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RESEARCH

INTIMATE PARTNER VIOLENCE IN A REGION OF THE TRIPLE BORDER

VIOLÊNCIA POR PARCEIRO ÍNTIMO EM REGIÃO DE TRÍPLICE FRONTEIRA

VIOLENCIA DE PAREJA EN UNA REGIÓN TRIPLE FRONTERA

Gabriela Kauana Silva[1]
Sheila Cristina Rocha-Brischiliari[1]
Aline Suelen Miura[1]
Wesley Martins[1]
Mariane Becker[1]
Marieta Fernandes Santos[1]

[1]Universidade Estadual do Oeste do Paraná - UNIOESTE, Enfermagem. Foz do Iguaçu, PR - Brazil.

Corresponding Author: Gabriela Kauana Silva
E-mail: gabrielaksilva12@gmail.com

Authors' Contributions:
Conceptualization: Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Marieta F. Santos; ***Data Collect:*** Gabriela K. Silva, Aline S. Miura, Mariane Becker, Marieta F. Santos; ***Funding Acquisition:*** Sheila C. Rocha-Brischiliari, Wesley Martins, Marieta F. Santos; ***Investigation:*** Gabriela K. Silva, Sheila C. Rocha- Brischiliari, Wesley Martins, Mariane Becker, Marieta F. Santos; ***Methodology:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Wesley Martins, Marieta F. Santos; ***Project Management:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Wesley Martins, Marieta F. Santos; ***Resource Management:*** Gabriela K. Silva, Sheila C. Rocha- Brischiliari, Wesley Martins, Marieta F. Santos; ***Software:*** Marieta F. Santos, Marieta F. Santos; ***Statistical Analysis:*** Gabriela K. Silva, Wesley Martins, Marieta F. Santos; ***Supervision:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Wesley Martins, Marieta F. Santos; ***Validation:*** Gabriela K. Silva, Sheila C. R. Brischiliari, Wesley Martins, Mariane Becker, Marieta F. Santos; ***Visualization:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Marieta F. Santos; ***Writing - Original Draft Preparation:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Mariane Becker, Marieta F. Santos; ***Writing – Review and Editing:*** Gabriela K. Silva, Sheila C. Rocha-Brischiliari, Aline S. Miura, Mariane Becker, Marieta F. Santos.

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Janaina Soares
Luciana Regina Ferreira da Mata

ABSTRACT

Objective: to analyze the prevalence of intimate partner violence against women and its associated factors. **Method:** a descriptive, cross-sectional and quantitative study, conducted with women who are users of the Foz do Iguaçu Basic Health Units. Analysis was performed using Mantel-Haenszel chi-square tests in the risk and protection factors based on Odds Ratio (OR). **Results:** a total of 565 interviews were conducted with women who use Family Health Units in the primary care network of the municipality. The highest prevalence was that of psychological violence (51.3%), followed by physical (36.5%) and sexual (22.8%). Based on the data, the highest risk factors for violence were as follows: high schooling level; marital status: divorced; drug abuse and family history of violence in the partner's family; and partner's temper. **Conclusion:** knowing the factors associated with the problem helps in its identification and improves the management in the Family Health Strategy (Estratégia Saúde da Família - ESF), as well as it contributes so that the municipality establishes continuing education actions for ESF professionals, in order to raise awareness for an approach to violence in the routine of these services.

Keywords: Primary Health Care; Women's Health; Family Health Strategy; Violence Against Women; Domestic Violence; Intimate Partner Violence; Border Areas.

RESUMO

Objetivo: *analisar a prevalência da violência por parceiro íntimo contra mulheres e seus fatores associados.* ***Método:*** *estudo descritivo e transversal, quantitativo, com mulheres usuárias das unidades básicas de saúde de Foz do Iguaçu, análise realizada por meio de testes qui-quadrado de Mantel-Haenszel nos fatores de risco e proteção baseados na OddsRatio (OR).* ***Resultados:*** *foram realizadas 565 entrevistas com mulheres usuárias das unidades de saúde da família na atenção básica do município. A maior prevalência foi de violência psicológica (51,3%), seguida da física (36,5%) e sexual (22,8%). Com base nos dados, os maiores fatores de risco para a violência foram: idade; alto nível de escolaridade; estado civil divorciado; uso de drogas e antecedentes familiares de violência na família do parceiro; e temperamento do parceiro.* ***Conclusão:*** *conhecer os fatores associados ao agravo ajuda em sua identificação e melhor manejo na Estratégia Saúde da Família (ESF), bem como contribui para que o município estabeleça ações de educação continuada para profissionais do ESF, a fim de sensibilizar para uma abordagem da violência no cotidiano desses serviços.*

Palavras-chave: *Atenção Primária à Saúde; Saúde da Mulher; Estratégia Saúde da Família; Violência Contra a Mulher; Violência Doméstica; Violência por Parceiro Íntimo; Áreas de Fronteira.*

RESUMEN

Objetivo: *analizar la prevalencia de violencia de pareja contra la mujer y sus factores asociados.* ***Método:*** *estudio descriptivo, transversal, cuantitativo con mujeres de unidades básicas de salud en Foz do Iguaçu, análisis realizado mediante pruebas de chi-cuadrado de Mantel-Haenszel sobre factores de riesgo y protección basados en OR (OddsRatio).* ***Resultados:*** *se realizaron 565 entrevistas a mujeres usuarias de unidades de salud familiar en atención primaria de la ciudad. La mayor prevalencia fue de violencia psicológica (51,3%), seguida de física (36,5%) y sexual (22,8%). Según los datos, los mayores factores de riesgo de violencia fueron: edad; alto nivel de educación; estado civil divorciado; uso de drogas y antecedentes familiares de violencia en la familia de la pareja; y temperamento de pareja.* ***Conclusión:*** *conocer los factores asociados a la enfermedad ayuda en su identificación y mejor manejo en la Estrategia de Salud de la Familia (ESF), así como también ayuda al municipio a establecer acciones de educación continua para los profesionales de ESF, con el fin de sensibilizar sobre un abordaje de la violencia en la vida diaria de estos servicios.*

Palabras clave: *Atención Primaria de Salud; Salud de la Mujer; Estrategia de Salud Familiar; Violencia contra la Mujer; Violencia Doméstica; Violencia de Pareja; Áreas Fronterizas.*

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INTRODUCTION

Intimate partner violence (IPV) is the main form of violation of women's rights to life, dignity, and health worldwide. It is a multi-factorial and complex phenomenon that affects several segments of society, not being limited to people with predefined socioeconomic or cultural characteristics, that is why it represents a great challenge to public health.[1]

Worldwide, nearly one third of the women have already suffered some type of violence committed by their intimate partners, with 70% of the femicides also being committed by their spouses. In Brazil, this problem has been increasing exponentially and, between 2007 and 2017, there was a 30.7% increment in the number of femicides, placing the country among the five most violent for women in the world.[2]

In order to combat this problem, social movements have gained space in the last decades promoting local debate forums, such as the *Belém do Pará* Convention, which aims to pressure governmental spheres for a more consistent performance in the creation and implementation of coping policies, such as the *Maria da Penha* Law, which brought with it a list of protective measures aimed at ensuring fundamental rights of these women.[3] In addition, more recently, in 2015, the law that defines femicide due to gender as a heinous crime.[4]

Non-governmental organizations act equally in this struggle, encouraging initiatives that seek to promote female autonomy and continuing education of the professionals who work in this area, in addition to studies encouraging public policies.[5]

In order to better understand intimate partner violence and its associated factors, the World Health Organization (WHO) developed the *Multi-country Study on Women's Health and Domestic Violence against Women* research, applied in 10 countries. In this study, the prevalence rate of IPV ranged from 15% in Japan to 71% in rural areas of Ethiopia, just as the associated factors, being more linked to the economic conditions in certain regions and to cultural elements in others.[6]

Identifying factors related to violence against women, as well as delving into discussions about the repercussions of this phenomenon, becomes essential to guide the planning of the governmental actions and to generate comparative indicators among the different communities, regions, and countries.[8] Therefore, this study aimed to analyze the prevalence of intimate partner violence against women and its associated factors in *Foz do Iguaçu* - PR.

METHODOLOGY

This is a descriptive and cross-sectional study with a quantitative approach conducted with women who are users of basic health units with the Family Health Strategy (*Estratégia Saúde da Família* - ESF) implemented in the municipality of *Foz do Iguaçu*, PR.

Data collection took place in the Family Health Units (FHUs) and the selection considered the number of family health teams; selecting those that had three or more teams, which resulted in two units for each Health District, totaling eight units. The criteria used to select the participants were as follows: being female, aged from 15 to 59 years old; and having already been in some marital relationship during their life.

The sample was obtained for convenience during a five-day period in March 2017. Collection occurred simultaneously in the eight family health units selected and 575 interviews were obtained; however, there was a sample loss of 10 interviews that were incomplete, as the women invited did not feel comfortable to continue participating in the research. Consequently, the final sample obtained consisted of 565 interviews.

Data collection was conducted through an interview with a structured script validated by the World Health Organization.[6] Data was collected by interviewers who were attending fourth year of the Nursing course and who had previously worked with the issue of violence. Initially, the training of all the people involved in this process was conducted, with the presentation, explanation, and application of the instrument being conducted among the interviewers to standardize collection. The interview was carried out in a reserved room of the service, lasting a mean of 10 to 15 minutes and, immediately after that, these women were instructed regarding the Women's Protection Network in the city of *Foz do Iguaçu*.

All the participants were informed about the research, its purpose, risks and benefits, as well as they were guaranteed secrecy and confidentiality of the information provided. They were also informed that their participation was voluntary and that refusal to participate would not cause any kind of sanction. Then, the women who agreed to participate signed the Free and Informed Consent Form and received a copy of this document. This study was approved by the Ethics and Research Committee of the *Universidade Estadual do Oeste do Paraná* -UNIOESTE with Opinion No. 1,872,687/2016.

For data analysis, initially, descriptive procedures were performed with the aid of the Microsoft Excel2016 pro-

gram, and statistically analyzed with the Statistica Single User, version13.2 (2017), and the Open Epi 3.01 (2013) software programs, to calculate the prevalence values.

The assessment of percentages was performed based on simple and double-entry tables. In the double-entry tables, *Mantel-Haenszel* chi-square tests were performed to verify the level of association considering the types of violence (psychological violence, and physical and sexual violence) as dependent variables, and the sociodemographic characteristics of lifestyle, family history of violence, and partner's behavior as independent variables.

The association strength between the independent and dependent variables as risk or protection factors was expressed in *Odds Ratio* (OR) values, with values <1 being protection factors and >1, risk factors. The significance level adopted in all the tests was 5%, that is, comparisons with $p<0.05$ were considered significant.

RESULTS

Of the 565 interviews, the highest prevalence was that of psychological violence in 51.3% of the cases, followed by physical and sexual (Table 1). Regarding the number of pregnancies, the mean was 2.32.

Table 1 - Distribution of the prevalence of physical, sexual and psychological violence indicated by the women interviewed. *Foz do Iguaçu*, PR, Brazil, 2017

Type of Violence	No		Yes	
	N	%	N	%
Physical Violence	359	63.5	206	36.5
Sexual Violence	436	77.2	129	22.8
Psychological Violence	275	48.7	290	51.3

When assessing the age group, ages from 19 to 39 years old and from 40 to 59 years old were considered risk factors, only regarding physical violence. Being divorced was a risk factor for all three types of violence. When compared to white-skinned women, brown-skinned women presented 4.25 times more chances of suffering violence. In addition, having studied more than 12 years was a risk factor for the three types of violence.

The interviewees with a *per capita* income of up to one minimum wage present 16.20 and 7.70 times more chances ofsuffering physical and psychological violence, respectively, than those with an income of more than two minimum wages (Table 2).

The women who had their first sexual relation when aged between 15 and 18 years old or over 19 years old had an increased risk of suffering physical, sexual, and psychological violence. Frequent use of alcohol and drugs by the interviewee was a risk factor for sexual violence. Use of drugs and alcohol by the partner, aggressive temper, and involvement in quarrels were risk factors for the three types of violence. The absence of controlling behavior and good communication with the partner were also considered risk factors (Table 3).

The victim witnessing her mother in a situation of violence during childhood and the partner having witnessed his mother in a condition of violence and having suffered sexual abuse in childhood were considered risk factors for physical, sexual, and psychological violence (Table 4).

DISCUSSION

This research was the first at the local level in which the prevalence of factors associated with IPV were investigated *in loco* in the health services, since most of the studies are conducted through a survey on notification forms of the Information System for Notifiable Diseases (*Sistema de Informações de Agravos de Notificação*, SINAN) with scarce information to better understand the factors associated with violence. The field research was also able to reach women who did not come to report the aggressions suffered, especially regarding psychological violence.

Foz do Iguaçu is considered a pioneer in fighting violence against women in the border areas, for contemplating a multilateral agreement with Argentina and Paraguay, aiming to face violence perpetrated against women in this region.[8] However, the prevalence of IPV in the users of the *Foz do Iguaçu* health service was similar to those recorded in other Brazilian twin cities[9] and in developing countries such as Turkey, where 60% of the women have already experienced some type of IPV.[10]

Psychological violence was the most prevalent; it can cause countless consequences, significantly affecting the victims' self-image and self-esteem, being able to trigger psychological illness processes, depression being the most common[1]. In addition to that, IPV tends to start with episodes of verbal aggressions, evolving to other types of violence, such as physical, and can culminate in femicide.[11]

The age group most affected by physical violence was women of childbearing age, in accordance with the national and international scenario.[10,12,13] Taking into account that comprehensive health care for women is one

Table 2 - Sociodemographic characteristics of the women interviewed, according to type of violence: physical, sexual and psychological. *Foz do Iguaçu*, PR, Brazil, 2017

Variables	Physical Violence		Sexual Violence		Psychological Violence	
	OR	*p*	*OR*	*p*	*OR*	*p*
Age group						
Up to 18 years old	Ref.		Ref.		Ref.	
19-39 years old	4.85	0.0277*	2.92	0.0876	0.49	0.4823
40-59 years old	5.97	0.0145*	5.64	0.0175	1.13	0.2885
Marital status						
Married/Stable union	Ref.		Ref.		Ref.	
Single	0.55	0.4576	0.90	0.3423	1.94	0.1634
Divorced	6.08	0.0136*	5.89	0.0152*	6.57	0.0104*
Widow	0.16	0.6891	0.60	0.4402	0.01	0.9589
Skin color						
White	Ref.		Ref.		Ref.	
Brown	4.25	0.0392*	0.12	0.7336	0.78	0.4291
Black	2.64	0.1040	1.78	0.1834	2.59	0.1077
Religion						
Catholic	Ref.		Ref.		Ref.	
Evangelical	0.16	0.6866	0.08	0.7836	0.20	0.6544
Others	3.98	0.0459	0.24	0.6250	0.12	0.7338
No religion	0.50	0.4800	0.41	0.5238	0.09	0.7594
Schooling						
Less than 8 years	Ref.		Ref.		Ref.	
9-11 years	14.03	0.0002*	1.99	0.1587	3.94	0.0473*
More than 12 years	24.20	0.0001*	14.55	0.0001*	25.14	0.0001*
Type of housing						
Own	Ref.		Ref.		Ref.	
Rented	3.20	0.0736	0.12	0.7275	1.26	0.2619
Granted	2.93	0.0868	0.15	0.2699	0.01	0.9999
***Per capita* income**						
Between 2 and 3 minimum wages	Ref.		Ref.		Ref.	
Up to 1 minimum wage	16.20	0.0001*	0.05	0.8286	7.70	0.0055*
More than 4 minimum wages	0.01	0.9678	0.32	0.5690	0.68	0.4096

*Significant p-value by the *Mantel-Haenszel* chi-square test considering a significance level of 5%

of the Nursing professional's major care lines in family health, conducting prenatal Nursing, family planning, and sexual and reproductive health consultations becomes an important tool to identify violence in this life period of these women.[14] In this sense, the establishment of active listening and empathy by the professionals is determinant to raise awareness in women regarding their rights and to spread information, such as presenting the support network and the *Maria da Penha* Law.

Being divorced proved to be a risk factor in relation to other marital statuses, given that divorced women present four times more chances of suffering some type of violence from their former partners during their life, even after breaking the affective ties with their spouses.[7] That shows that gender relationships permeate the violent episodes and bring with them the perception of men owning women, in which the aggressors do not accept the end of the relationship.

Table 3 - Behavioral characteristics of the victim and of the aggressor for physical, sexual and psychological violence. *Foz do Iguaçu*, PR, Brazil, 2017

Variables	Physical Violence		Sexual Violence		Psychological Violence	
	OR	*p*	*OR*	*p*	*OR*	*p*
First sexual relation						
Under 15 years old	Ref.		Ref.		Ref.	
Between 15 and 18 years old	15.73	0.0001*	8.04	0.0045*	7.08	0.0078*
Over 19 years old	21.37	0.0001*	6.06	0.0138*	14.64	0.0001*
Use of alcohol - Interviewee						
Does not use / Occasional use	Ref.		Ref.		Ref.	
Often / Very often	3.33	0.0680	14.03	0.0002*	3.79	0.0514
Use of drugs - Interviewee						
Does not use / Occasional use	Ref.		Ref.		Ref.	
Often / Very often	0.48	0.4873	4.38	0.0363*	0.12	0.7288
Communication with partner						
Good	89.36	0.0001*	113.20	0.0001*	66.38	0.0001*
Hindered	Ref.		Ref.		Ref.	
Use of alcohol - Partner						
Does not use / Occasional use	Ref.		Ref.		Ref.	
Often / Very often	20.57	0.0001*	37.33	0.0001*	30.10	0.0001*
Problems with alcohol (Partner)						
No	Ref.		Ref.		Ref.	
Yes	73.58	0.0001*	33.50	0.0001*	36.74	0.0001*
Use of drugs - Partner						
No	Ref.		Ref.		Ref.	
Yes	51.34	0.0001*	7.77	0.0001*	20.38	0.0001*
Partner's involvement in quarrels						
No	Ref.		Ref.		Ref.	
Yes	73.91	0.0001*	43.19	0.0001*	43.15	0.0001*
Quarrels at home						
Up to 3 quarrels	Ref.		Ref.		Ref.	
More than 3 quarrels	68.28	0.0001*	56.02	0.0001*	55.66	0.0001*
Partner's temper						
Calm / Controlled	Ref.		Ref.		Ref.	
Aggressive / Loses control	114.60	0.0001*	88.99	0.0001*	67.32	0.0001*
Controlling behavior						
Absent / Moderate	51.06	0.0001*	60.12	0.0001*	63.13	0.0001*
Very controlling	Ref.		Ref.		Ref.	

*Significant p-value by the *Mantel-Haenszel* chi-square test considering a significance level of 5%

Low income and brown race were risk factors for physical violence, and women with these characteristics can present up to 16 times more chances of suffering this problem. By looking at the constituent particularities of this profile, it can be observed that they are supported by deep racial and class inequalities and reflect the violation of fundamental human rights, which increases the vulnerability of these women.[15] The way in which brown-skinned and black-skinned women are seen carries countless social stereotypes built along centuries, which influence their identities and end up making them vulnerable by "authorizing" violations against them.

Table 4 - Previous history of violence in the families of the interviewee and of the partner. *Foz do Iguaçu*, PR, Brazil, 2017

Variables	Physical Violence		Sexual Violence		Psychological Violence	
	OR	*p*	*OR*	*p*	*OR*	*p*
Mother assaulted						
No	Ref.		Ref.		Ref.	
Yes	30.89	0.0001*	14.89	0.0001*	14.33	0.0002*
Mother-in-law assaulted						
No	Ref.		Ref.		Ref.	
Yes	17.64	0.0001*	34.25	0.0001*	28.58	0.0001*
Partner assaulted in childhood						
No	Ref.		Ref.		Ref.	
Yes	10.53	0.0001*	3.24	0.0719	39.04	0.0001*
Sexual abuse suffered by partner in childhood						
No	Ref.		Ref.		Ref.	
Yes	45.15	0.0001*	24.13	0.0001*	38.27	0.0001*

*Significant p-value by the *Mantel-Haenszel* chi-square test considering a significance level of 5%

From this perspective, the ESF has its principles based on longitudinal care and, mainly, on equality. The professionals who act in it need to be aware of the inequalities to which the victim is exposed and to have a critical perspective on these elements, so that, when assisting these women, they can perform the most adequate referrals within the protection network.[16] Knowledge about these networks by primary care professionals is up utmost importance, as it transmits trust and avoids the unnecessary exposure of the victim. However, the professionals, especially from the Nursing area, are frequently unaware of the network flows in their municipality.[14]

The schooling variable pointed out that having more than 12 years of study was a risk factor for all types of violence, unlike what is shown in other studies, which reveal that the lower the victim's schooling, the higher the chances of suffering violence and not recognizing it.[11,17] On the other hand, the high schooling level of the interviewees can mean gender conflicts that favor violence in the relationships, since women with higher educational levels would have more resources to reach self-sufficiency and be more able to recognize and end abusive relationships.[18] In emerging countries, by becoming more independent, women tend to suffer a high risk of violence by their intimate partner, as shown in a research study conducted in India, where women who were involved in small companies or productive activities presented more chances of suffering violence.[19] Commonly, by identifying that their partner can become more independent, the aggressors tend to create control mechanisms, such as psychological games, blaming on the woman, and distancing from friends and families, thus making that the victim become emotionally dependent and lonely, promoting a situation in which she is not capable of escaping from this abusive relationship, even if having a sufficient schooling level to do so.

The frequent use of alcohol and drugs by the interviewees proved to be relevant to sexual violence, given that the use of alcohol has become a tool used by the partners to practice sexual abuse, since more than 70% of the women were under its influence when this violence was perpetrated.[20] The use of this resource by the spouses to enjoy sexual relations with their female partners shows that the social conceptions about women's obligations within relationships naturalizes sexual intercourse without having mutual and progressive desire in both parties, and this practice is considered marital rape.[17]

Nevertheless, the use of alcohol and drugs, quarrels at home, and aggressive behavior are common characteristics found in the aggressors and significantly increase the risk of perpetuating the three types of violence against their partners.[11,21] The use of alcohol and drugs act as an aggravating situational factor, increasing the probability of violence by reducing the aggressor's inhibitions and judgment sense, bringing up their darkest side.

Other individual characteristics analyzed were number of children, with a mean of two per interviewee, and the age at which they had their first sexual relation, with women who had that first sexual relation when aged between 15 and 18 years old presenting a high risk for physical, sexual, and psychological violence. In countries where early marriage is instituted and socially ac-

cepted, such as Tanzania, women who started their sex life at a younger age, around 14 years old, present 15 times more chances of suffering violence, as well as of having more than two pregnancies.[13] Early sexualization, high parity, and unwanted pregnancy can be considered consequences of violence, instead of a risk factor, as women in this situation cannot have autonomy to decide for their bodies.[22]

The fact that hindered communication with the partner and his controlling behavior are not considered risk factors for violence can point out the interviewees' difficulty in recognizing the types of violence considered as "minor", since there is a tendency in the victims to consider these types of violence as normal behaviors in their partners and to only recognize violence in aggressions that cause major physical harms.[23] These characteristics evidence the romanticization of violent behaviors in relationships, which generates "beautification" of the abuse and hinders its identification, both by the victim and by the professionals themselves, who sometimes delegitimize the victim's report.

History of intra-family violence is also mentioned as an important risk factor for violence in adulthood. The chances of suffering violence increase 92% for women whose mothers were assaulted; 96% if the partner had his mother assaulted; and three times if the partner was assaulted in childhood by his parents.[7] It is necessary to reflect on investing in care for the families, but the encouragement to behavior change itself does not contemplate broader issues that permeate violence. Therefore, it is necessary to integrate to this action an analysis of the conditions, situations, and lifestyle of the families, as well as the guarantee of human rights by the public managers, so that the complexity permeating violence is not reduced to technicist, restricted and limited actions.

The professionals who work with this phenomenon need to be committed with the cause and to make the referrals that are necessary to interrupt the violence cycle, since inadequate performance can seriously compromise the life of people in situations of violence, who, most of the times, do not have conditions to defend themselves from the violence imposed on them.[24]

In this regard, it is fundamental that the ESF nurses have knowledge and preparation to work in the front line for the diagnosis of IPV, when approaching women and in the referrals to care networks. They are also the professionals who are going to work as agents that multiply knowledge within their team.

As a study limitation, the fact that the research was carried out only in a single health public environment stands out, not including women in more favored socioeconomic situations. For future studies, it is suggested to seek more socioeconomic and cultural diversity in the women, considering that IPV is present in all social classes.

CONCLUSION

The findings in this study reiterate the relevance of intimate partner violence as a public health problem, revealing the high prevalence of intimate partner violence perpetrated in the life cycles of the ESF users in the municipality of *Foz do Iguaçu* - PR, which shows differences in the factors associated with this type of violence in the municipality in relation to the rest of the Brazilian cities.

Finally, given the magnitude of the problem revealed, knowing the factors associated with it helps in its identification and management within the ESF. This knowledge also contributes so that the municipality establishes continuing education actions for PHC or f professionals, in order to raise awareness of an approach to violence in the routine of these services.

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