information provided by the participants, these nurses had no ties with the units in which the study took place. On average four interviews were conducted per day, each with a duration of 30 to 40 minutes.

The research tool comprised a structured and multidimensional questionnaire which reflected the dimensions of the theoretical-conceptual model proposed in the Project. This article used items present in two dimensions: the sociodemographic characterization and the profile of the violence between intimate partners. The first dimension comprised the sociodemographic characteristics of those interviewed, using the items of the *Pesquisa Nacional por Amostra de Domicílios* – PNAD [National Research for the Sampling of Domestic Households][11]. Estimation of socioeconomic class used in the tool "Criteria of Economic Classification", as proposed by the *Associação Brasileira de Empresas de Pesquisa* - ABEP [Brazilian Association of Research Companies][12]. This instrument determines the economic class based on an evaluation of the house structure, goods and services used and educational level of the family head, the latter being given by the respondent. This provides the economic class, which varies from A (the highest) to E (the lowest). The environmental situation of the respondents home was assessed by a set of six variables which enabled a classification of "good" or "poor", as proposed by Reichenheim and Harpham[13].

The variables of interest – violence by intimate partner and its classifications – were analyzed using the tool "Revised Conflict Tactics Scales (CTS2)", validated and adapted trans-culturally for use in Brazil by Moraes, Hasselmmann, Reichenheim[14]. The instrument, which is based on the Theory of Conflict, considers the phenomena of intimate violence as an emerging result of intimate and intrafamily relationships. It enables a categorization of such events into psychological violence (with eight evaluation items), physical assault (12 items) and sexual coercion (seven items), as well as classifying the types of violence into "more severe" and "less severe"[15]. In a 12-month period of record taking, violence was considered when at least one of the items evaluated in each scale was present, using as a basis intimate partner violence against the woman and situations in which the woman is a perpetrator of violence.

Analysis of the results and statistics

The databank was constructed using the Epidata version 3.1 software, double digitations were realized in 10% of the collection instruments. The preparation, processing and statistical analyses were performed with the Stata version SE 12.0 software. Bivariate analyses were performed between the outcome and the independent variables of interest, the respective prevalence was calculated together with the *p* values by means of Fisher's exact test. The results were considered to be statistically significant when $p < 0.05$ and threshold values when in the 0.05 to less than 0.01 interval.

RESULTS

Records from the data collection phase revealed no sample losses and a 3% refusal rate, representing 20 individuals. The characterization of the sample revealed a predominance of women in the 30 two 49 years age group (50.4%), black or brown (56.1%), married (55.5%), eight years of education (57.8%), middle-class/class C (70.7%) and with good housing conditions (84.4%). Intimate partner violence committed against women in the previous 12 years presented a prevalence of 21.0%, 90.6% and 39.1%, for the categories of physical assault, psychological violence and sexual coercion, respectively; while the situations of violence which involved women presented: 28.6%, 92.2%, and 39.9%, respectively.

Tables 1 and 2 present the type and severity of domestic violence perpetrated against women according to sociodemographic level. Attention is called to the fact that educational

level demonstrated a statistically significant relationship with all forms of violence and also with severity of the acts. The housing conditions and severity of violence also presented statistical relationships.

Tables 3 and 4 demonstrate, respectively, the sociodemographic profile for the types and severity of the violent situations which involve women or that is, when a woman is the victim or perpetrator of the abuse. Regarding the type of abusive acts, it is highlighted that educational level has a statistically significant relationship with all of these. Whereas, in terms of severity of the act, it is necessary to consider, principally, the variables of marital status, economic class and housing conditions.

Table 1 – Profile of the population attended by the Family Health Strategy victims of intimate partner violence, Nova Iguaçu, Rio de Janeiro, Brazil, 2013

Sociodemographic variables	Physical assault % (n = 134)	Psychological violence % (n = 580)	Sexual coercion % (n = 250)
Age group (yrs)			
< 30	13.1	13.4	14.0
30 – 39	27.6	25.4	29.0
40 – 49	22.8	25.0	26.9
50 – 59	29.7	27.4	21.5
≥60	6.9	8.7	8.6
p value	0.878	0.149	0.722
Race/Color			
Black/Brown	57.9	57.0	56.4
Mixed	42.1	43.0	43.6
p value	0.341	0.087	0.522
Years of education			
Up to 8 years	63.4	60.2	58.5
Over 8 years	36.5	39.8	41.5
p value	0.071	**< 0.001**	0.488
Marital status			
Married	44.1	55.9	55.3
Other	55.9	44.1	44.7
p value	0.001	0.247	0.531
Economic class			
A/B	22.9	18.9	23.4
C	62.5	72.2	64.9
D/E	14.6	8.9	11.7
p value	0.014	0.016	0.334
Housing conditions			
Good quality	18.1	14.8	7.4
Poor quality	81.9	85.2	92.6
p value	0.218	0.047	0.009

Table 2 – Profile of the population attended by the Family Health Strategy victims of intimate partner violence, according to type and severity, Nova Iguaçu, Rio de Janeiro, Brazil, 2013

Sociodemographic variables	*MSPA% (n = 38)	†LSPA% (n = 126)	‡MSPV% (n = 433)	§LSPV% (n = 576)	‖MSSC% (n = 42)	¶LSSC% (n = 246)
Age group (yrs)						
< 30	16.2	12.0	12.4	13.1	16.7	11.2
30 – 39	21.6	29.6	23.8	25.6	30.9	21.5
40 – 49	29.7	20.0	23.1	25.2	21.4	24.3
50 – 59	27.1	32.0	30.4	27.1	28.6	30.7
≥60	5.4	6.4	10.3	9.0	2.4	12.3
p value	0.879	0.386	0.002	0.078	0.614	0.005
Race/Color						
Black/Brown	56.8	64.5	56.3	56.9	50.0	58.9
Other	43.2	36.5	43.6	43.1	50.0	41.0
p value	0.537	0.038	0.458	0.122	0.253	0.143
Years of education						
Up to 8 years	62.2	76.2	62.4	60.2	42.8	62.2
Over 8 years	37.8	23.8	37.6	39.7	57.1	37.8
p value	0.355	**<0.001**	0.001	**< 0.001**	0.032	0.045
Marital status						
Married	37.8	35.7	57.0	56.2	45.2	60.2
Other	62.2	64.3	43.0	43.7	54.8	39.8
p value	0.020	**<0.001**	0.141	0.145	0.112	0.035
Economic class						
A/B	11.1	16.8	18.3	19.5	28.6	20.8
C	61.1	64.8	73.4	72.0	57.1	71.0
D/E	27.8	18.4	8.3	8.5	14.3	8.2
p value	0.001	0.001	0.101	0.087	0.112	0.809
Housing conditions						
Good quality	30.6	16.0	13.4	14.4	2.4	8.2
Poor quality	69.4	84.0	86.6	85.6	97.6	91.8
p value	0.016	0.499	0.018	0.013	0.006	**<0.001**

*Notes: *MSPA% - prevalence of more severe physical assault; †LSPA% - prevalence of less severe physical assault; ‡MSPV% - prevalence of more severe psychological violence; §LSPV% - prevalence of less severe psychological violence; MSSC% - ‖prevalence of more severe sexual coercion. ¶LSSC% - prevalence of less severe sexual coercion.*

Tabela 3 – Perfil das usuárias da Estratégia Saúde da Família perpetradoras de violência contra parceiros íntimos, Nova Iguaçu, Rio de Janeiro, Brasil, 2013

Sociodemographic variables	Physical assault % (n = 145)	Psychological violence % (n = 588)	Sexual coercion % (n = 94)
Age group (yrs)			
< 30	12.6	13.0	14.2
30 – 39	26.9	25.4	26.1
40 – 49	23.6	26.0	24.2
50 – 59	30.3	27.0	27.2
≥60	6.6	8.6	8.3
p value	0.716	0.219	0.010
Race/Color			
Black/Brown	60.7	57.1	58.7
Other	39.3	42.9	41.3
p value	0.083	0.050	0.157
Years of education			
Up to 8 years	66.7	60.0	61.4
Over 8 years	33.3	40.0	38.6
p value	0.003	**< 0.001**	0.076
Marital status			
Married	42.6	56.1	58.3
Other	57.4	43.9	41.7
p value	**< 0.001**	0.169	0.134
Economic class			
A/B	18.0	19.0	19.8
C	69.0	72.2	71.3
D/E	13.0	8.8	8.9
p value	0.081	0.021	0.973
Housing conditions			
Good quality	15.9	14.8	8.1
Poor quality	84.1	85.2	91.9
p value	0.493	0.034	**< 0.001**

Tabela 4 – Perfil das usuárias da Estratégia Saúde da Família perpetradoras de violência contra parceiros íntimos, segundo os tipos e a gravidade, Nova Iguaçu, Rio de Janeiro, Brasil, 2013

Sociodemographic variables	*MSPA% (n = 37)	†LSPA% (n = 135)	‡MSPV% (n = 455)	§LSPV% (n = 583)	‖MSSC% (n = 5)	¶LSSC% (n = 93)
Age group (yrs)						
< 30 anos	16.2	13.3	13.1	13.1	20.0	14.1
30 – 39 anos	35.1	28.1	24.4	25.3	60.0	28.3
40 – 49 anos	18.9	20.0	23.6	25.3	0.0	27.1
50 – 59 anos	24.3	31.1	29.1	27.5	20.0	21.7
60 anos e mais	5.4	7.4	9.8	8.8	0.0	8.7
p value	0.712	0.616	0.065	0.044	0.487	0.759
Race/Color						
Black/Brown	56.8	58.5	58.5	57.1	20.0	57.0
Others	43.2	41.5	41.5	42.9	80.0	43.0
p value	0.537	0.295	0.036	0.063	0.120	0.471
Years of education						
Up to 8 years	64.9	65.2	60.7	60.4	40.0	59.1
Over 8 years	35.1	34.8	39.3	39.6	60.0	40.9
p value	0.236	0.031	0.014	**< 0.001**	0.355	0.435
Marital status						
Married	37.8	43.0	57.8	56.1	40.0	55.9
Others	62.2	57.0	42.2	43.9	60.0	44.1
p value	0.020	0.001	0.038	0.192	0.398	0.509
Economic class						
A/B	19.4	21.6	17.6	19.1	0.0	23.7
C	50.0	64.4	73.6	72.0	60.0	64.5
D/E	30.6	14.9	8.8	8.9	40.0	11.8
p value	**< 0.001**	0.025	0.031	0.058	0.085	0.302
Housing conditions						
Good quality	33.3	18.7	14.1	14.9	0.0	7.5
Poor quality	66.7	81.3	85.9	85.1	100.0	92.5
p value	0.005	0.172	0.060	0.090	0.426	0.011

*Notes: *MSPA% - prevalence of more severe physical assault; †LSPA% - prevalence of less severe physical assault; ‡MSPV% - prevalence of more severe psychological violence; §LSPV% - prevalence of less severe psychological violence; MSSC% -‖prevalence of more severe sexual coercion. ¶LSSC% - prevalence of less severe sexual coercion.*

DISCUSSION

This analysis enabled construction of a profile of those attended by the Family Health Strategy in order to better study the characteristics, which involve the complex phenomena of violence and thereby enabling theoretical deliberations regarding the work of these teams. Despite the possible differences arising in the data of various studies, a certain pattern has been established, which renders the present considerations perfectly applicable to scenarios with similar characteristics. The decision to use female interviewers that have no direct link to the women who participated in the study also generated good results. This is evidenced by the low percentage that refused to participate, even though the subject generates stigmatism

and a resistance to talk about this among those who are experiencing the problem. The exhaustive clarification regarding the objectives of the work, expected benefits and control of any risks related to the research, by means of data collection in a private room, also contributed to these good results in addition to respecting the recommendations and reflections regarding studies involving this subject matter[10].

In the field of studies on violence it is possible to distinguish multiple abusive practices which are summed together over a period of time, demonstrating a plural character and reinforcing the difficulty of precisely determining the prevalence of these events. The phenomena is often superimposed in its forms, or that is the same victim can at different times or concomitantly suffer the three types of abuse, which aggravates the process of conflict and harm suffered[2]. However, despite these difficulties in establishing common values, the elevated magnitude of the violence presented in this study corroborates the national literature, principally referring to its physical and psychological forms[16].

Nevertheless, it is important to highlight the marked reports of sexual coercion seen in this study, which is in line with existing knowledge on the subject and above all in the domestic environment of major urban centers. In this respect, it is possible to consider at least two points: the first is the difficulty itself in generating a consensus for the adoption of distinct study designs and tools to evaluate this construct, which invariably produce different measurements. The other point resides in the understanding and acceptance of individuals regarding sexual abuse. It is considered that the elevated quantity of this form of violence is related to the naturalizing of this practice during traditional marital relationships[17].

As can be observed, sexual violence was present in a predominant manner among married women, above all in the form of less severe abuse – as in the cases of sexual coercion which may or may not involve physical force, or in the case of practices wherein the partner is intimidated into having sex without the use of condoms – which is possibly not seen by the partners as abusive[4]. The traditional gender view, also introjected as natural in many cultures, ends up supporting and legitimizing this type of practice in marital relations, especially in relationships with traditional ties, which impute to women the risk of assuming a submissive role during sexual relations. The perpetuation of these abuses, often on an intergenerational basis, results in the imprinting of a certain degree of invisibility to this type of violence, especially when in the form of less severe sexual coercion[2-4].

On the other hand, the prevalence of physical aggression was almost two times less likely to occur in married women, although it was seen predominantly among black women. This profile may be associated with a new manner of dealing with conflict situations in present times following the Maria da Penha Law, which provides for the prosecution of crimes against women in specialized courts, thereby increasing the punishment and combating violence against this group. The sentences, which have become more rigid, may have assisted in the movement to reduce the prevalence of physical violence, since resulting lesions are often apparent and easily detected. A possible explanatory hypothesis for this finding may have been the transference of these aggressions to psychological and even sexual abuses, events that are difficult to detect and traditionally veiled and denied in the domestic environment[8].

The relationship between age and sexual violence is also a convergent aspect between the results of this study and others reported in the literature. It is observed that the magnitude of sexual violence was predominant in the age range between 30 to 59 years. There is a certain movement to associate the reduction of sexual violence in the marriage of older women, mainly because of a belief that there has been a decrease in the limits of tolerance among victims to the rules imposed in the domestic environment[18]. However, this variable did not present a statistical significance in the other relations. It is believed that these results were influenced by other factors not controlled in this study, due to the methodological design adopted.

Lower educational level and living conditions were also factors associated with violent relationships against women in physical, psychological or sexual forms. It is possible to reinforce such findings with the association between abusive events and the lower economic classes, especially the middle class[4,19-20]. Asymmetric relationships between the partners, as in the case of differences in income and education, can contribute to the loss of autonomy and increased dependence of women, especially in societies in which the patriarchal culture corroborates with the model of Man as provider and woman as submissive to him. In addition to this, characteristics that inhibit human development, as in the case of lower educational level, can directly affect interpersonal relations, propitiating the organization of family dynamics that resort to aggression as a means of resolving conflict[18].

On the other hand, it is important to note that the situations of violence involving women – that is, when the woman was also perpetrating abuse – presented a similar profile to the pattern identified in the victims. With due care not to reinforce the violation of rights, as widely practiced against women, nor to commit further – albeit discursive – acts of violence against women, it is important to understand that there is a certain degree of bidirectionality in this complex phenomenon. Thus, even considering that men are the main aggressor in the domestic environment, it is valid to recognize that women can also play the role of perpetrator of abuse, especially in its physical and psychological forms. Some studies have suggested that such events can be triggered by a situation of response by the victim when faced with constant aggressions suffered, which corroborates the need to understand this phenomenon as the generator of cyclical and interdependent suffering[2,9].

For the effective control of this complex phenomenon, it is not enough to characterize the victim, as such a position would be considered partial and focused only on the actors present in these relations. Perhaps a broader reflection becomes necessary, since in some cases the abuser is the only reference for the woman, and vice versa, such that this is also the only actor in the social support. It is believed that the more unpredictable the routine of domestic abuse becomes, the less women's chances of mobilizing psychological and social resources to break the cycle of violence, thereby adapting more and more to this relationship and sometimes reacting[9,18].

Although not an easy task, understanding and handling the family context has become a challenge to be faced by health teams. Due to the possibility of action on a nationwide basis, the teams of the Primary Health Care and above all the Family Health Strategy should work towards the objectives of: a better understanding of family and community dynamics; diverse possibilities for action that interrupts the cycle of suffering generated by violence among intimate partners; and overcoming a model of programs based exclusively on biological aspects. However, many authors have demonstrated that care for women is often limited to technical aspects, while masking the phenomenon of violence itself. Ignorance of the diverse forms in which this phenomenon is presented and an understanding of the various conceptions – which are socially and historically constructed – tend to impose implications for the teams, implying risks of denial in the detection and management of these cases[21].

Understanding that management is possible through a pooling of knowledge can be an element of support to the new practices of coping with the phenomenon. A recent study has proposed a model to combat abuse and care for women who are victims of violence, based on the principles of confidentiality, privacy, respect for the autonomy of women and maintaining their safety. It also proposes that care should be taken based on several fundamental elements: knowledge regarding the clinical care and the necessary referrals to the various centers of the care network; awareness about gender issues and equality; attitudes seeking an absence of judgment; empathy; the skills for emergency and longitudinal assistance for the physical and psychological damage; and an understanding of the different contexts for the construction of support networks[22].

Removing the veil from these events in the community and providing qualified assistance to women certainly requires articulation between knowledge and practices that extend beyond the confines of the health sector, requiring new professional positions for a collaborative and intersectoral practice with other segments of society. To think that the actions of the protocol, common to the clinical management of some diseases, are not compatible with assistance in situations of violence can contribute to the maintenance of their invisibility by many professionals. On the other hand, to join forces with the judicial system through the adoption of practices that prevent new cases and the constitution of a protective network based on the characteristics of the country, in partnership with the *Centros de Referência Especializados em Assistência Social* (CREAS) [Specialized Social Welfare Reference Centers] and other equipment provided by the National Social Welfare Policy, can offer a new direction for the care programs of the health teams[6,23-24]. The synergy of these nation-wide strategies could, above all, enable qualified assistance for the entire family – the victim, the perpetrator and all those who experience directly or indirectly the multiplicity of expressions of the abusive events.

Study limitations

Bearing in mind that transversal studies have evaluated at the same time the outcome and the exposure, in a single measurement, it is important to consider that the analysis of the results presented here does not intend to establish causal relationships between the variables studied. Another aspect which merits attention is the fact that study collected data exclusively from the central region of the municipality, which could have generated divergences from the prevalence of these events in the suburbs. In this manner, the interpretation and generalization of this information should be undertaken in the light of these methodological limitations and considering the possibility that the number of these cases has been underestimated.

Contribution to the field of public policy

The debate regarding the profile of violent situations involving women has contributed to a more profound discussion of this subject by aggregating elements with a view to developing strategies closer to the reality lived by the community. Overcoming the victims restricted vision is also a point that raises reflections on the (re)formulation of programs to control this phenomenon by the Family Health Strategy teams. It is considered that the mobilization of technological resources present in the Strategy, such as health surveillance programs and the promotion of intersectorial practices, could guarantee especially the detection, management and accompaniment of the families in a situation of vulnerability and with an already instituted process of violence. The articulation with other institutions and social equipment present in the territory constitutes a fundamental and viable point in the daily work of these teams, by offering new possibilities for the combating and emancipation of the actors involved.

CONCLUSION

The elevated levels of abuse found in this study could arise from the characteristics of the sample under study. Nevertheless, it is considered that the data reflects an underestimated reality, singular to situations which involve fear among the participants in revealing these aggressions. However, it was possible to observe certain variables related to a greater vulnerability to situations of violence, such as age range from 30 to 59 years, lower educational level, low socioeconomic level and poor housing conditions. Such physical aggression was most common among single black women. While in the case of sexual violence, especially in the form of less severe sexual coercion, these events were most present in women with traditional conjugal relationships (for example, married). A similar profile was found in the cases in which the woman participated as a perpetrator of the phenomenon, suggesting a bidirectional nature of the violence, as has been reported by other workers. It is considered that recognition of this profile could aid in the considerations and formulation of emancipating strategies and in recognition of the mutual suffering and interdependence of those involved in order to help the family nucleus by means of actions that are more protagonistic and less judgmental.

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