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Occurrence of violence caused by intimate partners in brazilian rural working women: a descriptive study

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ABSTRACT

Aim: To describe the occurrence of violence perpetrated by intimate partners (IPV) according to the interpretation of rural working women. **Method**: This is a descriptive study that included 795 participants of the Fourth March of the Daisies in the Brazilian capital. Data was collected using the ballot technique and analysed by means of descriptive statistics. **Results**: Forty-one percent (41%) of women experienced at least one episode of IPV; seventy percent (70%) mentioned physical violence; sixty-three percent (63%) psychological violence; and fourteen percent (14%) sexual violence. Variables: age, marital status, position in the family, geographical origin, and types of violence. **Discussion**: Physical violence was the most prevalent issue, followed by psychological and sexual violence. Women who have lived in union had higher odds of experiencing violence. **Conclusion**: The occurrence of violence by intimate partners was confirmed by rural working women. We expect to contribute to the development of networks of protection for women in situations of violence, family health strategy and the training of health and nursing professionals.

Descriptors: Rural Population; Women; Violence against Women; Health Public Policy; Nursing Research.

INTRODUCTION

The recognition of violence against rural women workers - at home, at work and in society – does not have a privileged position in the scenario of health research and the production of knowledge that reveals the magnitude of the problem[1]. Studies conducted in partnership of the Pan American Health Organization (PAHO) and the World Health Organization (WHO) showed high levels of the occurrence of violence against women, especially in urban areas. The results of a study conducted in Latin America and the Caribbean on violence against women registered the persistence of violence, in the same rates as those found on a global scale, with levels of around 25-50% incidence[1.2].

The Map of Violence 2012 revealed that Brazil ranks 7th in femicides - fatal violence against women. It was observed that in 42.5% of all assaults the perpetrator was the intimate partner or ex-partner[3]. A Brazilian study on female mortality resulting from aggression highlighted other socio-economic and demographic factors associated with the murder of women by partners, such as poverty, the disparity of age between spouses and unformalized marital status[4]. Brazilian research into the national and regional levels of violence committed by intimate partners (IPV) showed similar overall rates according to the results obtained by WHO and PAHO, in which women experienced some type of aggression by the current or former partner[5.6].

Violence against women is recognized as a serious public health problem and a barrier to the development of a country[1,2,6]. The main cause of aggression against women, unlike other types of violence, is manifested by inequalities in traditional gender relations. Gender violence is defined by inequalities in relations between men and women and includes physical, psychological, sexual, moral and patrimonial aggression[2.5]. The family environment is where most of the acts of aggression occur and women usually know their attacker[6]. These are the multi-determined and polysemic scenarios of violence that involve the whole society in their complex dimensions - social, economic, political and cultural[6]. Nevertheless, important government policies have emerged in the years 2007 and 2008 when the National Policy on Violence against Women and the National Plan of Policies for Women II, which now include rural working women, were established[1]. The National Comprehensive Health Policy of the Rural and Forest Populations, which aimed to ensure the right and access to health care based on the principles of equity, universality and comprehensiveness of the Unified Health System (UHS) for the rural population, was also created[7].

In 2011, rural working women were awarded the Guidelines and National Actions to Confront Violence against Women in Rural and Forest Areas due to the significant impact of the political articulation of these women[1]. However, these policies have been only partially implemented. This is due to the following factors:

1- The services specializing in assisting women in situations of violence are concentrated in larger cities;
2- The rural areas are geographically isolated;
3- There is a lack of trained human resources to recognize the problem and make the appropriate referrals[1].

These aspects hinder the access of rural workers to social infrastructure for combating violence against women.

While advancements of governmental initiatives are recognized, much remains to be done, both at the level of public health policies and in meeting the demands of rural women in terms of primary care, such as from the insertion of the Family Health Strategy. Importantly, the work process is multidisciplinary and has the

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nurse as an articulator in educational activities, in strengthening the bond with the community and with the family, and also in the sectoral articulation, among other aspects that could be mentioned[8].

A study in Peru showed structural features similar to those found in Brazil. It identified difficulties in the distribution of human resources in health which tend to be concentrated in large urban centers[9]. In this context, the important role of nursing is highlighted, since nursing professionals traditionally approach users, communities and health services[5,8,9]. Precisely because of this, the inclusion of this theme in research fields such as nursing, health sciences and the academic training process is essential. Future professionals should be trained to recognize the different forms of violence, for healthcare management to women in situations of violence and to adopt preventive strategies in order to minimize gender-based violence[9]. Thus, any and all intervention strategies aimed at minimizing violence against women are welcome.

This study emerged from the need to verify episodes of violence committed by intimate partners against women living in rural areas. It is relevant because the knowledge produced by the research may contribute to organizing the agendas of coordinated demands by the trade union movement of rural workers and the intervention plans for politicizing the problem of structuring the safety net for women in situations of violence. The main objective was to describe the occurrence of violence perpetrated by intimate partners, in the interpretation of rural working women.

METHOD

This is a descriptive study using a quantitative approach, which adopted sampling by convenience[10]. The following information was pre-established: confidence level = 95%, and p-value <0.05. The data collection scenario was the fourth edition of the March of the Daisies, held in Brasilia. The March of the Daisies is a socio-political collective action and activity.It is connected to the World March of Women, which denounces and applies pressure, but also proposes dialogue and political negotiation with the State[11]. It occurs every four years and is organized by the women of the Trade Union Movement of Rural Workers and coordinated by the National Confederation of Agricultural Workers. The participants were 795 rural working women who met the inclusion criteria: aged 18 years and upwards who participated in the 4th March of the Daisies. The questions were adapted from a validated instrument of a multi-country study to estimate violence against women, conducted by WHO[6.13].

Data collection took place on August 16 and 17 2011 in the external dependency of the lodgings for women located in the City Park in Brasilia and also during the event. It was accompanied by a team of volunteers, scholars from different areas of health, previously trained in the ballot box technique. This permits confidentiality of the data source in order to improve the reliability of the answers to socially controversial issues, such as abortion, violence, and behaviors, among others, that relate to the privacy of the participants[12]. The questionnaires were self-completed and subsequently deposited in ballot boxes placed strategically at the event venue. The purpose of using the ballot box was to safeguard confidentiality and ensure anonymity of participants.

For statistical analysis, the following independent variables were used: age, years of education, marital status, family status, color, religion and geographical origin. Four issues were defined as dependent variables, which

aimed to identify the nature and the occurrence of episodes of violence by intimate partners and two questions were about episodes of violence committed by them.

The operational definition used in this study followed the WHO classification to identify the nature of violence from the violent acts committed by intimate partners. They are:

1) Psychological violence (PsV): including humiliation, public insults, swearing or threats;
2) Physical violence (PhV), which covers two types:
   a) Moderate physical violence (MPhV): characterized by jerks, shoves or jolts, slaps or throwing objects;
   b) Serious physical violence (SPhV): including punching, kicking, dragging or beating, strangulation, burns, attempts to use a weapon - cold steel, fire, or other types of weapons;
3) Sexual violence (SV): women are physically or psychologically forced into sexual relations[1.13].

We used the Data Editor Statistical Package for Social Sciences - SPSS© [version 18] to create the database and statistical analysis[10]. We tried to determine the distribution of the types of violence according to the socio-demographic profile of women and possible associations between variables. The chi-square test was used to compare the proportions of amounts of positive responses between the groups, identify the existence of differences and evaluate the odds ratio in terms of the occurrence of violence[10].

The development of the study met the national and international standards of ethics in research involving human subjects. The study was approved by the Research Ethics Committee of the Health School of the University of Brasilia (CEP-FS/UnB) under the Protocol No. 068/2011.

RESULTS

The socio-demographic profile of the 795 rural working women respondents is shown in Table 1. The results revealed that most belonged to the age group considered adult (25-59 years). More than half of respondents reported having up to 10 years of education. Regarding marital status, over 70% said they lived in a consensual union or had previously lived with a partner. About 40% of women claimed to be the head of the household in the family. The study showed that 77% of women were black, representing the contingent of self-declared black colored women (16%) and brown (61%). In terms of geographical origin, the Northeast region was predominant .

Table 1 - Socio-demographic profile of rural working women participating in the study. Fourth March of the Daisies. Brasília, 2011.

Socio-demographic variables	n	%
Total number of respondents	795	100
Age Group		
18 to 24 years	66	8
25 to 49 years	465	59
50 to 59 years	164	21
60 and over	90	11
Did not answer	10	1
Years of study		
Did not study	22	3
1 to 3 years	90	11
4 to 7 years	198	25
8 to 10 years	129	16
11 or more	332	42
Did not answer	24	3
Marital Status		
Living in a consensual union	498	63
Not living, but have lived in union	72	9
Have never lived in union	209	26
Did not answer	16	2
Family position		
Reference person (householder)	316	40
Spouse, wife or partner	341	43
Daughter	107	13
Other positions	18	2

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Did not answer	13	2
Color		
White	154	19
Black	130	16
Brown	486	61
Yellow or Indigenous	18	3
Did not answer	7	1
Religion		
Catholic	630	79
Evangelic	117	15
Another	26	3
Has no religion	14	2
Did not answer	8	1
Origin		
Midwest	54	7
North	29	4
Northeast	607	76
Southeast	67	8
South	38	5

Source: Prepared by the authors, 2011.

Table 2 shows the profile of women exposed to episodes of violence. Among the survey participants, 41% (n=326) reported having experienced violence by intimate partners at some point in life. Most episodes occurred with adult women with up to 10 years of education, in a consensual union, and these women were the head in the family. The women declared black, representing all of the self-declared black women (16%) and brown color (61%), accounted for 90% of all women who have experienced IPV.

The analysis showed statistically significant differences for the following variables: age (p<0.036), marital status (p<0.000), position in the family (p<0.000), geographic origin (p<0.0048) and occurrence of violence. The significance between the variable geographical origin and episodes of violence was due to the large number of respondents in the Northeast region of Brazil and one cannot infer that this is the region with the highest incidence of IPV.

The odds ratio in terms of violence suffered by women who have already lived, but no longer live in a consensual union is 5.25 times higher than those living in other civil status situations. Likewise, women who are reference persons (householders) are 3.39 times more likely to suffer violence.

Table 2 - Socio-demographic characteristics of rural working women who reported having suffered some episode of IPV. Fourth March of the Daisies. Brasília, 2011.

Socio-demographic variables	n(%)	Odds ratio	Sig. p--value
Total	326(41)		
Age group			
18 to 24years	19(6)	0,56	
25 to 49 years	185(57)	0,89	
50 to 59 years	78(24)	1,4	p < 0,036*
60 and over	42(13)	1,3	
Did not answer	2(0)	0,36	
Years of study			
Did not study	12(4)	1,75	
1 to 3 years	40(12)	1,17	
4 to 7 years	91(28)	1,31	p < 0,176
8 to 10 years	53(16)	1	
11 or more	123(38)	0,75	
Did not answer	7(2)	0,58	
Marital Status			
Living in a consensual union	181(56)	0,59	
Not living, but have lived in union	49(15)	5,25	p < 0,000*
Have never lived in union	90(28)	0,17	
Did not answer	6(1)	0,72	
Position in the family			
Reference person (householder)	185(57)	3,39	
Spouse, wife or partner	106(33)	0,48	p < 0,000*
Daughter	26(8)	0,42	
Other positions	6(2)	0,71	
Did not answer	3(3)	0,43	

Color			
White	55(17)	0,76	
Black	58(18)	1,19	
Brown	201(62)	1,04	p < 0,501
Yellow / Indigenous	8(2)	1,15	
Did not answer	4(1)	1,93	
Religion			
Catholic	255(78)	0,89	
Evangelic	55(17)	1,36	
Another	6(2)	0,65	p < 0,232
Has no religion	5(2)	0,5	
Did not answer	5(1)	1,81	
Origin			
Midwest	21(7)	2,84	
North	19(6)	0,97	
Northeast	248(76)	0,91	p < 0,048*
Southeast	27(8)	0,97	
South	11(3)	0,57	

*Source: Prepared by the authors, 2011. * Significance level of the association test p-value <0.05*

Table 3 presents data related to the nature and type of violence practised by intimate partners that showed higher prevalence (41%), considering the sum of the percentage of moderate physical violence and serious physical violence, followed by psychological violence (35%). As for the frequency of violent acts, the data showed the intensity in both dimensions (moderate and severe), that physical violence accounted for 70% of the very frequent repetition of violence and psychological violence by 63%. As for sexual violence, only 14% of the interviewees reported a low frequency of episodes.

It is noteworthy that about 26% of women reported having experienced multiple combinations of types of violence. Women also reported practising violence: 28% of them reported episodes of psychological violence and 10% reported physical violence against their partners. As to psychological violence, the episodes were repeated more often in intimate-affective relationships for 38% of the respondents. The same index for single or infrequent episodes of physical violence was also observed.

DISCUSSION

In this study, we observed that the result of the demographic profile of rural working women matched the characteristics of the general profile of the population. The WHO estimates IPV prevalence ranges between 25% and 50%[14]. This prevalence is considered compatible with the present study, in which 41% of rural working women reported having experienced episodes of intimate partner violence.

With regard to education, the proportion of rural working women who entered high school and/or higher education is linked to the fact that

Table 3 - Nature, prevalence and frequency of violence committed by intimate partners against rural working women. Fourth March of the Daisies. Brasília, 2011.

Type of violence	Prevalence	Frequency		
	Has suffered violence	Infrequent	Frequent	Very frequent
	n(%)	n(%)	n(%)	n(%)
Psychological violence	279(35)	35(12)	58(20)	186(63)
Moderate Physical Violence	187(24)	73(36)	42(21)	72(35)
Serious Physical violence	136(17)	51(34)	32(21)	53(35)
Sexual violence	119(15)	19(14)	36(26)	64(47)

Source: Prepared by the authors, 2011. Rural working women who reported episodes of violence (n=326).

Griiboski RA, Guilhem D, Moura LBA. Occurrence of violence caused by intimate partners in brazilian rural working women: a descriptive study. Online braz j nurs [internet] 2015 Mar [cited year month day]; 14 (2):151-60. Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/4653

they were women engaged in social movements and trade unions. These are people who value education as a tool for human emancipation. Although there was proportion of respondents with higher education, there were still women with low or no education[6,11,15]. Previous studies in Ethiopia and Brazil have shown that low educational level was associated with IPV[6.13]. It was observed that education alone does not represent a preventative element to the experiences of violence. The results are similar and meet the findings in this study, in which being married, living in rural areas and having low or no education are factors associated with IPV[4.15]. While education alone is incapable of helping to minimize the episodes of violence, it is integrated with the process of forming a more egalitarian society. It is considered essential to the reduction of economic inequalities, both in urban and rural areas[6.15]. In Brazil, the information about women's education describes a pattern of improvement, while inequalities in gender relations and work persists. These are factors that expose women to the different situations of vulnerability[14-16].

In this context, gender violence involving the relationships of power, whether physical, economic, political, social or even intellectual is configured[6,9,17,18]. Relationships of gender, generation, income and even family in rural contexts are influenced by complex webs of power that perpetuate institutions and social hierarchies. In this context, men use violence as a tool for female submission, regardless of socio-economic issues[17].

Another important result was the occurrence of violence against women at older ages, which was also observed in the study on elderly women in southwestern rural Virginia, United States. Violence is rarely mentioned by the victims and is not recognized as a relevant issue by the community and by health professionals. In addition, the attacks would be old or less valued in the reports provided by women. This study showed that women in an age group older than 50 years were more likely to suffer episodes of violence than young women. This fact deserves special attention in the intersection between the public policy aimed at adult and elderly women[18].

Similarly, being the person of reference and head of household does not translate into personal safety against violations of rights in intimate-affective relationships mediated by the domination-subordination system[6,9,17]. Even if a woman has financial autonomy and is the provider of the home, these attributes are not configured as protective elements as it relates to IPV. In this light, the association between financial autonomy and increased IPV in rural areas should be considered, since there are preferential transfer programs of income and property for rural working women[11]. It is noteworthy that the presence of violent acts against black women also constitutes an important bias of race and this incidence is related to other forms of violence, such as sexual violence.

One of the main causes of violence against women is the gender differences imposed on intimate-affective relationships. Episodes of IPV tend to scale and may increase over the years[18,19]. This study found similarities in relation to a study conducted in the Ugandan rural community, where most of the women interviewed reported exposure to PsVand PhV; more than half suffered isolation and restriction of liberty; and 23% had been victims of sexual violence[19].

Still on the prevalence of IPV, the study showed that episodes of violence can be severe, recurrent and overlapping, that is, the combination of any type of violence that is considered more frequent may be followed by all kinds of violence[4.15 19]. This study also noticed a similarity as rural working women pointed out the

existence of a high VF index and the frequency of episodes, combined with VP and VS present in a single event.

Violence against women has been linked to the difficulties of access to fundamental rights such as education, employment, health, and income, present both in urban and rural areas. Both are marked by socio-spatial inequalities[6.15]. There are other factors that can trigger, motivate or increase episodes of violence in the home, such as alcohol and drug use, social maladjustment, and poverty[6].

A determining factor for the identification of violence against the women who are seeking a health service is the training of professionals who will meet them within the Family Health Strategy in a welcoming and humane way. It is known that, in educational practice, the actions used by health professionals can assist in care processes, promote and prevent health problems[20]. In this sense, health education includes a combination of opportunities that encourage health promotion and enable their adoption in daily practices. The exercise of autonomy presupposes the development of a sense of responsibility, both with regard to their own health and the community in which it operates[20]. In this context, the shortage of professionals in the areas most in need hinders a broad coverage by health systems.

Studies in Brazil and Peru on labor attractiveness to keep health professionals in rural areas showed that these professionals perceive political disinterest in its operations. This is reflected in low wages, low professional qualifications, lack of infrastructure and appropriate equipment, and a reduced number of health professionals[8.9]. While any changes to the full implementation of public policies in rural areas do not happen, health professionals, especially nurses, can initiate a dialogue strategy by creating instruments that contribute to social change and women's empowerment. This is justified by the fact that nurses are key elements, since they are the first professionals to provide care, thus opening the dialogue channel with women in situations of violence and rural communities[5.20].

CONCLUSION

The study allowed the identification of socio-demographic characteristics of rural working women, the prevalence and the occurrence of violence committed by intimate partners. Almost half of the women interviewed reported having experienced at least one episode of violence during their lifetime. Physical abuse was more prevalent and was accompanied by psychological and sexual violence. For each of the types of reported violence, there was a mosaic of personal, family, community and societal interactions mediated by incivilities, asymmetrical power relations and civilizing processes affected by intercultural and inter-subjectivities. The results revealed the magnitude of the problem, with persistent gender inequalities in intimate-affective and/or family relationships in which the use of physical force, whether by oppression or subservience, exposed rural working women to constant risk situations.

An important aspect aims to develop actions in order to modify the asymmetries of power and consequently the existing gender violence in rural areas. It is expected that the results contribute as a source of information to provide grants for new studies in health. Another approach is the possibility of incorporating the results in the process of training for health and nursing professionals. This is because nurses are considered social agents and the first link in the care management that can collaborate in building local, regional and national plans to raise awareness, reduce, cope with, and minimize IPVs.

Griiboski RA, Guilhem D, Moura LBA. Occurrence of violence caused by intimate partners in brazilian rural working women: a descriptive study. Online braz j nurs [internet] 2015 Mar [cited year month day]; 14 (2):151-60. Available from: http://www.objnursing.uff.br/index.php/nursing/article/view/4653

On the other hand, these results also can be part of a monitoring system of public policies for the establishment of autonomy, equality and justice for rural working women.

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