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Approval Sheet

'Sometimes all she wants is a kind word': the moderating role of social support on women's experience of intimate partner violence in Santo André, Brazil

By

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Degree to be awarded: MPH

Hubert Department of Global Health

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Abstract Cover Page

'*Sometimes all she wants is a kind word'*: Social support as mitigator of intimate partner violence in Santo André, Brazil

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Abstract

Title: '*Sometimes all she wants is a kind word'*: Social support as mitigator of intimate partner violence in Santo André, Brazil

By: Olivia C. Manders

In Brazil, an estimated 13.5 women have experienced physical or sexual violence (Instituto Avon, 2013). In 2010, more than 80% of reported cases were perpetrated by intimate partners (Agência Patricia Galvão). Between 2009 and 2013, cases of reported violence against women doubled in the municipality of Santo André, São Paulo. The objective of this study was to characterize the role of social support in mediating women's experience of intimate partner violence (IPV). We performed a secondary analysis of 30 individual in-depth interviews conducted with female patients visiting three public health clinics in Santo André, Brazil. Using a modified grounded theory approach, we used deductive and inductive strategies. For this study, the first author read all interviews and applied codes using the senior author's codebook. The first author then reviewed data coded as 'social support', created new sub-codes based on source and type of support mentioned, applied them to the data and analyzed them thematically. MAXQDA 11 software (VERBI GmbH, Berlin, Germany) was used for all data analyses. A subset of 23 interviews was used for this study.

Interviewees described personal experiences with IPV and those of friends, neighbors and relatives. In sorting the sources and types of support women described offering and receiving, we identified functions of these exchanges that helped describe the effect of support on women's experience of IPV. From this, we developed a disclosure model that helps explain the process of abuse disclosure. Consistent with other studies, women sought informal support when abuse was verbal or emotional, and progressively accessed more substantive support from both informal and formal sources as their situations became life-threatening or intolerable. A primary trigger for women to activate support to leave their relationships was concern about setting a bad example for their children. This overcame the desire to maintain the family unit intact and the fear of stigma attached to leaving. Most women cited accessing help from their mothers, who then helped them access formal support. Survivors expressed preference for discussing IPV with psychologists rather than clinicians, but most said they would like providers to ask. Several indicated counseling sessions should be available at clinics to help adolescent girls as well as women.

These findings suggest interventions targeting women experiencing emotional or verbal abuse may prevent relationships from advancing to physical. Targeted interventions addressing social norms around gender roles, and improving communication skills in adolescents and young couples may address some of the issues that result in IPV. School and community-based interventions that address social norms and promote positive relationships developed by Promundo and others have yielded positive results among adolescent and adult men in Brazil. Court-mandated, psychologist-led group sessions have helped male abusers modify their views on gender roles and improve their ability to communicate, and have helped women develop self-esteem. Leveraging existing interventions led by formal sources of support that teach communication, interpersonal relationships, and parenting skills could help break generational cycles of violence in these communities.

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Finally, this study would not have been possible without the participation of the 30 women of Santo André, Brazil who agreed to be interviewed. They trusted Jasmine and Danielle and shared their stories with candor. Their experience provided us with valuable insight into intimate partner violence in their city that hopefully we can incorporate into meaningful action to reduce the impact of IPV for future generations.

Cover Page

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List of Acronyms

APG	Agência Patrícia Galvão
CAPS	Psychosocial Care Center Centro de Atendimento Psicosocial /
CEAM	Centro
DEAM	Women's Specialized Police Station / Delegacia Especial de Atendimento da Mulher
IDI	In-depth Interview
IPV	Intimate Partner Violence
REAM	Women's Services Network / Rede de Atendimento a Mulher
SV	Sexual Violence
VAW	Violence Against Women
WHO	World Health Organization

Chapter 1: Introduction

Introduction and Rationale

Intimate Partner Violence (IPV) is a complex problem of global public health significance. It is defined by The World Health Organization (WHO) as "behavior by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse, and controlling behaviors." The WHO has estimated that globally, 1 in 3 women (35%) will experience physical or sexual violence in her lifetime (2013). In Brazil, in 2013 the Avon Foundation reported that out of the estimated 13.5 million Brazilian women that had suffered abuse, 31% continued living with their abuser, and 14% experienced on-going violence. They estimated 700,000 women to be targets of abuse on a daily basis. (Instituto Avon, 2013). Intimate partners were responsible in more than 80% of reported cases of violence against women in 2010, and it was estimated that every hour, 150 women were abused (Agência Patricia Galvão, 2017). In 2015 Brazil ranked fifth globally for femicide, or female homicide, averaging 4.8 homicides per 100,000 women yearly (Waiselfisz, 2015).

Cases of violence reported by women in the municipality of Santo André, Brazil, doubled between 2009 and 2013 (from 238 to 479). In 74% of those cases, the violence women experienced was in their own homes. The primary types of violence women reported were physical (79%), psychological abuse (87%), and sexual (84%), and their attackers were primarily intimate partners and household members or known individuals (Prefeitura de Santo André, 2015). Due to this increase, the Santo André municipal government declared violence against women to be a public health concern. To understand the scope of the problem in the municipality

and identify points for intervention, a research team was convened to undertake a mixed methods study among members of the public health system, and female consumers of health services.

Purpose

There is limited research addressing the role of social support in IPV in the Brazilian context. While several studies in Brazil have approached IPV from the healthcare provider or system perspectives (D. P. Evans, Sahay, K., Shojaie, D. Z., Vertamatti, M.A.F.,, Forthcoming; L. B. Kiss & Schraiber, 2011; L. Netto, Moura, Queiroz, Leite, & Silva, 2017; Schraiber, D'Oliveira, Couto, et al., 2007; Schraiber & d'Oliveira, 2002; Signorelli, Taft, & Pereira, 2013) and there are several qualitative studies mapping the primary and secondary social support networks of survivors (L. Netto, Moura, Araujo, Souza, & Silva, 2017; L. Netto, Moura, Queiroz, et al., 2017; L. Netto, Moura, Silva, Penna, & Pereira, 2015; Vieira, Souza, Tocantins, & Pina-Roche, 2015), few have looked qualitatively at help-seeking patterns to contextualize the role of social support as mitigator of the experience of IPV. Research on women shows that women primarily access informal support, only turning to formal support services when violence becomes severe, they sustained severe injury, or their children were present during the attacks (L. Kiss et al., 2012). In this study, Kiss and colleagues called for messaging targeting informal networks and the community, and for the consideration of women's options and decision-making in the development of appropriate national policies and initiatives, but the existing literature does not adequately provide guidance to inform this messaging.

Understanding the choices a woman makes to access different types of social support to address an abusive relationship from her own perspective can provide useful context for developing appropriate messaging and interventions. Considering the reasons women choose to engage with informal over formal social services, the types of support they seek, the processes

they go through to access help, and the perceived or actual barriers and facilitators in their decision making, can help to identify areas to target for improvement in the social services network. Likewise, it can help to inform and guide the community messaging suggested by Kiss et al., using women's own language to address the barriers women identify as problematic.

Objectives

In order to understand the role social support plays for women experiencing IPV in Santo André, Brazil, we sought to understand the factors involved in their decision-making about how and when to access support. To describe the role of social support as mitigator of IPV, this study:

Aim 1: Categorizes the various types and sources of social support women access;

Aim 2: Explores how women describe the role of social support in addressing IPV; and

Aim 3: Documents any perceived barriers and facilitators in decision-making about accessing social support for IPV.

Significance

With a large proportion of women in Santo André experiencing intimate partner violence, it is important to understand from a women's perspective how engagement with social support may serve to mitigate their experience of IPV towards the development of appropriate and acceptable interventions. Characterizing social support in terms of source, type and how it operates can help to identify points for intervention at the community level. Further, leveraging existing sources of support that women are comfortable accessing may increase the acceptability of interventions. Finally, identifying perceived barriers to accessing formal support may provide the municipal government of Santo André with entry points for improvements in the public health social support system as well. This study will add to a growing body of research into women's response to IPV and social support in Brazil, and contribute to the parent study goal of

development of a gender-sensitive health sector intervention for IPV by exploring community perceptions and experiences of IPV in Santo André though the lens of social support.

Chapter 2: Comprehensive Review of the Literature

Introduction

This study seeks to characterize the role of social support as a mitigator of Intimate Partner Violence (IPV) as described by the women living in Santo André, Brazil. To accomplish this, we will examine key informant interviews conducted with women in that community, and document the informal and formal sources of support, the types of support each source provides, the interaction, and how women describe these interactions and any outcomes in the context of IPV. We will then analyze the data to identify emerging themes around these aspects of social support, and compare commonalities and differences to see if we can determine how it operates in this context for women experiencing IPV.

We have conducted a review of literature relating to IPV, social support, and social norms, to understand current knowledge and research in IPV, the nature of the problem in the Brazilian context, and to identify gaps for potential future research and interventions in the region. Selection criteria for this review include, study methodology, study sample and size, relevance of the findings, conclusions, and recommendations to this study population. Intimate Partner Violence and Violence Against Women (VAW) are complex, multifaceted problems of public health significance. For the purpose of this paper, we will focus on violence in heterosexual relationships, with a particular focus on IPV. Intimate partners in this context are defined as the individuals that the interviewees are currently or previously dated, are or were cohabitating with, married to, or divorced from.

Violence Against Women

The United Nations defined violence against women, as "any act of gender-based violence that results in, or is likely to result in, physical, sexual or mental harm or suffering to

women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or private life" (United Nations, 1993). It encompasses intimate partner violence (IPV), sexual violence (SV), and female homicide, or femicide. Intimate partner violence encompasses emotional, physical, and sexual abuse. Battering, a severe and escalating pattern of partner violence, includes multiple forms of abuse that include threats, controlling behavior, and terrorization (Feder, 2012). Sexual violence consists of forced or coerced sexual acts that are unwanted and/or intended to demean the victim, and may be perpetrated by unknown individuals, or by current or former intimate partners (World Health Organization, 2013). In a systematic review of the global prevalence of intimate partner homicide, Stockl and colleagues found that intimate partners committed 13.5% of all homicides. Of this, the proportion of female homicides was six times higher than for male homicides (Stockl et al., 2013).

Intimate Partner Violence

Intimate partner violence (IPV) is a complex global problem with repercussions for health. IPV encompasses violent behaviors by former or current intimate partners that cause physical, sexual or psychological harm. These include physical aggression, sexual coercion, psychological abuse, and controlling of partners (World Health Organization, 2017) that have corresponding adverse effects on women's physical, sexual, reproductive and mental health (Campbell, 2002). The WHO Global and Regional Estimates of Violence Against Women Report (2013), undertaken by the WHO's Department of Reproductive Health and Research (RHR), with faculty of the London School of Hygiene and Tropical Medicine (LSTHM) and the South African Medical Research Council (SAMRC), is the first substantive systematic review of global studies on violence against women. This data was compiled to capture how women

around the world experience violence. In this study, the team distinguished between physical and sexual violence perpetrated by an intimate partner (IPV), and sexual violence by someone other than a partner. They found that globally, approximately 1 in 3 or 35% of women have experienced intimate partner physical and/or sexual violence or non-partner sexual violence in their lifetime. When excluding non-partner sexual violence, they found that 30% had experience partner physical or sexual abuse. While the global definition of IPV includes emotional abuse, in this report, the study team did not include emotional abuse or controlling behaviors in the analysis that generated this data. They determined that standard measures for this type of abuse had not been established (World Health Organization, 2013). Thus, the percentage of women who also experience emotional abuse, and other controlling behaviors may be higher. In Latin America, regionally 25 – 50% of women experience IPV (Bott, 2013), with up to 70% experiencing abuse in her lifetime in Brazil (Instituto Avon, 2013). In 2015, Brazil ranked fifth globally for femicide (average of 4.8 homicides per 100,000 people), up from seventh place in 2012 (Waiselfisz, 2015). This makes VAW a major concern for Brazil.

Violence Against Women Laws in Brazil

A series of global acts and conventions laid the groundwork for broader legislation aimed at addressing violence against women, and the related issue of gender equality. The United Nations Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was signed in 1984, gender equality was constitutionally recognized in 1988, and in 1995 Brazil joined as signatory to the 1994 Inter-American Convention on the Prevention, Punishment, and Eradication of Violence Against Women—the Belém do Pará Convention (Gattegno, Wilkins, & Evans, 2016; Organization of American States, 1994). In 2006, with the passing of Law No. 11,340 (Lei No 11.340) known as the Maria da Penha law on Domestic and

Family Violence, the Brazilian government defined forms of violence and established the formal mechanisms through which to address VAW (Presidência da República, 2006; Waiselfisz, 2015). Law No. 11,340 which expanded CEDAW and the Belém do Pará Convention, provided for the creation of the Domestic and Family Violence Courts against Women, and amended the Code of Criminal Procedure, the Penal Code, and the Criminal Enforcement Law (Presidência da República, 2006). Finally, Law No. 13,104 (Lei No 13.104) amended the Brazilian Penal Code to define any crime due to reasons of gender that results in a woman's death as femicide and a heinous crime. This encompasses deaths that are the result of domestic and family violence, and discrimination and disparagement for being female. The law also increases the penalty for crimes committed against adult women who are pregnant, within 3 months post-partum, disabled, or over 60; girls age14 years or younger, or violence resulting in death in the presence of a child or parent of the victim. It further establishes services to protect women, including shelters (Presidência da República Brasileira, 2015; UN Women, 2015).

The Maria da Penha law, passed in August 2006 creates legal mechanisms to reduce and penalize domestic and family violence against women, and creates family courts to deal with issues of violence against women. The Agência Patricia Galvão (APG), a non-profit organization that produces content on women's rights issues for the media, highlights four important points from Article 5 of the Law, which defines "Domestic and family violence against women as any action or omission based on gender that causes death, injury, physical, sexual or psychological suffering and moral or property damage." According to APG, "…the law represents recognition on the part of the Brazilian Government, that in our context, roles associated with the female gender and the privileged position of the male gender in relationships generate vulnerabilities for women, who end up being exposed socially to certain types of violence and violations of [their]

rights (Agência Patricia Galvão, 2017; Presidência da República Brasileira, 2015).” The law defines and outlines five forms of domestic and family violence which include psychological, physical, sexual abuse, property damage, damage to morale, and recognizes that in most cases, these forms of violence are co-occurring. Finally, those observing abuse and not reporting it are considered to be complicit in the act.

The evidence relating to the impact of the law is mixed, with some study results showing an increase in report of physical violence since the laws were passed, but which may also be reflective of an increase in understanding of violence against women, a lesser tolerance for abuse on the part of women, and a broader recognition of the services in place for women to access (Gattegno et al., 2016).

National Policies and Social Services

Women's Specialized Police Services

In 1985, the first specialized “Delegacia de Atendimento da Mulher (DEAM)” police station for women, was established in the city of São Paulo. According to the original design, the DEAMs are be staffed by women to serve women, based on the concept that women would feel more comfortable talking about their experiences with other women, and that they would receive proper information and gender-appropriate support in filing complaints of abuse. Recent in-depth reporting by a popular online news source and a report by an online feminist journal AZMina in 2016 (Bertho, 2016) found the DEAMs are understaffed, underfunded, and often provide poor services. They also found that several of these specialized police stations listed on the state government website don't exist or are not functioning; the ones that do are open limited hours during the week, and are often very busy. One of the articles indicated women in major cities often go to a regular police station that is closer to where they live but staffed by men. Women

interviewed reported that the men did not respond to them appropriately. The women's police station was an innovative first step in extending protective services to women and there are now some 450 across the country, of which 21 are in the city of São Paulo, and 130 in the state itself, but only 7.9% of cities in Brazil have them, and the problems cited about indicate a less than ideal use (Bertho, 2016; de Andrade, 2016).

Single Unified Health System (SUS)

Brazil's national public health system is the Sistema Única de Saúde, or 'SUS'. Health posts and clinics in the SUS system offer a range of services according to their size and location, from basic health and urgent care, to specialist treatment, including gynecological, pre-natal, pediatric and psychological care (Governo Brasileiro, 2018).

Women's Services Network (REAM)

Law No. 11,340 (The Maria da Penha Law) and Law No. 13,104 of 2015 provided for the establishment of public services to protect and harbor women at risk of violence, and to expand, integrate, humanize and improve the quality of care provided women experiencing violence. The idea behind the Women's Services Network, is to streamline and link services provided by the social welfare, justice, public security, and public health sectors. It is comprised of the federal, state and local government organizations, non-governmental organizations, civil organizations, universities, and specialized providers who deal with women experiencing violence (Presidência da República Brasileira, Ministério de Direitos Humanos, & Secretaria Nacional de Políticas para Mulheres, 2017).

A unique example of the Women's Services Network (REAM), is The Casa da Mulher Brasileira (The Brazilian Woman's House), which was established as a safe space for women. All of the services women might need to access were combined in one location, including the

public defender's office, social assistance, health and psychosocial services as well as temporary safe housing for women and their children leaving an abusive environment. These services were all provided for under the Maria da Penha law (2006), and under the auspices of the Special Secretary of Policy for Women, Ministry of Women, Racial Equality and Human Rights established by former President Dilma Rousseff (Secretaria Especial de Póliticas para as Mulheres).

Specialized Women's Assistance Center

The Specialized Women's Assistance Centers (Centro de Referência de Atendimento da Mulher em Situação de Violência [CEAM]) help women in violent situations. The centers are a part of and may serve as entry point to the REAM. They both provide services as well as link women to other services in the network. Services the CEAM provide range from safe housing, psychosocial counseling and services, and providing legal advice, as well as linking them to other services s (Presidência da República Brasileira, Ministério de Direitos Humanos, & Secretaria Nacional de Políticas para Mulheres, 2017).

Social Support

There are many definitions and concepts relating to social support. For the purpose of this study, we will refer to Gottlieb and Bergen's 2010 study on concepts and measures that clearly defined concepts and approaches to evaluating social support, and to Heaney and Israel's discussion of social networks and social support (2002). Informal sources of support will include the parents, grand-parents, in-laws, siblings, children, neighbors, co-workers, friends and fellow church congregants ; formal sources will be the entities of the State that provide services in the areas of health, legal representation or counsel, criminal justice, education, or women's support centers (Barnett, 2001). Following Heaney and Israel (2002), types of support are emotional

(empathy, love, trust, caring), instrumental (financial and other types of direct aid such as housing, childcare, and medical or legal services), informational (advice, suggestions, information to help address problems) and appraisal or esteem (constructive feedback and affirmation) (pp. 190-1).

The presence of formal and informal sources of social support as a key mitigator or deterrent for women experiencing violence is well established (Bosch & Schumm, 2004; Coohey, 2007; Katerndahl, Burge, Ferrer, Becho, & Wood, 2013; Koepsell, Kernic, & Holt, 2006; Naeem, Irfan, Zaidi, Kingdon, & Ayub, 2008; Plazaola-Castano, Ruiz-Perez, Montero-Pinar, & Grupo de Estudio para la Violencia de, 2008; Rose, Campbell, & Kub, 2000). Studies have shown that formal and informal sources of social support increase the likelihood a woman will be willing and feel able to access services for help relating to abuse (Liang, Goodman, Tummala-Narra, & Weintraub, 2005; Plazaola-Castano et al., 2008). Types of support provided by informal sources fall into three categories: care or affective, which encompasses expressive, counsel and affirmation, provision of information about services, and material, ranging from provision of financial assistance to temporary housing and/or child care (Liang et al., 2005; L. A. Netto, CLF, Souza, MHN, Silva, GF, 2017; Zavala, 2017).

Social support studies from the 1980's to 1990’s find the more affective and material support from informal sources—either received or perceived to be available—the better an individual's mental health function (Cohen & Wills, 1985; Flannery & Flannery, 1990; Liang et al., 2005; L. A. Netto, CLF, Souza, MHN, Silva, GF, 2017; Plazaola-Castano et al., 2008; Zavala, 2017). Relating to victims of IPV, however, some findings suggest that women experiencing controlling forms of violence generally do not have strong levels of social support

available to them, and tend to avoid accessing available informal and formal resources (Liang et al., 2005).

Research on social support in Brazil

Since the enactment of the Maria da Penha lawin 2006, many studies have addressed IPV at the national and regional level. Several investigators have sought to describe IPV in the population and its repercussions on health (Pedreira, Biondo, Kotovicz, FFAJ, & Schraiber, 2005), women's perceptions about whether or not they have experienced IPV (Mathias, Bedone, Osis, & Fernandes, 2013; Schraiber, D'Oliveira, Couto, et al., 2007), and the possibilities for a broader role for formal support from the health sector in helping women managing IPV with an emphasis on nursing and community health workers (L. Netto, Moura, Araujo, et al., 2017). Population studies using national survey data on violence and IPV in Brazil have quantified the prevalence of VAW and IPV (Schraiber, D'Oliveira, Franca, et al., 2007), and of women's health-seeking behaviors in relation to national policy on IPV, calling for improved messaging and interventions (L. Kiss et al., 2012). Using evidence from the 2006 WHO multi-country study on women's health and domestic violence, Kiss and colleagues (2012) examined women's help-seeking patterns in relation to Brazil's strategies and policies on violence against women. They found that only 33.8% of women in urban São Paulo who reported experiencing IPV sought help from formal sources, such as health, legal, or social services, as opposed to informal sources of support, such as family, friends and neighbors. These women also reported experiencing more severe violence, were seriously injured, or their children witnessed the violence. Kiss and colleagues (2012) suggest messaging targeting informal networks to reach this base with information about formal services, and how to access them may prove beneficial in helping women to access services.

Kiss and colleagues (2012) found that women's close social networks informed their decisions to seek help. Many women chose to talk with family, neighbors and friends about their abuse, and when they did consult with formal support sources, they were more likely to be community health workers, police and clergy. The study found that while family often provided instrumental support that allowed them to leave, they could also reinforce traditional values and roles, including pressuring a woman to stay in a relationship or suggesting that she was at fault.

Much recent literature on IPV and social support in Brazil has focused on women and IPV from a national network perspective, arguing for a more formal integration of health care providers with other services, known as the "Rede de Atendimento a Mulher (REAM)", or Women's Services Network (Berger, 2011; L. Netto et al., 2015; Santi, Nakano, & Lettiere, 2010). Several qualitative studies have focused on engaging women's social networks and the health sector in addressing IPV. Their framework is based on Lia Sanicola's social network theory, and involves a mapping exercise of women's social networks. This defines a social network is comprised of the people and services that provide emotional, instrumental or material help, information, and services to an individual. This network also can influence an individual's beliefs, values and customs, and serve to uphold social norms pertaining to interpersonal and gender relationships. As such, it both influences, and is influenced by the members of the network (L. Netto, Moura, Araujo, et al., 2017; Vieira et al., 2015). Their studies have used this framework to map individual's social networks to identify points of strength and weakness. These studies have primarily been undertaken by researchers attached to departments of nursing, and have sought to identify opportunities for formal institutional support to play an expanded role in addressing IPV, and for nursing and community health workers in particular (L. Netto, Moura, Queiroz, et al., 2017; L. A. Netto, CLF, Souza, MHN, Silva, GF, 2017; Vieira et al.,

2015). However, most of these qualitative studies were undertaken with very limited samples (n=9), and with particularly vulnerable women at specific points in time. In some of these studies (n=5), investigators recruited and interviewed women following their participation in group counseling sessions at Specialized Women's Assistance Centers (CEAM), (L. Netto, Moura, Queiroz, et al., 2017) or in specialized police stations (DEAM) immediately following filing a violence report (Perova & Reynolds, 2017; Vieira et al., 2015). While these studies are limited to women accessing formal support at very specific points in time, they are useful in that they help understand the triggers for women to seek formal support.

Other studies have addressed healthcare professional readiness to address IPV. These studies found that while a few isolated HCPs mentioned addressing IPV with patients, many don't feel adequately prepared neither to identify nor address IPV, and don't know how or where to refer them for assistance. Further, these studies found that many of providers hold traditional views on IPV and why women stay in abusive relationships (L. B. Kiss & Schraiber, 2011; Pereira-Gomes et al., 2015). These studies suggest that provider attitudes and beliefs about IPV, must change before they can successfully be integrated into the Women's Services Network (REAM). Understanding why women choose specific forms of support over others, or what drives their choices this may help to guide the suggested messaging and interventions for both women and providers.

Santo André, São Paulo

Santo André, a municipality of greater metropolitan São Paulo, has a population of approximately 715,231 (Instituto Brasileiro de Geografia e Estatística (IBGE), 2017), of which 43.1% are formally employed, and 30.5% have a monthly income below $110 USD. (Instituto Brasileiro de Geografia e Estatística (IBGE), 2017) Women, who comprise 52% of the

population on average, earn half as much as men (Prefeitura de Santo André, 2015) and approximately one third have not completed elementary or high school (Prefeitura de Santo André, 2015). Reported cases of VAW doubled over 4 years and the Santo André municipal government recognized VAW as a public health issue. To better understand the nature of the issue, the Santo André Secretariat of Health, Santo André Secretariat for Women's Policies (Secretaria de Políticas para as Mulheres, SPM), and the ABC School of Medicine (Faculdade de Medicina do ABC, FMABC) formed a research team with Emory University and served as local partners on this study.

Until the fall of 2016, the city hall of Santo André, São Paulo, had a Secretariat of Women's Policy (SPM in Portuguese), which was headed by social scientist and lecturer in public health at the ABC School of Medicine, Silmara Conchão. During this time, the SPM led several community and school-based initiatives aimed at reducing Femicide and VAW/IPV. School-based programs, including the "Quem Ama Abraça", or "Those who love, hug," campaign was based on a national government initiative. The program consisted of a school-based module "Quem Ama Abraça … Fazendo Escola", (Those Who Love, Hug: At School) that targeted 38,000 school children in Santo André. District teachers attended a training on violence prevention based on the comic book to address issues of gender. The comic book addressed diverse issues such as violence against women, racism, homophobia, inequality and sexism. Another module in the series, "Quem Ama Abraça … Fazendo Género", or "Those Who Love, Hug: Gender" campaign, targeting public service professionals from diverse areas such as education, public safety, health, and transportation to inform them about issues relating to gender.

Conchão co-developed and ran a program called “E Agora, José? (And now what, José?), a socio-educational program for domestic violence offenders, established by a provision for men in the Maria da Penha law that provided for education and rehabilitation centers for male offenders who have committed lesser crimes against women (threats, bodily injury) as an alternative to prison. This program addressed from a gender perspective the roles in which men and women are socialized to practice certain behaviors that have legitimized social inequalities and violence against women, in ways that promote reflection and engenders a sense of responsibility for their actions. Participants attend twenty sessions led by a male psychologist to complete the cycle. Sessions span diverse topics including what it means to be a man, division of household labor, stereotypes, risky behaviors, sexual diversity and sexual violence (Urra & Pechtoll Pache, 2016).

Social Norms

Social norms have played an increasing role in social change interventions. Norms are shared beliefs about how others behave (what is typical) and one’s beliefs about of how others think one should behave (what is appropriate) (Bicchieri, 2017; Chung & Rimal, 2016; Clark et al., 2018; Heise & Manji, 2016). Heise and Manji (2016) suggest they are one of four types of social constructs—attitudes, norms, beliefs and behaviors—and that each should be approached differently. Norms are unwritten, socially understood codes of conduct that guide and reinforce human behavior (Chung & Rimal, 2016) through approval or disapproval, and positive or negative sanctions (Heise & Manji, 2016). Attitudes are the individual beliefs that have an evaluative component of the quality of something. Social norms function at the collective (societal) and individual levels. At the collective level, norms serve as codes of conduct for behaviors that individuals perceive and interpret according to what they believe to be typical and

appropriate. Norms can be descriptive, reflecting individual perceptions about prevalence of a behavior, and injunctive, referring to how people understand what others expect of them (Chung & Rimal, 2016; Lapinski & Rimal, 2005). People conform to societal norms out of a desire for social approval from their reference group, or the people whose opinions they value, and to avoid negative sanctions.

For this reason, Heise and Manji suggest creating new beliefs among reference groups or communities that will allow for new behaviors to emerge at the collective level. Because individuals seek the approval of their reference group, they contend attitude change alone may not result in changes in behavior as people continue to conform to norms out of need a for belonging and approval (Heise & Manji, 2016). Likewise, Mackie and colleagues (2016) emphasize the importance of considering the social motivations that drive or block change, and suggest that programs that support a change in social expectations at the community level may be more effective. Consideration of social norms is relevant to the present study as social expectations enforce and reward sexist, violent behavior in men, and submissive, tolerant behavior in women. Women who do not accept this behavior or role may continue to conform if they fear being gossiped about or sanctioned in find themselves ostracized in another way (Heise & Manji, 2016).

Summary

This study will add to the existing body of literature on IPV and social support by focusing on how participants describe social support in relation to their experience of IPV. This study looks at women's lived experiences of IPV to characterize the role of social support. We examine the way they describe their interactions with sources of formal and informal support, the types of support they seek from these supporters, and the effect these interactions hold for them.

From this, we expect to gain a broader understanding of how, at what points in time, and why women engage with various sources of support to address their abuse. These results may be used to inform the development of materials to help healthcare providers understand how to identify and address IPV. This information could help them to understand the complexity involved in the thought processes and needs that drive women's decision-making around addressing IPV. An understanding of what women seek during different stages of the decision-making process could help them to link them, whenever possible, with appropriate resources in the Women's Services Network, and potentially contribute to the development of a gender-sensitive health sector intervention for IPV.

Chapter 3: Manuscript

Contribution of the Student

The student conducted secondary data analysis of qualitative interviews undertaken in São Paulo, Brazil in 2016. Student was responsible for reading the in-depth interview transcripts in Portuguese, coding, drafting memos, and data analysis, drafting of the manuscript, and development of figures and tables under the guidance of thesis chair Dr. Dabney P. Evans.

Intended Journal for First Submission: Journal of Interpersonal Violence (Sage Publications)

Style: APA

Length: No longer than 30 double-spaced pages, including references, tables, and figures.

Abstract: 250 – 300 words

Discussion of Diversity

Formatting:

Font: 12-point Times New Roman font.

Margins: 1" on all sides

Pages: Numbered sequentially.

Title Page

'*Sometimes all she wants is a kind word'*: Social support as mitigator of intimate partner violence in Santo André, Brazil

Information for Journal

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Keywords

Intimate partner violence, public health, social support, disclosure, Brazil, qualitative

Abstract

In Brazil, an estimated 13.5 women have experienced physical or sexual violence (Instituto Avon, 2013). In 2010, more than 80% of reported cases were perpetrated by intimate partners (Agência Patricia Galvão, 2017). This study seeks to characterize the role of social support in mediating intimate partner violence (IPV) in Santo André, Brazil, where cases of reported IPV doubled between 2009 and 2013. We performed a secondary analysis of 30 transcripts of in-depth interviews with adult women* on their experiences with relationships and local healthcare services, and knowledge of laws relating to violence and women. Using a modified grounded theory approach, we reviewed and coded all transcripts. We identified a sub-set of 23 interviews, and developed a study-specific set of sub-codes based on source and type of support mentioned in data coded 'social support.' We then conducted thematic analyses of the sub-sets of data generated.

Interviews described women's experiences with IPV and those of friends, neighbors and relatives. We linked types of support participants described offering and receiving with the sources accessed, and the functions of the interactions. From this, we developed an interpersonal exchange disclosure model describing interviewee's processes of disclosure of abuse at different stages in an abusive relationship. Combined, these indicated the role social support played to mediate the experience of IPV.

Consistent with other studies, women sought informal support when abuse was verbal or emotional, and progressively accessed more substantive support from both informal and formal sources as their situations became life-threatening or intolerable. Mothers were an important conduit to formal support. Survivors expressed preference for discussing IPV with psychologists rather than healthcare providers. Personal reputation and breaking up the family were barriers to leaving.

Social support interventions for women experiencing emotional or verbal abuse may prevent it from turning physical. Engaging mothers in teaching communication and parenting skills to young couples may reduce some issues that result in IPV. Leveraging existing models of psychologist-led group sessions that modify men's views on gender roles and teach anger management and communication, and help women develop self-esteem may lead to improved interpersonal relationships and break generational cycles of violence.

*we have used pseudonyms to protect participants' identities

'*Sometimes all she wants is a kind word*':

Social support as mitigator of intimate partner violence in Santo André, Brazil

Introduction

Intimate Partner Violence (IPV) is a complex problem of global public health significance. IPV is physical, sexual or psychological violence targeting current or past intimate partners. It is characterized by physical aggression, sexual coercion, psychological abuse, and controlling behaviors (World Health Organization, 2017) that have lasting adverse effects on women's physical, sexual, reproductive and mental health (Campbell, 2002). The WHO has estimated that globally, 1 in 3 women (35%) will experience physical or sexual violence in her lifetime (World Health Organization, 2013). In Brazil, data from the World Health Organization multi-country study on women's health and domestic violence against women found that more than 60% of women who had been abused by their partners said they had experienced physical abuse alone, and 30% said they experienced physical and sexual abuse (World Health Organization, 2005). The Avon Foundation reported that out of the estimated 13.5 million Brazilian women that had experienced abuse, 31% continued living with their abuser, 14% experienced on-going violence, and estimated 700,000 women to be targets of abuse on a daily basis (Instituto Avon, 2013). Intimate partners were responsible in more than 80% of reported cases of violence against women (VAW) in 2010, and it was estimated that every hour, 503 women were abused (Agencia Patricia Galvão, 2017). In 2015 Brazil ranked fifth globally for femicide, or female homicide, averaging of 4.8 homicides per 100,000 women yearly (Waiselfisz, 2015), the 2017 Public Security Annual reported that one woman is raped every 11 minutes, and one woman is assassinated every two hours (Fórum Brasileiro de Segurança Pública (FBSP) & Instituto DataFolha, 2017).

Globally, perceived or actual presence of social support is well documented as a mediator or deterrent to IPV, yet there is limited research addressing the role of social support in IPV in the Brazilian context and how it operates to either help or hinder a woman's decision-making processes about a violent relationship (Bosch & Schumm, 2004; Katerndahl et al., 2013; Koepsell et al., 2006). Further, women who perceive the availability of affective and material support from informal supporters have better mental health function (Cohen & Wills, 1985; Flannery & Flannery, 1990; Netto, Moura, Araujo, et al., 2017; Plazaola-Castano et al., 2008). Using Brazilian data from the 2006 WHO multi-study on women's health and domestic violence, Kiss and colleagues (2002) found that two thirds of women that responded they had experienced IPV accessed informal sources of support, such as family, friends and neighbors. Only 33.8% of women in urban São Paulo who reported IPV sought help from criminal justice, social or health services, and those who did had experienced severe violence, serious injury, or their children witnessed the violence.

In the municipality of Santo André, São Paulo, Brazil, cases of violence reported by women doubled between 2009 and 2013 (from 238 to 479). In 74% of those cases, the violence occurred in their own homes. Women reported physical violence (79%), psychological abuse (87%), and sexual violence (84%), and their attackers were primarily intimate partners and household members (Prefeitura de Santo André, 2015). Due to this increase, the Santo André municipal government declared violence against women to be a public health priority (Evans DP, Vertamatti M, Conchao, S, 2017; Gattegno et al., 2016). To understand the scope of VAW in the community, a research team comprising Emory University and the Faculdade de Medicina do ABC in Santo André joined the municipal government to conduct a mixed-methods study that explored the relationships between women's experiences and perceptions of IPV, the federal

laws protecting women from violence, and role of health professionals in the prevention of VAW. The research team sought to learn more about the nature of the problem of VAW in the municipality from the women's perspective, to identify possible points for preventive interventions, and to propose improvements in the quality of the health services provided to women experiencing IPV.

Methods

Background

The present study is a secondary analysis of qualitative data collected as a part of the larger, mixed methods study conducted during July and August of 2016 in Santo André, Brazil (Evans DP, DeSousa Williams N, Wilkins J, Chiang E, Manders OC, Vertamatti M, 2018). The parent study was undertaken in partnership with the Santo André Municipal government, and the local ABC Medical College. The study team wanted to learn about violence against women (VAW) in Santo André from the community perspective, women's experiences at the public health clinics, and their knowledge and understanding about the VAW protective laws (Evans DP, DeSousa Williams N, Wilkins J, Chiang E, Manders OC, Vertamatti M, 2018; Evans DP, Sahay K, Shojaie DZ, Vertamatti M, Forthcoming; Evans, DP, Vertamatti M, Conchao S, 2017).

The Parent Study

Study Sites

The parent study was conducted in three public health clinics each located in a low, middle and high income neighborhood of Santo André, São Paulo. The Santo André Municipal government served as a community partner, and undertook site selection to ensure representation of the sociodemographic diversity of the municipality as well as adequate representation from priority neighborhoods that had high reports of VAW (Evans DP, Sahay K, Shojaie, DZ,

Vertamatti, M, Forthcoming; DP Evans, Vertamatti, M, Conchao, S, 2017; Evans, DP, Vertamatti, M, Conchao, S, 2017; Instituto Brasileiro de Geografia e Estatística (IBGE), 2017; Prefeitura de Santo André, 2015).

Data Collection

Instruments

The study team selected qualitative research methods for this arm of the study as the nature of the research questions sought to gain the "emic," or insider, perspective of women's experiences and views on VAW as well as insight into their perceptions of the laws enacted to protect them (Hennink, Hutter, & Bailey, 2011). Given the complex and highly personal nature of the topic, the study team chose in-depth interviews (IDIs) for data collection, working with local partners to develop an original, culturally-appropriate, semi-structured IDI guide. Domains of inquiry encompassed viewpoints about the types of relationship problems people have in their neighborhoods, knowledge about the Maria da Penha law and perception of its effectiveness, and experiences with the staff of the health post. The guide was drafted in English, translated into Portuguese by a native speaker, and then back-translated to ensure accuracy of translation (Appendix A). Interviewers conducted pilot interviews among a small sample of women at local clinics with comparable patient bases for feedback on cultural appropriateness and relevance.

Participants

The study team sought to recruit women of differing ages and race to gain the broadest range of experiences and perspectives possible through purposive sampling. Participant recruitment took place during regular hours in the waiting areas of study site clinics. The team approached women visiting these clinics, asked if they would be willing to talk about women's health issues and explained the goals of the study. Inclusion criteria limited participants to

residents of the Santo André municipality who self-identified as women over the age of 18. Thirty interviews in total were conducted to ensure saturation.

Interview process

Women that agreed to participate provided written consent and completed a short sociodemographic survey prior to interview. Interviews were conducted in private rooms within the clinics in order to ensure participant confidentiality. Participants were informed that they were free to discontinue the interview at any time. Interviews were audio-recorded, conducted, and transcribed by native Portuguese speakers trained in qualitative research methods. Women were given a gift card to a local grocery store in recognition of their time.

Data Management and Analysis

To maintain participant confidentiality, transcripts were assigned an interview number and de-identified prior to coding; recordings and transcripts were stored on a password-protected drive. To ensure culturally appropriate analyses, bilingual members of the research team reviewed all transcripts in Portuguese. The team created the codebook, coded transcripts, and drafted memos and interpretations in English to facilitate drafting of manuscripts. Finally, interpretations of coded segments were discussed with a Brazilian study team member to ensure the validity of analyses. The study team used a modified grounded theory approach (Corbin & Strauss, 2015) utilizing both deductive and inductive strategies to develop a parent study codebook. This served as the foundation of all qualitative data analyses. The parent study interview guide, literature review, and conceptual framework, an application of the Social Ecological Model (see Figure 1 below), informed deductive codes.

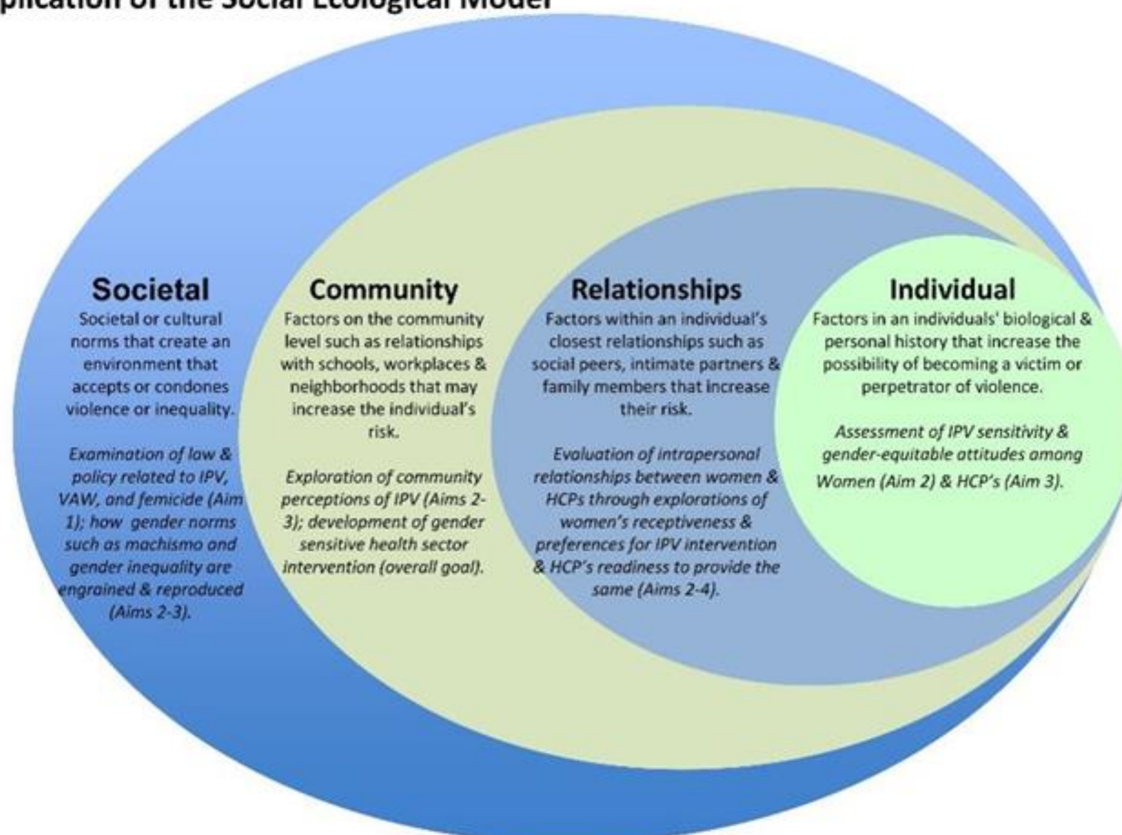


Figure 1. Parent study application of Dahlberg and Krug's Social Ecological Model.

The senior author and a study team member read all interviews, adding, defining, and refining inductive codes as patterns and issues emerged. Together they drafted and tested a formal codebook that encompassed issues relating to VAW, IPV, law, healthcare, health conditions, community violence, community problems, alcohol and drugs, social support, and geography. The final codebook was uploaded into MAXQDA 11 software (VERBI GmbH, Berlin, Germany) to serve as the foundation for all qualitative data analyses under the parent study.

Study ethics

The parent study protocol was submitted for review and approved by Emory University's Institutional Review Board (IRB), the Santo André municipal government, and Plataforma Brasil (CAAE 57344616.0.000.5485). Further, the study team followed the WHO guide for researching

violence against women (Ellsberg & Heise, 2005) and took steps throughout the process to ensure the safety and well-being of participants and researchers. These steps included asking women if they wanted to a break or change the topic when recounting difficult or emotionally charged experiences, and reminding them they could discontinue the interview at any time. At the end, interviewers offered participants information about local VAW resources with verbal explanation of services provided and contacts at each study site.

The Present Study: A secondary data analysis of social support among participants

Data Analysis

The present study is a secondary data analysis of the de-identified interview transcripts undertaken by the first author. She conducted an in-depth analysis of social support as it relates to IPV for the women interviewed for the parent study, starting with a review and preliminary coding of all 30 transcripts (in Portuguese) using the parent study code book, and taking notes and memos throughout.

Mirroring the parent study team process, the first author took a modified grounded theory approach using deductive and inductive strategies. Deductive codes were identified from a review of social support literature and the study aims relating to the individual, relationships, community, and society levels of the study's adaptation of the Social Ecological Model (Figure 1). The author then took the parent study social support code, defined as "identified social supports for abuse, i.e.: friends, family; may also include descriptions of healthy relationships", and used it to develop social support-related sub-codes and definitions that encompassed its different conceptual characteristics and dimensions. These included codes for each formal and informal source of support and type of social support, which were identified in the first reading of the 30 interviews. To tease out the effects of social support for analysis, the first author

refined this code by source and type, and expanded the definition. Referring to the socioecological model, the first author created new sub-codes for each formal (police, lawyer, religious leader, healthcare providers such as nurses, doctors, and psychologists) and informal (mother, father, siblings, grandparents, in-laws, other relatives, friends, coworkers, neighbors) support sources, and defined them. These were added to the codebook along with sub-categories within each type of social support such as emotional (empathy, protecting), instrumental (financial support, housing), informational (counsel), and esteem or appraisal (encouragement, self-reliance) (Heaney & Israel, 2002).

A close reading of the social support-related notes, memos and interview segments made during initial review, revealed defining characteristics, commonalities and differences within and among the interviews. These were used to develop inductive codes. The new codes were uploaded into MAXQDA 11 software and used together with the parent study codebook for all subsequent analyses for this study. See Table 1 below for complete list of codes.

Table 1

Social Support Study Codebook

Code System	Code Definition	Code Frequency
Social Support		346
Barrier	Things that prevent women from disclosing or reporting abuse. May be members of the informal or formal support network, systems, geography, etc.	34
Communication	Mention of communication relating to relationships.	19
Counsel to Leave - No	Specific mention of NOT actively counseling someone to leave a relationship.	15
Counsel to Leave - Yes	Specific mention of counseling someone to leave a relationship.	31
Defending / Protecting	Emotional or effective support provided to or received by others in formal or informal networks. Appraisal Support if providing feedback and information for self-evaluation or self-realization. Instrumental Support if providing assistance such as calling the police or taking to the police station.	29
Venting	Mention of venting to someone, or having someone vent to you.	21
Embarrassment	Embarassment in relation to women not disclosing or reporting abuse.	20
Emotional Health	Mention of depression, sadness, psychosomatic illness.	10
Facilitator	Things that help a women to leave or address her relationship, or disclose or report abuse. May be members of the informal or formal support network, systems, geography, etc.	22
Formal: Church	The institutional aspect of religion. May be related to doctrine, or clergy.	28
Formal: HC provider	Members of the healthcare field including clinic staff, doctors, nurses, community health workers, emergency medicine and specialists at health posts, clinics and hospitals.	28
Formal: Legal	Legal and judicial segment of the criminal justice system. The lawyers, advocates and judges who preside over the administration of the protective measures afforded under Maria da Penha and anti-femicide laws.	10
Formal: Psychologist	Members of the psychosocial support teams, such as CAPs and clinic psychologists.	29
Formal: Police	Members of the police force, either traditional or specialized precincts for women.	29
Informal: Children	Children of the interviewee. Either providing to or receiving support from the participant.	37
Informal: Church members	Fellow congregants at church. May also be individuals encouraging participants to attend church.	11
Informal: Dad	Father or step-father of interviewees.	19
informal: Family	References to family in non-specific terms.	4
Informal: Friends	Friends who provided support to the interviewee.	29
Informal: Mother	Mother of the interviewee. May also be the interviewee as a mother providing support to a daughter experiencing abuse.	52
Informal: Neighbor	Interviewee as neighbor. May also be references to neighbors experiencing abuse or interacting with others.	19
Informal: Other Relatives	Aunts, uncles, cousins, grandparents, in-laws, aggregated members of the extended family.	37
Informal: Sibling	Sisters and brothers.	35
Informational Support	Provision of information about services, how to address abuse, contact information for Formal support sources.	21
Instrumental Support	Informal support source provision of financial support, shelter, transportation, childcare, or other material support to others to help them to endure or escape abuse. Receiving financial support, shelter, transportation, childcare, or other forms of material suport from informal sources of support that help to endure or escape abuse. Formal support source provision of financial support, shelter, protection or curative services, or other material support to help endure or escape abuse. Receiving financial support, housing or other forms of material suport from formal sources of supoprt to help them to endure or escape abuse.	9
Intergenerational Tensions	Descriptions of conflict between generations. May be between mothers and daughters, mothers and mothers-in-law, or fathers and daughters.	10
Listening	The act of listenting to someone experiencing abuse.	10
Minimizing Behaviors	Rationalization of abuse, downplaying abuse or its impact.	28
Religion	Mention of religion, church, God, prayer.	70
Self Defense	Descriptions of defending the self from injury or abuse, etiher physical or emotional.	11
Stage of Change	Readiness to adress abuse, and own situation.	72
Talking	Descriptions of talking.	55
Undermining	Descriptions of actions that demoralize or minimize a woman's ability to address abuse.	7

Process

The first author applied the new codes to all 30 previously coded transcripts. She then conducted a close reading of social support related notes, memos and interview segments to verify initial interpretations as well as compare defining characteristics, differing perspectives, and commonalities among the interviews. Special attention was paid to explanations for problems or issues, and what interviewees said about them in the context of abusive relationships. These were considered together in the context of each narrative to develop thick descriptions of how sources and types of social support interact.

Criteria for inclusion in this analysis were: 1) the interview had sections coded as social support relating to a form of abuse, 2) the participant mentioned personally experiencing physical, emotional or sexual abuse, or 3) the participant did not explicitly state they personally experienced abuse but mentioned actively providing support to someone that had. This combination of support seeker and support provider would allow the analysis of social support from both perspectives: the survivor and the support provider, to see how each described the experience of accepting or providing support.

The first author practiced reflexivity in approaching the reading, coding and analysis of the data for the current study. Any emotional reaction to the transcripts at each step of the process was noted in related memos to reduce the possibility for subjectivity during analysis. Constant comparisons of data were made to help organize the data into categories for further analysis.

Study ethics

The present study involved de-identified, existing data that could not be linked to study participants, and was exempt from Institutional Review Board (IRB) review. Study participant

numbers were replaced by pseudonyms, which were selected from the list of popular baby names (A Gazeta Online, 2017). The first author retained the pseudonyms of two participants whose cases of surviving extreme violence were described in Evans and colleagues (2018).

Results

Social Support Study Population Demographics

Study participants (n=23) were between 19 and 78 years of age. Two thirds (65%) were of childbearing age (between the ages of 19 and 50 for this study). Slightly more than half (58%) of the sample self-identified as Afro-Brazilian (Black) or mixed race (n=16), and the rest as white (n=14). Average monthly household income of those providing income (n=13) was $406, but half (n=8) lived in households earning under $280 per month (30% of an average minimum monthly salary in Santo André in 2016) while one that was retired listed an income that was almost four times the average ($1,597). Three had not completed school beyond the 8th grade, and six had not completed 12th grade. Two thirds (n= 11) were unemployed and dependent on a partner or family member. Almost one half (n=7) listed themselves as Catholic and the rest (n=11) as Evangelical.

Partnering and household arrangements reflected the complexity of relationships in the municipality. Six women mentioned being married or cohabitating with their first partner, and eleven were divorced or separated and single. Almost half (n=8) mentioned that their current partner was not their first. Households were comprised of participants, and their children (n=2), partners and children or grandchildren (n=3), parents, children and other relatives (n=4), mother and children (n=2), mother and siblings (n=1), a boarder (n=1), and one lived alone. The remainder (n=4) mentioned living with both children and partners, but their demographic information did not match what they verbally reported (Table 4: Study Demographics).

Table 2

Demographic Characteristics of Women Interviewed about Their Perceptions of IPV, Santo André, Brazil, 2016 (n=30; n=23)

Characteristic	Total study population (n=30)		Social Support Analysis (n=23)	
Age (years)	n	%	n	%
19 – 39	13	43.3%	9	39.1%
40 - 49	15	50.0%	12	52.2%
=60	2	6.7%	2	8.7%
Race				
Black	6	20.0%	6	26.1%
Mixed Race	10	33.3%	6	26.1%
White	14	46.7%	10	43.5%
Marital Status				
Single never married	1	3.3%	0	0%
Cohabitating	3	10.0%	3	13.0%
Married	10	33.3%	8	34.8%
Separated	2	6.7%	2	8.7%
Single, divorced or separated (not specified)	3	10.0%	2	8.7%
Divorced, single	2	6.7%	2	8.7%
Divorced, cohabitating	1	3.3%	1	4.3%
Divorced, remarried	1	3.3%	0	0%
Divorced, separated	2	6.7%	0	0%
Widowed, single	1	3.3%	1	4.3%
Widowed, cohabitating	2	6.7%	2	8.7%
Widowed, separated	2	6.7%	2	8.7%
Religious Affiliation				
Catholic	12	40.0%	9	39.1%
Evangelical	18	60.0%	14	60.9%
Schooling				
Up to 8th Grade	7	23.3%	7	30.4%
Some high school	20	66.6%	16	69.57%
Some College	2	6.7%	0	0%
No Response	1	3.33%	0	0%
Employment				
Employed	8	26.7%	6	26.1%
Unemployed	20	66.7%	15	65.2%
Retired	2	6.7%	2	8.7%
Average Household Monthly Income				
$0 - $399	14	46.7%	14	60.9%
$400 - $699	6	20.0%	3	13.0%
$700 - $999	3	10.0%	1	4.3%
$1,527	1	3.3%	1	4.3%
Don't Know	6	20.0%	4	17.4%
Household Members				
Participant, participant's children, mother and/or other relatives	8	26.7%	6	20.0%
Participant and children	3	10.0%	3	10.0%
Partner	4	13.3%	3	10.0%
Partner and children	12	40.0%	9	30.0%
Other non-partner	2	6.7%	2	6.7%
Alone	1	3.3%	1	3.3%

Note: Age for study inclusion was over 18. Mixed Race includes women who self-identified as "morena" or "parda" rather than black (Afro-Brazilian) or white. Marital status attempts to capture the complexity of civil status in this community as described by participants lived experience. Employed includes any partial or full-time employment. Average monthly household income is represented in equivalent USD for June – August, 2016. Household members include participant and others mentioned in the demographic survey and during the interviews.

IPV in the study population

Of the 30 total interviews, 23 fulfilled the inclusion criteria of experiencing emotional, sexual and/or physical abuse (n=19) and/or providing support to someone who had (n=4). Table 5 below displays participant IPV experience by age, perpetrator, whether or not she still lives with the perpetrator, abuse type and whether she was experiencing IPV currently or in the past, and if she has provided support to someone else for IPV.

Table 3

Study population by age, perpetrator, type of abuse, current living status, and role of survivor and/or support provider (n=23)

Pseudonym[1]	Age	Perpetrator[2]	Abuse type[3]	Lives w/ Perpetrator[4]	Survivor / Supporter[5]
Alice	41	H1	E, P, S, F	N	P
Beatriz	32	H	E	Y*	C, S
Bianca	43	N/A	N/A	N/A	S
Clara	78	H1	E, A	N	P, S
Eduarda	34	H, O	E	Y	C, S
Emanueli	19	H1	E, A	N	P
Esther	25	B, H, U, SF	S, P, E	N	P
Heloísa	47	H	E	Y	P, S
Isadora	36	H	E	N	P, S
Isis	23	H	E, P	N	P
Laís	40	H	E, A	N	P
Laura	60	H, B, BR	P	N	P, S
Lívia	48	N/A	N/A	N/A	S
Lorena	53	N/A	N/A	N/A	S
Luíza	58	H	P, F	Y	P, S
Luna	50	H	E, A	Y	P
Manuela	48	H	P	N	P
Maria	51	H1, H2	P, X	N	P, S
Mariana	46	H1	E, P	N	P, S
Melissa	23	H	E, P	N	P, S
Raquel	56	B, E, H, BR, S	E, P, S, F, X	N	P
Sofia	26	N/A	N/A	N	S
Stella	25	H1	E	N	P, S

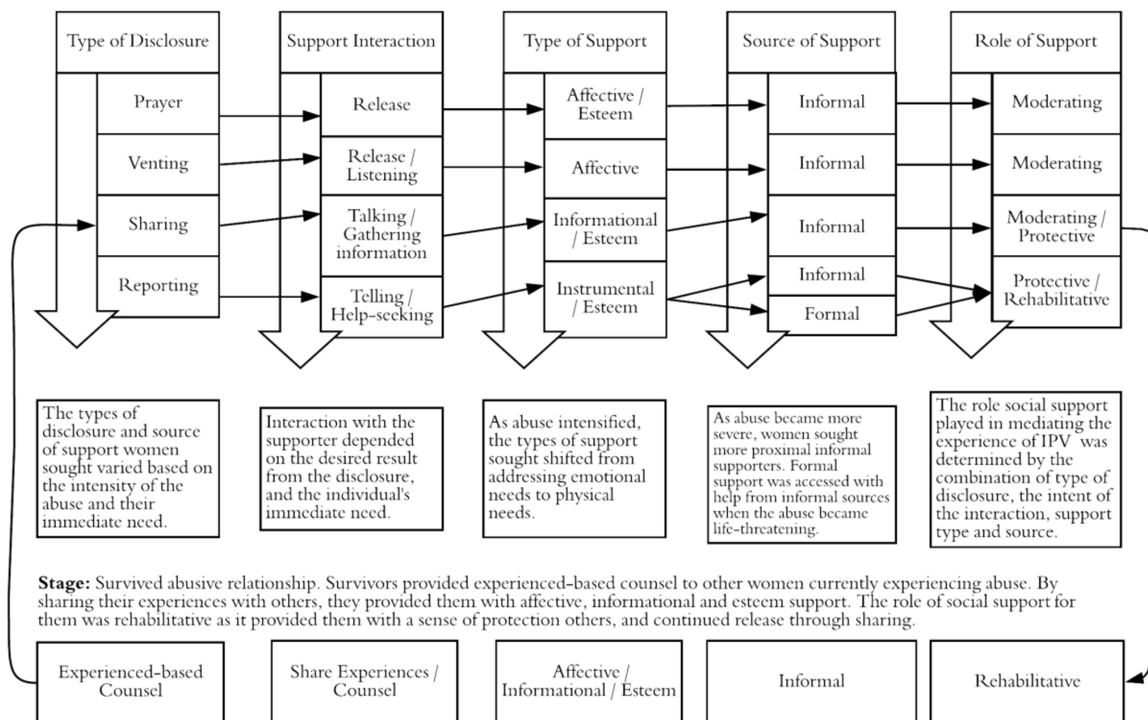
[1]Pseudonyms selected from A Gazeta Online (2017) Popular Baby Names, and do not coincide with actual interviewee names.
The author retained Raquel and Maria's pseudonyms from Evans et al. (2018).
[2] Perpetrator: Father (F), Boyfriend (B), Fiancé (E), Husband (H), Former Partner (FP), Brother (BR), Son (S), Uncle (U), Other (O), by order abuse occurred.
[3]Abuse Type: Emotional (E), Physical (P), Sexual (S), Patrimonial (F), Extreme (X), Coercive (C), Aggressive but no physical
(A), Not Applicable (NA)
[4]Currently living with perpetrator: Yes (Y), No (No), Not Applicable (N/A)
[4]Abusive Relationship: Stay (S), Left (L), Contemplating leaving (CL, Not Applicable (NA)
[5]Survivor status or support provider: Currently experiencing abuse (C), Past abuse (survivor) (P), Support Provider (S)

Social support in the study population

Study participants spontaneously described several different aspects of social support during their interviews. Figure 2 below describes a model that characterizes the role of social support in managing IPV among these women.

Figure 2. Disclosure model

Stage: Currently experiencing abuse, experienced abuse in the past, or described providing support to someone experiencing abuse. Decisions about disclosure, need from the interaction, type of support sought, and source of support accessed vary as women cycle through the stages of readiness to end an abusive relationship.



Sources of social support

Women said they primarily accessed informal sources of support, such as neighbors, friends, church members, parents, siblings, children, and extended family for help managing emotional and physical abuse. As the abuse escalated and the type of support they needed increased, they accessed more proximal sources of support, such as family members, particularly their mothers. Women only approached formal sources to address violent or life-threatening

situations. In most of these cases, informal supporters, usually their mothers, took them to the institutional formal supporter (doctor, hospital, or police) for help. Women that filed incidence reports of physical abuse, did so at both regular and specialized police stations for women. Three women mentioned seeking legal aid from lawyers. A few sought help from healthcare providers for physical injuries stemming from abuse, and a few were referred to psychologists for related emotional or mental health problems. Few disclosed abuse to doctors, even when it was physical and violent, and the doctor specifically asked them about bruises or marks.

Types of social support

Women cited the availability of instrumental support as important in their decision-making. Informal supporters, such as family members and friends, offering to provide housing, childcare, financial assistance, and transportation, releasing them from the uncertainty about how they could provide for themselves and their children if they left. While women only approached formal sources to address violence or life-threatening situations, several sought protective services from the police, and lawyers provided legal assistance relating to child custody and support, and they accessed medical attention and psychological care for injuries. Finally, women cited both encouragement, and candid assessments of their choices (appraisal) as helping them to find the courage to address their abuse and abusers.

One of the survivors of extreme violence provides a good example of the types of social support women received from both informal and formal sources and how these can overlap. Raquel , a 51 year-old mother of three, talked about how a fellow congregant from church of listened to her (affective), provided her with details about how she had addressed her own abuse along with her lawyer's business card (informational), and encouraged her to get help citing her personal success (appraisal/esteem). Following a particularly violent incident with her husband,

Raquel contacted the lawyer. He provided her with legal aid, referred her to the women's police station and to the court system to activate the protective measures and child support (instrumental) stipulated in the Maria da Penha legislation of 2006 (Presidência da República, 2006). Of this experience, Raquel said,

> I talked with my friend at church about my situation. She was in a bad relationship too, and gave me the card of her lawyer. My husband had written down everything he did to me in notebooks, and I took them to that lawyer. He read them and told me, "Your husband is crazy! This is evidence against him!" [The judge] awarded me a consensual separation and child support at the first hearing. When I got home, my husband beat me, threw hot water and alcohol on me and tried to set me and my son on fire. I was badly hurt. I went back to my lawyer and he told me to go to the police station. Up until then I didn't have the courage to report him because he threatened to kill me and destroy the house. But I went and reported him and they gave him 48 hours to leave. When he said he wouldn't, the judge told him if he didn't leave, the police would come and take him away (Evans DP et al., 2018).

This case provides a good example of the complexity of social support and how supporters and the types of support they provide can intersect. Raquel had limited informal sources of support. She was dependent on her husband, and her conservative and religious family, including her mother, sided with her husband. When her doctor asked her about her injuries, she had been too embarrassed and afraid to talk to him. She described her children as growing up in a war zone, and she needed help to manage it. While her familial support was weak and undermined her efforts to address her situation, her friend gave her the information she needed to take steps to address her relationship through formal avenues.

Prayer moderates IPV for Evangelical women

Although most interviewees said that religion and prayer was important in their lives, Catholic and Evangelical women approached this differently when talking about help seeking. While Catholic participants mentioned praying and attending church, they cited seeking and receiving affective and instrumental support for IPV from family members and friends. Further,

they described the process of deciding to leave actively, using terms like “taking action,” “making a decision,” or “making a stand”. External forces influenced them, but they decided ultimately what to do.

On the other hand, Evangelical participants almost unanimously said they would pray to God for advice, and would advise others to do the same. Eduarda, age 34 said,

> If I’d had God at the time that I suffered through a difficult time, I would have known how to ask Him for help. I can’t advise anyone to seek help, and I can’t help them. They need to talk to God. Get down on [their] knees, pray, fast, ask God, because God will provide an answer.

Their faith in God provided them with a sense of being loved and accepted, and of hope. This interaction lies within the boundaries of faith, and while there is no physical form of support, for the supplicant the action of prayer provides the same outlet and release as if she were talking with a friend or neighbor. Bianca, 43, a mother of three and whose oldest daughter was in an abusive relationship, mentioned seeking help outside of her church for her daughter, and also reaching out to like-minded family members, “I talk to my sister who is very faithful. She tells me, ‘Don’t lose hope.’” Like Raquel and other Evangelical women who reached out to formal support sources outside of church—a lawyer, judge or the police—Bianca reached out to police only when the situation had become life-threatening for her daughter and family.

Venting has a moderating effect on how women experience IPV

For women experiencing emotional abuse, both survivors and support providers mention venting as a means of releasing pent-up emotions. At this point, these women were not experiencing physical abuse, but they were hurt, angry, and frustrated. The only expectation the woman venting had for this exchange at this point, was for the listener to receive the information as the she talked and got it off her chest. In this case, the listener did not give the venter advice

about leaving her abuser because it may not have been what the venter wanted from the exchange, or needed to hear. In this example, Sofía, 23, described providing support by listening:

> I have one neighbor who told me, 'My husband cheated on me, so I left him'. Another one just vents. Sometimes they have no one to talk to and so they end up talking to me. Sometimes she just wants a friendly word. I could tell her, 'Just leave your husband!' But let's suppose she does not end up leaving her husband? You can't say that, right? So I just keep quiet. Even with everything she is talking about that's going on, [leaving] is not even crossing her mind.

Informal sources such as family members, friends and neighbors provide this type of affective support. This exchange offers temporary relief from emotional suffering and isolation, and a sense of connection to the person listening. It has a moderating effect for women not ready to address their abuse, making the experience tolerable and less intense, at least temporarily, and provides her with an outlet other than her partner for her hurt feelings, anger, and frustration.

Sharing personal experiences with others moderates the experience of IPV.

Sharing personal experiences gave women the opportunity to vent, share information, and encourage each other (esteem/appraisal). Survivors shared their personal experiences with others who approached them to talk, or that they perceived as being in a similar situation and receptive to the discussion. Lívia, 48, described how her adolescent daughter, and her friends and neighbors shared opinions and experiences. She called the young women "hungry for information" about how to deal with relationship problems and said she "provided her daughter with guidance whenever she could". Women shared their own experiences with others, and in some cases served as models of success. Manuela, 48, said,

> When I hear about cases of assault, I tell them to get out of the situation because the tendency is for it to get worse. Or even to go to the police, because the minute verbal abuse starts, it can get physical very quickly.

In this way, sharing information may have both moderating and protective effects in that it provides an outlet other than the partner for frustration and sadness, affective support, and may provide information about strategies to address IPV.

Women report abuse when they need instrumental help

Women disclosed abuse when they could no longer tolerate their situation or it had become physically dangerous. The majority sought informal support from family members or friends first, unless like Raquel and Esther, they lacked reliable informal support. When disclosing IPV to a mother, sibling, child, or friend, they requested or received financial assistance, help with childcare, housing, or transportation. This supporter source often also encouraged or helped them to seek protective action through the criminal justice system. Likewise, when the relationship was very violent, family members or neighbors sometimes called the police on the woman's behalf. For some women, knowing that the instrumental support was available was enough; even if they did not use it. When women reported abuse to the police, legal counsel or healthcare provider, it was because they needed instrumental assistance (protection), and information.

Experienced-based Counsel

About a quarter of the women who had ended their abusive relationships successfully said they counseled other women to leave similar circumstances. Manuela, 48, talked about the process of leaving an abusive relationship, and said,

> You start to go through the process and it takes some time until you decide to take action. I tell my daughter, if he starts fighting or attacks you, separate, take care of your own life, and each to his own. Because to keep on suffering… it is better to suffer alone, because it will happen again. It doesn't matter if he asks your forgiveness, because he will do it over again. Try not to be embarrassed and get help.

Laura, now retired and aged 60, left her husband when her daughter was a year old. She raised her with help from her mother, while maintaining a career. She said, “I’m not a good counselor, but I talk about my experience. Whoever comes to share hers with me knows more or less about my life.” Melissa, 23, left her husband before he started physically abusing her and moved home with her mother. He started to beat his new girlfriend, and she tried to counsel her about how to deal with him:

> It's like I told that woman that is with him. "He never laid a hand on me the way he does with you. You are very foolish. If it was me, I'd have even already gone to the police to report it, I will not allow a man to hit me." And she said: "Ah no, but I like him. They will want to arrest him, they will hurt him." And she's still a minor! Her mother has already put her in a place for minors because he beat her up. She told her mother to get her out of there, because she didn't want to stay there. Her mom said, "Fine then, keep taking beatings."

While they continued to be embarrassed about the abuse, many of the women counseled others, providing them with information about the process they went through to leave, and providing a positive example for the women they counseled. While not all women were receptive to what they had to say, they mentioned that they talked to as many women that came to them to talk, or that they knew were in similar situations.

Women are selective with whom they discuss IPV

Women most often sought support from a female family member, close friends, or neighbors. They sought help from friends or neighbors when there was no mention of a family member living nearby or when they did not expect help from family members. In some cases, women were selective about what they told family members. At times they were protecting someone, often their own mothers. Bianca, 43, said,

> I vent mostly to my sister. My mother has health problems—heart problems, high blood pressure—so some things I tell her, but when things aren’t going well and I’m depressed, I vent to my sister.

This often occurred when the mother was elderly, unwell, had not been supportive of her daughter in the past, or there was fear associated with telling her.

Women compartmentalize healthcare provider roles

Many of the women compartmentalized support from healthcare providers. When participants sought care from healthcare professionals for IPV-related physical injuries, Most said they did not discuss it with their doctors, even when they asked, although one or two did. One said, “Doctors are gruff, the nurses are all heart.” A few mentioned being asked by nurses and feeling comfortable talking with them about their relationships, while others did not. Alice, age 41, said,

> The community health nurse at the clinic asks how I am, if everything is okay in my relationship, but I’d rather not talk to her. I prefer to talk with my psychologist at CAPs [Psychosocial Care Center].

Like her, many expressed a preference to talk with a specialist, such as a psychologist, and not a medical doctor or nurse at their clinic. Luíza, age 58, noted,

> If someone from the clinic were to ask me about my relationship, the right person would be a psychologist. The doctor takes care of the pain, the psychologist takes care of the emotions.

Like Luíza, some participants said they didn’t recognize the healthcare provider as someone to turn to for IPV. Laura, age 60, said she didn’t know if talking about it would help with treatment, unless it was with a psychologist. Alternatively, Manuela, 48, said that although she didn’t get help from the health sector herself, her views have changed:

> In those days you had to be strong. There wasn’t a social services network, I don’t know how it is now, but in those days, we didn’t have it. There is a difference between 16 years ago and now. You couldn’t get help from a psychologist then if you didn’t have a way to pay for it. […] Now I tell people to seek help through medical channels. Now I am more aware about this. At that time, 16 years ago, I didn’t understand about that. And now there are better services.

Most women did not mention the social services network by name, although they utilized some of its services.

Several women mentioned seeing a psychologist for anxiety or depression, but did not link their need for psychological services to their abuse. Heloísa, 47, was referred to a psychologist for depression. Her doctor didn't ask her, and she suggested repeated and direct questioning so women wouldn't avoid answering the question. Mariana, 46, said she saw a psychologist for "a breakdown", but did not elaborate. Raquel's doctor referred her to a psychologist for depression and insomnia. She didn't mention what she discussed with the psychologist, but she said she hadn't had the courage to talk with her doctor, even though he'd asked her about her injuries and told her the abuse was against the law.

Isis, 23, and Manuela said they wished they had felt comfortable seeking help when their healthcare provider had asked about abuse. Isis said she felt embarrassed and judged for staying in the relationship:

> I was ashamed of the assaults and the situation, understand? Because it's like I was saying, there are people who think you're in that [situation] because you want to be. Because they say: "You shameless woman, why don't you leave that guy?" But it is not like that. You have to see what is happening in the woman's head, understand? What she is thinking, what she is feeling. Like me, I was thinking about my daughter, you know? Sometimes the others say, "Oh, she's a bad [cheap, easy] girl, she doesn't want to leave him," right? But it's not like that, you know, because I think, there are some [women] who don't even care. They just leave and that's that. And they are like, "So what about the kid?," right? But no, I was thinking about my daughter. Even though I was suffering, I was putting up with it, if my daughter was ok, I was ok.

Isis' example summarizes the complexity of the decision-making process involved in leaving an abuser. Several of the participants indicated they were embarrassed about the abuse, and disclosing it in the healthcare environment opened them up to criticism and judgement by clinic staff. They expressed the same about the broader community. Another participant, Emanueli, 19,

said her family had gone through counseling when she was young, and that it had been helpful throughout her life. She said she thought there should be a psychologist at the health clinics where women could share their stories and learn communication techniques. Lívia, 48, a mother with a teenaged daughter experiencing relationship problems, had a similar suggestion,

> It would be good for the girls to have some counseling. I try to orient my daughter as best I can, but questions should be asked to someone trained in this, a doctor, nurse or psychologist.

This suggests that while many women don't feel comfortable talking with their doctors about abuse, and many were never asked about it, they recognized the potential for the medical system to serve as a potential ally.

Barriers to accessing social support

Most said they hesitated to approach formal supporters about abuse, including healthcare providers and police. They cited embarrassment about their situation, fear of others' judgement or blame, including by health facility staff, and said that the police were not always helpful. Women approached formal sources for instrumental assistance involving personal protection or care, because there had been a trigger to leave. In this case, the violence had become life threatening, their partner had severely injured them, or they were worried about the example they were setting for their children. For most women, accessing formal support such as the police signaled the final stages of preparation to leave, or when they were ready, to leave.

Social norms impede disclosure of IPV

Social norms and expectations about women's roles in society can impede an individual's willingness to report abuse. Women currently experiencing abuse and survivors alike mentioned not talking with HCPs at the clinic or others in the social network about abuse because they were afraid of what others would say. This fear stemmed from personal experience, and what women

had heard people say about other women in similar situations. They were afraid others would call them derogatory slang terms for women that suggest that they were "cheap", "easy", "slutty" or they liked, wanted, or deserved poor treatment. Manuela said in some health posts, the women are discriminated against by female staff, who blame abused women. Others blamed them for staying in the relationship, but were equally accusatory if they left it. Emanueli, age 19, asked her previously supportive sister-in-law to intervene on her behalf with her unfaithful husband. She said:

> I went to talk to his sister, when he started to get really ignorant. Once he tried to beat me, and I told his sister I wouldn't take it. His sister said, "Emanueli, you knew what he was like. You accepted him the way he was. It is up to you to change him, or put up with it."

This example shows how an individual's social support serves to uphold social norms around gender roles, and undermine the survivor's ability to address her situation.

Consequences to challenging social norms

Some of the support providers explained their decision-making about when and whether to intervene. Several of the interviewees that did not intervene said they did not get involved citing a proverb: "Nobody should get involved in fights between a man and wife." The husband of one victim threatened the participant physically if she continued to get involved. Another interviewee that did get involved said she had always spoken up when she observed abuse. In one case, she threatened to call the police on a neighbor who was abusing his young wife. He appeared to have stopped, but she alluded to feeling conflicted about whether she would get involved in the future because people on her street that "she had always had good relations with" distanced themselves from her after that.

Limitations to this study include interviewer leading during the interviewing process which can bias interviewee response. Desirability bias may have led women to respond to

questions in ways which may also bias results, particularly relating to responses to questions that are contradictory to social norms around intimate partner violence against women. Social support was not one of the primary domains of inquiry for this study. Therefore, probing questions often were not asked about relationships and interactions that would have been asked had it been a primary focus of the study. Likewise, while interactions with healthcare providers was a focus, although some women volunteered this information specific questions relating to interactions with formal support systems such as police and lawyers were not specifically asked or followed up.

Discussion

This study seeks to characterize the role of social support on women's experience of IPV among the study sample in Santo André, Brazil. Study participants responding that they had personal experience with or knowledge of IPV in their neighborhoods fell into three categories: support providers in self-described "good" relationships, women experiencing on-going abuse, and survivors. Each group described providing or receiving types of interpersonal exchange consistent with social support theory (affective, informational, instrumental and appraisal/esteem) (Barrera, 1986; Cohen & Wills, 1985; Gottlieb & Bergen, 2010) and that served a specific purpose for the woman experiencing abuse at a specific point in time. A fourth group of women that did not mention experiencing abuse, or were not aware of abuse in their neighborhoods, were excluded from this analysis.

Analysis of this sample found that the effects produced by the different combinations of disclosure type, interactions, types of support and supporters, operated to determine how social support functioned to mediate IPV. The role of social support in mediating the experience of IPV thus fell into three sometimes overlapping categories: moderating, protective or rehabilitative. In

this sample, women accessed informal and formal supporters when one or both of the following triggered a decision to leave: the violence became unmanageable, or the desire to provide a positive example for their daughters overcame the need to maintain the family unit. Finally, social norms negatively affected social support in relation to IPV. Both women experiencing IPV, and supporters of women experiencing IPV cited situations in which social norms hindered their willingness to seek or provide help.

Our analysis of social support among the women in the sample revealed that positive interactions with formal and informal sources of social support can serve to mitigate the experience of IPV for some women, and provide moderating, protective and rehabilitative effects for others. Consistent with findings in other studies, women sought formal sources of support in extreme cases of abuse (Kiss et al., 2012; Kiss et al., 2015; Liang et al., 2005), and/or when they lacked informal support in close regional proximity to offer them affective and instrumental support (Kiss et al., 2015; Liang et al., 2005). Likewise, we also found that negative interactions with social support, such as the formal support of police and the healthcare professionals that women most often seek out when in physical danger or have sustained injury, reduce the likelihood of women pursuing their support when they most need it. This can lead to revictimization, as women trying to cope with abusive partners are exposed to resistance and contradictory attitudes from formal (police, healthcare professionals) and informal support sources (family members and fellow congregants) that maintain traditional or patriarchal views of gender and family. These often counsel women to remain in the relationship and work to minimize conflict (Gottlieb, Bergen, 2010; Vieira et al., 2015), reinforcing her dependence and delaying decision-making about leaving the relationship. Offering women alternatives to

negative supporters may enable women to address their abuse more quickly, or earlier in her abuse.

Mothers are a pathway to formal sources of support

In most cases, mothers were providers of all forms of social support, and a key pathway to a survivor's access to formal sources of support. Almost all of the participants who were mothers in the role of supporter for their daughters mentioned taking their daughters to the police station, or where available, a DEAM, and to seek legal aid for child support and custody issues. Most survivors had good relationships with their mothers, and felt supported by them. Two of the mothers mentioned that their young daughters and their peers wanted information about relationships and how to manage them. One of the survivors said her family had undergone counseling when she was young, and felt that it would be useful for all young families. These women suggested holding group sessions at the local health clinic or post who could provide information and counseling to young mothers and couples.

The Role of REAM in providing support to survivors

Currently, efforts are underway in Brazil to link the various components of the Women's Support Network, or REAM. The REAM is intended to serve as a vital link in the care of survivors of abuse. However, recent changes in political leadership, at the state and local level in 2017, and the national level in 2018, have signaled a shift in priorities away from women's health and human rights. Michau and colleagues (Michau et al., 2015) recommend holistic, multisectoral approaches to intervention that span the social ecology and are complementary and reinforce each other. Further, using a similar example from Australia, they highlighted the need for primary prevention approaches across sectors to address IPV that can serve to maintain support when political priorities change in the middle of implementation of new policy.

While many women in this study did not recognize or trust their healthcare provider as a resource for IPV. While a few women felt comfortable talking with their healthcare provider about abuse, most said they felt or would feel more comfortable talking with a psychologist. This underscores the importance of counseling services offered as part of the REAM, but also an opportunity for clinicians to have a broader role in this network. While several women talked about having been referred to a psychologist of counseling for a variety of conditions including stress-related illness, insomnia, and depression, they did not link this to their abuse. While research has called for a larger role for healthcare professionals in getting women connected with interventions for IPV (Kiss & Schraiber, 2011; Netto, Moura, Araujo, Souza, & Silva, 2017; Pereira-Gomes et al., 2015), guidance around routine screening has been mixed due to a lack of evidence. Jewkes reviewed the results of three large global studies undertaken in the U.S, Canada and Australia that found that routine screening for IPV of asymptomatic women did not improve health outcomes. However, she suggests there is value in screening for IPV when asymptomatic women present with related health problems through helping women recognize that their health problems may stem from the abuse, and help them come to a decision about their situation. Further, asking about IPV may help the clinician determine the best course of treatment for an individual (Jewkes R, 2013). This is supported in our small sample. Many women said that while they hadn't been asked about IPV, they would like to be. Some said they had not had the courage to discuss it when their provider raised the subject with them, but wished that the provider had pushed a little harder. This suggests that women may be open to a greater role for clinicians if appropriately asked.

The role of social support as mediator of women's ability to address IPV

Moderating effects of Social Support on the experience of IPV

Women used prayer, venting and sharing, to moderate their experience of emotional and verbal abuse and their ability to manage it. These exchanges allowed women to release pent up emotions and "get it off their chest". These interactions took place with neighbors, mothers, sisters or friends, and the primary intent was to direct their hurt and frustration to someone other than their partner. Prayer and venting were unidirectional actions focused outward, an activity of release, with no expectation of or desire for feedback. Women vented to a neighbor or sister, or through prayer to God—someone who would simply listen. Sharing was bidirectional, with both parties exchanging experiences and information. Women were at the pre-contemplation stage of readiness to address their IPV, and family integrity was important. At this stage, they were hoping that either their partner would stop abusing them or go back to being the person he had been in the past, and were generally not thinking about leaving. The ability to vent gave them the opportunity to release their anger and frustration to someone supportive and not judgmental. A disadvantage to relying on prayer to resolve IPV is that while it doesn't expose the individual to IPV, it may put her at greater risk for increasing or violent abuse.

The protective effects of social support on the experience of IPV

Women accessed informal and formal supporters for instrumental help when one or both of the following triggered a decision to leave an abusive relationship: the violence became unmanageable or the desire to provide a positive example for their daughters overcame their need to maintain the family unit intact. This expands on the finding of Kiss and colleagues (2012) that women activate formal supporters (i.e.: police) after children have been present during violence. This also may signal a shift in social norms around acceptability of partner abuse and a concern that exposing children to abuse normalizes it. Bidirectional exchanges, such as sharing and reporting abuse, also had a moderating and/or protective effect. These individuals

were primarily seeking information about ways others addressed their situation and the outcomes (what to do), and instrumental support such as financial assistance and shelter from informal sources, and legal aid or protection form formal sources (how to do it). This suggests that women are actively seeking sources of information about dealing with abuse. Implanting formal resources such as referral centers in neighborhoods, or establishing the local clinic or health post as a resource may provide an alternative for women seeking information who either lack or don't feel comfortable discussing their abuse with an informal support source.

Social support had rehabilitative effects on the experience of IPV

Taking action, such as seeking help from informal sources, or reporting abuse to formal sources, as well as providing counsel to others, had a potentially rehabilitative effect. Peer counseling or survivors counseling other women in violent relationships may also serve a rehabilitory effect for survivors. Passing on what they learned from their experience is a form of agency. Some women use themselves as potential role models as women who successfully overcame abuse. While some women still experienced embarrassment about their abuse, the repetition of their story to others reinforces this personal agency and is reaffirming of their own success. For the individual being counseled, this offers a peer-level source of information that can be both affirming and informative. For survivors who successfully left their abusive relationship, providing esteem support and peer-counseling to women currently experiencing abuse may not only aid the women she counsels, but may serve to reinforce her own self-esteem and continue her process of recovery. Engaging these women in sensitization activities involving members of formal networks, such as the criminal justice and medical sectors, may provide an opportunity to support the development of decision trees, protocols or other materials to help healthcare and members of the Women's Support Network help abused women.

Consistent with previous studies (Kiss et al., 2012; Kiss et al., 2015; Liang et al., 2005), some women sought formal sources of support in extreme cases of abuse, and/or when they lacked informal support. Women experiencing violence that lacked informal social support living in close proximity to offer them affective and instrumental support were also at higher risk (Liang et al., 2005).

The effect social support had on the individual's experience of IPV was not limited to one or two types of exchange, but was related to the severity of the situation, readiness to address her situation, and the level of her perceived need for intervention. Combined, these indicated the mediating role of social support as moderating, protective or rehabilitory of the experience of IPV. Further, as other studies show, the offer and perception that instrumental help was available was important to the survivor as actualizing the help (Gottlieb, Bergen, 2010), and also served to moderate the effect of abuse.

Social Norms and IPV

Concerns about what other people think is strong enforcer of social norms and support stigmatizing attitudes. This is reflective of Brazilian social norms around not getting involved in other people's relationships. Gossip is a potent enforcer of social norms and reinforces attitudes that stigmatize women in abusive situations. The fear of judgement can hinder a woman's willingness both to seek help for abuse. Indeed, interviewees that did not intervene when they observed abuse specifically mentioned the old adage that says, "In fights between man and wife, nobody [should] get involved". Many of these women cited selectivity in how they would get involved, providing support by listening to women vent, talking with them, and providing companionship. Some mentioned sharing their own experiences and techniques for surviving

abuse. Survivors cited this support as having been helpful to them, even when they weren't ready to leave or accept counsel to end their relationship (Meneghel et al., 2011; Vieira et al., 2015). Younger women, and older women that had survived abuse, affirmed they had or would get involved, either by talking with her or calling the police. This may be indicative of changing social norms within the neighborhood, where it may be becoming more socially acceptable for others to intervene in abusive situations as abuse becomes less culturally acceptable (McDonnell et al., 2011; Netto, Souza, Silva, 2017).

The role of religion and prayer in addressing IPV is complicated.

The role of prayer as moderator of the experience of IPV can be explained through internal and external locus of control. Catholic and Evangelical women alike said that prayer and religion were important to them, but while they mentioned going to church and the importance of religion to their family, Catholic women talked about accessing informal social support to address or leave abusive relationships. Most of them also used active language that indicated and internal sense of control of their own actions, even when their situation was out of their control. They talked about "taking a stand", "making a decision" [to leave], or "standing up for themselves". This indicated a sense of autonomy and recognition that whether they stayed in the relationship or left, in most cases, the choice was theirs to make. They themselves were the agents of change.

In contrast, the Evangelical women in the sample expressed that most often they prayed to God for advice for what to do and for help rather than seeking it in others. They both received this advice from their clergy and fellow congregants, and would recommend that others do the same. The act of placing their fate in the hands of a higher power, or following the suggestions of their clergy suggests they have no autonomy or volition in the decision. In this way, they have no

choice but to follow the path that “God” or their religious tenets mandate. This may provide them with as sense of release in the short term, but may expose them to harm in the long term. Further, as Michau and colleagues point out (2015), even when national legislation and policy are favorable to equity for women and prevention of violence, religious tenets and customs may promote male dominance and have penalties for non-conforming women. This may come from the family, as in Raquel’s case or the religious community. This may serve to counteract programs that intend to shift social norms, as well as impede women from addressing abusive situations out of fear of retribution or rejection by their community. In this way, the perception that control is exerted by an external force may have a negative effect in the long term, and place women at risk of physical danger.

Survivors of IPV talked about the role social support played in their decision-making processes around leaving or remaining in their relationships. For some, the offer and availability of instrumental support—financial assistance, housing and childcare—was sufficient for them to be able to tolerate their situation until they decided to leave – they were not “stuck” in their relationships, and could make the choice. One interviewee in an on-going abusive relationship and in the process of leaving mentioned that her parents and brothers repeatedly told her she could come and live with them, offering her and her children safe housing and financial support. While this provided her with a sense of comfort while she came to terms with ending her relationship, her initial response was that she didn’t want to break up her family, and raise her children in someone else’s home. For some women, this type of support has been found to delay women’s decision-making around leaving, as they don’t want to feel pressured to make changes they are not ready for (Vieira et al., 2015).

Conclusion

Findings in this sample include several previously under-studied aspects of social support that suggest possible points for intervention. Evangelical women resorted to prayer Mothers are a key pathway to accessing formal support. Women in violent situations who engaged family members, particularly mothers, were more likely to have accessed formal supporters such as the police, to deal with abuse. Findings indicated a compartmentalization of healthcare provider roles and the types of medical specialist it is considered appropriate to talk with about IPV; women preferred talking about abuse with their psychologist to their physician. Women are also selective about whom they disclose abuse at different stages of their relationships, with some avoiding disclosure of abuse to any social network members holding traditional views on gender roles, and/or in the past tried to ensure she remained with their abuser. It revealed that enlisting churches in the campaign to prevent IPV may prove effective for a large segment of the community. This may be useful particularly engaging churches that have existing support programs and workshops for congregants in place, and framing the issue in terms of health and well-being, and communication skills. Mackie and colleagues (2016) emphasize the importance of considering the social motivations that drive or block change, and suggest that programs that support a change in social expectations at the community level may be more effective.

Strong social support networks have been shown to protect women from violence in their relationships. (Liang et al., 2005; Longmore et al., 2014; Matlow, DePrince, 2015) Understanding how the role of social support operates in abusive situations has implications for community based health interventions, particularly in an atmosphere of reduced funding. Participants in Santo André expressed preference for discussing relationship and emotional issues with their psychologist rather than their healthcare provider. This suggests a cultural distinction between what constitutes the roles of healthcare provider and psychologist, and when

and by which IPV ought to be addressed. Interventions to provide physicians with information about signs of abuse, and where to refer women at the appropriate time could help improve provider comfort as well as relations with their patients. Changing the view that the "Doctor treats the physical, the psychologist treats the emotions" may help get women into services faster as well. Likewise, expanding access to psychosocial interventions with women who are at risk or known to be experiencing violence, and potentially their partners, may serve to prevent violence. This study helps to understand from participants own perspectives the dynamics at play in addressing partner violence in their neighborhoods. It can help inform future studies that examine how targeting existing social support structures to better serve women at risk of violence. Further, an understanding of the mechanisms behind when and for what purpose women access social support can help us identify points of intervention that would be timely and acceptable.

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Conclusions

Public Health Implications and Future Research

Findings from this analysis suggest the following:

1. Convene a cohort of survivors to meet with local SUS health officials to help them understand the complexities of IPV in Santo André. Further, engaging survivors and medical staff in planning community-level interventions could potentially increase the possibility of uptake by both women and health care professionals. This group would:
    a. Work together to design appropriate community-based interventions and research informed by the survivor's perspective.
    b. Work together to develop a disclosure framework to help healthcare providers identify IPV in their patients, and what patients might say that indicate, a) they are experiencing IPV, b) and how to respond. Additional flow-charts could help providers understand where in the stage of decision-making they are to help connect them with the appropriate provider in the Women's Services Network (WSN). This cascade of care and flowchart would be distributed to all medical providers as well as other members of the WSN.
    c. Engage survivors in discussions with providers to develop messaging about the impacts of IPV on health.
2. Conduct facilitated sensitization workshops with members of law enforcement, the legal, and healthcare systems that place participants in the shoes of a survivor. Provide them with a first-hand understanding of the difficulties women face in leaving violent relationships, or reporting physical or sexual assault. Understanding the thought processes women go through, may positively change their comprehension of what

women encounter in reporting abuse to formal support sources, or disclosing to family members. Transforming the "E Agora José" intervention to meet a broader audience may serve to prevent abuse before it takes place.

3. Kiss and colleagues (2012) suggest messaging targeting informal networks to reach this base with information about formal services and how to access them may prove beneficial in helping women to access services. Collaborate with regional schools, places of worship, community centers and employers to implement interventions that address IPV as a health and economic issue, and to reduce stigma. The Avon Foundation and Promundo have interventions that could be leveraged. Training on non-judgmental information targeting women at different stages of their relationship, and with varied levels of social support could be beneficial.

Appendices

Appendix I: In-depth Interview Guide (English Version)

Women's health and life experiences
Qualitative instrument
In-depth interview guide

Inclusion criteria:

18+ years of age
self-identifies as woman
currently residing in Santo André, São Paulo, Brazil

Introduction:

Are you now or have you ever been married or in a committed relationship?
> ***Probe:*** Tell me about how you met.

Community experiences, attitudes, beliefs about intimate partner violence:

In your community, what kind of problems do people experience in relationships?
> ***Probe:*** communication, money, parenting, values

Do people in your community talk with others about relationship problems?
> ***Probe:*** If so, with whom?

Sometimes relationship problems result in people being insulted, hit, or threatened, among other things. In your community, what happens when partners experience relationship problems?
> ***Probe-physical:*** hitting, slapping, kicking, strangling
> ***Probe-emotional/psychological:*** threats, insults, harassment, controlling behaviors, financial control
> ***Probe-sexual:*** forced sex acts, degrading sex acts

How does knowing that people in relationships have these experiences make you feel?
> ***Probe:*** indifferent, upset

Are there women in your community who have had similar experiences in their relationships?
> ***Probe:*** What is their relationship to you? There's no need to include names.
> ***Probe:*** If you don't mind, we would like you to tell us about it. You don't have to, you know.

Transition: Next, I would like to ask you some questions about your personal experiences with relationships.

Individual experiences, attitudes, beliefs about intimate partner violence:

How would you describe your current or past relationship?

Probe: How does your partner treat you?
(*Past:* How did your partner treat you?)

Have you and your partner ever experienced relationship problems?
(*Past:* Did you and your partner ever experience relationship problems?)
Probe: Communication, money, parenting, values.
Probe: Tell me more about that.

People in relationships argue and fight at times. What are arguments or fights like between you and your partner?
(*Past:* What were arguments or fights like between you and your partner?)
Probe: How have these arguments or fights changed over time?
(*Past:* How did these arguments or fights change over time?)
Probe: Do the arguments or fights ever become physical?
(*Past:* Did the arguments or fights ever become physical?)

In what ways have these arguments or fights impacted your health and well-being?
(*Past:* In what ways did these arguments or fights impact your health and well-being?)

Have you ever discussed your relationship problems and related health issues with others?
(*Past:* Did you ever discuss your relationship problems and related health issues with others?)
Probe: If so, with whom? Family, friends, community health worker, nurse, or doctor.
Probe: How did they respond?

Was there more that you would have liked them to do or say?
Probe: To address your relationship problems?
Probe: To address your health needs?

What sort of things would have helped to support you during a difficult time?
Probe: With family and friends?
Probe: With community health worker, nurse, or doctor?

Looking back on your personal experience, what advice would you give another woman who has started to experience similar relationship problems?

Transition: To continue, I would like to ask you a few questions about how health care providers can talk with women about what they experience in relationships.

Communication preferences:

How would you like a healthcare provider (e.g., community health worker, nurse, or doctor) to talk with you about relationship problems and related health issues?
Probe: one-on-one in private room, discussion in group setting, not at all

In what ways can health care providers share information with you during home or clinic visits?
Probe: direct or indirect communication in semi-private setting

Probe: ask questions about intimate relationships during appointments, provide information on services and resources during appointments, post flyers about services and resources in health posts

Transition: Next, I would like to ask you a few questions about your experiences with healthcare services in recent months.

Health service use:

Have you met with a health care provider (e.g., community health worker, nurse, or doctor) in the last three months?

Probe: If so, what for?

What were the positive aspects of that experience?

Probe: communication, knowledge and support, therapy or treatment

What did the health care provider do that encouraged you to talk openly about your life and health issues?

Probe: made eye contact, showed respect, acknowledged concerns and worries

What did the health care provider do to help you address your health issues?

Probe: provided advice, taught skills, provided therapy or treatment, referred to specialist

Transition: Now, I would like to ask you some questions about laws that may impact women in Brazil.

Laws and public policies:

In your opinion, what is violence against women?

Can you think of a time when violence against women is justified?

Are there laws in your country that address violence against women? What are they called?

Probe: Maria da Penha law(2006), anti-femicide law (2015)

How did you become aware of these laws?

Probe: family, friends, work, newspaper, television, radio

What do you think these laws do?

Probe: increase awareness, reduce violence, penalize perpetrators, provide legal and social resources for women

Probe: effectiveness

In what ways have these laws impacted you or people you know?

What else is needed to address violence against women?

Transition: Lastly, I would like to bring this interview to a close by asking some final questions about your interview experience and information discussed today.

<u>Wrap-up:</u>

Is there anything else you'd like to share based on what we've already discussed?

I have asked about many difficult things. How has talking about these things made you feel?
  Probe: relaxed, relieved, nervous, uncomfortable

Would you like more information about anything we've discussed today?
  Probe: If so, what?
  Probe: IPV resource guide

Closing 1
(Note: Use if participant revealed individual and/or community experiences of violence.)

Thank you for sharing your time and experiences with me today. From what you have told me, I can tell that you have had difficult experiences in your life. No one has the right to treat someone else this way. However, from what you have told me, I can also tell that you are strong and have survived through some difficult circumstances. If you would like to talk with someone about anything we've discussed today, please see me or contact <<insert name of local contact>>. I would also like to assure you once more that all of your responses will be kept strictly confidential.

Closing 2
(Note: Use if participant only revealed community experiences of violence.)

Thank you for sharing your time and experiences with me today. From what you have told me, I can tell that you have witnessed difficult experiences in your life. No one has the right to treat someone else this way. If you would like to talk with someone about anything we've discussed today, please see me or contact <<insert name of local contact>>. I would also like to assure you once more that all of your responses will be kept strictly confidential.

Closing 3
(Note: Use if participant did not reveal individual or community experiences of violence.)

Thank you for sharing your time and experiences with me today. If you would like to talk with someone about anything we've discussed today, please see me or contact <<insert name of local contact>>. I would also like to assure you once more that all of your responses will be kept strictly confidential.

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Note: Wrap-up questions and closing adapted from above source.

Appendix II: In-depth Interview Guide (Portuguese Version)

Experiências de vida e saúde das mulheres

Instrumento qualitativo

Guia de entrevista em profundidade

Critério de inclusão:

18+ anos de idade
Se auto identifica como mulher
Atualmente residindo em Santo André, São Paulo, Brasil

Introdução:

Você é ou você já foi casada ou esteve em um relacionamento sério?
Sonda: Conte-me sobre como se conheceram.

Experiências comunitárias, atitudes, crenças sobre a violência por parceiro íntimo:

Em sua comunidade, que tipo de problemas as pessoas experienciam em relacionamentos?
Sonda: comunicação, dinheiro, pais, valores

As pessoas em sua comunidade falam com os outros sobre problemas nos relacionamentos?
Sonda: Se assim for, com quem?

Às vezes, problemas em relacionamentos resultam em pessoas sendo insultadas, agredidas, ou ameaçadas, entre outras coisas. Em sua comunidade, o que acontece quando os parceiros experimentam problemas de relacionamento?

Sonda-física: agressão, tapa, chute, estrangulamento
Sonda-emocional / psicológica: ameaças, insultos, assédio, comportamentos controladores, controle financeiro
Sonda sexual: atos sexuais forçados, atos sexuais degradantes

Como conhecer as pessoas em relacionamentos que têm essas experiências faz você se sentir?
Sonda: indiferente, chateada

Há mulheres em sua comunidade que tiveram experiências semelhantes em seus relacionamentos?
Sonda: Qual é a sua relação com elas? Não há necessidade de incluir nomes.

Sonda: Se você não se importa, gostaríamos que você nos falasse sobre isso. Você não tem que, só caso você queira.

Transição: Em seguida, eu gostaria de lhe fazer algumas perguntas sobre suas experiências pessoais com relacionamentos.

Experiências individuais, atitudes, crenças sobre a violência por parceiro íntimo:

Como você descreveria seu relacionamento atual ou passado?
Sonda: Como é que o seu parceiro lhe trata?
(Ex: Como é que o seu parceiro lhe tratava?)

Você e seu parceiro já experimentaram problemas de relacionamento?

(Passado: E no passado?
Sonda: Comunicação, dinheiro, pais, valores.
Sonda: Conte-me mais sobre isso.

Pessoas em relacionamentos às vezes discutem e brigam. Quais são argumentos ou discussões entre você e seu parceiro?
(Passado: Quais foram os argumentos ou discussões entre você e seu parceiro?)

Sonda: Como essas discussões ou brigas mudam ao longo do tempo?
(Ex: Como essas discussões ou brigas mudaram ao longo do tempo?)

Sonda: As discussões ou brigas já se tornaram físicas?
(Passado: As discussões ou brigas alguma vez se tornaram físicas?)

De qual forma essas discussões ou brigas impactam a sua saúde e bem-estar?
(Passado: De que forma estas discussões ou brigas impactaram a sua saúde e bem-estar?)

Você já discutiu seus problemas de relacionamento e problemas de saúde relacionados com os outros?
(Passado: E no passado?)
Sonda: Se assim for, com quem? Família, amigos, agente comunitário de saúde, enfermeiro ou médico.
Sonda: Como eles reagiram? Houve outras vezes que você teria gostado de dizer?
Sonda: Para lidar com seus problemas de relacionamento?
Sonda: Para atender às suas necessidades de saúde?

Que tipo de coisas teria ajudado a apoiá-la durante um tempo difícil?
Sonda: Com a família e os amigos?
Sonda: Com agente comunitário de saúde, enfermeiro ou médico?

Olhando para suas experiências pessoais, que conselho você daria uma outra mulher que começou a ter problemas de relacionamento semelhantes?

Transição: Para continuar, eu gostaria de lhe fazer algumas perguntas sobre como prestadores de cuidados de saúde podem conversar com as mulheres sobre o que elas experimentam nos relacionamentos.

Preferências de comunicação:

Como você gostaria que um prestador de cuidados de saúde (por exemplo, agente comunitário de saúde, enfermeiro ou médico) falasse com você sobre problemas de relacionamento e problemas de saúde relacionados?
Sonda: pessoalmente em quarto privado, discussão em ambientes de grupo, nenhuma forma.

De que forma os prestadores de cuidados de saúde podem compartilhar informações com vocês durante visitas à casa ou clínica?
Sonda: comunicação direta ou indireta no ambiente semi-privado
Sonda: fazer perguntas sobre relações íntimas durante as consultas, fornecer informações sobre os serviços e recursos durante as consultas, folhetos sobre os serviços e recursos em postos de saúde

Transição: Em seguida, eu gostaria de lhe fazer algumas perguntas sobre as suas experiências com os serviços de saúde nos últimos meses.

Utilização de serviços de saúde:

Você se encontrou com um prestador de cuidados de saúde (por exemplo, agente comunitário de saúde, enfermeiro ou médico) nos últimos três meses?
Sonda: Se sim, para quê?

Quais foram os aspectos positivos dessa experiência?
Sonda: comunicação, conhecimento e apoio, terapia ou tratamento

O que o médico fez que lhe encorajou a falar abertamente sobre seus problemas de vida e saúde?
Sonda: fez contato visual, mostrou respeito, reconheceu as preocupações.

O que o prestador de cuidados de saúde fez para ajudá-la a resolver os seus problemas de saúde?
Sonda: prestou assessoria, ensinou habilidades, desde terapia ou tratamento, designou especialista.

Transição: Agora, eu gostaria de lhe fazer algumas perguntas sobre as leis que podem afetar as mulheres no Brasil.

Leis e políticas públicas:

Em sua opinião, o que é violência contra a mulher?

Você pode pensar em um momento em que a violência contra a mulher é justificada?

Existem leis em seu país que lidam com a violência contra as mulheres? Como elas se chamam?
Sonda: Maria da Penha law(2006), a lei anti-femicídio (2015)

Como você se tornou ciente dessas leis?
Sonda: família, amigos, trabalho, jornal, televisão, rádio

O que você acha que essas leis fazem?

Sonda: sensibilizam, reduzem a violência, penalizam os acusados, providenciam recursos legais e sociais para as mulheres
Sonda: eficácia

De que forma essas leis tem impactado você ou pessoas que você conhece?

O que mais é necessário para combater a violência contra as mulheres?

Transição: Por último, gostaria de trazer esta entrevista ao fim fazendo algumas perguntas finais sobre a sua experiência de entrevista e informações discutidas hoje**.**

Finalização:

Existe alguma coisa que você gostaria de compartilhar com base no que já discutimos?

Perguntei sobre muitas coisas difíceis. Como o fato de falar sobre estas coisas fez você se sentir?
Sonda: relaxada, aliviada, nervosa, desconfortável

Gostaria de obter mais informações sobre qualquer coisa que discutimos hoje?
Sonda: Se sim, quais?
Sonda: guia de recursos IPV____

Fechamento 1

(Nota: Utilize se o participante revelou experiências individuais e / ou da comunidade de violência.)

Obrigado por compartilhar seu tempo e experiências comigo hoje. Pelo que você me contou, eu posso dizer que você já teve experiências difíceis em sua vida. Ninguém tem o direito de tratar alguém assim. No entanto, a partir do que você me disse, posso também dizer que você é forte por ter sobrevivido algumas circunstâncias difíceis. Se você gostaria de falar com alguém sobre qualquer coisa que discutimos hoje, por favor me contate ou venha me ver << inserir nome do contato local >>. Eu também gostaria de assegurar-lhe mais uma vez que todas as suas respostas serão mantidas em sigilo.

Fechamento 2

(Nota: Utilize se o participante só revelou experiências comunitárias de violência).

Obrigado por compartilhar seu tempo e experiências comigo hoje. Pelo que você me contou, eu posso dizer que você tem testemunhado experiências difíceis em sua vida. Ninguém tem o direito de tratar alguém assim. Se você gostaria de falar com alguém sobre qualquer coisa que discutimos hoje, por favor me contate ou venha me ver << inserir nome do contato local >>. Eu também gostaria de assegurar-lhe mais uma vez que todas as suas respostas serão mantidas em sigilo.

Fechamento 3

(Nota: Utilize se o participante não revelou experiências individuais ou comunitários de violência.)

Obrigado por compartilhar seu tempo e experiências comigo hoje. Se você gostaria de falar com alguém sobre qualquer coisa que discutimos hoje, por favor me contate ou venha me ver << inserir nome do contato local >>. Eu também gostaria de assegurar-lhe mais uma vez que todas as suas respostas serão mantidas em sigilo.

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Note: Wrap-up questions and closing adapted from above source.

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