RIASE
REVISTA IBERO-AMERICANA DE SAÚDE E ENVELHECIMENTO
REVISTA IBERO-AMERICANA DE SALUD Y ENVEJECIMIENTO

DOMESTIC VIOLENCE:
INVESTIGATE TO ACT

Otília Brites Zangão – Professor (PhD). University of Évora. Portugal
Isaura Da Conceição Serra – Professor. University of Évora. Portugal
Maria Laurência Gemito – Professor (PhD). University of Évora. Portugal
Maria Felícia Tavares – Professor. University of Évora. Portugal
Maria Dulce Magalhães – Professor. University of Évora. Portugal
Maria Fátima Marques – Professor. University of Évora. Portugal

VOL. 4 N.º 1 APRIL 2018

ABSTRACT

Objective: To know the prevalence, periodic and throughout life, of Domestic Violence in adults who resorted to health care units.

Method: Epidemiological quantitative study. Sample intentional and constituted by people who aged 18 or more, a total of 648, which over a period of three months, went to functional units in the Grouping of Health Centers of Alentejo Central (south of Portugal). Collection of data performed by health professionals, during their interventions and after specific training, using a questionnaire. Positive opinion of the Ethics Committee.

Results: Ages of participants range from 18 to 91 years-old with an average of 45.73 years-old, they are mostly female and married. From the total of respondents 20.9% (143) had experienced some form of violence throughout life and only 5% reported having been victims of domestic violence in the last year, in both situations prevailing psychological violence. Regarding the offender, most of the time was the husband/partner. As to the risk evaluation, it was concluded that the majority (25.8%) has a score of 4, i.e. has a variable risk.

Conclusions: The data analysis concluded that people who only know how to read or write, without any degree and who are between 80-89 years-old, are those that are more exposed to domestic violence. It is highlighted the combination of various types of violence simultaneously, including psychological, physical and financial.

Descriptors: Violence; domestic violence; health; community network.

INTRODUCTION

In a consenting way or not, we are daily confronted with situations of violence, reported by the media, or anyone of our social sphere. Violence happens from what or that which is violent; it is the act of violent other or violence to themselves. This is a deliberate behavior that can cause physical injury and/or psychic to them or to another, compromising the well-being and sometimes life.

It is currently considered a public health problem[1], although for not represent a new health problem, but a phenomenon that has been perpetuated in the history of mankind that happens in various situations and contexts. Violence is manifested as a reality that goes beyond any border, regardless of their ethnic, cultural, geographic, political, social,

economic or financial. Extremely versatile nature, violence is a phenomenon that becomes incapacitating because it generates personal suffering, both victims and the aggressors, promoting anxiety disorders, mood disorders, substance abuse or other health problems.

Within the family contexts actually we have greater knowledge both as empirical science and, therefore, a greater awareness of the levels of violence in the family environment, as well as the size of their impacts[2].

Violence does not discriminate against any family member, regardless of gender or age. In 2003, the Centers for Disease Control and Prevention revealed that the levels of violence in the context of family relationships, which is more perpetuated, happened between family members where there is a greater relationship intimacy. Violence has focused heterosexual or homosexuals intimate partners, and in it, women are more likely than men to suffer different types of injuries, both physical and psychological. In Portugal, the Annual Report of Domestic Violence Monitoring of 2015[3] reveals that 84.6% of victims were female and 57% were married or in common-law union.

The above data may somehow explain why violence against women was commonly assumed to domestic violence although violence against women is known as gender violence, as it relates to submission condition that still women have in society[4], as well as the social role of the man who allows the acceptance of violence as a strategy of conflict resolution[5].

Despite the knowledge we already have, the definition of this problem as domestic violence or gender violence is still a relatively unexplored subject. It makes us attentive to the possibility that there are different styles of violent marital or different causal factors, in which gender oppression can be one of them. Regardless of the argument, women and men, although in different ways, have health problems for reasons of domestic violence[6]. There is still much to learn, the result of a culture of silence in respect to what happens in the family environment. Oblivious to gender, this culture is installed on women and men although for different reasons. The shame associated with stereotypical ideas about the role that plays in the family, stigma, fear, revenge or family resilience levels and/or its constituents are, among others, fundamentals of not denunciation.

The World Health Organization (WHO) states that these feelings which are inhibitory to the denunciation are transversal in various regions of the world, with values of 20% to 70% of non-complaint. The financial dependence, subordination to the social condition and the lack of legal advice in many countries limit the possibilities of the victims protect themselves[7]. It is not, therefore, to create more legislation but to intervene to sup-

port the victims. It is essential to create a system that is facilitator of the complaint and at the same time to ensure the necessary support, and as appropriate, the reservation of the complaint.

With respect to the securities, in 2015 by the Portuguese security forces, 26,595 participations were registered, verifying a 2.6% decrease over the previous year. The incidence rate, overall, results in about 3 participations for every 1 000 people living in Portugal (2.58)[3].

Despite the undeniable importance of the known data, these do not represent the extent of the problem of violence in our country, especially since they only relate to complaints, not including the any complaints what constitutes a critical aspect for the victims and accountability for areas of health. Many people who use healthcare services live or have lived situations of violence of various kinds, but this condition often is not explored[8]. The embarrassment and lack of experience in addressing the issue, ignorance and fear of dealing with situations revealed are some of the reasons given by professionals for they do not question[9]. In this way, they lose the opportunity to intervene, forward and even develop actions of a preventive nature that could be effective in other situations[8].

Portugal, under the assistance in combating domestic violence, recognized health services as essential because besides the extensive network of services, professionals have privileged access to users' premises, in particular the professionals of Primary Health Care, the proximity they have with the people, letting them know the real living conditions of families. In order to improve the response to the phenomenon of interpersonal violence in its various forms, the Portuguese Ministry of Health created an integrated intervention model of interpersonal violence throughout the life cycle, with the Health Action designation on Gender Violence and Life Cycle (ASGVCV). It stands as recognition of violence as a public health problem and at the same time the recognition of the key role that health professionals can and should take on this issue. Professionals must acquire/develop skills that allow them to assess the risk and impact of violence using in their routine ways to conduct an assessment to enable them to identify signs and symptoms of abuse[10].

Aware that we are far from knowing the extent of the phenomenon of violence in Portugal and in particular in the district of Evora, we took as good epidemiological practices to meet the periodic prevalence and lifelong of domestic violence in adults who resorted to health services, even knowing that it is impossible to measure the phenomenon accurately the characteristics associated with it.

METHODOLOGY

The study we present is epidemiological and quantitative. The sample was intentional and constituted by people who aged 18 or more, a total of 648, which over a period of three months, went to functional units in the Grouping of Health Centers of Alentejo Central (Portugal). Inclusion criteria were being over 18 years-old and agree to participate in this study, after duly informed.

Data collection was carried out by health professionals in the course of their interventions and after specific training, using a structured instrument in three distinct parts. The first part is for gathering population data, the second is a screening of domestic violence, where we got information about violence suffered lifelong and in last year detailing the type of violence suffered, the aggressor and the frequency of same. In the third and last part is an assessment of risk of people, over the last year, have been victims of domestic violence, using a set of 20 items[11]. The score can range from 0 to 20 from the positive responses, corresponding to the variable risk scores (0-7); increased risk (9-13); serious risk (14-17) and extreme risk (greater than 18).

It proceeded to the statistical treatment of data using the IBM SPSS Statistic Software (Statistical Package for Social Sciences) version 18.0.

We verified using the Kolmogorov-Smirnov test the dependent variable DV does not follow a normal distribution, it presents values of $p \leq 0.05$, and however there is homogeneity in the sample. Thus, we resort to non-parametric tests to perform statistical inference, i.e., to test the significance of the independent variables that can influence the dependent variable, by using such a nonparametric ANOVA one way.

All ethical procedures were met, according to the Helsinki Declaration of Ethics in Research Involving Human Beings having obtained positive opinion of the Health Ethics and Welfare Committee of the University of Évora (No. 13001 of January 14, 2013).

ANALYSIS AND DISCUSSION OF RESULTS

Socio-demographic characterization of the sample

From the total sample (648 participants) 82.1% are female and 17.9% male. Their ages are between 18 and 91 years-old with an average of 45.73 years-old. Most respondents are in the age group of 40-49 years-old (20.8%), followed by 30-39 years-old (17.5%). There is also that about a quarter of respondents (26%) have more than 60 years-old and 2.8% are over 80 years-old. Regarding marital status participants are mostly married/de facto relationship (67.9%), followed by the single (18.2%), widowers (7.1%) and finally separated/divorced (6, 8%). Nationality is mainly Portuguese (99.4%), and the language spoken at home (99.5%). Most live with their spouse/partner/children and a small proportion of participants living alone (7.5%). On average, households are composed of 3 people. Most respondents have secondary education (29.2%), followed by the 1st cycle of basic education (23.7%), higher education (19.6%), 3rd cycle of basic education (12.4%) and second cycle of basic education (9.2%). It was noted that 3.5% of respondents read and write without any level of education completed and 2.4% cannot read or write. The generality developed or developing their professional activity in the tertiary sector (42.8%). From these ones, 17% are health professionals, mainly technical assistants/operational assistants, and nurses. Most respondents (71.9%) is employed by others, 13.5% are pensioners, 7.7% unemployed and 6.9% self-employed. Most considered to belong to the middle class (61.5%), followed by low or middle-class low (35.4%) and finally the upper middle class or high with 1.8% (1.3% of respondents did not answer this question).

Victims of violence throughout life

Regarding the analysis of the screening of domestic violence, from the total respondents, 143 (21.4%) have been victims of violence throughout life. Regarding gender, most are female (84.6%), only 15.4% are male. Most of these people (21%) is in the age group of 40-49 years-old, followed by the age group of 60-69 years-old (18.9%), having noticed that 32.9% are over 60 years-old and 2.1% have 80 or more years-old. The average age is 50.44 years-old. With regard to marital status, we found that most victims (62.4%) are married/common-law union, 14.9% separated/divorced, 12.8% were single and 9.9% were widowed. The family members are in most cases two people (38.3%) and single-person represent 11.3%. As for education, the majority of victims (31%) have the 1st cycle of basic education, 21.1% secondary education, 15.5% higher education and 9.2% the 2nd cycle of basic education. Most respondents who reported domestic violence (DV) throughout

life develop/developed professional activity in the tertiary sector (37.1%), followed by the primary sector (30%), secondary sector (20.7%) , domestic (8.6%), students (2.2%) and no profession (1.4%). From those who are health professionals, we found that generally are technical/operational assistants, medical action assistants, nurses and doctors. The situation in relation to the labor market indicates that 65% of victims are employed by others, pensioners (15.7%) followed by self-employed (10.7%) and unemployed (8.6%). Almost half of respondents consider to belong to the lower class or lower middle (49%), and this value is close to that refer belong to the middle class (45.5%).

By considering the data of the last report of the security forces, in Portugal[3] the victims are mostly female, married or in common-law union, so we can conclude that sociodemographic characteristics are identical to those found in our study.

In a survey involving 12 women, older than18 years-old, that regardless of race, socioeconomic status and education, they have experienced domestic violence by an intimate partner, held in two Reference Centers for Victims of Violence in Porto Alegre, we can also note that the participants are older than 30 and have low educational level[12]. Another retrospective exploratory study in Curitiba, with a total of 886 women victims of violence, corroborates these findings to conclude that the victims were aged between 18 and 88 years-old, most aged between 19 and 49 years-old, with low education[13].

A study in Cuba with 137 women attending a menopause consultation states that the victims are mainly women with unstable relationships, with low level of education but, contrary to the results presented by us, they have no profession[14].

Regarding the type of violence they suffered, most subjects (52.2%) reported psychological violence, 8.1% physical violence and 2.2% financial violence. The other mentioned simultaneously several types of violence, which highlight the association of psychological and physical violence with a representation of 25%. We also highlight the fact that sexual violence alone does not have expression among the victims and, when it is mentioned, it appears in association with other forms of violence, corresponding to very low values. In most cases the perpetrator was the husband/partner (41.7%), followed by the father/mother (15%) and co-worker (7.9%). In 40.8% of cases the respondents have experienced violence "often".

These data are also consistent with the European study on violence revealed as the most common psychological violence between partners[15]. Another author found that psychological violence reached values of 67.2%, adding that this had significant effects on well-being[14]. Similarly, in a study of 12 women living in the city of João Pessoa, which have suffered or suffer some kind of violence of companions, it was found that

there is prevalence of psychological violence, with long-term emotional damage and serious damage to the development spheres and psychological health of women[16].

Portugal data indicate that despite prevailing psychological violence, the difference between this and the physical violence is minimal, with other types of violence in lower values. Physical violence was present in 71% of cases, the psychological 80%, sexual 2%, economic/financial 9% and social in 12%[17].

On the other hand, according to data of WHO 2002, from 10% to 69% of women reported having an episode of physical violence by a partner at some time in their lives, proving these results the critical nature of domestic violence, there heterogeneities structural and cultural level[18]. Other authors concluded that the victims suffered mostly physical violence, followed by psychological, carried mostly by the partnet[13].

With regard to responsibility for acts of domestic violence reported by victims, which was in most cases the husband/partner, the results are similar to those in a report[3], that the victim-reported relationship, indicates that 57% of the victims held at the time of the occurrence participation, a marital relationship with the reported. Similar findings appear in studies presented by other authors[2,7,12,19]. The report "Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence"[19], it is mentioned that intimate partner violence affects 30% of women worldwide; the prevalence indicates that 35% of women worldwide have suffered or suffer violence by an intimate partner or non-partner.

Through the nonparametric ANOVA one-way, we can say that there were no statistically significant differences between the dependent variable and the various age groups ($p = 0.120$), sex ($p = 0.393$), the number of people that make up the aggregate family ($p = 0.176$) and the situation in relation to the labor market ($p = 0.119$). On the other hand, there were statistically significant differences between the dependent variable and marital status ($p = 0.000$), household ($p = 0.019$), education ($p = 0.017$), occupation ($p = 0.003$) and social class ($p = 0.000$).

Some authors conducted a survey in Florianópolis who studied the association between sex and physical violence between intimate partners stating that there is no significant difference in moderate physical violence between men and women. Older women, widowed or separated, poor and less educated are more likely to suffer violence[20].

Another study was conducted in order to assess the prevalence of domestic violence and risk factors in India. The study focuses on married women aged from 15 to 49. The results show that 31% suffered physical violence in the last 12 months prior to the

survey; the corresponding figure for sexual violence was 8.3%. The multivariate logistic regression results show the main determinants of physical and sexual violence. The results suggest that the role of gender and culture contribute to domestic violence(21).

Victims of violence in the last year

When asked whether they had been victims of some form of violence in the last year, 34 (13.5%) answered affirmatively. We found that from people who were victims of violence in the last year, 31 are women. Regarding age, 10 respondents are in the age group of 40-49 years-old, 7 between 30-39; 3 in the range 20-29 and 3 between 50-59 years-old. With age or over 60, there are 9 victims (2 people did not respond). From these, 17 are married/cohabitation, 7 singles, 6 separated/divorced and widowed 4. Predominantly there are family members consisting of 3 persons(12) and they identified 5 people living alone. About half of these victims have secondary or higher education, mainly develop their professional activity in the tertiary sector and for others. Regarding social class, the majority of victims considered to belong to the middle class(21), followed by low or low middle class(12) and one person claims to belong to the upper middle/high class. Regarding the type of violence they suffered, the prevailing psychological violence perpetrated by her husband/partner. Most concerns have been attacked several times.

A study involving 624 women between 15 and 49 years-old examined the prevalence of physical, psychological and sexual abuse by a multivariate logistic regression analysis and the authors reported an association between the attitudes of wives in relation to the roles of gender and violence by intimate partner. From the total 36% had experienced at least one episode of physical, psychological or sexual abuse by their husbands and 19% experienced abuse during the last 12 months(22).

Risk assessment on the victims of violence in the last year

Making inferential analysis of the risk score to the independent variables (age, sex, marital status and level of education), we found that between the ages of 30-39 and 40-49 there is the highest number of responses statements (25.8%). Almost all of affirmative answers come from female victims (93.5%). From the people who reported being married we obtained 35.5% of affirmative answers. Victims with higher education and secondary education represent the most positive responses with 25.8% and 22.6%, respectively.

The risk assessment analysis in people who reported having been victims of violence in the past year allows us to conclude that 90.4% have variable risk; 6.4% and 3.2% increased risk serious risk.

Networks and the combat to the domestic violence: Integrated Intervention Network of Évora District (RIIDE)

As discussed before, it is agreed that violence is not a recent phenomenon, currently there is more visibility and is, by its characteristics and consequences, a public health problem. The complexity of this phenomenon is priority response in the prevention, identifying gaps and allowing for a more effective intervention. Thus, who recommends that health care provision should take place in various locations and professionals must be prepared to meet with cross-sectoral responses[23].

Portugal was not oblivious to this problem, it was ratified in 2013 the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (Istanbul Convention)[24]. The challenge is an integrated intervention model of interpersonal violence to those offered responses are concerted, coordinated and efficient, requiring a multi and interdisciplinary intervention.

The network intervention model is the most recommended for the area of violence. Access to the network can happen anywhere and cases must go through the services that make it up, according to their characteristics and needs identified. The relationship established between the services is a horizontal organization in which all have different functions, essential and with the same degree of importance[23]. Networks are, by nature, open structures with an unlimited capacity expansion, adding new nodes as long as there is communication, sharing the same codes. A network social-based structure is an open, dynamic, and capable of innovation and no threats to its equilibrium[25].

Through the combination of several wills of a set of entities that in the district of Évora, activities were developing in the fight against domestic violence, it was created Integrated Intervention Network of Évora District (RIIDE), to enhance synergistically existing skills and installed features, allowing to articulate a more tailored response to people's needs. All have the same level of responsibility, each autonomous and responsible member in achieving the set objectives. These characteristics define an organizational structure in horizontal network.

Taking into account the already mentioned characteristics of this network, although at first, it has resulted from a partnership established between the Commission for Citizenship and Gender Equality, the Alentejo Regional Health Administration, University of Évora and Hospital do Espírito Santo and EPE , new organizations were integrating (Health Services, Protection and Monitoring organizations, prosecutors and security forces) and it was signed a Declaration of Commitment between the constituent entities of RIIDE, understood as a structure without legal personality and has a view to contribute to achieving the goals set together.

The RIIDE set as goals to know the phenomenon of violence, through the perception of the number of the agents; to qualify the technical who do care the problem of violence, giving them the specific skills; to establish an effective partnership between the many intervening in the issue of violence, enabling a more effective intervention; to create conditions to provide victims of violence an integrated and multidisciplinary response and to mobilize the community to fight against violence in its various expressions.

The actions developed throughout this RIIDE are in the progressive implementation of a set of good practices based on the four strategic areas of intervention IV (2011-2013)[26] and V (2014-2017)[27] National plan against Domestic Violence, in particular; Prevention, awareness and education; To train and qualify professionals; To intervene the aggressors and investigate and monitor.

FINAL THOUGHTS

The World Report on Violence Prevention[28] notes that are in motion a number of violence prevention activities around the world. However, it is still referred to the existence of gaps in this area, among which stand out those concerning the extent of the problem and the access of victims to service.

Based on the 2010 Eurobarometer data, in Portugal, 21% of respondents knew in their circle of friends and family, some women victims of domestic violence. However, despite the aforementioned percentage of concern, the same data show that the values obtained for Portugal are slightly below the European average[18].

This study confirms the feminization of violence, to the extent that the total number of participants who reported being victims of domestic violence throughout their lives, more than three quarters is women. Similarly, when asked whether they had been victims of some form of violence in the last year, 34 answered yes, and 31 of the subjects are women, which reinforces the feminization of the population who are victims of violence.

With regard to victims of violence in the last year, and according to the obtained data, we found that the largest number of affirmative answers comes from victims aged between 30 and 49 years-old, and that almost all affirmative answers belong to women, married and whose qualifications secondary education and higher education. Given this reality, the opinion commonly assumed that victims of violence have low levels of literacy is undoubtedly weakened, allowing a new vision of the complexity of this phenomenon.

As for the risk assessment carried out to victims of violence in the last year, the vast majority has a variable risk, while 6.4% are at increased risk and only 3.2% severe risk. Although this last value is a little unrepresentative in percentage, it cannot be neglected, because it includes the potential violation of physical, psychological and emotional integrity of subject, often with threat of life.

This is not a recent or transitory phenomenon, and they should ensure the investment that has been done at the level of qualification of human resources, service spaces and procedures. Over the past 20 years, we have witnessed a growing public concern about the existence and complexity of domestic violence and the importance of understanding, preventing and combating this phenomenon[18].

In this context, and given this complexity it is unquestionably the role of work/intervention in Network enabling streamlining of procedures in order to minimize the problems that victims are exposed. The RIIDE has played an important role in raising awareness of the population, especially the younger ones, and training professionals who treat victims of violence.

We believe this is the way, in that, through the joint efforts of various organizations, articulating capabilities, knowledge and resources, quality intervention is possible with victims and perpetrators in order to mitigate the negative effects and maybe to decrease the long term domestic violence.

BIBLIOGRAPHIC REFERENCES

1. WHO. World report on violence and health. Edited by Etienne G. Krug, Linda L. Dahlberg, James A. Mercy, Anthony B. Zwi and Rafael Lozano. Geneve. [Internet]. 2000 [cited on 23 May, 2016] Available from: http://whqlibdoc.who.int/hq/2002/9241545615.pdf

2. Miranda Milma Pires de Melo, Paula Cristiane Silvestre de, Bordin Isabel Altenfelder. Violência conjugal física contra a mulher na vida: prevalência e impacto imediato na saúde, trabalho e família. Rev Panam Salud Publica [Internet]. 2010 Apr [cited on 23 May, 2016]; 27(4): 300-308. Available from: http://dx.doi.org/10.1590/S1020-49892010000400009

3. Ministério da Administração Interna. Relatório Anual de Segurança Interna. [Internet]. 2015 [cited on 24 May, 2016]. Available from: http://www.portugal.gov.pt/media/18859123/20160331-rasi-2015.pdf

4. Marinheiro André Luis Valentini, Vieira Elisabeth Meloni, Souza Luiz de. Prevalence of violence against women users of health services. Rev. Saúde Pública [Internet]. 2006 Aug [cited on 23 May, 2016]; 40(4): 604-610. Available from: http://dx.doi.org/10.1590/S0034-89102006000500008

5. Silva Maria Arleide da, Falbo Neto Gilliatt Hanois, Figueiroa José Natal, Cabral Filho José Eulálio. Violence against women: prevalence and associated factors in patients attending a public healthcare service in the Northeast of Brazil. Cad. Saúde Pública [Internet]. 2010 Feb [cited on 23 May, 2016]; 26(2): 264-272. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0102-311X2010000200006&lng=en.

6. Oliveira, Kátia Lenz Cesar de. Gomes, Romeu. Homens e violência conjugal: uma análise de estudos brasileiros. Ciência e Saúde Coletiva [Internet]. 2011, [cited on 23 May, 2016] 16 (5):2401-2413. Available from: http://arca.icict.fiocruz.br/handle/icict/9377

7. Karchmer, Samuel. Violência por motivos de género: un precio demasiado alto. Gincol Obstet Mex; [Internet]. 2013, [cited on 23 May, 2016] 81(5):284-290. Available from: http://www.medigraphic.com/pdfs/ginobsmex/gom-2013/gom135i.pdf

8. Osis, Maria José Duarte, Duarte, Graciana Alves, Faúndes, Aníbal. Violência entre usuárias de unidades de saúde: prevalência, perspectiva e conduta de gestores e profissionais. Rev. Saúde Pública [Internet]. 2012 Apr [cited on 23 May, 2016]; 46 (2): 351-358. Available from: http://www.scielo.br/pdf/rsp/v46n2/en_3137.pdf

9. Schraiber, Lilia Blima & d'Oliveira, Ana Flávia Pires Lucas. Violence against women and Brazilian Health care policies: a proposal for integrated care in primary care services. International Journal of Gynecology & Obstetrics [Internet]. 2002, [cited on 23 May, 2016] 78 (1): 21-25. Available from: http://ac.els-cdn.com/S0020729202000401/1-s2.0-S0020729202000401-main.pdf?_tid=b8d29d14-20d3-11e6-99a3-00000aacb361&acdnat=1464000619_c295eca01cf138b6f7ddbf6e5c0818ef

10. Lopes, Manuel., Gemito, Laurência. & Pinheiro, Felicia. (coord.) Violência doméstica – Manual de recursos para a rede de intervenção integrada do distrito de Évora. Évora: Universidade de Évora. [Internet]. 2012. Available from: http://www.violenciadomestica.uevora.pt/index.php?/Recursos/Livros-e-Artigos

11. Campbell, Jacquelyn C., Webster, Daniel, Koziol-McLain, Jane, Block Carolyn, Campbell, Doris, Curry, Mary Ann, Gary, Faye, Glass, Nancy, McFarlane Judith, Sachs Carolyn, Sharps Phyllis, Ulrich, Yvone, Wilt Susan A, Manganello Jennifer, Xu, Xiao, Schollenberger, Janet, Frye, Victória, Laughon, Kathryn Risk factors for femicide in abusive relationships: results from a multisite case control study. American Jounal of Public Health. [Internet]. 2003 Jul [cited on 23 May, 2016] 93(7):1089-97. Available from: http://web.a.ebscohost.com/ehost/pdfviewer/pdfviewer?vid=4&sid=2f53912b-4c0b-4191-b687-341a711b03aa%40sessionmgr4004&hid=4206

12. Lima, Gabriela Quadros de, Werlang, Blanca Susana Guevara. Mulheres que sofrem violência doméstica: contribuições da psicanálise. Psicologia em Estudo. [Internet]. 2011 Out/Dec [cited on 23 May, 2016]; 16(4): 511-520. Available from: https://dx.doi.org/10.1590/S1413-73722011000400002

13. Labronici Liliana Maria, Ferraz Maria Isabel Raimondo, Trigueiro Tatiane Herreira, Fegadoli Débora. Perfil da violência contra mulheres atendidas na Pousada de Maria. Rev. Esc. Enferm. USP [Internet]. 2010 Mar [cited on 20 Aug, 2015]; 44(1): 126-133. Available from: http://www.scielo.br/scielo.php?script=sci_arttext&pid=S0080-23420100000100018&lng=pt. http://dx.doi.org/10.1590/S0080-62342010000100018.

14. Martínez Camilo Rodolfo Valentín. La violencia doméstica en la mujer de la edad mediana. Rev Cubana Obstet Ginecol. [Internet]. 2011 [cited on 20 May, 2016]; 37(3): 367-374. Available from: http://www.bvs.sld.cu/revistas/gin/vol37 _3_11/gin09311.htm

15. FRA – European Union Agency for Fundamental Rights. Violência contra as mulheres: um inquérito à escala da União Europeia Luxemburgo: Serviço das Publicações da União Europeia. [Internet]. 2014 [cited on 20 May, 2016]. Available from: http://fra.europa.eu/sites/default/files/fra-2014-vaw-survey-at-a-glance-oct14_pt.pdf

16. Fonseca, Denire Holanda da, Ribeiro, Cristiane Galvão, Leal, Noêmia Soares Barbosa. Violência doméstica contra a mulher: realidades e representações sociais. Psicologia & Sociedade. [Internet]. 2012 [cited on 20 May, 2016]; 24(2): 307-314. Available from: http://www.scielo.br/pdf/psoc/v24n2/07.pdf

17. Ministério da Administração Interna Relatório Anual de Monitorização da Violência Doméstica de 2013 [Internet]. 2014 [cited on 20 May, 2016]; Lisboa: MAI. Available from: http://www.dgai.mai.gov.pt/files/conteudos/Rel%20VD%202013_%20v14ago2014.pdf

18. Quaresma, Carina. Violência Doméstica: da participação da ocorrência à investigação criminal. Direção Geral da Administração Interna. [Internet]. 2012 [cited on 24 May, 2016]. Available from: http://popdesenvolvimento.org/images/ficheirospt/genero/Publicacao_VD_dez_2012_v1.pdf

19. WHO. Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. WHO Library Cataloguing-in-Publication [Internet]. 2013 [cited on 24 May, 2016]; ISBN 978 92 4 156462 5. Available from: http://apps.who.int/iris/bitstream/10665/85239/1/9789241564625_eng.pdf

20. Lindner Sheila Rubia, Coelho Elza Berger Salema, Bolsoni Carolina Carvalho, Rojas Paulo Fernando, Boing Antonio Fernando. Prevalência de violência física por parceiro íntimo em homens e mulheres de Florianópolis, Santa Catarina, Brasil: estudo de base populacional. Cad. Saúde Pública [Internet]. 2015 Apr [cited on 24 May, 2016]; 31(4): 815-826. Available from: http://dx.doi.org/10.1590/0102-311X00159913

21. Kimuna, Djamba, Ciciurkaite & Cheruk. Domestic Violence in India: Insights From the 2005-2006 National Family Health Survey. Journal of Interpersonal Violence [Internet]. 2012 [cited on 24 May, 2016]; XX(X) 1–35. Available from: http://jiv.sagepub.com/content/early/2012/08/27/0886260512455867.full.pdf

22. Jayatilleke A; Poudel KC; Sakisaka K; Yasuoka J; Jayatilleke AU; Jimba M. Wives' attitudes toward gender roles and their experience of intimate partner violence by husbands in Central Province, Sri Lanka. Journal of Interpersonal Violence [Internet]. 2011 Feb [cited on 24 May, 2016]; 26(3):414-32. Available from: http://jiv.sagepub.com/content/26/3/414.long

23. Silva Ethel Bastos da, Padoin Stela Maris de Mello, Vianna Lucila Amaral Carneiro. Women in situations of violence: limits of assistance. Ciênc. Saúde coletiva [Internet]. 2015 Jan [cited on 24 May, 2016]; 20(1): 249-258. Available from: http://dx.doi.org/10.1590/1413-81232014201.21202013

24. Council of Europe. Istanbul Convention: Action against violence against women and domestic violence [Internet]. 2011 [cited on 24 May, 2016]. Available from: https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=090000168046253d

25. Castells, Manuel. A Sociedade em Rede. São Paulo: Paz e terra; 2000.

26. Presidência do Conselho de Ministros (2010). IV Plano Nacional contra a Violência Doméstica – Resolução do Conselho de Ministros 100/2010, [Internet]. 2010 Dez [cited on 24 May, 2016]; 5763-5773. Available from: http://dre.pt/pdf1sdip/2010/12/24300/0576305773.pdf

27. Presidência do Conselho de Ministros (2013). V Plano Nacional de Prevenção e Combate Violência Doméstica e de Género 2014-17 – Resolução do Conselho de Ministros 102/2013, [Internet]. 2013 Dez [cited on 24 May, 2016]; 7017-7035. Available from: https://www.cig.gov.pt/wp-content/uploads/2014/01/V_PL_PREV_COMBATE.pdf

28. WHO. Global status report on violence prevention. WHO Library Cataloguing-in-Publication Data. [Internet]. 2014 [cited on 24 May, 2016]; ISBN 978 92 4 156479 3. Available from: http://www.who.int/violence_injury_prevention/violence/status_report/2014/en/

Correspondence: otiliaz@uevora.pt