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Intimate partner violence from a public health perspective: conceptual framework

Lucía Artazcoz[1 2 3 4], Amaia Garrido[1], Olga Juárez[1], Isabel Otero[1], Maribel Pasarín[1 2 3 4] Katherine Pérez[1 2 3 4], Glòria Pérez[1 2 3 4] and María Salvador[1].

The aim of this chapter is to offer a conceptual framework for understanding intimate partner violence (IPV) and its impact on health based on a structural context that determines gender norms and hierarchies, as well as the intersection between various types of inequalities. Preventing IPV demands intersectoral work, where having a conceptual framework shared by all the sectors involved is the first step to having a clear picture of the mechanisms through which primary prevention interventions can be successful.

Introduction

Gender violence is a structural problem which is deeply rooted in the patriarchal model that determines unequal relationships between men and women. This violence is perpetuated by social and cultural expectations concerning gender roles. Using data from 2012, it is calculated that around 8% of the women in EU-28 countries have suffered physical or sexual violence in the last year; one out of three (32%) has experienced psychological violence from an intimate partner during their lives; around 5% have suffered economic violence in their current relationship, and around 13% have suffered some form of economic violence in previous relationships (European Union Agency for Fundamental Rights - FRA, 2014).

The aim of this chapter is to offer a conceptual framework for understanding intimate partner violence (IPV), one form of gender violence, and its impact on health, based on a structural context that determines gender norms and hierarchies. In order to do this, a narrative review of scientific bibliography in the last 20 years has been carried out. The framework focuses on IPV, as the determining social factors for the various forms of gender violence are different (Organización Mundial de la Salud y Escuela de Higiene y Medicina Tropical de Londres, 2011).

There are several reasons for focusing on IPV. Firstly, it is the most researched form of gender violence, which facilitates an understanding of the problem. From the perspective of preventing gender violence, preventing IPV is the strategic starting point for preventing violence in a more extensive way, because the family, where most violent acts occur, is also one of the environments

[1] Agència de Salut Pública de Barcelona, Barcelona
[2] CIBER de Epidemiología y Salud Pública (CIBERESP), España
[3] Universitat Pompeu Fabra, Barcelona
[4] Institut de Recerca Biomèdica Sant Pau (IIB Sant Pau), Barcelona

where the habits and behaviour of successive generations are formed. Furthermore, IPV shares a series of determining social factors with other types of gender violence, especially in terms of norms and institutional responses. And lastly, IPV is the most common form of gender violence. In terms of populations, its frequency surpasses that of all other forms of violence in women's lives. Therefore, focusing on IPV creates an essential, solid foundation for preventing other forms of gender violence (Heise, 2012).

Definition of IPV

IPV is defined as physical, psychological, sexual or economic violence exercised against a woman and perpetrated by a man who is or has been her spouse or by a person who has or has had a similar affective relationship with her ("Llei 5/2008 del dret de les dones a erradicar la violència masclista" 2008). In EU-28 countries, the most common forms of physical violence are pushing, slapping and grabbing or pulling a woman's hair; the most common forms of psychological violence are those where the spouse belittles or humiliates a woman in private and insists on knowing where she is, as a means of control (European Union Agency for Fundamental Rights - FRA, 2014).

Conceptual frameworks in public health

Until now, little attention has been paid to the primary prevention of IPV, because most of the resources are allocated to secondary prevention (early detection) or tertiary prevention (once the aggression has occurred) (ONU mujeres, 2015). This chapter adopts a public-health perspective and therefore focuses on primary IPV prevention, i.e. trying to avoid it happening.

The basic element of a gender-violence prevention strategy in public health is to identify the underlying social mechanisms, instead of focusing on more visible symptoms. This makes it possible to produce and try out effective approaches that respond to the original causes and thereby improve people's health (Organización Mundial de la Salud y Escuela de Higiene y Medicina Tropical de Londres, 2011). Therefore, the first step in implementing IPV prevention policies and programmes is the formulation of a conceptual framework that is shared by all the sectors involved, in order to have a clear, shared vision of the mechanisms through which primary prevention interventions may be successful (Organización Mundial de la Salud y Escuela de Higiene y Medicina Tropical de Londres, 2011). These frameworks, through graphic representations, are crucial for theorising, describing and explaining the distribution of the population's health inequalities. They can therefore be extraordinarily useful in tackling primary IPV prevention (Krieger, 2008).

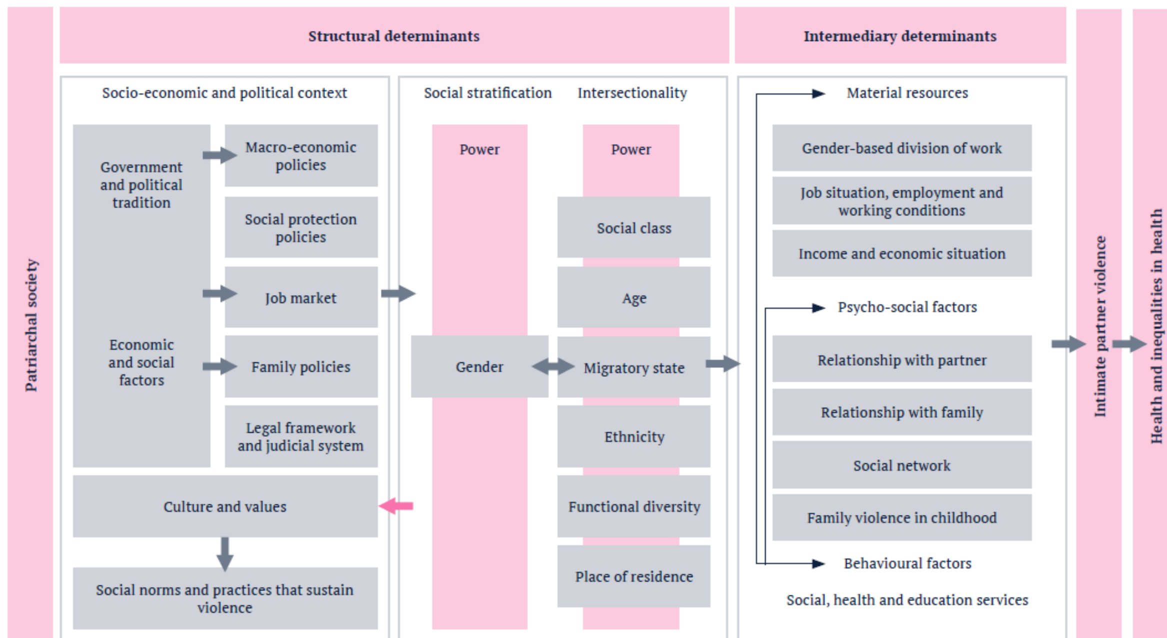
Research on IPV is dominated by studies carried out in the USA and other high-income areas that have placed emphasis on individual factors, such as personality and relationships, development, childhood trauma and adversities, along with anti-social behaviour (Capaldi & Kim, 2007). However, feminism defends the position that it is necessary to place emphasis on the structural factors of IPV, i.e. the gender norms and hierarchies created by patriarchal society which determine the relationships between men and women and structure gender inequalities in terms of access to power and resources. These factors, along with other more proximal aspects, determine the probability of a woman suffering violence, as well as the general level of IPV in a given environment. Therefore, feminist theory recognises the role of individual factors throughout life, but emphasises the importance of community and macro-level factors, as being essential for explaining IPV (Heise, 2012).

1. Social determinants of IPV model

The social determinants of health are the circumstances in which people are born, grow up, live, work and grow old. These circumstances are the result of the distribution of money, power and resources on a global, national and local level, which ultimately depend on the policies that are adopted. Social determinants explain most of the inequalities found in health, i.e. the systematic differences in the state of health found among the various socio-economic groups (Whitehead, 1992). Diagram 1 shows the IPV conceptual framework proposed in this chapter, based on the

model of social inequalities in health (Ministerio de Sanidad Servicios Sociales e Igualdad. Comisión para reducir las desigualdades sociales en salud en España, 2015) and adapted to tackling IPV. There are several differences between the two models, one of which is that the model proposed in this chapter includes the social determinants of IPV within a framework of inequalities, where the starting point is patriarchal society.

Diagram 1. Social determinants of intimate partner violence (IPV) model.



Source: Own model, based on the social inequalities in health model (Ministerio de Sanidad, Consumo y Bienestar social de España. Comisión para Reducir las Desigualdades Sociales en Salud en España, 2015).

1.1. Patriarchal society

The concept of *patriarchy* refers to a form of social, political, economic and religious organisation that is based on the authority of men and male domination over women. Among other things, it involves gender-inequality structures in public and private spheres of life, and in rights and resources, sustained by trajectories driven by the market, the state and the legal framework (Walby, 2004). It also refers to the constant social construction of what is considered to be “feminine” and “masculine”, which is based on power and socio-cultural norms concerning women and men (West & Zimmerman, 1987).

The patriarchy determines gender norms that give shape to society's ideas about which social spheres should be the main areas for women and men, as well as the value that society places on these social spheres, which are ultimately the basis for IPV (Reed, Raj, Miller, & Silverman, 2010). Men are socialised in such a way as to make them believe they are superior to women and must dominate their female partners (Taft, Bryant-Davis, Woodward, Tillman, & Torres, 2009). The subordination and submission of women is considered to be normal, expected, accepted and, in some cases, attractive to men (Russo & Pirlott, 2006).

It has been reported that physical and sexual violence in couples is more frequent in countries where there are norms which justify the mistreatment of women, and this is associated with the degree to which laws and practice are biased against women, compared to men, in terms of access to land, possessions and other productive resources (Heise & Kotsadam, 2015). Along these lines, the risk of women dying because of IPV in Spain is higher for those living in provinces with a lower gender development index (Vives-Cases, Alvarez-Dardet, Carrasco-Portiño, & Torrubiano-Domínguez, 2007). These results suggest that reducing the problem requires strategies which promote gender equality.

1.2. Structural determinants

1.2.1. Socio-economic and political context

This context includes all the social and political mechanisms that generate, shape and maintain social hierarchies: macro-economic policies; social protection policies; the job market and the family; the legal framework and the legal system. These structural factors define an individual's socio-economic position within the hierarchies of power, prestige, access to resources and discrimination.

• Macro-economic policies. Macro-economic policies, whose main aim is sustainable economic growth, the stability of prices and full employment, play a fundamental role in the general public's well-being, as well as the degree of inequality, according to the various types of inequality, including gender. Until now, the distribution of income and wealth has been largely ignored by macro-economics but the overall economic growth of countries and fairness do not necessarily go hand in hand (Aghion & Williamson, 1998).

• Social protection policies. Social protection policies are "all the public and private initiatives that provide the transfer of income or consumption to people in a situation of poverty, protect vulnerable groups from a lack of resources for subsistence and improve the social status and rights of marginalised people, with the aim of reducing economic and social vulnerability in disadvantaged groups" (Devereux & Sabates-Wheeler, 2007). Given that the roots of IPV are gender inequalities in terms of power and that one of the consequences may be an increase in the vulnerability of women, these policies have an essential role to play.

• Job market and family. The division of housework by gender and the organisation of job-market participation are subject to the influence of institutions, which means that the composition of gender is a key factor in determining gender inequalities. In particular, our society's traditional family model, which allocates men the role of main breadwinners in the home and makes women responsible for housework and care, is one of the reasons why women have less power than men.

• Legal framework and judicial system. Governments can legitimise power inequalities within families and society and perpetuate IPV by means of enacting discriminatory laws and policies or through discriminatory application of the law. It can also promote or not promote a tolerance of IPV in a non-official environment (i.e. in the family or the community).

There is currently a legal framework that makes it possible to tackle gender violence in various areas. The Council of Europe's Istanbul Convention, ratified by Spain in 2014 (Consell de la Unió Europea, 2011), and the EU Directive concerning victims (Unió Europea, 2012), establish regulations for responding to gender-violence victims. In Catalonia, Framework Act 1/2004, of 28 December, on comprehensive protective measures against gender violence, represents progress in terms of tackling gender violence, which has led to a major increase in measures (care protocols, awareness-raising, training and data registration). Subsequently, Act 5/2008, of 24 April, on the right of women to eradicate gender violence, lists the most common forms of violence (physical, psychological, sexual and economic) in the areas in which they occur (workplace, intimate partners, family and social or community environments). In 2017, the National Agreement against Gender Violence was approved, and subsequently ratified by all parliamentary groups, autonomous regions and the Spanish Federation of Municipalities and Provinces.

In Barcelona, in 2001, the Barcelona Circuit Against Violence Towards Women (CVM-BCN) was created. It is currently known as the Barcelona Circuit Against Gender Violence, jointly led by Barcelona City Council and the Barcelona Health Consortium. The Citizen Agreement for a Barcelona Free of Violence Against Women was approved on 21 November 2002, as a result of recommendations made at the 1st Barcelona Women's Congress, which was held in 1999 on the initiative of the Barcelona Women's Council. The citizen agreement is part of a commitment to implement the 2016-2020 Gender Justice Plan, the government measure for improving the system

for a comprehensive approach to gender violence and the 2017-2022 Strategic Plan for Preventing Sexism in the City.

In spite of the legal context, the judicial treatment of gender violence, influenced by anthropocentric practices and gender stereotypes, produces results that could be interpreted as institutional violence: a low conviction rate, discriminatory stereotypes in the conceptualisation of gender violence and revictimising attention to women (Bodelón González, 2015). Women's lack of confidence in the judicial system may partly explain why only 14% of women in Europe report the most serious violent incident perpetrated by their partners that they have experienced to the police, only 13% report the most serious incident committed by a man other than their partner (European Union Agency for Fundamental Rights - FRA, 2014) and that many of them stay with their partners in spite of suffering mistreatment (Barnett, 2000). In some cases, the actions of the judicial system can create a sensation of impunity among abusive men.

• Culture and values. In terms of structural factors, it is also important to include the habitual use and tolerance of violence in the resolution of conflicts. This factor appears in hierarchical gender roles, the notions concerning the right of men in sexual matters, the low social standing of women and their lack of social power, as well as the ideas of masculinity associated with dominating women (Jewkes, 2002). These attitudes can be transmitted from generation to generation through the family, the media and schools, as well as the experience of being a witness to, or victim of, violence during people's lifetimes.

1.2.2. Social stratification and intersectionality

Social stratification refers to a system with fairly predictable rules underlying the classification of people and groups, which involve the legitimisation of an unequal distribution of assets, services and prestige (Walby, S., Amrstrong, J., & Strid, S., 2012). The concept of *intersectionality* refers to the interaction between various types of inequality (Walby, S. et al., 2012). This conceptual framework considers the intersectionality between genders – as a fundamental type of IPV inequality – social class, age, migratory state, ethnicity and place of residence. It is essential to recognise the increased impact of the various types of inequality that occurs within the contexts of women's lives in communities, the workplace, schools and families (Sokoloff & Dupont, 2005). In accordance with these types of inequality, we will now analyse the current state of knowledge concerning social inequalities involved in IPV.

• Gender. Gender inequalities and male dominance limit women's opportunities for taking part in all levels of decision-making, reduce the resources available to them and are associated with accepting the use of violence against them. This situation contributes to gender inequalities in terms of job and promotion opportunities, income levels, health, access to healthcare, participation and representation in politics and education.

• Social class. As a consequence of the existence of social classes, social stratification involves another intersection of power and oppression systems, which affects the risk of women suffering IPV. IPV is more common and more serious among women in the most disadvantaged situations (Breiding, Black, & Ryan, 2008; Heise & García-Moreno, 2002). There are various mechanisms through which poverty and economic privation increase the risk of suffering IPV: it could just be because of low incomes or due to other factors that accompany poverty, such as overcrowding or desperation. It is possible that living in a situation of poverty may create stress, frustration and a feeling of maladjustment in men, because they have not been able to fulfil the function that is culturally and socially expected of them as the breadwinners of the household. Poverty or major economic difficulties can also give rise to conflicts within couples or make it more difficult for women to leave relationships that are violent or unsatisfactory in some way. Whatever the precise mechanisms may be, it is probable that poverty or the lack of economic resources act as markers for a variety of social determinants which combine with each other and increase the risks faced by women.

Research on the relationship between educational levels – a factor related to social class – and IPV show contradictory results (Vyas & Watts, 2009). However, in rich countries – including Spain (Meil Landwerlin, 2014)– most studies find that the risk of suffering IPV is higher among women with lower levels of education. Analogously, it has been reported that men with a low level of education commit acts of violence against their partners more often than those with a higher level of education (Ackerson, Kawachi, Barbeau, & Subramanian, 2008). Education empowers women, through their social networks, their self-confidence and their ability to use information and resources available in society, as well as providing them with higher income levels (Jewkes, 2002).

In addition to individual education levels, it is important to consider the difference in education level between the two members of the couple. Some studies observe greater risk of women suffering IPV when their partner has a lower educational level, which could be explained by a subsequent transgression in the gender division of power within the couple (Abramsky et al., 2011). However, in Spain, the fact that women have a similar or higher level of education than their partner is associated with a lower risk of suffering IPV (Meil Landwerlin, 2014).

• Age. Youth is a risk factor for committing an act of IPV or being a victim of it (Vest, 2002; World Health Organization., 2014). In Catalonia, IPV is also more common among younger women (*Enquesta de violència masclista a Catalunya*, 2016).

• Migratory state. Various studies have reported the incidence of violence towards immigrant women is higher than that of women who are native to a particular country. This can be explained by several mechanisms. Immigrant women live between two cultures, which are often conflictive, and within a context where they may be isolated and discriminated against; furthermore, some are living in the country illegally, which imposes restrictions on them. In some cases, recently arrived immigrant women do not have the necessary linguistic knowledge and training which would enable them to find work. As a result, they find themselves in a situation where economic survival can be the most urgent problem for them and their families, so that they stay with their partners even when they are mistreated (Barnett, 2000; Kim & Gray, 2008). Some aggressors may increase the insecurity of immigrant women by questioning their ability to function in the host country without their spouses, degrading the women based on their limitations in the new language, level of education or employment skills. Furthermore, mistreated women immigrants are often cut off from their families and friends because of their migratory experience (Raj & Silverman, 2002).

In Spain, intimate partner violence in general, physical, psychological control and sexual, is more frequent among foreign women and those with dual nationality (Meil Landwerlin, 2014). In Catalonia, IPV is almost twice as common in the case of foreign women (*Enquesta de violència masclista a Catalunya*, 2016).

• Ethnicity. Ethnicity describes a social group whose members share a sense of common origins, claim a common and distinctive history and future, have one or more dimensions of collective individuality and have a sense of unique collective individuality (Paradies et al., 2009). Although underlying patriarchal values may be widely shared, the women of various ethnic groups can differ in the type of violence they suffer and in their responses to that violence (Kasturirangan, Krishnan, & Riger, 2004).

• Functional diversity. There have been very few studies concerning violence towards women with functional diversity and still fewer on women with functional diversity who suffer IPV (Brownridge, 2006). A risk marker that is often cited for IPV against women with functional diversity is their situation of dependence. Women with functional diversity are more likely to have a low socio-economic level. As with men, the overall education level of women with functional diversity is lower (Shandra & Hogan, 2009), and functional diversity and a low educational level are barriers to employment, which in turn, is associated with more unemployment, as well as worse employment and working conditions (Barnes & Mercer, 2005). This means that they are more likely to be living in poverty, In so far as women with functional diversity find themselves in a situation of

dependence, the differences in power are associated with a greater risk of being victims of IPV (Petersilia, 2001).

In Spain, the frequency of IPV among women with functional diversity is much higher than for women who have no problems in carrying out their daily activities, and that is true for any indicator used to measure gender violence (Meil Landwerlin, 2014). In Catalonia, IPV is also higher among women with functional diversity (*Enquesta de violència masclista a Catalunya*, 2016).

• Place of residence. The place where we live (municipality, neighbourhood, etc.) also acts as a determining factor for health and well-being. For example, it has been reported that communities can perpetuate an existing family structure and the power inequalities within the family and society. It can justify the behaviour of men who are violent in order to establish control over the women in the family, and give support to traditional practices, such as mistreatment and corporal punishment. The neighbourhood's socio-economic disadvantage, along with the residential instability of neighbours, the instability of male employment and the perception of economic difficulties, have all been identified as factors that are associated with a greater probability of suffering IPV (Benson, Fox, DeMaris, & Van Wyk, 2003).

1.3. Intermediary determinants

1.3.1. Material resources

• Gender-based division of work. By various means, the gender-based division of work, which has to some extent marked women in all societies, determines inequalities between men and women in terms of power and access to economic and other types of resources. The gender-based division of work dictates that men should have a central role in work and public spheres, while women should play a leading role in family life. This inflexible division of social life means that while the public sphere and paid employment provide economic independence and full recognition as a citizen, the domestic and family sphere does not provide an income nor social recognition. Although IPV is less prevalent in countries with a high proportion of women in the formal job market, paid employment may increase the risk of women suffering this violence in countries where very few women are involved in the job market (Heise & Kotsadam, 2015).

• Job situation, employment and work conditions. It has been reported that unemployment among men is associated with a greater risk of IPV. In Spain, the probabilities of suffering IPV increases when both members of a couple are inactive (Meil Landwerlin, 2014). In this situation, violence against women can arise from the social expectations of traditional masculinity, which become unattainable due to factors such as the poverty experienced by men (Peralta & Tuttle, 2013).

In the job market, women are concentrated in feminised jobs, such as healthcare, teaching and cleaning (horizontal segregation), while they also remain in lower categories than men who have the same level of training (vertical segregation). The feminised sectors offer lower salaries, have worse working conditions and have more psycho-social risks than masculinised sectors (Brindusa, Anghel, Conde-Ruez, & Marra de Artiñano, 2018). Unemployment is also more common among women. Gender-based discrimination in the job market contributes to gender inequality in power, something which is also associated with IPV.

• Income and economic situation. Difficulties in combining working and family lives in a context where men have little involvement in reproductive work, and a lack of care services for dependent people, mean that many women work full-time as housewives or have part-time jobs. This accentuates gender inequalities in terms of power in the home (Artazcoz, Borrell, Cortès, Escribà-Agüir, & Cascant, 2007). The lack of public services dedicated to the care of dependent people is also an obstacle to abandoning an abusive partner (Barnett, 2000).

In Spain, if women's income from work or their pensions (retirement or disability) are the same or greater than that of their spouses, the risk of suffering IPV is lower. Overall, in our environment, the

more power-based resources that women have, the less risk they have of being a gender-violence victim (Meil Landwerlin, 2014).

1.3.2. Psycho-social factors

• Relationship with partner. IPV is more common in couples where there is a low level of satisfaction, continual disagreements or conflicts (Morrison, Ellsberg, & Bott, 2007). The types of conflict that are especially likely to be associated with IPV are often due to the woman's transgression of traditional gender roles or challenges to male privilege, as well as economic matters (Jewkes, 2002). IPV becomes a way of managing a conflict or resolving a disagreement (Organización Mundial de la Salud y Escuela de Higiene y Medicina Tropical de Londres, 2011).

• Relationship with family. The family is a key factor in tackling IPV. It prepares its members for social life, forms gender stereotypes and perceptions of the gender-based division of work and it is the scenario where physical or psychological mistreatment often occurs. The family’s social support for a mistreated woman can indicate that she is valued, and it can increase her self-esteem and be a source of practical information during or after IPV episodes (Jewkes, 2002).

• Social network. Social contacts are important for women who suffer IPV. In relationships where women suffer IPV, their networks are often smaller, as their abusive partners often restrict their movements and contact with other people, making them more isolated (Katerndahl, Burge, Ferrer, Becho, & Wood, 2013). This isolation may be heightened by the effects of mistreatment on women's mental health, causing them to close themselves off (Heise, Ellsberg, & Gottemoeller, 1999). It has also been stated that social support provides protection from the negative effects that IPV has on mental health (Coker et al., 2002). In Spain, having good social support is clearly associated with a lower risk of suffering IPV (Meil Landwerlin, 2014).

• Family violence in childhood. Exposure to violence in childhood increases the likelihood of committing acts of IPV in men (Diana Gil-González, Vives-Cases, Ruiz, Carrasco-Portiño, & Álvarez-Dardet, 2008) and the risk of suffering IPV among women (Martin, Taft, & Resick, 2007). This exposure to violence during childhood may increase the probability of accepting violence in future relationships, either as a victim or as an aggressor(Organización Mundial de la Salud y Escuela de Higiene y Medicina Tropical de Londres, 2011).

1.3.3. Behavioural factors

• Alcohol consumption. Various studies have reported the relationship between the abusive consumption of alcohol and IPV. However, these results must be interpreted with care, as the evidence for a causal association between the harmful consumption of alcohol and violence is weak. The role that alcohol plays in women being IPV victims is not clear (European Union Agency for Fundamental Rights - FRA, 2014; D Gil-González, Vives-Cases, Alvarez-Dardet, & Latour-Pérez, 2006). It is possible that the fact that violence occurs is not associated with any direct effect of alcohol, but rather that alcohol's role in IPV may be explained by its disinhibiting effects (Caetano, Shafer, & Cunradi, 2001).

• Consumption of illegal drugs. There is evidence of a link between the consumption of illegal drugs and IPV (Chermack et al., 2008; Moore et al., 2008). However, as with alcohol, the causal relationship is not clear. The complex association between substance addiction and IPV victimisation is further complicated by differences according to the substance of choice, the scale of consumption and the additional risks associated with the use of multiple substances (McKee & Hilton, 2017).

There are various mechanisms that may explain these associations. In some cases, the consumption of addictive substances is preceded by an experience of violence or a traumatic event, where drugs become a strategy for dealing with it (trauma theory). Alternatively, consumption may provide a false sense of improvement in relationships that are established and

maintained, which may act as a risk factor for suffering IPV, in the context of unequal personal relationships (relational theory) (Covington, 2002).

The relationship between the consumption of illegal drugs and IPV is also structural. In relation to IPV, the importance of the living environment for women who are addictive-drug consumers has been noted. Women who live in an unfavourable social environment, closely linked to, and strongly shaped by, their neighbours, are surrounded by economic, emotional and psychological aspects that have a strong influence on their way of life (James, Johnson, & Raghavan, 2004). Therefore, a poor neighbourhood may become a complex system where the roots of substance abuse and drug-related violence are connected. In this risk scenario, women are constantly exposed to drugs, which increases the probabilities that their partners will initiate them in drug taking and, in consequence, increase the risk of them being attacked in a domestic setting. Due to limited resources and social support, women are socially isolated and often trapped in situations that put their lives in danger (Simonelli, Pasquali, & De Palo, 2014).

Women who consume drugs are also more stigmatised than men in the same situation, given that society sees them as transgressing the roles that they have been assigned in social terms, especially those of mother and carer. This can lead to more social tolerance of the violence that they may suffer, as well as being blamed for their situation because they have broken the rules of appropriate behaviour attributed to them (Simonelli et al., 2014). This double stigma (caused by being a consumer and a woman) together with criminalisation or the fear of losing the custody of their children, makes access to social and health services more difficult for women, and this may therefore increase their vulnerability in terms of a possible IPV situation. In addition, these services are often discriminatory, due to their anthropocentric focus, and these women may perceive them as being hostile or relatively inaccessible.

1.3.4. Services

It has often been stated that social, health and education services do not provide an adequate response for women who are IPV victims (Barnett, 2001).

• Social services. Although social-services interventions that address IPV-related emergency needs provide critical help for some women and their children, the needs relating to basic aspects of family survival, such as housing and care for children, are bigger priorities for many mistreated women on low incomes. Many choose to stay with the potentially dangerous men in their lives in order to satisfy these basic needs, not because they accept the mistreatment or trivialise it, but because, from their perspective, the frequency or seriousness of the mistreatment is not as important as the necessary resources or economic security that these relationships provide for them (Barnett, 2000). The universalistic focus on IPV often ignores the particular needs and circumstances of women on low incomes who are more vulnerable to mistreatment. This is something that needs to be addressed.

• Healthcare services. At some point in their lives, all women come into contact with healthcare services. Above all, those who have suffered mistreatment visit primary healthcare, mental health, orthopaedic and emergency services more often (Coll-Vinent et al., 2008; Ruiz-Pérez et al., 2006). It has been reported that IPV is under-detected in primary healthcare (Sala Musach, Hernández Alonso, Ros Guitart, Lorenz Castañe, & Parellada Esquius, 2010). There are various reasons: (1) time limitation for care; (2) a lack of preparation and training on this subject; (3) the fact that this problem makes healthcare professionals uncomfortable; (4) the sensation of invading the intimacy of the woman concerned; (5) fear of losing control of the situation and not knowing how to intervene once the violence has been detected; (6) not knowing how to ask the questions, and (7) the idea that there are very few women who go to primary care with this problem and that healthcare services have a minor role to play regarding this problem (Wathen & MacMillan, 2003).

• Education Services. The education system is a powerful socialisation factor which, in spite of not being immune to the hierarchical system of social organisation, can contribute to transforming it by

means of critical revision (Hamberg, 2008; Torres San Miguel, 2010). It can therefore perpetuate the gender system based on traditional roles and stereotypes, maintaining the tolerance of gender violence, or it can promote a change in this model and the transgressions in it. As part of the system that sustains IPV, values and beliefs can be transmitted or transformed, in both academic content taught in classrooms and in the teaching process itself, as well as in everyday interactions (Brugeilles & Cromer, 2009; Díaz-Aguado, 2004). Furthermore, the education system can help to develop alternative interpersonal skills to that of violence, which enable people to express conflicts and resolve them in a constructive way, as well as skills that protect people against victimisation, in order to avoid risk situations or get out of them and ask for help (Pastorino Mellado, 2014). At the same time, the education system is a means for detecting and helping to deal with mistreatment situations. However, in order to do this, it is essential to provide teaching staff with the skills they need to detect these situations.

1.4. Intimate partner violence

As stated above, IPV is the most common form of gender violence. In accordance with a definition of gender violence based on behaviour, in 2011 for women aged 18 or over in Spain, the frequency of gender violence perpetrated by a current spouse or partner, whether living under the same roof or not, was 8.6%, while 1.1% if women suffered violence at the hands of an ex-spouse or ex-partner. The most common form of violence was psychological belittling, which affected 8% of the women with a current spouse or partner, followed by psychological control, which affected 3.8% of women in a relationship, although sexual violence within the couple was also relatively common, as 4.1% of women in a relationship were victims of this. Physical violence was the least extensive form of mistreatment (2.1%), especially the most harmful types involving physical injury (1%). It must be taken into account that many women suffer various types of violence. However, in accordance with a subjective definition of *gender violence*, only 1.5% of women state that they have felt mistreated by their spouse or partner, and a further 1.5% have felt mistreated by their ex-spouse or ex-partner. There could be multiple reasons for these discrepancies, but one of them may be tolerance towards gender violence (Meil Landwerlin, 2014).

1.5. Health and social inequalities in health

In 1996, the World Health Organisation (WHO) declared IPV to be a priority public health problem (Organización Panamericana de la Salud, 2003). IPV is associated with various short- and long-term health problems. The most serious consequence is death by murder or suicide. In 2018, 47 women died in Spain as a result of IPV (Ministerio de la Presidencia, Relaciones con las Cortes e Igualdad, 2019). Women who suffer IPV are in a worse state of general and mental health (Blanco, Pilar, Ruiz-Jarabo, García de Vinuesa, & Martín-García, 2004). The chronic stress caused by IPV favours the appearance of chronic illnesses and makes existing ones worse, it increases the risk of fractures and bruising, chronic pain syndrome, fibromyalgia, digestive disorders, the abuse of alcohol and other drugs, depression and anxiety, low self-esteem, post-traumatic stress, physical inactivity and alterations in sexual and reproductive health, such as sexual dysfunction, sexually transmitted diseases, undesired pregnancies and cervical disorders (Raya Ortega et al., 2004). Women may also suffer from isolation, an inability to work, loss of income, a lack of participation in regular activities and a limited capacity for looking after themselves and their children (World Health Organization., 2014). Furthermore, children who grow up in families where they are exposed to violence can suffer from emotional and behavioural disorders, as well as having an increased risk of perpetrating or experiencing violence later in life.

Conclusion

The proposed conceptual framework is based on existing evidence and may facilitate the intersectoral tackling of IPV prevention by reinforcing a shared understanding of the social mechanisms that contribute to IPV and identifying the role that various sectors and disciplines may have in preventing this violence. Furthermore, it makes it possible to guide the analysis of data, which is often carried out in a non-theoretical way, by simply analysing existing sources, as well as the needs of research. Lastly, it may guide the monitoring of determining IPV factors, the

development of policies and programmes and their evaluation. Preventing gender violence before it happens is essential for ensuring that women are really able to live their lives without violence.

Bibliography:

Abramsky, T.; Watts, C. H.; Garcia-Moreno, C.; Devries, K.; Kiss, L.; Ellsberg, M.; Jansen H. A. F. M.; Heise, L. “What factors are associated with recent intimate partner violence? Findings from the WHO multi-country study on women’s health and domestic violence”. *BMC Public Health*, https://doi.org/10.1186/1471-2458-11-109.

Ackerson, L. K.; Kawachi, I.; Barbeau, E. M.; Subramanian, S. V. “Effects of individual and proximate educational context on intimate partner violence: A population-based study of women in India”. *American Journal of Public Health*, núm. 98(3) (2008), p. 507-514. https://doi.org/10.2105/AJPH.2007.113738.

Aghion, P.; Williamson, J. G. *Growth, Inequality, and Globalization*. Cambridge: Cambridge University Press, 1998.

Artazcoz, L.; Borrell, C.; Cortès, I.; Escribà-Agüir, V.; Cascant, L. “Occupational epidemiology and work related inequalities in health: a gender perspective for two complementary approaches to work and health research”. *Journal of Epidemiology and Community Health*, núm. 61, supl. 2 (2007), p. ii39-i45. https://doi.org/10.1136/jech.2007.059774.

Ministerio de Sanidad, Servicios Sociales e Igualdad. Comisión para Reducir las Desigualdades Sociales en Salud en España. *Avanzando hacia la equidad. Propuesta de políticas e intervenciones para reducir las desigualdades sociales en salud en España*. Madrid, 2015

Barnes, C.; Mercer, G. “Disability, work, and welfare: Challenging the social exclusion of disabled people”. *Work, Employment and Society*, núm. 19(3) (2005), p. 527-545. https://doi.org/10.1177/0950017005055669.

Barnett, O. W. “Why battered women do not leave, part 1: External inhibiting factors within society”. *Trauma, Violence, & Abuse*, núm. 1 (2000), p. 343-372. https://doi.org/10.1177/1524838000001004003

Barnett, O. W. “Why battered women do not leave, part 2: External inhibiting factors - social support and internal inhibiting factors”. *Trauma, Violence, & Abuse*, núm. 2(1) (2001), p. 3-35.

Benson, M. L.; Fox, G. L.; DeMaris, A.; Van Wyk, J. “Neighborhood disadvantage, individual economic dstress and violence against women in intimate relationships”. *Journal of Quantitative Criminology*. https://doi.org/10.1023/A:1024930208331.

Blanco, P.; Ruiz-Jarabo, C.; García de Vinuesa, L.; Martín-García, M.. “La violencia de pareja y la salud de las mujeres”. *Gaceta Sanitaria*, núm. 18, supl. 1 (2004), p. 182-188. https://doi.org/10.1157/13062524.

Bodelón González, E. “Violencia institucional y violencia de género”. *Anales de La Cátedra Francisco Suárez*, núm. 48 (2015); p. 131-155.

Breiding, M. J.; Black, M. C.; Ryan, G. W. “Prevalence and risk factors of intimate partner violence in eighteen U.S. states/territories, 2005”. *American Journal of Preventive Medicine*, núm. 34(2) (2008), p. 112-118. https://doi.org/10.1016/j.amepre.2007.10.001.

Brindusa, A.; Conde-Ruez, J. I.; Marra de Artiñano, I. *Estudios sobre la economía española - 2018/06. Brechas salariales de género en España*. Madrid: FEDEA, 2018.

Brownridge, D. A. "Partner violence against women with disabilities: Prevalence, risk, and explanations". *Violence Against Women*, núm. 12(9) (2006), p. 805-822. https://doi.org/10.1177/1077801206292681.

Brugeilles, C.; Cromer, S. *Promoting Gender Equality through Textbooks. A Methodological guide* (vol. 91). París: United Nations Educational, Scientific and Cultural Organization, 2009.

Caetano, R.; Shafer, J.; Cunradi, C. B. "Alcohol-related intimate partner violence among white, black, and hispanic couples in the United States". *Alcohol Research & Health*, núm. 25(1) (2001), p. 58-65. https://doi.org/10.1177/088626002237858.

Capaldi, D. M.; Kim, H. K. "Typological approaches to violence in couples: A critique and alternative conceptual approach". *Clinical Psychology Review*, núm. 27(3) (2007), p. 253-265. https://doi.org/10.1016/j.cpr.2006.09.001.

Chermack, S. T.; Murray, R. L.; Walton, M. A.; Booth, B. A.; Wryobeck, J.; Blow, F. C. "Partner aggression among men and women in substance use disorder treatment: Correlates of psychological and physical aggression and injury". *Drug and Alcohol Dependence*, (2008). https://doi.org/10.1016/j.drugalcdep.2008.04.010.

Coker, A. L.; Smith, P. H.; Thompson, M. P.; McKeown, R. E.; Bethea, L.; Davis, K. E. "Social support protects against the negative effects of partner violence on mental health". *Journal of Women's Health & Gender-Based Medicine*, núm. 11(5) (2002), p. 465-476. https://doi.org/10.1089/15246090260137644

Coll-Vinent, B.; Echeverría, T.; Farràs, Ú.; Rodríguez, D.; Millá, J.; Santiñà, M. "El personal sanitario no percibe la violencia doméstica como un problema de salud". *Gaceta Sanitaria,*. https://doi.org/10.1157/13115103.

Consejo de la Unión Europea, 2011. *Convenio del Consejo de Europa sobre prevención y lucha contra la violencia contra las mujeres y la violencia doméstica*. Council of Europe Treaty Series, https://rm.coe.int/CoERMPublicCommonSearchServices/DisplayDCTMContent?documentId=0900001680462543.]

Covington, S. S. "Helping women recover: Creating gender-responsive treatment". A: Straussner, L.; Brown, S. (editors). *The Handbook of Addiction Treatment for Women: Theory and Practice* (p. 1-17). San Francisco: Jossey-Bass, 2002. https://doi.org/10.1016/j.chemosphere.2017.08.156.

Devereux, S.; Sabates-Wheeler, R. "Editorial introduction: Debating social protection". *IDS Bulletin*, núm. 38(3) (2007), p. 1–7. https://doi.org/10.1111/j.1759-5436.2007.tb00363.x.

Díaz-Aguado, M. J. "Prevenir la violencia de género desde la escuela". *Revista de Estudios de la Juventud*,

Generalitat de Catalunya. Departament d'Interior. *Enquesta de violència masclista a Catalunya*. Barcelona, 2016.

Gil-González, D.; Vives-Cases, C.; Alvarez-Dardet, C.; Latour-Pérez, J. "Alcohol and intimate partner violence: do we have enough information to act?" *European Journal of Public Health*, núm. 16(3) (2006), p. 278-284. https://doi.org/10.1093/eurpub/ckl016.

Gil-González, D.; Vives-Cases, C.; Ruiz, M. T.; Carrasco-Portiño, M.; Álvarez-Dardet, C.

"Childhood experiences of violence in perpetrators as a risk factor of intimate partner violence: A systematic review". *Journal of Public Health*, núm. 30(1) (2008), p. 14-22. https://doi.org/10.1093/pubmed/fdm071.

Hamberg, K. "Gender bias in medicine". *Women's Health,* (2008), https://doi.org/10.2217/17455057.4.3.237.

Heise, L. L. *Determinants of partner violence in low and middle-income countries: exploring variation in individual and populationlevel risk* (tesi doctoral). London School of Hygiene & Tropical Medicine, 2012.

Heise, L. L., Ellsberg, M.; Gottemoeller, M. "Ending violence against women". *Population Reports*, núm. 27(4), (1999), 1.

Heise, L. L.; García-Moreno, C. "Violence by intimate partners". A: Krug, E.G.; Dahlberg, L. L.; Mercy, J. A.; Zwi, A. B.; Lozano R. (editors). *World Report on Violence and Health*. Ginebra: World Health Organization, 2002.

Heise, L. L.; Kotsadam, A. "Cross-national and multilevel correlates of partner violence: An analysis of data from population-based surveys". *The Lancet Global Health*, núm. 3(6) (2015), p. e332-e340. https://doi.org/10.1016/S2214-109X(15)00013-3.

James, S. E.; Johnson, J.; Raghavan, C. "'I couldn't go anywhere': Contextualizing violence and drug abuse: A social network study". *Violence Against Women,* https://doi.org/10.1177/1077801204267377.

Jewkes, R. "Intimate partner violence: causes and prevention". *The Lancet*, núm. 359 (2002), p. 1423-1429.

Kasturirangan, A.; Krishnan, S.; Riger, S. "The impact of culture and minority status on women's experience of domestic violence". *Trauma, Violence, & Abuse*, núm. 5(4) (2004), p. 318-332. https://doi.org/10.1177/1524838004269487.

Katerndahl, D.; Burge, S.; Ferrer, R.; Becho, J.; Wood, R. "Differences in social network structure and support among women in violent relationships". *Journal of Interpersonal Violence*. https://doi.org/10.1177/0886260512469103.

Kim, J.; Gray, K. A. "Leave or stay? Battered women's decision after intimate partner violence". *Journal of Interpersonal Violence*, núm. 23(10) (2008), p. 1465-1482. https://doi.org/10.1177/0886260508314307.

Krieger, N. "Ladders, pyramids and champagne: The iconography of health inequities". *Journal of Epidemiology and Community Health*, núm. 62(12) (2008), p. 1098-1104. https://doi.org/10.1136/jech.2008.079061.

Llei 5/2008, del dret de les dones a erradicar la violència masclista. *Butlletí Oficial del Parlament de Catalunya*. Barcelona, 2008.

Martin, E. K.; Taft, C. T.; Resick, P. A. "A review of marital rape". *Aggression and Violent Behavior*, núm. 12(3) (2007), p. 329-347. https://doi.org/10.1016/j.avb.2006.10.003.

McKee, S. A.; Hilton, N. Z. "Co-occurring substance use, PTSD, and IPV victimization: implications for female offender services". *Trauma, Violence, & Abuse* (2017), 1524838017708782. https://doi.org/10.1177/1524838017708782.

Meil Landwerlin, G. *Análisis sobre la macroencuesta de violencia de género*. Madrid: Ministerio de Sanidad, Servicios Sociales e Igualdad, 2014.

Ministerio de la Presidencia, relaciones con las Cortes e Igualdad. (2019). Portal Estadístico. Delegación del Gobierno para la violencia de género. 2019. http://estadisticasviolenciagenero.igualdad.mpr.gob.es.

Moore, T. M.; Stuart, G. L.; Meehan, J. C.; Rhatigan, D. L.; Hellmuth, J. C.; Keen, S. M. "Drug abuse and aggression between intimate partners: A meta-analytic review". *Clinical Psychology Review,* https://doi.org/10.1016/j.cpr.2007.05.003.

Morrison, A.; Ellsberg, M.; Bott, S. "Addressing gender-based violence: A critical review of interventions". *The World Bank Research Observer*, núm. 22(1) (2007), p. 25-51. https://doi.org/10.1093/wbro/lkm003.

Office of the European Union (FRA). *Violence against women: An EU-wide survey*. Publications, 2014.

ONU Mujeres. *Un marco de apoyo a la prevención de la violencia contra la mujer*. Nova York: 2015.

Organització Mundial de la Salut. (2014). *Violence against Women*. Ginebra: World Health Organization. https://doi.org/10.1016/B978-0-12-803678-5.00483-5.

Organización Mundial de la Salud; Escuela de Higiene y Medicina Tropical de Londres. *Prevención de la violencia sexual y violencia infligida por la pareja contra las mujeres. Qué hacer y cómo obtener evidencias. Organización Panamericana de la Salud*. Washington D. C.: Organización Panamericana de la Salud, 2011.

Organización Panamericana de la Salud. *Informe mundial sobre la violencia y la salud*. *Informe mundial sobre la violencia y la salud: resumen*. Washington DC: Organización Panamericana de la Salud, Oficina Regional para las Américas de la Organización Mundial de la Salud, 2003. https://doi.org/10.1590/S0036-46652003000300014.

Paradies, Y.; Chandrakumar, L.; Klocker, L.; Frere, N.; Webster, K.; Burrell, M.; McLean, P. *Building on Our Strengths. Full report.* Melbourne: Victoria Health Promotion Foundation, 2009.

Pastorino Mellado, M. J. "Violencia de género en las aulas de educación secundaria". *RESED. Revista de Estudios Socioeducativos*, núm. 2 (2014), p. 122-133.

Peralta, R. L.; Tuttle, L. A. "Male perpetrators of heterosexual-partner-violence: The role of threats to masculinity". *The Journal of Men's Studies*, núm. 21(3) (2013), p. 255-276. https://doi.org/10.3149/jms.2103.255.

Petersilia, J. R. "Crime victims with developmental disabilities: A review essay". *Criminal Justice and Behavior*, núm. 28(6) (2001), p. 655-694. https://doi.org/10.1177/009385480102800601.

Raj, A.; Silverman, J. "Violence against immigrant women. The roles of culture, context, and legal immigrant status on intimate partner violence". *Violence Against Women*, núm. 8(3) (2002), p. 367-398.

Raya Ortega, L.; Ruiz Pérez, I.; Plazaola Castaño, J.; Brun López-Abisaba, S.; Rueda Lozano, D.; García de Vinuesa, L.; González Barranco, J. M.; Garralon Ruiz, L. M.; Arnalte Barrera, M.; Lahoz Rallo, B.; Acemel Hidalgo, M. D.; Carmona Molina, M. P. "La violencia contra la mujer en la pareja como factor asociado a una mala salud física y psíquica". *Atencion Primaria*, núm. 34(3) (2004), p.

117-127. https://doi.org/10.1157/13064519.

Reed, E.; Raj, A.; Miller, E.; Silverman, J. G. “Losing the ‘gender’ in gender-based violence: The missteps of research on dating and intimate partner violence”. *Violence Against Women*, núm. 16(3) (2010), p. 348-354. https://doi.org/10.1177/1077801209361127.

Ruiz-Pérez, I.; Plazaola-Castaño, J.; Blanco-Prieto, P.; González-Barranco, J. M.; Ayuso-Martín, P.; Montero-Piñar, M. I., Grupo de Estudio para la Violencia de Género. “La violencia contra la mujer en la pareja. Un estudio en el ámbito de la atención primaria”. *Gaceta Sanitaria,* https://doi.org/10.1157/13088851.

Russo, N. F.; Pirlott, A. “Gender-based violence concepts, methods, and findings”. *Annals of the New York Academy of Sciences*, núm. 1087 (2006), p. 178-205. https://doi.org/10.1196/annals.1385.024.

Sala Musach, I.; Hernández Alonso, A. R.; Ros Guitart, R.; Lorenz Castañe, G.; Parellada Esquius, N. “Violencia doméstica: Preguntar para detectar”. *Atencion Primaria*, núm. 42(2) (2010), p. 70-77. https://doi.org/10.1016/j.aprim.2009.04.007.

Shandra, C. L.; Hogan, D. P. “The educational attainment process among adolescents with disabilities and children of parents with disabilities”. *International Journal of Disability, Development and Education*, núm. 56(4) (2009), p. 363-379. https://doi.org/10.1016/j.neuroimage.2013.08.045.

Simonelli, A.; Pasquali, C. E.; De Palo, F. “Intimate partner violence and drug-addicted women: From explicative models to gender-oriented treatments”. *European Journal of Psychotraumatology*, vol. 5, núm. 1 (2014), 24496. https://doi.org/10.3402/ejpt.v5.24496.

Sokoloff, N. J.; Dupont, I. “Domestic violence at the intersections of race, class, and gender: Challenges and contributions to understanding violence against marginalized women in diverse communities”. *Violence Against Women,* https://doi.org/10.1177/1077801204271476.

Taft, C. T.; Bryant-Davis, T.; Woodward, H. E.; Tillman, S.; Torres, S. E. “Intimate partner violence against African American women: An examination of the socio-cultural context”. *Aggression and Violent Behavior*, núm. 14(1) (2009), p. 50-58. https://doi.org/10.1016/j.avb.2008.10.001.

Torres San Miguel, L. “Nuevos retos para la escuela coeducativa: iniciativas y experiencias para la prevención de la violencia de género en las aulas: una mirada general”. *TABANQUE Revista Pedagógica*, núm. 23 (2010), p. 15-44.

Unión Europea. (2012). *Directiva 2012/27/UE del parlamento Europeo y del Consejo de 25 de octubre de 2012. Diario Oficial de la Unión Europea, 14 de noviembre de 2012, núm. 315*.

Vest, J. “Multistate analysis of factors associated with intimate partner violence”. *American Journal of Preventive Medicine*, núm. 22(3) (2002), p. 156-164. https://doi.org/10.1016/S0749-3797(01)00431-7.

Vives-Cases, C.; Alvarez-Dardet, C.; Carrasco-Portiño, M.; Torrubiano-Domínguez, J. “El impacto de la desigualdad de género en la violencia del compañero íntimo en España”. *Gaceta Sanitaria*, núm. 21(3) (2007), p. 242-246.

Vyas, S.; Watts, C. “How does economic empowerment affect women’s risk of intimate partner violence in low and middle income countries? A systematic review of published evidence”. *Journal of International Development*, núm. 21 (2009), p. 577-602. https://doi.org/10.1002/jid.1500.

Walby, S.; Amrstrong, J.; Strid, S. “Intersectionality: Multiple Inequalities in Social Theory”. *Sociology*, núm. 46(2) (2012), p. 224-240.

Walby, S. “The European Union and gender equality: Emergent varieties of gender regime”. *Social Politics*, núm. 11(1) (2004), https://doi.org/10.1093/sp/jxh024.

Wathen, C. N.; MacMillan, H. L. “Prevention of violence against women: Recommendation statement from the Canadian Task Force on Preventive Health Care”. *CMAJ*, núm. 169(6) (2003), p. 582-584. https://doi.org/10.1103/PhysRevLett.117.114503.

West, C.; Zimmerman, D. H. “Doing gender”. *Gender & Society*, núm. 1 (1987), p. 125-151. https://doi.org/10.1177/0891243287001002002.

Whitehead, M. “The concepts and principles of equity and health”. *International Journal of Health Services*, núm. 22 (1992), p. 429-445. https://doi.org/10.2190/986L-LHQ6-2VTE-YRRN.