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Violence against women in life: study among Primary Care users

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Abstract *This article aims to estimate the prevalence and factors associated with intimate partner violence among primary care users. Cross-sectional study with women aged 20 to 59 years. Physical, sexual and psychological violence was screened by the World Health Organization instrument. Poisson regression was used for crude and adjusted analysis. Nine hundred ninety-one women participated in the study. The prevalence of violence throughout the lifespan was: psychological 57.6% (95%CI 54.6-60.7); physical 39.3% (95%CI 36.2-42.3) and sexual 18.0% (95%CI 15.7-20.5). Women with up to eight years of schooling, divorced or separated, whose mothers suffered intimate partner violence, who reported drug use and experienced sexual violence in childhood showed a higher prevalence of the three types of violence. Religion was associated with psychological and sexual violence and the use of cigarettes to physical and psychological violence. Participants with lower household income had a higher prevalence of physical violence. A high prevalence of intimate partner violence was identified among users. Worse socioeconomic conditions, risk behaviors and a history of assault are associated with greater occurrence of this problem.*

Key words *Violence, Socioeconomic factors, Marital abuse, Intimate partner violence, Domestic violence*

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Introduction

Violence against women is a complex phenomenon based on gender relationships, which triggers physical, psychological harm or suffering to women[1]. This condition is a worldwide problem and builds on unequal power relationships, that is, it is a type of violence motivated by the unequal gender condition, which begins in the family universe, and gender relationships are established hierarchically[2].

According to the World Health Organization, in 2013, 30% of women in the world had already been victims of intimate partner violence[3]. In Brazil, a population-based study with a representative sample of 15 years or more showed that 43% of Brazilians reported having suffered violence by men in their life; one-third admitted having suffered some form of physical violence, 13% sexual and 27% psychological. Husbands, former husbands, boyfriends and former boyfriends were the main perpetrators, ranging from 88% of slaps and shoves to 79% of perpetrators of forced sex[4].

This high-prevalence social phenomenon dramatically affects women's health and lifestyle[5]. The damage caused by such violence can last a lifetime and reach generations, with severe effects on health, education, work, crime and economic well-being of individuals, families, communities and societies[6], thus being a great concern for the Brazilian population and the health sector, since it can lead to deaths and physical and emotional traumas[7]. Therefore, the knowledge and proper posture of the professionals in the care of the victims, identifying and notifying the cases is crucial, since the health services should receive and support, and not be an obstacle for the victims[8].

However, the literature indicates that the suffering of women in a situation of violence is not yet seen as an element that deserves intervention from health professionals unless there is some objective anatomopathological basis to justify it. In the latter case, the interpretation of disease can be accepted, and violence loses meaning and relevance and tends to be disregarded[7]. The practices of primary care teams in the face of situations of domestic violence are still challenging and are a dilemma for the construction of comprehensive care. The professionals' unpreparedness in addressing situations of violence is added to their conception of the phenomenon and its causes, the actions developed (or not) and the relationship established with the family and other stakeholders of the intersectoral network[9].

Given the above, considering the violence a health problem and the absence of studies that address the occurrence of this phenomenon during the life of women in the city of Vitória, this research aimed to estimate the prevalence and factors associated with intimate partner violence throughout the life among primary care users.

Methods

This is a cross-sectional epidemiological study carried out with data from a primary research on violence against women in the municipality of Vitória, Espírito Santo, conducted in the period from March to September 2014, in all health facilities (US) of the municipality with a Family Health Strategy (ESF) or Community Health Workers Program (PACS), totaling 26 establishments. The municipality of Vitória, capital of the Espírito Santo State, has 327,801 inhabitants[10] and a Human Development Index (HDI) of 0.845[11].

The sample size calculation considered an acceptable margin of error of 5% and a 95% confidence level. We considered a 95% confidence level, 80% power and an exposed/unexposed ratio of 1:1 to study the association with risk factors. Ten percent were added for possible losses and 30% for adjusted analyses, requiring a total of 998 women. We used the proportional sampling by health facility technique.

Women were approached in the US and invited to participate in the study and, after accepting and signing the Consent Form, were interviewed individually, with only the respondent and a duly trained interviewer, in a reserved space in the US. Patients who had an intimate partner at the time of the interview or in the last 12 months were included in the study. Intimate partners were defined as partners or former partners, regardless of the formal relationship, and current boyfriends, provided they were having sexual intercourse. Exclusion criterion adopted was women with intellectual or sensorial deficits unable to communicate. Regarding this research, we used the database containing socioeconomic characteristics: age (categorized by decades); self-reported skin color (white, black and brown), excluding indigenous or Asian origin because they are a negligible group and no inference of the results is possible; schooling (up to eight years, nine years or more); household income at the time of the interview (> = 1,500; 1,501-2,924; < 2,925);

marital status (married, single, divorced or separated, and in common-law marriage); religion (Catholic or evangelical: yes/no). To identify the family experience and life of violence the following were asked, respectively: "Has your mother ever suffered any intimate partner violence?" (yes/no) and "Did you suffer sexual violence in childhood?" (yes/no). Regarding the behavioral characteristics, we asked about: doses of alcoholic drink intake (less than or equal to two, more than two and up to eight, or more than eight doses). One dose corresponded, on average, to a 350 ml can of beer or draft, a 90 ml wine glass, a 30 ml distillate dose, a can or a small bottle of any iced beverage; tobacco use (distributed in two categories: smokers: smoked at least one cigarette per day; non-smokers: who included former smokers) and history of drug use (drug use ever in life: yes/no).

The second instrument applied was the short version of the questionnaire of the World Health Organization (WHO) entitled "World Health Organization Violence Against Women" (WHO VAW STUDY)[12], validated for use in Brazil, containing 13 questions that determine the endpoints in studies: psychological, physical, and sexual violence perpetrated by the intimate partner throughout life. Violence was considered present when women answered "yes" to one of the items of the instrument. It is worth mentioning that all the participants received a folder containing the primary services for women in situations of violence at the end of the interview and, if necessary, referrals were made to the center for the care for the victims of the municipality of Vitória.

Stata 13.0 was used to analyze data. For the bivariate analysis, which investigated the association between the outcomes and the exposures under study, we used the chi-square or Fisher exact test according to assumptions. The multivariate analysis was evaluated using the Poisson regression, with a robust, crude and adjusted variance for control of the confounding factors according to the hierarchical model (Figure 1). Concerning input to the model, a p-value was not determined so as not to exclude possible confounding factors; the permanence in the model was determined by the value of $p < 0.05$. The Research Ethics Committee of the Federal University of Espírito Santo approved this study.

Results

A total of 991 women were interviewed, i.e., seven women refused to participate in the study. Among the participants, a lifelong predominance of psychological violence was found, with a prevalence of 57.6% (95% CI: 54.6-60.7). Physical violence was the second most prevalent, with 39.3% (95% CI 36.2-42.3). Violence with the lowest prevalence was sexual, with 18.0% (95% CI 15.7-20.5). (Data not shown in Table).

In assessing the prevalence of violence according to the characteristics under study (Table 1), a higher prevalence of psychological, physical and sexual abuse committed by the partner in life among women with up to eight years of schooling, belonging to the group of lower household income, divorced/separated, whose mother suffered intimate partner violence, smokers and with a history of drug use was identified. Evangelical women evidenced higher frequencies of physical and sexual violence. Participants in the research with a history of sexual violence in

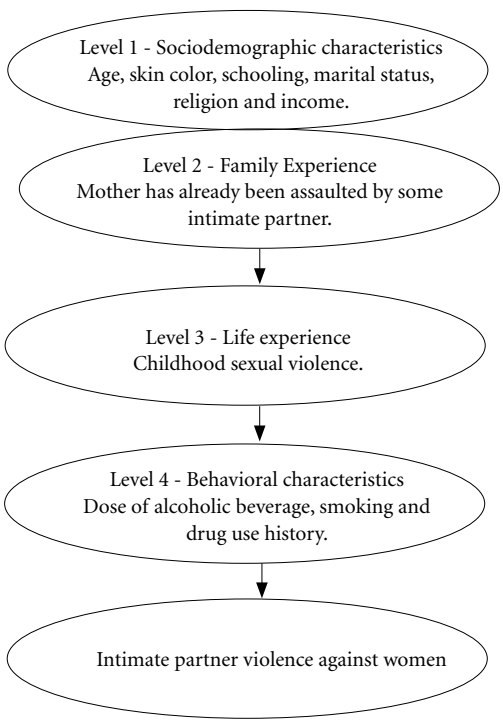

Figure 1. Hierarchical model of the relationship between the risk factors for the outcome of intimate partner violence against women.

Table 1. Prevalence of intimate partner violence against women, throughout life, according to socioeconomic and behavioral characteristics, and family and life experience. Vitória, Espírito Santo, Brazil. March to September 2014.

Sociodemographic characteristics	Psychological violence		Physical violence		Sexual violence	
	P (CI 95%)	p-value	P (CI 95%)	p-value	P (CI 95%)	p-value
Age (years)						
20-29	54.4 (48.6-60.1)	0.529 [c]	40.4 (34.4-45.8)	0.612 [c]	15.4 (11.7-20.1)	0,055 [c]
30-39	57.8 (52.2-63.2)		36.6 (31.4-42.1)		15.0 (11.4-19.5)	
40-49	58.7(52.1-64.9)		42.2 (35.9-48.8)		22.7 (17.6-28.6)	
50-59	61.1 (53.4-68.1)		38.8 (31.9-46.3)		21.1 (15.7-27.8)	
Skin color [a]						0,910 [c]
White	51.1(44.4-57.8)	0.086 [c]	32.5 (26.6-39.1)	0.038 [c]	18.6 (13.9-24.4)	0,910 [c]
Brown	58.2 (53.9.-62.4)		40.5 (36.3-44.9)		17.3 (14.2-20.9)	
Black	61.09 (54.7-67.1)		43.9 (37.7-50.3)		18.0 (13.6-23.4)	
Schooling (years of study)						
0-8	67.0 (61.4-72.1)	<0.001 [c]	51.1 (45.5-56.8)	<0.001 [c]	25.1 (20.5-30.3)	<0,001 [c]
9 or more	53.5 (49.7-57.2)		34.0 (30.5-37.6)		14.8 (12.3-17.7)	
Household income (in Reals)						0,036 [d]
>= 1500	65.6 (60.4-70.4)	0.001[d]	48.7 (43.4-54.0)	<0.001[d]	13.9 (10.6-18.1)	0,036 [d]
1501-2924	55.0 (49.5-60.4)		42.1 (36.8-47.6)		21.6 (17.5-26.6)	
< 2925	51.8 (46.4-57.2)		26.7 (22.1-31.7)		18.4 (14.6-22.8)	
Marital status						0,027 [c]
Married	48.2 (43.5-52.9)	<0.001 [c]	27.2 (23.2-31.5)	<0.001 [c]	14.6 (11.6-18.2)	0,027 [c]
Common-law marriage	63.1 (57.4-68.4)		47.1 (41.4-52.8)		19.3 (15.2-24.2)	
Single	66.0 (59.7-71.7)		49.2 (42.8-55.5)		21.0 (16.3-26.7)	
Divorced / separated	85.0 (61.6-95.2)		70.0 (46.7-86.2)		35.0 (17.3-58.1)	
Catholic						0,585 [c]
Yes	55.6 (50.1-60.3)	0.273 [c]	38.9 (34.3-43.7)	0.846 [c]	17.2 (13.9-21.1)	0,585 [c]
No	59.1 (55.0-63.0)		39.5 (35.6-43.6)		18.5 (15.5-21.9)	
Evangelical						0,034 [c]
Yes	60.2 (55.8-64.5)	0.110 [c]	42.7 (38.3-47.2)	0.031 [c]	20.6 (17.2-24.5)	0,034 [c]
No	55.2 (50.1-64.5)		36.0 (32.0-40.3)		15.5 (12.6-18.9)	
Family and life experience						
Mother has already been beaten by some partner [b]						
Yes	66.8 (61.4-71.8)	<0.001 [c]	48.2 (42.7-53.8)	<0.001 [c]	22.7 (18.4-27.7)	0,003 [c]
No	51.6 (47.6-55.7)		32.8 (29.1-36.7)		14.7 (12.0-17.8)	
Sexual violence in childhood						
Yes	71.9 (63.2-79.2)	0.001 [c]	57.0 (48.9-65.6)	0.100 [c]	37.2(29.0-46.2)	<0,001 [c]
No	55.6 (52.3-58.9)		36.8 (33.6-40.0)		15.3 (13.0-17.8)	
Behavioral characteristics						
Dose of alcoholic beverage						
None	57.3 (53.5-61.1)	0.016 [c]	37.2 (33.6-41.0)	0.001 [c]	20.3 (17.3-23.5)	0,056 [c]
<=2	48.2 (40.1-56.5)		35.5 (28.0-43.7)		11.4 (7.1-17.8)	
2.1-8.0	62.9 (54.7-70.5)		42.0 (34.1-50.2)		14.7 (9.8-21.5)	
>8.0	69.2 (56.9-79.3)		61.5 (49.1-72.6)		16.9 (9.6-28.2)	
Smoker						
Yes	77.1 (68.2-84.0)	<0.001 [c]	65.1 (55.7-73.5)	<0.001 [c]	24.8 (17.5-33.8)	0,050 [c]
No	55.2 (51.9-58.5)		36.1 (32.9-39.3)		17.1 (14.8-19.7)	
History of drug use						<0,001 [c]
Yes	85.8 (77.8-91.3)	<0.001 [c]	73.6 (64.3-81.1)	<0.001 [c]	34.9 (26.4-44.5)	<0,001 [c]
No	54.2 (50.9-57.5)		35.1 (32.0-38.3)		15.9 (13.7-18.5)	

[a] n=957; [b] n=898; [c] Pearson chi-square; [d] Linear trend chi-square.

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childhood had a higher occurrence of intimate partner psychological and sexual abuse throughout life. Also, women who drink more than eight doses of alcohol are among the group with the highest prevalence of psychological and physical violence ($p < 0.05$).

Table 2 shows the crude and adjusted analysis of the effects of socioeconomic, behavioral, and family and life experience on partner psychological violence throughout life variables. After adjustment, psychological violence was associated with schooling, marital status, evangelical religion, maternal IPV history, sexual violence in childhood, smoking and drug use ($p<0.05$). Women with up to eight years of education, whose mother has suffered some intimate partner violence, who were sexually abused or are smokers, have a 20% higher frequency of partner psychological abuse over the lifetime when compared to those with higher education, with no maternal and personal violence history and non-smokers. Likewise, the prevalence of this condition was 70% more likely among the separated or divorced women when compared to married women (PR: 1.70; 95% CI: 1.37-2.10). Women who have already used drugs are 1.37 more likely to experience psychological violence compared to non-drug users (PR: 1.37, 95% CI: 1.21-1.55). It is also observed that having referred to being evangelical increased by 12% the prevalence of psychological violence (PR: 1.12; 95% CI: 1.01-1.24).

After adjusting for the confounding factors, we verified that the partner physical violence in life was almost 2.27 times more prevalent in divorced and separated women when compared to married ones. As for household income and schooling, an increase in this type of abuse was observed in 41% of the women in the lower income group (≤ to R$ 1,500.00/month), when compared to the higher income group (R$ 2,925.00/month), and 33% among those with lower schooling (up to eight years of schooling). Women who smoke and with a history of drug use are among the groups with the highest prevalence of physical violence, respectively: 34% and 64% when compared to those who did not report such behaviors. Regarding family and life experience, an increase of 27% is noted among those whose mother has already been beaten by the partner. Among those with a history of sexual violence in childhood, the prevalence of physical violence is 45% higher than those who did not suffer from this abuse in childhood (Table 3).

Table 4 shows the crude and adjusted analysis for intimate partner sexual violence throughout life. After adjustment, a 2.18 times greater prevalence of this violence is observed among divorced or separated women, when compared to married women. Those with up to eight years of schooling have a 63% higher incidence of sexual abuse compared to those with higher schooling. Sexual violence was still twice as prevalent in women who had been sexually abused in childhood and had used drugs compared with those who denied these facts. Another point to highlight is the 33% increase in intimate partner sexual abuse in life in evangelical women, compared to those who do not belong to this group. There was a higher prevalence of sexual violence among those whose mother has been beaten by the intimate partner (PR: 1.37, 95% CI: 1.03-1.84).

Discussion

This study reveals a high prevalence of intimate partner violence throughout life among female PHC users in the city of Vitória, and psychological violence was the most prevalent (P = 57.6% 95%CI: 54.6-60.7), confirming the findings of a cross-sectional study conducted in 2014, with women in the city of Recife, Pernambuco, where psychological abuse was also the most frequent[13]. For some authors, this type of violence may be more easily shared due to factors that may involve fear of further assaults or shame of talking about relationship abuse[6]. It is important to highlight the relevance of analyzing the occurrence of psychological violence and ways to prevent it since it is considered the starting point that triggers all other forms of violence[14].

The second type of abuse was physical violence (P = 39.3%, 95%CI 36.2-42.3), with prevalence similar to that of other national studies[15], and although the frequency of partner sexual violence has been the lowest among type of violence investigated (P = 18.0%, 95%CI 15.7-20.5), it was higher than the prevalence revealed by another study conducted in Brazil, at 13.6%[13]. It is believed that several factors contribute to the fact that sexual violence within relationships of solid partnerships is difficult to recognize and delimit, among them, the fact that women do not understand forced sex as violence if they are married or live with the perpetrator. In some countries, while rape has already been recognized as a crime in marriage, in others, the husband still has the legal right to unlimited sexual access to his wife[16].

The study identified the association of violence with socioeconomic variables. The lower

Table 2. Crude and adjusted analysis of the effects of socioeconomic, behavioral and family and life experience variables on psychological violence perpetrated by the intimate partner throughout life. Vitória, Espírito Santo, Brazil. March to September 2014.

Sociodemographic characteristics	Crude analysis		Adjusted analysis	
	Crude PR (CI 95%)	p-value	Adjusted PR (CI 95%)	p-value
Age (years)		0.532		0.178
20-29	1.0		1.0	
30-39	1.06 (0.92-1.23)		1.09 (0.95-1.25)	
40-49	1.08 (0.93-1.26)		1.09 (0.94-1.27)	
50-59	1.12 (0.96-1.31)		1.21 (1.02-1.42)	
Skin color [a]		0.103		0.446
White	1.0		1.0	
Brown	1.19 (1.01-1.40)		1.11 (0.94-1.31)	
Black	1.14 (0.98-1.32)		1.04 (0.90-1.22)	
Schooling (years of study)		<0.001		<0.001
0-8	1.49 (1.22-1.83)		1.23 (1.10-1.36)	
9-11	1.0		1.0	
Household income (in Reals)		<0.001		0.191
>= 1500	1.27 (1.11-1.44)		1.09 (0.95-1.25)	
1501-2924	1.06 (0.92-1.23)		0.98 (0.84-1.13)	
< 2925	1.0		1.0	
Marital status		<0.001		<0.001
Married	1.0		1.0	
Common-law marriage	1.31 (1.15-1.49)		1.30 (1.14-1.48)	
Single	1.37 (1.20-1.56)		1.41 (1.24-1.61)	
Divorced or separated	1.76 (1.43-2.17)		1.70 (1.37-2.10)	
Catholic		0.277		0.265
Yes	0.94 (0.84-1.05)		0.93 (0.82-1.05)	
No	1.0		1.0	
Evangelical		0.110		0.041
Yes	1.09 (0.98-1.21)		1.12 (1.01-1.24)	
No	1.0		1.0	
Family and life experience				
Mother has already been beaten by some partner [b]		<0.001		0.001
Yes	1.29 (1.16-1.44)		1.21 (1.09-1.36)	
No	1.0		1.0	
Sexual violence in childhood		<0.001		0.004
Yes	1.29 (1.14-1.47)		1.23 (1.07-1.41)	
No	1.0		1.0	
Behavioral characteristics				
Dose of alcoholic beverage		0.013		0.114
None	1.0		1.0	
<=2	0.84 (0.70-1.01)		0.85(0.69-1.04)	
2.1-8.0	1.10 (0.95-1.27)		1.10 (0.95-1.28)	
>8.0	1.21 (1.01-1.44)		0.95 (0.79-1.14)	
Smoker		<0.001		0.005
Yes	1.40 (1.24-1.57)		1.20 (1.06-1.36)	
No	1.0	1.0	1,0	
History of drug use		<0.001		<0.001
Yes	1.58 (1.43-1.74)		1.37 (1.21-1.55)	
No	1.0		1.0	

[a] n=957; [b] n=898.

Table 3. Crude and adjusted analysis of the effects of socioeconomic, behavioral, family and life experience variables on intimate partner physical violence throughout life. Vitória, Espírito Santo, Brazil. March to September 2014.

Sociodemographic characteristics	Crude analysis		Adjusted analysis	
	Crude PR (CI 95%)	p-value	Crude PR (CI 95%)	p-value
Age (years)		0.613		0,416
20-29	1.0		1.0	
30-39	0.91 (0.75-1.12)		0.95 (0.78-1.15)	
40-49	1.06 (0.86-1.30)		1.07 (0.87-1.32)	
50-59	0.97 (0.77-1.23)		1.14 (0.89-1.45)	
Skin color [a]		0.047		0,430
White	1.0		1.0	
Brown	1.35 (1.06-1.71)		1.03 (0.82-1.28)	
Black	1.25 (1.00-1.56)		1.14 (0.89-1.45)	
Schooling (years of study)		<0.001		<0,001
0-8	1.62 (1.35-1.95)		1.34 (1.15-1.56)	
9 or more	1.0		1.0	
Household income (in Reals)		<0.001		0,005
>= 1500	1.82 (1.48-2.25)		1.41 (1.13-1.76)	
1501-2924	1.58 (1.27-1.97)		1.38 (1.10-1.72)	
< 2925	1.0		1.0	
Marital status		<0.001		<0,001
Married	1.0		1.0	
Common-law marriage	1.73 (1.43-2.10)		1.61 (1.32-1.97)	
Single	1.81 (1.48-2.21)		1.83 (1.50-2.24)	
Divorced or separated	2.58 (1.86-3.57)		2.27 (1.64-3.15)	
Catholic		0.847		0,802
Yes	0.98 (0.84-1.15)		1.02 (0.86-1.22)	
No	1.0		1.0	
Evangelical		0.031		0,022
Yes	1.19 (1.01-1.39)		1.20 (1.03-1.40)	
No	1.0		1.0	
Family and life experience				
Mother has already been beaten by some partner [b]		<0.001		0,003
Yes	1.47 (1.25-1.73)		1.27 (1.08-1.49)	
No	1.0		1.0	
Sexual violence in childhood		<0.001		<0,001
Yes	1.55 (1.30-1.85)		1.45 (1.18-1.77)	
No	1.0		1.0	
Behavioral characteristics				
Dose of alcoholic beverage		<0.001		0,463
None	1.0		1.0	
<=2	0.95 (0.75-1.22)		1.03 (0.79-1.35)	
2.1-8.0	1.13 (0.91-1.40)		1.19 (0.96-1.47)	
>8.0	1.65 (1.33-2.05)		1.05 (0.81-1.36)	
Smoker		<0.001		0,002
Yes	1.81 (1.53-2.13)		1.34 (1.11-1.62)	
No	1.0		1.0	
History of drug use		<0.001		<0.001
Yes	2.09 (1.81-2.42)		1.64 (1.35-1.99)	
No	1.0		1.0	

[a] n = 957; [b] n = 898.

Table 4. Gross and adjusted analysis of the effects of socioeconomic, behavioral, family and life experience variables on intimate partner sexual violence throughout life. Vitória, Espírito Santo, Brazil. March to September 2014.

Sociodemographic characteristics	Crude analysis		Adjusted analysis	
	Crude PR (CI 95%)	p-value	Crude PR (CI 95%)	p-value
Age (years)		0,055		0,111
20-29	1,0		1,0	
30-39	0,97 (0,66-1,42)		0,97 (0,66-1,42)	
40-49	1,47 (1,02-2,11)		1,37 (0,94-2,01)	
50-59	1,37 (0,92-2,03)		1,43 (0,94-2,17)	
Skin color [a]		0,910		0,485
White	1,0		1,0	
Brown	0,97 (0,65-1,43)		0,89 (0,60-1,33)	
Black	0,93 (0,66-1,30)		0,81 (0,58-1,14)	
Schooling (years of study)		<0,001		0,001
0-8	1,53 (1,22-1,83)		1,63 (1,24-2,14)	
9 or more	1,0		1,0	
Household income (in Reals)		0,039		0,106
>= 1500	1,56 (1,11-2,19)		1,30 (0,92-1,86)	
1501-2924	1,32 (0,93-1,87)		0,97 (0,67-1,41)	
< 2925	1,0		1,0	
Marital status		0,021		0,015
Married	1,0		1,0	
Common-law marriage	1,32 (0,96-1,83)		1,31 (0,94-1,82)	
Single	1,44 (1,03-2,01)		1,55 (0,38-1,68)	
Divorced or separated	2,40 (1,26-4,54)		2,18 (1,17-4,08)	
Catholic		0,586		0,717
Yes	0,93 (0,71-1,22)		0,94 (0,67-1,31)	
No	1,0		1,0	
Evangelical		0,035		0,042
Yes	1,33 (1,02-1,74)		1,33 (1,01-1,74)	
No	1,0		1,0	
Family and life experience				
Mother has already been beaten by some partner [b]		0,003		0,028
Yes	1,54 (1,16-2,05)		1,37 (1,03-1,84)	
No	1,0		1,0	
Sexual violence in childhood		<0,001		<0,001
Yes	2,43 (1,83-3,21)		2,08 (1,50-2,88)	
No	1,0		1,0	
Behavioral characteristics				
Dose of alcoholic beverage		0,070		0,081
None	1,0		1,0	
<=2	0,56 (0,34-0,91)		0,91 (0,41-1,15)	
2.1-8.0	0,73 (0,47-1,11)		0,70 (0,45-1,08)	
>8.0	0,83 (0,48-1,46)		0,59 (0,33-1,04)	
Smoker		0,043		0,292
Yes	1,45 (1,01-2,07)		1,24 (0,83-1,89)	
No	1,0		1,0	
History of drug use		<0,001		<0,001
Yes	2,19 (1,62-2,96)		2,06 (1,46-2,91)	
No	1,0		1,0	

[a] n = 957; [b] n = 898.

level of schooling was associated with higher prevalence of violence, corroborating another study[17]. It is believed that women's enlightenment leads to lower tolerance for violence. The more women qualify, the more they are likely to find paid work, thus improving self-esteem and independence[18]. It is also suggested that women with higher education levels would have more resources to achieve greater autonomy and could have more skills to recognize and break with abusive relationships[15].

The association of physical violence throughout life with lower income levels was also evidenced. In this context, despite the violence affecting all socioeconomic groups, more impoverished women are primarily affected[19]. These findings are probably explained, since women in a situation of violence, with low social and economic conditions, may have more significant difficulties in decision making in order to break with the violent relationship, considering that she does not have financial autonomy[20].

It is also important to reflect on the fact that exposure to violence has adverse effects on school performance[21]. This can be related to the lower level of schooling of the victims and, thus, to lower income and occupation of less valued positions[22]. Also, the higher prevalence of domestic violence among poorer households may suggest that the mechanism of intergenerational transmission of violence may be related to the low intergenerational income mobility. A negative relationship is noted between the prevalence of domestic violence and income, both against parents' income and women's current income[23].

Consistent with the literature[15], the study also revealed a high prevalence of violence among separated and divorced females, suggesting that many women can break free from the situation of violence, breaking with the stereotype that intimate partner violence is a hopelessly chronic situation.

The condition referred to as "mother victim of intimate partner violence" was associated with violence. The literature indicates that a family environment with a history of violence witnessed or endured in childhood can trigger a space for violent behavior. Also, it may suggest a gender vulnerability highly related to the violence experienced in adult life. Thus, it is suggested that patterns of violence in the family can reproduce through generations[24].

Women smokers and those with a history of drug use showed a higher prevalence of physical and psychological violence throughout their lives. However, sexual violence revealed association only with drug use. The literature confirms higher frequencies of intimate partner violence[13] among women with high-risk behavior, such as drug use. Also, it is worth reflecting that experiencing a situation of violence can make women more likely to report alcohol and illicit drug use to address the violent event[25,26], or violence in its various forms can lead to the act of smoking to minimize and support this problem[27].

The present research reveals that psychological, physical and sexual violence have a significant association with the evangelical religion, a finding that is similar to that pointed out in a recent systematic review that shows that domestic violence is associated with religion[28]. Thus, the literature suggests a search for religion as a way to support or overcome violence[29].

It is also worth reflecting that the confrontation of violence, that is, the act of denouncing or deciding to break with the silence in the face of the situation of violence, has both facilitating and hindering aspects. Personal attitudes such as feelings of exhaustion, outrage and awareness of the potential risk of life are among the facilitating aspects, and the hindering factors include fear, guilt and shame, as well as family, material and institutional barriers[30]. In this context, it is necessary to allocate adequate human resources to expand care centers for victims of violence, considering violence against women an essential public health issue[31].

Some limitations of this study must be highlighted. The first of these is that it was conducted in the health service. Thus, the participation of women of better socioeconomic status with access to health insurance may have been lower, and although it is known that the occurrence of violence was lower among these women, it may be that the associations were even stronger with the lowest socioeconomic condition. Also, there may have been less participation of women in situations of violence that might be inhibited to seek the US. However, the high prevalence of violence identified may suggest that this problem would be even more significant if these women were included in the study. Finally, the cross-sectional design prevents the cause-and-effect relationship between the variables. However, strong associations show the importance of establishing measures of interventions concerning the exposures that trigger the highest occurrence of victimization.

Conclusion

This study met the proposed objective and evidenced the high prevalence of intimate partner violence throughout life among primary care users in the city of Vitória and the association of psychological, physical and sexual violence with sociodemographic, behavioral and personal and maternal experiences of violence.

Finally, it is understood that this research brings essential contributions to the area of public health, indicating new looks and ways to care for women in situations of violence. Before the sizeable extent of the problem revealed, there is a need to implement detection-sensitive instruments and instruments that focus on violence in the daily routine of primary care services, thus promoting greater visibility to violence against women, as well as the promotion of trained caregivers attending these victims in an integrated way.

Collaborations

IB Santos participated in the data interpretation, drafting of paper, critical review and approval of the version to be published. MHC Amorim participated in the critical review and approval of the version to be published. DP Gigante participated in the design, analysis, data interpretation, critical review and approval of the version to be published. PMA Maciel participated in the critical review and approval of the version to be published. FMC Leite participated in the conception, design, analysis, data interpretation and approval of the version to be published.

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