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Brazilian policy responses to violence against women: Government strategy and the help-seeking behaviors of women who experience violence

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Abstract

Over the past three decades, international covenants have been signed and countries have implemented strategies and legislation to address violence against women. Concurrently, strong evidence on the magnitude and impact of violence against women has emerged from around the world. Despite a growing understanding of factors that may influence women's vulnerability to violence and its effects, key questions about intervention options persist. Using evidence from a WHO household survey on domestic violence, our paper discusses women's help-seeking patterns and considers these findings in relation to Brazil's policies and strategies on violence against women. For the WHO survey, data from a large urban center (the city of São Paulo) and from a rural region (Zona da Mata Pernambucana [ZMP]) was collected. Findings from this survey indicate that in São Paulo, only 33.8% of women who experienced intimate partner violence (IPV) sought help from a formal service provider, including health, legal, social, or women's support services; in the Forest Zone of the State of Pernambuco, an even smaller proportion (17.1%) sought formal assistance. The majority of women were likely to contact only informal sources of support, such as family, friends, and neighbors. Women who used formal services were primarily those who experienced more severe levels of violence, were severely injured, had children who witnessed the violence, or whose work was disrupted by the violence. Brazil adopted progressive laws and national and local strategies to address violence against women (VAW). Messages about violence and equality now need to reach informal networks and the wider community in order for national anti-violence policies to be successful in supporting women before violence reaches the more extreme levels of severity at which women seek formal help. To translate international standards and national policies into actions that genuinely reach women experiencing violence, states must carefully consider evidence on women's options and decision making.

Introduction

For more than three decades, there has been increasing recognition that violence against women (VAW) constitutes a widespread human rights violation.[1-4] International standard-setting instruments such as the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) support this recognition.[5] Following this attention to violence against women, evidence on the individual and public health implications of abuse has steadily emerged. For example, the World Health Organization Multi-Country Study on Domestic Violence and Women's Health found that women around the world experience high levels of physical or sexual violence by an intimate partner. The WHO study found that prevalence of reported intimate partner violence ranged from 15% in Japan to 71% in Ethiopia.[6] These rates are very high, especially when we consider that women are likely to under-report experiences of violence.[7] Moreover, research on health consequences has found that VAW results in a wide range of health problems, including injury, chronic pain, coronary heart disease, spastic colon, digestive problems, vaginal bleeding, pelvic pain, miscarriages, low birth weight, unintended pregnancies, depression, anxiety, memory loss, appetite loss, and alcohol and drug abuse.[8-13]

As the global agenda was set to eliminate VAW, civil society mobilized and certain governments have responded with policies, national legislation, and on-the-ground strategies to protect women from violence and support those who seek assistance. International agencies such as the United Nations and WHO have recognized violence as a public health concern and a human rights violation.[14] In the 1980s, human and financial resources were made available for promoting gender equality and preventing violence against women at the global level. The United Nations had a central role in bringing together the global discussions and centralizing coordination of these resources. In 1984, the General Assembly established the United Nations Development Fund for Women as a separate and identifiable entity in autonomous association with the United Nations Development Programme. Later, this initiative developed into UNIFEM, which is currently part of UN Women.[15-16]

Over the past three decades, in response to pressure from feminist movements and organized civil society, governments from developing countries have increasingly implemented policies and actions to tackle violence against women.[17] One of the main strategies to reduce VAW still focuses on creating and expanding services and institutions to assist women who experience violence.[18]

Yet as calls for action against violence continue to grow, and advocates and pro-active nations promote legislation and support services to assist violence survivors, it remains unclear how well these services suit the protection and support needs of the women experiencing violence. Moreover, in some countries, political turnover and widespread underfunding of services make it challenging to assess the effectiveness of these services.[19] This paper examines Brazil's innovative strategy on violence against women in conjunction with data from the WHO multi-country study on women's experiences of violence and their use of services. In doing so, we explore how well formal rights and mandated services translate into protection for women experiencing violence.

Brazil's response to VAW provides an excellent case study to examine the translation of international standards into support mechanisms for women. Moreover, the availability of household survey data on violence and women's responses offer a unique opportunity to explore the relationship between rights, services, and women's responses.

In the 1970s, Brazil's well-organized and active women's movement became a political force that pushed VAW onto the national policy agenda after a long history of female partner homicides, justified as 'honor crimes,' that had been left unpunished.[20] The government translated the demands into legal, judicial, and institutional changes intended to respond to violence.[21-22] Although Brazil ratified CEDAW in 1984, it was not until 1988 that constitutional provisions were included to guarantee formal gender equality, and not until 2002 that Brazil approved CEDAW nationally.[23] The organized civil society, including some grassroots feminist organizations, put forward multiple strategies and campaigns, with UN support, to promote the adoption of the international law by the Brazilian government.[20]

In 2006, Brazil adopted the Maria da Penha Law, which specifically addressed domestic violence and met the commitments made when the country had initially ratified CEDAW.[22,24,25] This law specifically defined violence against women as a human rights violation and stated that violence included any gender-based "action or omission that causes death, lesion, physical, psychological, or sexual affliction, and moral or patrimonial damage."[24,26] The law specified that male or female perpetrators may commit violence against women.[27] It laid the foundation for the implementation and strengthening of multidisciplinary networks, including legal aid for victims, psychological support, law enforcement, social services, health, education, work, and housing. As a result of this law, penalties for perpetrators have tripled in cases of detention.[24,25,27] The law also created the possibility of preventive imprisonment, and indicated that prevention activities should be carried out in schools.[21,24,25]

This landmark legislation, which enshrined women's rights to be free from violence, was built on decades of growing resources to support women suffering violence.[19] In 1985, the Brazilian state of São Paulo began opening special women's police stations, an innovative strategy to guarantee specific police and legal assistance to women experiencing violence.[21-22] During the following decades, this law enforcement approach and other VAW services were put into place in São Paulo and elsewhere in Brazil.[22] In 2007, approximately 336 women's police stations were operating.[22,28] Despite the growing number of women who seek help at such stations, formal changes in the legislation still meet with resistance in their implementation.[29] A wide gap persists between gender equality as stated by the law, and gender equality in social institutions and cultural norms.[28] As a result, policy to prevent and stop violence against women progresses slowly and meets many obstacles in its consolidation.[28,29]

In 2000, a VAW assistance network of considerable size was already operating in the city of São Paulo, but these assistance services were poorly coordinated, with sectors operating in relative isolation.30 Moreover, fifteen years after the implementation of the first women's special police station, female officers frequently reported that other law enforcement officials made them feel undervalued, having the impression that they worked on a low priority issue.[30] In addition, the officers believed that they did not have access to adequate legislation to indict and prosecute perpetrators.[21,30] Before the changes to the national legislation on violence against women, punishment for male perpetrators of partner violence was often limited to a relatively small fine, there was no preventive imprisonment of perpetrators, and women could retract a legal complaint at any point during the process.[19,28] As a result, officers were frequently frustrated with the lack of instruments and conditions to punish perpetrators and prevent further violence.[31]

Similarly, in 2000, primary health care services in São Paulo did not appear to have incorporated VAW into their assistance work. For example, despite an overall physical or sexual IPV prevalence of 43% among women attending primary care practices in the city, only 4% of medical records had case file notes on violence perpetrated by any aggressor. Inadequate training and awareness-raising among health providers may have meant that professionals working in these areas did not identify cases in their daily work, and had important misunderstandings about the magnitude, risk factors and health consequences of VAW.[32,33]

Despite the social invisibility of intimate partner violence, and with most cases remaining unreported, women themselves often take action to mitigate the violence or deal with its consequences.[34,35] Women's responses frequently include self-defence, temporary or permanent separation, and use of formal and informal resources.[35-38] Studies suggest that the ways that women respond to IPV are associated with the frequency and severity of violence, their age, education, economic situation, relationship status, number of children, attachment to the partner, the partner's controlling behavior, their own use of violence against the partner, availability of social support, confidence (or lack thereof) in specific services, and self-blame.[27, 36-46]

In 2000, the WHO survey established the prevalence of intimate partner violence in two settings in Brazil: a large urban centre (the city of São Paulo) and a rural region (Zona da Mata Pernambucana [ZMP]). In São Paulo (SP), the prevalence of lifetime physical IPV was 27.2% (95% CI: 24.4-30.1), and in ZMP the prevalence was 33.8% (95% CI: 31.1-36.4).

In order to develop adequate, comprehensive policy and strategies to prevent, stop, and assist in cases of VAW, there is a need for sound knowledge of people's experiences with violence, of women's responses to IPV, and of women's use of services.[47,48] This paper aims to contribute to the debate on violence prevention by discussing the Brazilian policy in light of the evidence on women's response to IPV.

Methods

To explore the links between the Brazilian policy and women's experiences with and responses to violence, we reviewed policy instruments, conducted a narrative review of the literature on women's rights and policy, and analyzed survey data on women's responses to violence. The survey data was collected by WHO in partnership with the Medical School University of São Paulo.

Data and sample

WHO survey

Data on women's response to IPV was collected in 2000 as part of the WHO Study on Women's Health and Domestic Violence. The survey was conducted by the Medical School of the University of São Paulo in households in São Paulo (SP) and in the Forest Zone of the state of Pernambuco (PE). In São Paulo, 72 census tracts were selected at random using probability proportional to size from a probability matrix of 263 census ordered by head of household literacy rate. Thirty households were then selected in each census tract, and one female household resident was randomly selected.[49] In ZMP, the sample frame included all 42 villages and towns in the Forest Zone in the state of Pernambuco. Fifteen villages/towns were systematically sampled from a list ordered by population density, urbanization rate, and literacy of household head. In each village, eight census tracts were selected, and in each of them 18 households were sampled. One woman per household was then selected and invited to participate in the research. In both sites, eligible women were 15 to 49 years old. Forty percent oversampling was used to guarantee a representative population sample even with low participation rates. Response rates were high (94.4% in SP and 99.2% in PE) and 940 ever-partnered women in SP and 1186 in PE were interviewed. In this paper, data from the 657 women who reported physical violence by an intimate partner (256 in SP and 401 in PE) was analyzed.

Instruments and measures

Outcome variable

Formal help. Women were coded as positive for formal help if they sought help from the following services: police, hospitals/health centers, social services, legal advice centers, courts, shelters, and women's organizations. If they did not seek help or if sought it from other sources (including religious and local leaders), they were coded as negative. Help from priests and community leaders was excluded because advocacy and policy does not usually target this type of support.

Exposure variables

Socioeconomic and demographic characteristics. Women's ages were divided into three tertiles for clarity in the descriptive and bivariate analysis. Age was modelled as a continuous variable in the multivariate analysis. Education was divided into two categories: secondary education or less and higher educational level. An indicator variable was also created for financial dependency, with those who earned money as the reference category.

Violence. Respondents who did not report physical IPV were excluded from the analysis, since questions about women's responses to violence were only asked to those who reported any lifetime physical IPV. Variables on the severity of physical violence, and women's exposures to emotional and sexual violence were created. Women who reported to have been hit, kicked, dragged, beaten up, choked, burned, or threatened/aggressed with a weapon were considered to have experienced severe physical violence. Emotional abuse included belittlement, public humiliation, intimidation, intentional causation of fear, and threats of physical harm directed to the woman or someone she cared about. Sexual violence was considered positive for women who reported forced sex, coerced sex, or were forced to perform sexual activities that they found degrading or humiliating. The complete set of questions can be found in other published articles[6,50]

Consequences of violence. Consequences of violence on the women's health, work, and children were also measured. Three variables on health consequences were included in the bivariate analysis: 1) A respondent was physically injured at least once resulting from IPV; 2) a respondent felt that IPV had affected her mental or physical health; 3) a respondent had suffered loss of consciousness as a result of violence. For women whose partners had caused them injury, questions about need and use of health care were also asked. A variable was created for having work disrupted and another for children witnessing partner violence. Women who had left their partner because of violence were coded as positive, regardless of whether this was a temporary or permanent decision. For women who had left home temporarily, reasons for returning home were also investigated.

Informal support, barriers, and other responses to IPV. Informal support was considered positive if a respondent reported that her parents, family members, friends, or neighbors tried to help her. The following items on partner-controlling behavior were included in the analysis, having been hypothesized to discourage or impede women from seeking help: The violent partner: 1) attempted to prevent the respondent from seeing her friends; 2) tried to restrict her contact with her family of birth; 3) insisted on knowing where she was at all times; 4) expected her to ask his permission before seeking health care for herself. Associations of formal help with other types of responses to IPV were also measured, including whether the respondent left home temporarily or permanently, and if she fought back physically (or to defend herself). Respondents were also asked if they hit or physically mistreat their partners when the partners were not hitting or physically mistreating them. Women who agreed that it was acceptable for a husband to hit his wife in the following situations were coded as positive for acceptability of IPV: 1) The woman does not complete her household work to the man's satisfaction; 2) she disobeys him; 3) she refuses to have sexual relations with him; 4) she asks him whether he is unfaithful; 5) he suspects that she is unfaithful; 6) he finds out that she has been unfaithful. These women were hypothesized to be less inclined to seek for help and more likely to blame themselves for the violence.

Common mental disorders. The SRQ-20 was used to measure common mental disorders. The scale was previously validated in Brazil and includes 20 questions: four on physical symptoms and 16 on psycho-emotional symptoms. Items in the SRQ measure symptoms of somatic disorders, depression, and anxiety. It was used as an additive scale with the cut-off point set on 7/8.[50]

Data analysis

Bivariate analysis was used to estimate the crude associations of predictors with the outcome variable 'formal help.' Multivariate stepwise logistic regression was then carried out to model factors associated with the outcome. The purpose of this analysis was to identify variables that influenced a woman's search for formal help in São Paulo and in ZMP, and to estimate strength of associations. The best-fit model was presented for each site. Stata 11 was used in the analysis.

Ethical approval

This paper is the result of a data analysis project funded by the Economic Social Research Council (ESRC). The project received ethical approval (n. 5670) by the London School of Hygiene & Tropical Medicine in February 2010.

Results

Brazilian women's experience of violence

Findings from the WHO survey indicate that up to one-third of women in Brazil report experiencing physical violence (São Paulo (SP) 27.2% [95% CI: 24.4-30.1]), ZMP (PE) 33.8% [95% CI: 31.1-36.4]).

The median age of respondents who had experienced physical violence was 34 in SP and 32 in PE. In SP, 41.4% had achieved secondary or higher education and 66% earned income. In PE only 16% had completed secondary education and more than half (57.1%) did not earn income.

More than half of women who experienced physical violence were submitted to severe acts of aggression (57% in São Paulo and 59.3% in ZMP). Approximately one-third of these women (30.9% and 33.2%) had also experienced sexual violence and the majority (84% and 87%) had suffered emotional violence.

A minority of respondents believed that physical violence by a partner is acceptable (13.8% in SP and 39.4% in PE). Many of them had controlling partners: 45.3% in SP and 40.9% had partners who tried to keep them from seeing their friends; 27.7% in SP and 25.7% in PE reported that the partner tried to restrict contact with family; 54.7% and 50.4% had partners who insisted on knowing where they were at all times.

Women's responses to violence

Among women who experienced physical IPV, 39.8% in SP and 37.4% in PE have been injured as a result of the aggression. More than one-third of that group (35% in São Paulo and 36% in ZMP) needed health care because of the injury. In ZMP, not all (76%) received this health care. Not all the women who received health care (58% in São Paulo and 56% in ZMP) told the health worker about the real cause of their injury. More than half of the women's children (59.2% in SP and 52.1% in PE) had seen or heard the violence that their mother experienced. Almost one in six women in SP (14.7%) and more than that in PE (19.3%) had lost consciousness as a result of IPV. Common mental health disorders were experienced by almost half of the women (43%) in SP and almost 60% of the women in PE.

The majority of women who experienced physical violence told someone about it (73.9% in SP and 69.3% in PE). Most relied on their close social circle. Women most often told a family member (47.8% in SP and 47.7% in RE), friends or neighbors (33.8% in SP and 25.8% in RE), and their partner's family (17.3% in SP and 17.6% in RE). Some women, especially in SP, spoke to the police, health workers/doctors, counselors, and priests (10.6% SP; 3% PE). Five women in SP and three women in PE told their children about the violence.

The majority of women who told anyone about their experience of IPV reported that someone tried to help them (77.6% in SP and 79% in PE). Regardless of whether they reported disclosing the violence to someone, 59.2% of women in São Paulo and 56.4% in ZPM received help from family members, friends or neighbors. In São Paulo, women reported that family members tried to help even when they had not directly told them about the violence (58 women told family and 61 reported that family members tried to help). Conversely, in ZPM 121 women told family members about partner physical violence and 107 reported that family members ever tried to help them.

In São Paulo, 33.8% of women who experienced IPV sought help from health, legal, social, or women's services (formal support services). In ZMP, a smaller proportion (17.1%) sought assistance from one or more formal support services (Table 1).

Across all categories, women in ZMP sought less formal help than women in São Paulo.

The majority of women (87% in SP and 92% in PE) who went to services that specialized in assistance to domestic violence cases had family members, friends, and neighbors who had tried to help.

In São Paulo, more than half of the women (55.2%) who experienced severe physical or sexual violence did not seek services or professional support services. In ZMP, 78.9% did not seek formal support services. More than half of women (52.8%) who sought formal support services in São Paulo left home at least once because of the violence, compared to 27.8% of women in ZMP.

In São Paulo, the most-reported reasons that women sought formal support services were: 1) the woman could not endure more violence (48.9% of women who sought formal help); 2) she was badly injured or afraid her partner would kill her (20.9%); 3) she was encouraged by family or friends (10.9%); 4) her partner threatened or tried to kill her (10.9%). Only 11% of women reported more than one of these four reasons. In ZMP, the main reasons reported were 1) the woman was badly injured or afraid he would kill her (38.7%); 2) she could not endure more violence (32.0%); and 3) she was encouraged by her friends or family (20%). In ZMP, 9% of women reported more than one reason.

The reported reasons women from São Paulo and ZMP did not seek formal help were, respectively): 32.2% and 44.1% minimized the importance of their experience or of IPV in general; 10% and 16% feared the partners' threats or more violence; 6.7% and 8% were embarrassed, ashamed, or afraid they would not be believed or would be blamed; 4.4% and 2.5% believed this action would not help or knew other women who were not helped in this way; 2.8% and 6.6% were afraid it would end the relationship. Among women who returned to a violent partner after leaving home, both in São Paulo and in ZMP, more than half (respectively 57.4% and 58.9%) reported that they went back because of feelings for the partner. More practical reasons, especially consequences for children, were also important reasons why women went back to the violent partner (35.2% in São Paulo and 40.2% in ZMP).

Table 2 presents the descriptive statistics and results of the bivariate analysis, and Table 3 presents the final logistic regression models for each site.

After controlling for other factors, women in São Paulo who had children had a six-fold likelihood of seeking formal help when compared to women who did not have children. Women whose children had seen or overheard a violent episode were nine times more likely to look for formal assistance. Women who had suffered injury as a result of violence were

Table 1. Women's search for formal help among women who experienced violence by their partner

	São Paulo (n=256)		ZMP (n=401)	
	n	%	N	%
Police	45	17.6	40	10.0
Hospital or health centre	35	13.7	44	11.0
Social services	15	5.9	1	0.3
Legal advice centre	38	14.8	13	3.2
Court	31	12.1	13	3.2
Shelter	5	2.0	1	0.3
Local leader	5	2.0	0	0.0
Women's organization	2	0.8	2	0.5
Priest/religious leader	39	15.2	21	5.2
Others	8	3.1	2	0.5

at least four times more likely to seek help. Severe violence more than doubled the likelihood of a woman seeking formal services; women who had left the partner temporarily or permanently because of the violence were also twice as likely to seek formal help. Women who initiated the violence were also twice as likely to seek formal help.

In PE, the severity of the acts perpetrated against the woman did not influence a woman's odds of looking for formal help; these odds were also not influenced by children witnessing physical violence or the woman initiating the violence. A woman who had been injured more than three times as a result of violence was more than eight times more likely to seek help; a woman who was injured once or twice was five times more likely to seek help. Women who had their work disrupted as a result of partner violence were more than seven times more likely to seek formal assistance when compared to women who did not have their work disrupted. Women who did not work were also more likely to seek help than those whose work was not affected by the violence. Having left home because of IPV almost tripled a woman's odds of seeking formal help.

Discussion

Brazil's Maria da Penha Law on women's rights and violence against women undeniably advanced the fight against VAW and moved Brazil toward gender equality.[51] The national feminist movement, with support from the international human rights framework, has achieved government recognition of the importance of VAW and promoted major legal and institutional transformations within the national scenario.[21, 25]

Our findings suggest the importance of the women's close social networks in their help-seeking decision-making and behaviors. Talking to family, friends, and neighbors were often the only resource women used to deal with the violence they experienced. When women went beyond their close social network of family or friends, they tended to seek help through the more familiar non-domestic violence-specific sources, which included the police, health workers, and priests. For a number of reasons, such as fear of the partner, shame, guilt, and attachment to the partner or relationship, women in both locations did not often seek formal support. More importantly, women minimized the importance of their experience and of IPV in general, dismissing potential formal help opportunities.

The centrality of women's immediate social networks calls attention to the importance of prevalent gender norms at the community level. Violence can remain invisible and accepted in communities where it is regarded as a trivial part of everyday life.[52] In such contexts, women may not only be less likely to disclose violence, but also be more inclined to justify and tolerate male abusive behavior. Family members, friends, and neighbors may sometimes reinforce acceptance of IPV and potentially increase risk of further violence.[53-54] Informal support can provide women with the emotional and material conditions to escape from violence, but may also reinforce male

Table 2. Frequency and crude Odds Ratio (OR) for likelihood of seeking formal help among women who experienced IPV

		São Paulo (n=170)		ZMP (n=263)	
		n (%)	OR (95% IC)	n (%)	OR (95% IC)
Age	2nd tertile (29 to 38 yrs)	95 (37.1)	2.9 (1.5;5.8)*	141(35.2)	1.2(0.7-2.2)
	3rd tertile (39 to 49 yrs)	81(31.6)	3.2(1.6;6.4)*	109 (27.2)	0.9(0.5-1.7)
Secondary or higher education		106(41.4)	0.9(0.6-1.6)	64(16.0)	1.1(0.7-1.9)
Earned money		169(66.0)	0.9(0.5;1.5)	172(42.9)	1.1(0.7-1.8)
Severity of violence		146 (57.0)	6.8 (3.7-12.4)*	237 (59.3)	4.6 (2.5-8.5)*
Sexual violence		79(30.9)	2.0(1.1-3.4)*	133(33.2)	3.1(1.8-5.1)*
Emotional violence		215(84.0)	3.2(1.3-7.5)*	349(87.0)	4.2(1.3-14.0)*
IPV impact on her work	Does not work	78(31.1)	1.6(0.8-2.9)	228(57.6)	2.5(1.2-5.1)*
	IPV affected her work	56(22.3)	3.2(1.6-6.2)*	45(11.4)	9.9(4.1-23.7)*
Children witnessed physical violence	Has children, but not witnessed violence	71(28.4)	4.9(1.1-22.7)*	162(40.8)	2.0(0.5-9.2)
	Children witnessed violence	148(59.2)	12.7(2.9;55.0)*	207(52.1)	4.3(1.0-18.5)*
Perceived health effects of violence	Little	32 (19.5)	1.9 (1.0; 3.6)*	20 (26.7)	2.2(1.2-4.2)*
	A lot	26 (15.9)	2.3 (1.2;4.4)*	26 (34.7)	3.2(1.7; 5.8)*
Injured as a result of IPV	Once/ twice	53(20.7)	5.2(2.6-10.1)*	88(22.0)	6.0(3.1-11.6)
	Several (3-5) times	49(19.1)	6.8(3.3-13.8)*	62(15.5)	11.4(5.7;22.7)*
Lost consciousness as a result of IPV		15(14.7)	5.3(1.12;24.8)*	29(19.3)	2.4(1.1-5.5)*
Left home because of IPV		106(41.4)	3.5(2.1-6.1)*	205(51.5)	3.7(2.1-6.6)*
Mental health symptoms (SRQ-20)		110 (43.0)	1.3 (0.8;2.2)	227(56.7)	1.7 (1.0-2.8)*
Acceptability of IPV		35(13.8)	0.9(0.4;1.9)	158(39.4)	0.7(0.4-1.2)
Partner tries to keep her from seeing her friends		140(56.7)	2.0(1.2;3.4)*	237(59.1)	1.4(0.8;2.4)
Partner tries to restrict her contact with her family of birth		185(72.7)	1.3(0.8-2.3)	298(74.3)	1.9(1.1;3.2)*
Partner insists on knowing where she is at all times		116(45.3)	1.0(0.6;1.6)	199(49.6)	1.7(1.0;2.9)*
Partner expects her to ask permission before seeking for health care		234(91.4)	1.5(0.6-3.7)	297(74.1)	1.6(0.9;2.7)
Family member, friends or neighbors tried to help		161 (62.9)	2.7 (1.5-4.6)*	247 (61.6)	2.1 (1.2-3.6)*
She fought back when partner was hitting her		202(78.9)	1.8(0.9-3.5)	252(63.0)	1.6(1.0-2.9)*
Hit partner when he was not hitting her		65(25.4)	1.9(1.1-3.4)*	64(16.0)	1.1(0.6-2.2)

* $p<0.05$

Table 3. Adjusted OR for likelihood of seeking formal help for women who experienced IPV (best fit models)

		SP	PE
Age (continuous)		1.6 (1.1-2.5)	0.9 (0.6-1.3)
Severity of violence		2.2 (1.0-4.6)	-
IPV impact on her work	Does not work	-	3.3 (1.5-7.3)
	IPV affected her work	-	7.4 (2.8-19.4)
Children witnessed physical violence	Has children, but not witnessed violence	6.2 (1.2-32.0)	-
	Children witnessed violence	9.7 (2.0-47.7)	-
Injured as a result of IPV	Once/ twice	4.2 (1.8-9.9)	5.2 (2.5-10.7)
	Several (3-5) times	3.8 (1.6-9.0)	8.5 (4.0-18.2)
Hit partner when he was not hitting her		2.1 (1.0-4.4)	-
Left home because of IPV		2.1 (1.1-4.1)	2.7 (1.4-5.1)

violent behavior and female victimization.[55] Parents and family members may offer essential resources, such as money and housing, which may ultimately allow the woman to seek formal help or leave the violent relationship. However, the family can also sometimes pressure a woman to stay in a violent relationship or blame her for the violence, reinforcing gender norms of female submission and obedience. In some contexts, more symmetric social ties, such as those with friends and neighbors, can be protective and contribute to the prevention of IPV.[56]

For Brazil's strategies to be successful in supporting women before violence becomes intolerable, messages about violence and equality need to reach informal networks. For example, community-based interventions and social marketing campaigns have proven effective in other related intervention areas. In addition to the coordinated service network that is emerging in Brazil, promoting equitable gender norms and behaviors within communities will sensitize women's close social environment to the consequences of VAW and enable them to be more informed sources of support. The message of the law has been widely disseminated on television, radio, and other national media. The influence of those campaigns in prevalent gender norms should be measured to inform policy of potential indirect effects of the legislation in preventing and stopping VAW.

Having children who witnessed violence was identified as the most important predictor of formal help-seeking among women in SP. Women seemed more inclined to try a more formal solution or seek for support to negotiate an agreement if children were somehow in contact with the violence. Protecting children from violence in the family should indeed constitute a priority in long-term prevention of violence. Analyses of Brazilian and international data have shown the numerous deleterious consequences in children of exposure to IPV.[57,58] The new Brazilian law against VAW tackles long-term preventive efforts by including VAW in schools' curriculum.[25] These educational strategies should be accompanied by more focused efforts to protect children from exposure to domestic violence, as CEDAW suggests.

Promoting primary preventive strategies should complement and not replace the investment in the multidisciplinary assistance network. Even if the informal network is a more readily available resource, women do seek formal help, especially when they experience severe violence or are injured as a result of IPV. Women who were injured or reported negative health consequences as a result of IPV were consistently more likely to look for formal help. Nonetheless, more than 40% of women who went to heath services because of violence did not tell the health provider about the cause of their injuries.

It is possible that stigma, fear, and low expectations of assistance from health services prevents women from telling professionals about violence-in a similar way that women reported that it prevents them from seeking formal help. The lack of preparedness of health providers to respond or refer in cases violence could also contribute to women's silence. Evidence showed that, at the time of our research, there were still many barriers for primary health care provider in São Paulo to assist in cases of violence against women.[33] In the past decade, however, the SP city council has actively supported the sensitization and training of health workers. An evaluation of this effort is timely in order to help better understand and explore the potential of the primary healthcare network to help prevent violence and offer more comprehensive assistance to women. If the visible consequences of violence are the only ones treated, women are likely keep returning to services with similar or worse complaints.

Research has also suggested that romantic expectations about the relationship and the cultural meaning attached to not having a partner may lead to women's ambivalence towards their partners, and consequently, keep them from seeking help.[59] In a common abusive cycle, the partners may oscillate between loving and violent behavior, and therefore a woman may feel caught between the thought that she loves the partner but hates the violence.[60] Moreover, women may not seek help from services because they fear losing their home or children.[59] Our findings suggest that this may be the case for less severe cases, but when tangible and urgent consequences or dangers are present, women do tend to seek more structured help.

Women were more likely to seek formal help when they experienced concrete and limiting consequences of violence, such as health problems, impact on children, disruption of work, and leaving home because of the violence. Most of the body of the Brazilian new law is dedicated to police and court intervention and to multidisciplinary assistance in cases of domestic violence.[51] For detection and assistance purposes, it is, therefore, important to consider that these cases are often characterized by severe physical violence, resulting injuries, heightened perception of mental health problems, exposure of children, and may be accompanied by other social issues, such as housing needs and work disruption.

These findings indicate that women may be in immediate need of protection from the perpetrator, and that, in addition to criminal measures, more focused health assistance and social work are needed. Health providers should also be prepared to detect, assist, and refer cases. The multidisciplinary approach also needs to incorporate a more integrative cross-departmental strategy. Finally, from an epidemiological perspective, figures on female homicides should be monitored more closely, and quality of routine data should be homogenous across the country. For the civil society, government and NGOs it is also essential to think about how to reach and prevent cases, which may not spontaneously present to the VAW assistance resources.

This study was developed from secondary data and has several limitations. First, we only analyzed violence perpetrated by an intimate partner in the present paper, not including violence perpetrated by other aggressors. Despite IPV being the most common form of VAW, women are also exposed to other common and severe violence such as child sexual abuse, dating violence, and rape by men other than her partner.[1,4] Intimate partner violence is also the type of VAW that the Brazilian government and feminist movement prioritizes.[22] Secondly, data on women's experiences of IPV was collected for any partner the woman may have had, whereas questions on her responses to violence and his controlling behavior included only her current or most recent partner. Therefore, there may have been misclassification of cases in which violence was not perpetrated by the current or more recent partner, and the odds ratio for severe physical, emotional, or sexual violence may be underestimated. Further studies should be carried out in order to understand associations between partner's behavior and responses to IPV. Thirdly, we have no data on whether families' and friends' attempts to help women were effective in stopping the violence or preventing new episodes.

Despite these limitations, this study brings important considerations about the opportunities and challenges in Brazilian policy and related strategies to implement on-the-ground, local resources to address VAW. It suggests that while international standards can foster national and local measures for women experiencing violence, states need to undertake wider and more locally informed strategies to increase awareness and prevention of and protection against violence in order to ensure that the available services are used by the largest group of women who need assistance or advice. From the findings, it appears that women who turn to services are generally those experiencing the most extreme or life-impinging forms of abuse.

Brazil has come a long way from not recognizing VAW as a criminal offense to approving the Maria da Penha Law. Nonetheless, the emphasis placed on responding to violence versus preventing cases may limit the law's reach and downplay the importance of awareness and prevention efforts. Evidence has shown the central role of gender norms in creating dispositions towards violent behavior against women.[18,53,61-63] Creating a society where domestic violence is truly unacceptable depends heavily on transforming gender norms and social structures that discriminate against and disadvantage women.64 Comprehensive strategies focused on promoting gender equality to prevent violence against women are needed and should expand their reach beyond women who experience violence to include communities of men and women of diverse age groups, race and sexual orientation.

The Maria da Penha Law represents a great step in guaranteeing women the right to lives that are free of violence and discrimination.[51] In 2007, the CEDAW committee, in its 39th session, congratulated Brazil for its sustainable political will and commitment in eliminating discrimination against women. The committee encouraged Brazil to establish effective measures for the full implementation of the new law.[22] It is now important to understand how well these rights are translating into practice and to realize what limitations are preventing their full actualization. International and national law has the capacity to shape the cultural meaning of gender, gender inequality, and gender-based violence, and ultimately translate CEDAW's broader intentions into actions that can impact the lives of all women at risk of violence. Data-informed policy can help bridge this gap.

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