Sexual and domestic violence among women attending a STI/AIDS clinic in Vitória, Brazil

Violência sexual e doméstica em mulheres atendidas em uma clínica de DST/AIDS em Vitória, Brasil

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ABSTRACT

Introduction: Violence against women can take several forms; ranging from sexual harassment, discrimination, and discounting to even more serious forms such as those physical and sexual in nature. **Objective:** To describe the frequency of domestic and sexual violence reported by women attending a sexually transmitted infections (STI) clinic in Vitória, Brazil. **Methods:** Women attending the STI/AIDS clinic during the period of study were invited to participate and were interviewed after signing a written consent form. The assessment questionnaire included information on socio-demographic characteristics such as risk behaviors for STI and clinical, domestic, and sexual violence reports. **Results:** A total of 276 (96.8%) women agreed to participate, of which 109 (39.5%) were HIV-positive and 167 (60.5%) were HIV-negative. History of domestic violence was reported by 52.6% of women, mainly related to alcohol abuse (41.6%), use of illicit drugs (27.2%), and psychiatric problems (25.3%). Previous sexual violence was reported by 28.6%, and 31.6% of these cases occurred when the participants were younger than 14 years old. A total of 69.2% of women were between 18 and 34 years old; 11.2% reported frequent use of alcohol; 21% use of illicit drugs and 2.2% reported injectable drugs. Regarding the use of condoms, HIV-positive women were less afraid to ask the partner to use condoms compared with HIV-negative women (31.2% *versus* 41.9%, p=0.022). **Conclusion:** History of domestic and sexual violence was frequently reported in this study. The effects of violence to women's physical and mental health are widely known as a serious public health problem. In addition to its importance, violence is an invisible problem in our society and we need to learn how to approach it during clinical consultation.
Keywords: sexual violence; domestic violence; sexually transmitted diseases; AIDS; women.

RESUMO

Introdução: A violência contra as mulheres pode assumir várias formas, desde assédio sexual, discriminação e desrespeito até formas mais graves tais como violência física e sexual. **Objetivo:** Descrever a frequência de violência doméstica e sexual relatadas por mulheres atendidas em um clínica de doenças sexualmente transmissíveis (DST) em Vitória, Brasil. **Métodos:** As mulheres que buscaram atendimento clínico na clínica de DST/AIDS, durante o período de estudo, foram convidadas a participar e responderam a uma entrevista após assinar um termo de consentimento informado. O questionário utilizado incluiu dados sobre as características sócio-demográficas e clínicas, os comportamentos de risco para DST e a história de violências domésticas e sexuais. **Resultados:** Um total de 276 (96,8%) mulheres concordaram em participar do estudo, das quais 109 (39,5%) eram HIV-positivas e 167 (60,5%) eram HIV-negativas. História de violência doméstica foi relatada por 52,6% das mulheres, principalmente relacionada ao abuso de álcool (41,6%), uso de drogas ilícitas (27,2%), e problemas psiquiátricos (25,3%). Violência sexual prévia foi relatada por 28,6% das mulheres, e 31,6% desses casos ocorreu quando as participantes tinham menos de 14 anos de idade. Um total de 69,2% das mulheres tinham entre 18 e 34 anos; 11,2% relataram o uso frequente de álcool; 21% o uso de drogas ilícitas e 2,2% relataram o uso de drogas injetáveis. Em relação ao uso de preservativos, as mulheres HIV-positivas tinham menos receio de pedir ao parceiro para usar preservativos em comparação com mulheres HIV-negativas (31,2 *versus* 41,9%, p=0,022). **Conclusão:** História de violência doméstica e sexual foi frequentemente relatada neste estudo. Os efeitos da violência sobre a saúde física e mental das mulheres são amplamente conhecidos como um grave problema de saúde pública. Para além dessa importância, a violência é um problema invisível em nossa sociedade e precisamos aprender como abordá-lo na prática clínica.
Palavras-chave: violência sexual; violência doméstica; doenças sexualmente transmissíveis; AIDS; mulheres.

INTRODUCTION

The impact of HIV/AIDS on women's health can be associated with women's autonomy in several ways. The prevalence of HIV is lower in more egalitarian societies where women's rights are protected[1]. Most women are infected with HIV through high-risk heterosexual contact, possibly due to a lack of HIV knowledge, lower perception of risk, drug or alcohol abuse, or different interpretations of safe sex[2]. Relationship dynamics also play a role, in which some women may not insist on condom use because they fear physical abuse or abandonment[3]. They may have less knowledge about infections and hold negative attitudes towards people living with the disease. They are also less likely to negotiate safe sex practices with their partners[4,5].

Domestic and sexual violence occurs globally, in various cultures, and affects people of all economic status[6,7]. The proportions of women who have reported being physically abused by an intimate partner vary from 15% to 71% depending on the country[8]. Laws on domestic violence vary by country. While it is generally outlawed in the Western World, this is not the case in many developing countries[6]. Victims of domestic violence may be trapped in violent domestic relationships through isolation, power and control, insufficient financial resources, fear, shame, or to protect children[9,10].

Domestic violence may be committed in or outside the home and consist of, in most cases, physical, psychological, sexual violence, and neglection[11,12]. The victims are predominantly women,

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children, the elderly, and people with disabilities — people who are vulnerable and physically disadvantaged. Sexual violence is defined as the sexual act performed without the desire of one party or the marketing of sexuality and the use of sexual exploitation through intimidation, threat, and use of force[13]. HIV-positive women report an increase in gender-based violence with partners and also in families, communities, and healthcare settings after their HIV diagnosis and throughout the life-cycle[10].

Brazilian Law No. 11,340/2006, known as the Maria da Penha Law, defines sexual violence as any act that constrains the individual to witness, maintain, or participate in any unwanted sexual activity. It also can be the annulment of sexual and reproductive rights, whether it is through prohibiting the use of contraception, prostitution, or inducing abortion[14]. This type of violence is considered a violation of sexual and reproductive rights and one of the most egregious forms of violence[15].

Violence against women is an important issue in Brazil.

OBJECTIVE

To describe the frequency of domestic and sexual violence reported by women attending a sexually transmitted infections (STI) clinic in Vitória, Brazil.

METHODS

Women aged 18 to 49 years attending a STI/AIDS clinic in Vitória, Brazil, between March and December 2008 were invited to participate in this descriptive study. Patient interviews included demographic, behavioral, and clinical data using a questionnaire validated during a pilot study. Participants were interviewed after providing informed consent. The Ethical Committee on Research of the *Universidade Federal do Espírito Santo* approved this study.

History of domestic violence was measured by the reported frequency of physical violence (at least once a week) involving the woman's sexual partner and/or other members of the family residing in the same home. The history of sexual violence was measured as any previous episode of sexual assault. The interview script that was used had been tested previously and was validated in a pilot study prior to the initiation of data collection for the present study. The interviewers were trained on how to approach questions about violence, and the data obtained during the interview was compared to the data on the patient's prenatal registration card, when available.

Standard descriptive statistical analyses were performed, including frequency distributions for categorical data and calculation of medians and interquartile ranges (IRQs) for continuous variables. The frequency of domestic and sexual violence was calculated to reflect the cumulative frequency of this outcome, with corresponding 95% confidence intervals (CI) in the 2 primary groups (HIV-infected and HIV-non-infected). Associations among demographic and behavioral variables with HIV infection were tested using the χ^2 test, with Yates correction or Fisher's exact test, when appropriate. Odds ratios and 95%CI were calculated in bivariate analyses to estimate the strength of the associations between violence and each covariate.

RESULTS

A total of 276 (96.8%) women agreed to participate in this study and answered the questionnaire, of which 109 (39.5%) were HIV-positive and 167 (60.5%) HIV-negative. The median age among all patients was 30 years (interquartile range [IQR]: 23–36) and the median years of schooling was 8 years (IQR: 5–11). There was no statistical difference between HIV-positive and HIV-negative groups regarding age and education.

Table 1 describes demographic and behavioral factors. A total of 69.2% of women were aged between 18 and 34 years; 11.2% of women reported frequent use of alcohol, 21% of illicit drug use in general, and 2.2% injection drug use. Regarding the use of condoms, HIV-positive women were less afraid to ask their partner to use condoms compared with HIV-negative women (31.2% *versus* 41.9%, p=0.022)

Women reported history of domestic violence in 52.6% of cases; the most common were related to alcohol abuse (41.6%), use of illicit drugs (27.2%) and psychiatric problems (25.3%). History of sexual violence was reported by 28.6%, and 31.6% of these incidences occurred when the participants were younger than 14 years old (**Table 2**).

DISCUSSION

This study showed a high rate of domestic and sexual violence among women attending a STI/AIDS clinic in Vitória. In São Paulo, the prevalence of violence among women attending health care facilities was 59.8% and recurrent violence was associated with HIV infection[16]. The notification of violence against women is compulsory in Brazil, however it is an underreported problem[17]. Many of these women do not report the violence to health care professionals or to the police and consequently, these issues stay invisible. This point highlights the importance of evaluating our approach towards the victims of violence when they seek health care facilities to treat the injuries. Health professionals should consider the situation as an opportunity to also offer emotional support, counseling, and treatment. Victims of violence, and those living in fear

Table 1 – Demographic and behavioral characteristics among women attending an STD/AIDS clinic in Vitória, Brazil (n=276).

Variables	n	%
Marital status		
Married/Living together	127	46.0
Single/Divorced/Widow	149	54.0
Age (years)		
18–34	191	69.2
35–49	85	30.8
Schooling (years)		
Up to 8	159	57.6
More than 8	117	42.4
Tobacco use	64	23.2
Regular use of alcohol (several times a week)	31	11.2
Illicit drugs abuse (no injectable)	58	21.0
Injectable drug abuse	6	2.2
Condom use (Always/almost Always)	189	68.5

of violence, require assistance and their needs must be considered in health care. Additionally, the effects of violence on the physical and mental health of women have been described in other studies conducted in Brazil and in other countries[18-21].

Domestic abuse often escalates from threats and verbal abuse to physical violence. Although physical injury may be the most obvious danger, the emotional and psychological consequences of domestic abuse are also severe. Emotionally abusive relationships can destroy one's self-worth, lead to anxiety and depression, and make one feel helpless and alone[22]. No one should be subjected to this kind of pain — and the first step to leaving is recognizing that the situation is abusive.

Brazilian law prohibits domestic violence, and the government has taken steps that specifically address violence against women and spousal abuse. In 2006, the Brazilian President signed the Law of Domestic and Family Violence. The law triples previous punishments for those convicted of such crimes, and also creates a special court system in all states to preside over these cases. It is also the first official codification of domestic violence crimes[23].

The "Maria da Penha" Law was introduced to punish men who attack their partners, or ex-partners, and forced the Brazilian government to establish public services to protect victims of domestic violence, including a special police force and court system. This law also helped to establish that the crimes are not just sexual assaults, but there are also cultural, psychological, and moral issues underlying these attacks. It is these secondary issues that can often lead to beatings and even murder[14].

Women, who are married or are in long-term cohabiting relationships, are particularly vulnerable to the diseases as a result of gender-inequalities[5,24]. The socioeconomic dependency on men results in low autonomy for women[9].

Table 2 – History of domestic and sexual violence among women attending an STD/AIDS clinic in Vitória, Brazil (n=276).

Violence	n (%)	HIV status	
		Positive	Negative
History of domestic violence related to:			
Alcohol	115 (41.6)	43 (39.4)	72 (43.1)
Illicit drugs	75 (27.2)	29 (26.6)	46 (27.5)
Psychiatric problems	70 (25.3)	26 (23.8)	44 (26.3)
Physical violence – partners	48 (17.4)	17(15.6)	31(18.5)
Physical violence – children	10 (3.6)	4 (3.6)	6 (3.6)
History of sexual violence	79 (28.6)	41(37.6)	38 (22.7)
Age of suffered sexual assault			
≤14 years	25 (31.6)	17(41.4)	8 (21.0)
15–19 years	21(26.5)	9 (21.9)	12(31.5)
20–24 years	14(17.7)	5 (12.1)	9 (23.6)
≥25 years	19 (24.0)	10 (24.3)	9 (23.6)
Sexual assault - more than once	32 (40.5)	17(41.4)	15 (39.5)
Who was the one that raped			
Adult in the family	10 (12.6)	4 (9.7)	6 (15.7)
Young men in the family	2 (2.5)	1 (2.4)	1 (2.6)
Neighbor	42 (53.1)	20 (48,8)	22 (57.9)
Unknown person	22 (27.8)	13 (31.7)	9 (23.7)
Several people	3 (3.8)	3 (7.3)	0 (0.0)

The data obtained in the present study, although relevant, does have limitations and cannot be extrapolated with respect to epidemiology and social risk factors in women because all patients interviewed in were specifically STI/AIDS clinic patients. The data excludes all consultations made in the participating family health or private clinics and the cross-sectional design of the study is not ideal for evaluating risk factors. The possibility that there may have been a response bias cannot be dismissed due to the tendency of an individual to give socially acceptable responses. Moreover, lack of accuracy in the women's responses with respect to age at first sexual intercourse, number of sexual partners, drug use, and condom use, among others, cannot be overlooked. However, despite these limitations, the high rate of participation demonstrates that programs focused on violence against women could successfully deliver acceptable, confidential, and private services for women attending a STI/AIDS clinic.

Health professionals should be trained to identify and counsel cases of domestic violence. It is important to consider violence when a women goes to a heath care facility to report STI/AIDS[16,25].

Analyzing violence against HIV women, from a public health perspective, offers a method of capturing the many dimensions of the phenomenon in order to develop multi-sector responses; it is important to develop and implement new approaches to guide program planners and policymakers[10]. Often the healthcare system is the first point of contact with women who are victims of violence. Data provided by this study will contribute to raising awareness among healthcare policymakers and care providers of the seriousness of the problem and how it affects women's health. Ideally, the findings will inform a more effective government response, including from the health, justice, and social service sectors, as a step towards fulfilling the state's obligation to eliminate violence against women under international human rights laws.

Violence against women has a far deeper impact than the immediate harm caused. It has devastating consequences for the women who experience it and a traumatic effect on those who witness it, particularly children. It is shameful for states that fail to prevent it and societies that tolerate it. Violence against women is a violation of basic human rights that must be eliminated through political will and by legal and civil action in all sectors of society.

It is important to highlight that the health sector alone has little impact in the fight against domestic and sexual violence. In order to achieve suitable and comprehensive care, it is essential to strengthen intersectional coordination, specifically by integrating all sectors of society involved and for them to work collaboratively. In this context, social service providers and healthcare professionals have prominent responsibilities. Beyond the clinical approach, they should understand their role as articulators of care and actors that share responsibilities for ensuring comprehensive care for women's health.

CONCLUSION

History of domestic and sexual violence was frequently reported in this study. The effects of violence on women's physical and mental health are widely known as a serious public health problem. In addition to its importance, violence is an invisible problem in our society and we need to learn how to approach it during clinical consultations.

Conflict of interests

The authors report no conflict of interests.

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