Seizing an Opportunity to Help- knowledge and attitudes of doctors and nurses towards women victimized by intimate partner violence in Brazil

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Abstract

In this study we combined quantitative (questionnaire survey of 221 HCPs) and qualitative (interviews with 14 doctors) methods to explore knowledge and attitudes towards health service assistance for women victims of intimate partner violence (IPV). Data was collected in Ribeirão Preto, Brazil in 2007. We found that most HCPs presented good knowledge of definitions of gender violence, but low awareness of its local prevalence, sympathetic attitudes to such women, but highlighted a range of barriers to assisting them. We analyzed these findings in relation to sex, age, profession and years of experience.

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Different types of violence against women have not been only tolerated but accepted as natural and normal in the constitution of gender roles in private life in several societies through history. Whilst there have been a number of broad lines of theory concerning intimate partner violence against women, gender subordination is one of the main perspectives (Harvey & Gow, 1994). However our particular interest in this study is with the especial opportunities that health care professionals (HCPs) have, here in Brazil, to help women who suffer from intimate partner violence (IPV). In introduction we provide an overview of the legal and policy measures that have been developed in Brazil to address the high prevalence of IPV. It is our contention that there is today an admirable raft of integrated policies to address IPV in Brazil, but the problem is with their effective implementation. In exploring the role of health care workers in this process we wanted to find out about their knowledge of, attitudes to, and experience of dealing with, women patients who present likely evidence of having been abused by an intimate partner (the detailed foci are elaborated below under methods). While we hope that our study can interest an international audience as a case study (Brazil) of interest to an international audience, we have also designed the study so as to contribute directly to the enhancement of health service training and education programs. To achieve this we have used an integrated combination of qualitative and quantitative methods to try to elicit both a greater sense of some of the wider discourses operating, obstacles preventing HCPs assisting such women, and the very specific misunderstandings that need to be addressed in appropriate health service education. In our study we try to shed some perhaps useful methodological light on the different kinds of research findings that emerge from using these different kinds of methods.

Although informally recognized for many years, efforts to combat violence against women were strengthened when it was placed explicitly in the international agenda after 1979 when the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) was adopted by the General Assembly of United Nations (WHO, 2007). More recently other International Conferences such as on Human Rights (1993), the Cairo Conference on Population and Development (1994) and the Beijing Conference on Women (1995) were keys to defining policies to support women's human rights.

Violence against women has only been relatively recently recognized as an issue pertaining to the health services in Brazil. In 1997 WHO explicitly recognized violence against women as a health problem. There are many forms of violence against women all over the world with intimate partner violence (IPV) being one of the most prevalent and the primary focus of this study. Due to its extensive scale it is an important public health problem at the global level (WHO, 1997). The WHO M*ulticountry study on women's health and violence against women* showed that lifetime physical violence among ever-partnered women is very high (Moreno-Garcia, Jansen, Ellsberg, Heise & Watts 2005). The health consequences of violence are well known, primarily involving chronic pain, pelvic pain, headaches, depression, anxiety, suicide (both attempted and completed) and reproductive health infections (Campbell, 2002), and an appropriate response from health services is now considered an international priority (WHO, 1997).

A growing number of both quantitative and qualitative studies have been undertaken into IPV, focusing for instance upon, prevalence (MCCauley *et al*., 1995; Kronbauer & Meneghel, 2005; Bruschi, Paula, & Bordin, 2006; Marinheiro, Vieira & Souza, 2006; Schraiber *et al.*, 2007), health consequences (Campbell, 2002), factors associated with IPV (Rodriguez, Sheldon, Bauer, & Pérez-Stable,. 2001), health service response to IPV, (Rodriguez, Bauer,

McLoughlin. & Grumbach, 1999; Schraiber & D'Oliveira, 1999, D'Oliveira, 2000; Lamberg, 2000; Ramsay, Richardson, Carter, Davidson & Feder, 2002), and training needs for HCPs (Sugg & Inui,. 1992; Departamento de Medicina Preventiva da Faculdade de Medicina da Universidade de São Paulo & Coletivo Feminista Sexualidade e Saúde, 1997; Sugg, Thompson, Thompson, Maiuro & Rivara, 1999; Waalen, Goodwin, Spitz, Petersen. & Saltzman, 2000; Peltzer & Mashego, 2003; Varjavand, Cohen & Novack, 2002). One specific issue that has concerned policy is that of whether there should be a formal screening, with a number of papers concluding that such an instrument would be counter-productive, given the complexity of the IPV situation (Ramsay *et al*., 2002).

In Brazil, the prevalence of physical and sexual violence against women can be as high as 29% of ever partnered women living in São Paulo city and 37% of women in Pernambuco (Moreno-Garcia et al., 2005, Schraiber. *et al*., 2007). In similar studies women reported 38% of physical violence in Porto Alegre (Kronbauer & Meneghel, 2005), 38% in Embu (Bruschi *et al*., 2006), and 27% in Ribeirão Preto (Marinheiro *et al.*, 2006).

Several distinguished sectors (legal, political and public health) of Brazilian society have endeavored to tackle the problem (Ministério da Saúde, 2004; Secretaria de Políticas para as Mulheres, 2005; Brasil, 2006), since 1985 when the first Specialized Police Station for Violence against Women was established in recognition of the public problem. However it took some decades to strengthen initiatives and articulation among the several sectors of Brazilian society to achieve a more proper response to this matter. It is important to note that Brazil has ratified the international conferences decisions to design policies to eliminate discrimination against women and to improve their rights (WHO, 2007).

Legal changes recognizing violence against women as a serious crime only became established in Brazil in 2006 when the Federal Act no. 11.340 was approved replacing a loose

regulation which permitted men "to wash their honor with blood". This law was named after *Maria da Penha,* a pharmacist who led a movement for this legal change. She became paraplegic after being shot by her husband, who had tormented and harassed her for 20 years. The main components of this highly detailed and lengthy Federal Act, include the clear legal definition of acts of IPV, a guarantee of security and protection of women sufferers of IPV under the law, a comprehensive framework for effective collaboration across the police, judicial, social work and other agencies, enabling others as well as the victim to be able to report such violence to the authorities, and exclusion or barring of the perpetrator from their home.

Another important landmark was the creation of the Special Secretariat for Women's Policy at federal level, in 2003, which has improved the ability to articulate the network of relevant sectors. It has been clear to this Ministry, that there is a need to enhance public sector services to offer support and care for women victimized by violence. Therefore in 2005 a National Plan for Women's Policy was established (Secretaria de Políticas para as Mulheres, 2005). This plan aimed to implement a national policy to guarantee a humanized, high quality of care, with a comprehensive approach to cases of violence. In 2007 a National Pact to address violence against women was launched proposing to invest in services between 2008 and 2011 (Secretaria Especial de Políticas para as Mulheres, 2007). One target among the actions planned is to increase by 30% the health care services to assist women who are victimized by intimate partner and family violence and to improve the services to assist the victims of sexual violence offering emergency contraception, legal abortion and to improve health professionals' knowledge and skills to manage these cases (Machado, 2002).

In the health sector many actions have been taken to address the problem. Since 2004 compulsory recording of violence has been determined by the Federal Act n^{o} 10778, as well

as the implementation of the assistance for legal abortion in cases of rape. In 2006 a Ministry of Health Law established a system of surveillance, based on HCP recording of cases, of all cases of violence passing through the health services (Brasil, Ministério de Saude, Portaria 1356, 2006). However, the continuing need to improve the extension of those services has been identified (Talib & Citeli, 2005).

The prevalence of violence perpetrated by an intimate partner is higher among health care users because such women have a recurrent pattern of visiting health clinics (McCauley *et al*., 1995). So health services can play a major role as a primary gate for the provision of assistance to such women.

However health care professionals (HCPs) consider violence a very difficult subject to address (Sugg & Inui, 1992, Schraiber & D'Oliveira, 1999). Studies show that despite health professionals positive attitudes to support women living in a violent situation many feel insecure to manage those cases (Peltzer & Mashego, 2003). Many tend to consider violence as not being a health issue but rather pertaining primarily to the fields of policing or justice (Rodriguez, Sheldon, Bauer & Pérez-Stable, 2001), or are afraid, for various reasons, of becoming involved with the patients (Rodriguez et al., 1999), some limit their treatment to their patients physical injuries (Lamberg, 2000) and many have not received any education or training on the subject (Waalen *et al*., 2000). It has been observed that many health professionals ignore signs of violence or merely refer the patient to a psychologist or psychiatrist which is not always an adequate response to women's need given the possible implication that some kind of 'fault' rests with the woman (D'Oliveira, 2000).

Training health professionals to assist women has been considered an important subject for research (Ramsay et al., 2002) mainly in order to define the content of training sessions and the appropriate knowledge to be acquired by HCPs. The current situation in Brazil is that

a model protocol for dealing with cases of sexual violence exists (Ministry of Health, 1999), but it does not explicitly address intimate partner violence, which is thus not covered in HCP training. Furthermore there is a gulf and even confusion in Brazil between policy statements on paper concerning HCP training to address IPV, and actual training carried out. The current *ad hoc* situation is highly variable and depends very much upon the individual teacher addressing the topic. Thus as elaborated upon below this study we sought, in general terms, to explore HCPs' perceptions of the scale and nature of intimate partner violence, experience of, and obstacles to, dealing with such cases, and likelihood of providing such assistance in the future, in order to assist in the structuring and delivery of such training.

Given our central concern with practical training implications, it is perhaps useful to briefly outline the range of issues that warrant inclusion in such training, which in turn structure the precise contents of much of the questionnaire we used. There is no consensus in the scientific literature as to whether a screening instrument should be applied to such cases, therefore training is critical to inform health care professionals (HCPs) about the subject[1].

We carried out his study in a medium sized city located in São Paulo State with about 547,500 inhabitants (IBGE 2007), which is an important regional, educational and health referral center for 22 municipalities containing a population of around three million people.

Method

[1] Such training should accordingly include the wide range of topics such as Violence against women and human rights, Information on the prevalence of IPV, Theoretical notions used in the of understanding violence and gender issues, Ethical and legal aspects of the assistance of women living in violent situation, How to facilitate the revelation of such violence, How to directly ask the patient appropriate questions when the HCP suspects violence, Health problems related to chronic violence, Counseling about women's rights, Risk assessment, The compulsory register of violence (Brazilian legal requirement), To provide addresses of other organizations such as police, legal advisors, social workers that deal with the problem, Scheduling follow up visits to the clinic to help HCPs to assess the ongoing risk, The need to avoid prescription of medication such as tranquilizers in order to preserve women's capacity of escape in case of risk. Referral of the case to psychotherapist, psychologist, psychiatrist, as just one component, Risks attendant in inviting the intimate partner to the clinic or any other kind of revelation of the case

We administered a questionnaire face to face to nurses and medical doctors in the sectors of general practice, gynecology/obstetrics and the emergency of all five District Health Clinics (DHCs) of Ribeirão Preto. We adapted our version of the instrument from one we had previously conducted with residents and medical students (Vicente & Vieira, 2008). We also undertook a literature review (Departamento de Medicina Preventiva da Faculdade de Medicina da Universidade de São Paulo e Coletivo Feminista Sexualidade e Saúde, 1997, Sugg *et al*., 1999, Grupo de Trabalho Movimento Popular da Mulher e Nzinga, 1999, Ministério da Saúde, 2004, Varjavand *et al*., 2002) to orient the inclusion of the variables to be used in the questionnaire. In the questionnaire we explored HCPs' previous experience of having treated battered women, their perception on the role they play as health professionals, the barriers they identify in the health service to properly assist battered women, previous experience of having an educational session on violence against women, their knowledge on the definition of gender, epidemiology of violence against women, case management of violence and attitudes regarding violence committed by an intimate partner. We also collected socio-demographic data in the questionnaire. We pilot tested the questionnaire with 13 HCPs working in health clinics, other than those to be included in the main survey. We carried out the data collection between August and October, 2007. Nine interviewers were selected (all experienced interviewers, most with health science backgrounds) and trained to administer the interviews. The health professionals were approached by the interviewers in the workplace and if he/she could not answer the questionnaire another meeting was scheduled. Our interviewers visited the health professional twice further if they were not found at the first visit in the workplace, especially if he/she were not on holidays or sick or pregnancy leaving.

We verified the knowledge component through true-false responses to 29 statements. For the knowledge on gender based violence definition five statements, on knowledge of epidemiology of violence against women four statements, and for the case management of

violence we used 20 statements. We established a score for each kind of knowledge giving one point for each correct answer. To assess health professional's attitudes toward violence against women we employed a set of previously used 17 Likert-type statements (Peltzer & Mashego, 2003). In its translation and adaptation to Portuguese we used a trans-cultural adaptation method involving two independent translators, back translation and the assessment of the better translation by three referees considered experts on the subject following the directions given by Guillemin, Bombardier & Beaton (1993).

We tested the knowledge score for association with independent variables such as age, education, profession, sex, length of profession and attitudes using the Chi-square and the Fisher's exact test. The attitudes were tested using the test of Mann-Whitney test. The hypotheses of association was accepted at the p<= .005 level.

We collected qualitative data through semi-structured interviews from June to August 2007 with 14 medical doctors and 11 nurses working in Primary Care Clinics and District Health Clinics. Our main objective of this qualitative component of our study was to seek to understand health professionals´ perceptions and perspectives on gender violence.

We found it was particularly difficult to recruit doctors from the DHCs for the qualitative interviews, largely because such clinics serve as highly pressurized emergency facilities. However we recruited the 14 doctors from the primary care clinics, which serve as the next and less pressurized level within the Brazilian health structure. These 14 doctors were from 14 different clinics, divided equally between the five districts of the city. The inclusion of personnel from each area was so we could explore, albeit qualitatively, whether differences could be discerned between the areas. Our qualitative analysis indicated that there were no geographical differences in the prevalence and types of IPV between these areas. We transcribed the qualitative interviews 100% and analyzed thematically, based upon *a priori*

categories, using content analysis. In our second phase of qualitative analysis we attempted a more holistic case study of particular reports of IPV patient management. Our multi-disciplinary research team held a series of seminars upon the qualitative findings to attempt to draw out the emerging range of discourses on IPV and case management.

We obtained the necessary ethical approval from the University of Sao Paulo (Ribeirão Preto) Medical School Ethics Committee. We informed the HCPs about the study prior to interviewer contact by their DHC manager, and were thus assured of their customary voluntary participation.

Results

Characteristics of the sample

We attempted to contact all 278 HCPs working at the selected health centers, and found that 36 (13%) were on sick leave or holiday. While all the nurses we contacted agreed to be interviewed, 42 (19%) doctors refused to be interviewed, and generally suggesting lack of time. Thus our final sample still represents 68% of the population of doctors and 87% of the nurses in these health centers. If there is any bias in the eventual sample we consider that those who declined to take part may be less sympathetic to the problem of IPV. Among those we interviewed 51 (23%) were nurses and 170 (77%) medical doctors. 90% of the nurses were female and 67% of the doctors were male. Their mean age was 39 years old; being nurses significantly ($p<0.000$) older than doctors (mean age 43 versus 37). Regarding their skin color, 200 (91%) considered themselves to be White or Asian and 21 (10%) Black or Mulattos. The nurses had more years of professional experience than the doctors, (18 years compared to 11 years, $p=0.000$).

Experience of and perception on health professional role towards IPV

Reflecting the ubiquity of violence against women in Brazil 91% (201) of our participants reported that they had already assisted women who reported IPV. When we asked if it was their role to query about violence against women, 88% (194) answered "yes". We did not find that this positive perception of believing that addressing gender violence is part of their professional role to be associated with age, color, religion or professions, but with the sex of the participant. Although only 26 of our participants answered that it was not their professional role to ask about violence against women, most of these, 81% (21), were men ($p<0,004$).

We asked the participants how many female patients in total they had assisted in the last 30 days and, of these, how many women they did they know or suspected of having suffered IPV. About 12% (24) did not know how to answer this question and almost one third (27%/54) answered they had not seen any case of such violence in the last month. The majority (82%/117) of the remaining 143 health professionals answered that 10% or less of the women they assisted suffered gender violence, about 10% answered between 11 and 20%, 3.5% between 25 and 40% and 5% said that above 50% of women they had seen within the last month were victim of such violence.

When we asked about the barriers within the health services to assisting women victims of IPV, only a small minority of participants (14%) reported that there are no barriers and the health service is able to assist women. The remaining 181 respondents identified a range of factors, which we classified as institutional, professional and cultural barriers. Among the institutional barriers, lack of time and privacy, no interest in IPV on the part of the health service and the lack of a protocol were highlighted by participants. In terms of professional barriers they indicated lack of knowledge or confidence, fear of being involved in such potentially dangerous situations, being a difficult subject to address or not a medical subject.

Some HCPs mentioned that they only enquired about possible IPV when there were obvious signs of violence. Cultural barriers that we identified included the patients'non-disclosure of the situation that IPV was a patient's private problem and there is discrimination in Brazilian society against women who are beaten and therefore they do not openly admit to suffering such abuse.

We feel that standard survey items are perhaps not the ideal means of exploring the causes of gender violence in Brazilian culture. When reference is made to our qualitative interviews a rather more complex picture starts to emerge. When doctors and nurses spoke in greater detail and with more flexibility about the causes of gender violence, we were able to identify a series of different yet inter-related discourses. We found the most commonly articulated discourse on gender violence to be focused upon gender inequality.

"The woman instead of thinking she is a victim she feels guilty. I mean, she thinks: 'what I have I done wrong to be beaten?' It is very hard to undo this idea she has because she is very submissive" (Doctor, female, 50 years old.)

Secondly we found that this gender inequality was elaborated with respect to a lack of education and women's economic dependence

"She is beaten but the husband is the one who has the money, she has the house, she depends upon him to give everything to her…" (Doctor, male, 52 years old).

We identified a third discourse that emphasizes cultural and socialization processes in reinforcing women's submissive situation.

"It is educational, families are very ignorant, they have no education at all…They were brought up as subjugated women. How can someone change her mind about this? How can

we make the woman understand that she is equal to the husband, that she can take a position of equality in relation to him? She was not brought up like this. The guy does not see her like this; she does not see herself like this". (Doctor, female, 30 years old).

We found a fourth often repeated discourse to revolve around dysfunctional aspects of people of low-economic status, in particular emphasizing the devastating domestic impact of drugs and alcohol use.

[…] alcohol, the men drink and become violent […] a stable person with a proper job, people who work do not hit the wife. But people craving drugs, drug users, using crack, cocaine, alcohol…become violent persons even to get the means to buy drugs. Sometimes the woman pays for that violence." (Doctor, male, 52 years old).

In general we found that the health professionals expressed sympathy for the victims of gender violence, however a few male doctors expressed the view that such women are to be blamed because they sometimes put up with the situation and even like it. The following quotation shows a certain lack of empathy.

"In my opinion if she has been beaten more than twice it is because she likes it… because whoever stays together with the one who beats her, likes it… In my opinion if someone hits me I would not stay in the relationship…" (Doctor, male, 46 years old).

Knowledge on the definition of gender based violence

In conducting research into health professionals´ knowledge and attitudes to gender violence the first task is to check participant's understanding of the concept, thus in the survey we tested the doctors and nurses level of agreement with a range of standard definitions using five statements (Table 1). All statements are true (a-e). We found most participants knew the

definitions of violence, obtaining with 77% to 91% obtaining correct answers. We did not find this knowledge to be associated with sex, color, religion, or profession. However we did find an association with age. Among those in the age group 24 to 36 years old 44% obtained the highest score, while in the age group older than 48 years old 73% reached the maximum score of definitions of violence. ($p < .001$).

Knowledge of the epidemiology of violence

The four statements we used to verify knowledge on gender based violence are presented in Table 1, the statement items h and item I are true, the others untrue. We observed that the lowest percentage of correct answers (16%) concerns the knowledge of the frequency of bodily injuries in victimized women (item h), with most HCPs over-estimating the likelihood of such visible injuries. Similarly concerning the prevalence of violence during pregnancy (item i), we found only 28% of participants gave the correct answer and 53% choosing to answer *"I don't know"*. Summating these three knowledge items we found that 47% (104) of the participants gave no correct answers, 46% (101) answered just one statement correctly, 7% (15) correctly answered two statements and only one respondent answered all three statements with correct knowledge.

We found that the score of the knowledge on the epidemiology of violence was not associated with sex, age, color and religion. However we did find it to be associated with profession. Doctors are more likely than nurses to know more about the epidemiology of violence. Among nurses nearly two-thirds (63%/32) obtained the lowest score, while among doctors about two-fifths (42%/72) obtained the lowest score ($p=0.035$). We feel that the general point is that a very significant proportion of this group of health professionals is insufficiently informed about the epidemiology of gender violence.

Knowledge on IPV case management

We used a total of 20 statements to verify knowledge on case management (presented in Table 2). Although most of the answers were correct, for about 70% or more of participants, some particular statements obtained a very low percentage of correct answers. About 83% of the participants answered that it was "correct to use the protocol of the Ministry of Health to manage cases of violence" while in fact we know that no such protocol currently exists in Brazil. About 50% answered that they would not directly ask: '*Are you suffering any kind of aggression at home?'* About 44% of the respondents would recommend that the couple turn to psychotherapy, and75% would recommend psychotherapy for women living in a violent situation, nearly two-fifths 38% would not record the violence even though compulsory recording is obliged by law, and 21% would ask the partner to come to the clinic to talk about the violent situation which may actually increase the risk of violence for both the women and the HCPs. In particular we consider that the lack of HCPs recording the evidence of IPV militates against the later effective recourse being taken through legal means

We also found that the qualitative interviews shed some interesting light on the process of doctors´ referral of women they identify as being victims of gender violence. Whilst in response to a standard survey item most doctors will confirm that they refer such women, in the qualitative interviews we repeatedly found that this basically involved the doctors merely directing the nurse to deal with the matter.

*"As I told you we try to convince the women to denounce the cases, and the nurses have to know how to do it. I send the cases to the nurse". (*Doctor, male, 55 years old*).*

"I see the woman and the nurse will … I don't know where they send them, but it is the nurse who does the referral. So, I don't know to where I am sending the case…" (Doctor, male, 41 years old)

Our evidence suggests that most doctors are neither well informed about the referral options although only 3% did not consider such a task to be their role.

We scored the set of 20 statements with each correct answer being awarded a point. The range of correct answers varied from 5 to 18 (media=13.41, SD=0.139, CI=13.14; 13.68). So scored, our sample divides into roughly equally into low, medium and high levels of knowledge. We considered a low level of knowledge on case management to be below 12 points, medium knowledge 13 and 14 points and high knowledge equal or above 15 points. We classified 31% (60) as low, 38% (83) with 32% medium and 32% (70) with high knowledge on case management. Our allocation to low, medium and high was made both upon the judgment of what is appropriate for assessing such knowledge among HCPs.

We did not find knowledge on case management to be associated with sex color, religion, marital status, or length of the professional life of the respondent. However we did find it to be associated with age and profession. Younger HCPs were more likely to have higher knowledge on violent case management than older ones. Whereas 39% of respondents aged 24 to 36 years old were found with high knowledge only 15% of respondents aged 48 or older were found with high knowledge (p=0.033). Reflecting the qualitative findings on referral noted above, nurses were more likely to achieve higher scores than medical doctors; while 29% scored high knowledge on case management 41% of the nurses did so.

Attitudes towards the cause of violence

We recognize that the causes of gender violence are very complex and we have only included a few items to try to tap into the respondents perspectives. Nevertheless the few items did yield some useful information. More than two-thirds of the respondents (69%) agreed that wife battering is caused by societal factors like unemployment and almost all (93%) agreed that is caused by alcohol and drug abuse. Only 22% agreed that wife battering is caused by the victims' psychological problems, while 73% agreed that it is caused by the husbands' psychological problems.

Younger HCPs are more likely to agree that wife battering is not caused by the victims' psychological problems. In general the participants strongly blamed the husband rather than the victim of violence and this is slightly more pronounced for younger than older respondents.

Attitudes towards victims and aggressors

Most of the HCPs (94%) disagreed it is alright for a husband to hit his wife even if he has really been provoked. More women disagreed with this statement than men. An overwhelming majority of participants (93%) disagreed that the wife battering victim stays in the battering situation due to their masochism. The HCPs who were younger than 40 years old were more likely to disagree with this statement. A large majority of the participants (82%) disagreed that wife battering is a purely private matter between the husband and wife. Women are more likely to disagree with this statement than men. Most participants (88%) disagreed that wife batterers should receive sympathy since they are emotionally disturbed and agreed (75%) that they should go to prison for assault. We found respondents who were younger than 40 year old are more likely to agree with this last statement.

Attitudes towards professional role

Most of the HCPs (93%) consider it to be their role to encourage the victim to leave the situation of violence, to provide another referral address (97%) and be alert to the disclosure of violence (93%). Most respondents (94%) disagree that the doctors or nurses should only treat injuries and not query the battered woman. However, almost half of them (42%) would not confront the victim if she did not admit the violent situation and more than half (59%) believe that prescribing tranquilizers to the victim is correct. About 30% disagreed that violence is a health problem and 29% believe that the doctor's role is different in the case of women or child abuse.

Our findings show that nurses are more likely to agree that HCPs should provide a referral address to women. Women are more likely to disagree that health professionals should only treat injuries and not query about violence or counsel battered woman and the doctor should prescribe tranquilizers. The participants who presented high knowledge on gender violence are more likely to agree that high knowledge on gender violence is a medical problem and health professionals should have the same role in assisting wife abuse as child abuse.

We found that the qualitative interviews provide a richer picture of the diversity of health professionals´ views of their role in dealing with gender violence:

These views spanned proactive views.

"As a doctor I see as my duty to give orientation, to do a risk assessment, I can give advice… but the decision is hers…but it is my duty to give information and ask her to go to the police..." (Doctor, female, 48 years old).

In some other qualitative interviews we also found expressions of a sense of impotence, in that the HCPs felt that they have neither the resources nor facilities to address gender violence.

"*I feel impotent against it…impotent. I can only assist her but she is the one who has to go to the police to make the complaint… "* (Doctor, male, 52 years old).

And finally, we found expressions of a purely medicalized perspective.

"If she does not want interference in her life, I don't do it… She makes her own decision in life. If she wants to continue with this life it is her problem. My problem is to stitch her arm…" (Doctor, male 57 years old.)

Education and training

When we asked the HCPs if they had participated in an educational session at the university or college 82 (37%) answered yes, 29 (13%) had participated in a lecture or training session in the health service where they work, 31 (14%) participated in an education session at university or health service training session and 78 (35%) have not received any training or class on the subject. We tested these four groups for differences and attendance of such training was found to be associated with age group, sex and profession. Younger professionals, of the age group 24 to 36 years old, were more likely to have participated in a training session or educational session (58%) while only 13% of HCPs who were older than 48 years old had the same experience ($p < .001$). Men were less likely to have received any training or educational session (32%) compared to women (68%) ($p < .001$). Nurses were more likely to have received such training (74%) than medical doctors (62%) ($p<.001$).

An open question we employed on the range of barriers HCPs face in assisting victims of IPV provoked an enormous range of feedback from the participants. Methodologically we

found that the previously used (quantitative) scales were insufficient, as nearly half of our sample gave reasons other than the standard customary fixed alternatives used for this question. Thus we found the range of barriers and difficulties to span health professional, cultural and institutional categories. Those who had received training on gender violence were much more likely to identify the significance of cultural barriers in Brazil's violence. Thus those with training have both a more sophisticated understanding of the problem and greater confidence in the health service capability to respond to victims of violence.

Discussion

Both our quantitative survey and the qualitative interview findings revealed a picture of substantial diversity in Brazilian health professional's attitudes and response to, gender violence. In our study we found the two methods produced highly complementary findings but with the semi-structured interview data yielding a richer perspective of the various discourses operating in this field.

This diversity of attitudes is perhaps to be expected in that, despite its ubiquity, gender violence has only been explicitly acknowledge by WHO since 1997, and has yet to be fully incorporated within the Brazilian Health system. But in overall terms our Brazilian findings are more positive than those previously reported from for instance South-Africa, (Peltzer & Mashego, 2003).

Most of the participants presented good knowledge about the definition of violence against women and believed that it is his/her professional role to ask patients about violence. That we found higher knowledge on the concept of violence to be associated with older age may imply that professional experience is an important component in understanding this matter.

However, we found that most respondents were not aware of the high prevalence of gender violence in Brazil. This can be confirmed in that the HCPs most commonly given answer was that they had not assisted any patient who they believed to have suffered violence (at least over the past thirty days), and they estimated that less than 10% of their assisted women patients had ever faced IPV. While there have been famous cases reported in the media of gender violence and indeed murders in the upper class groups in Brazil, (Schraiber *et al*., 2007) have shown that the prevalence is much higher in the middle educational group which is consistent with the characteristics of the primary care public service health users of our study. Thus, we may expect that health professionals may possibly underestimate the scale of violence, as it is not common in their own personal experience. This further reinforces the need for more education on the epidemiology of gender violence to sensitize health professionals to address this matter. Such training would be especially important for nurses who seemed to know less than doctors about the epidemiology of violence. Nevertheless, once IPV has been identified in a patient they probably manage the situation better than doctors given that they presented higher knowledge of the appropriate procedures, especially the younger nurses.

Although our survey findings showed that HCPs were generally highly sympathetic to victims of IPV, the greater flexibility offered by the semi-structured interviews enabled us identify a more complex and troubling range of discourse, some of which even involved blaming the victim.

The health professionals identified a wide series of institutional, professional and cultural barriers to effectively addressing gender violence within health services. Most of the doctors in the survey acknowledged their role to meet the needs of the victims of gender violence; however from the qualitative interviews we identified some problematic, misogynistic and medicalized discourses.

The participants, especially younger women, presented sympathetic and helpful attitudes towards women living in violent situations and this is related to the fact that they were more likely to have received any kind of relevant training or educational session.

There is a protocol in Brazil to address the victim of sexual violence but there is currently no protocol to address the wider problem of gender violence. Yet nearly all of the health professionals interviewed confused the existing protocol on sexual violence with intimate partner violence. As a subject for health professionals sexual violence would appear to be a much more medicalized subject with clear guidelines of procedures (medicines, test, etc.) than wider gender violence. There is a sense that many health professionals still view intimate partner violence, rather than sexual violence, as a chronic, time-consuming subject, which they find frustrating to try to deal with and for which they have neither the time nor skills to properly address the subject. Thus, there is the need for clear strategies for referral.

Conclusions

We found that the identification of precise training needs for health professionals is a key element for the proposed appropriate training and educational sessions to improve HCPs understanding of gender violence. It is our contention that rather than including a routine screening question about possible violence in a protocol which can become perfunctory, automatic and perhaps even superficial, it is better that health professionals are trained to better recognize the signs of such violence. Such training should include heightening awareness and encouraging doctors to listen carefully to what patients are actually saying about this social, rather than purely medical, aspect of their lives. Added to this the training must strongly address ways of ensuring health professionals, as regulations demand, record cases of IPV, have a clear understanding of the referral steps they should follow and provide a supportive health service environment in which to effectively help victims of gender violence.

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Table 1 – Knowledge of the definition of gender based violence and epidemiology of violence among doctors and nurses, Ribeirão Preto, 2008.

Definition of gender based violence (items a - f are true)	**Correct answer**	**(%)**	**Do not Know**	**(%)**
a) Domestic violence is any violence perpetrated by individuals linked to kinship bonds or natural bonds or affinities.	200	90.5	10	4.5
b) Belittling, humiliating, constantly insulting or intimidating a woman by an intimate partner can be considered as variations of violence against woman.	198	90	3	1.4
c) Occasional pushing and slapping by intimate partners are types of gender based violence.	193	87.3	24	10.9
d) To be forced into sexual intercourse by the intimate partner is gender based violence.	198	89.6	21	9.5
e) Any behavior implying retention, subtraction, destruction of objects, work tools, goods and economical assets is considered moral violence.	169	76.5	19	8.6
Epidemiology on violence against women (items h and I are true)				
g) In most cases violence against women is perpetrated by strangers.	213	98.4	7	3.2
h) Only occasionally when a woman is beaten are there bodily injuries	36	16.3	10	4.5
i) One out of five women attending ante-natal care is abused by the intimate partner.	61	27.6	117	52.9
j) Most women who are abused report the violence to the doctor or nurse in the health clinics of Ribeirão Preto.	170	76.9	15	6.8

Table 2 – Table Knowledge on management of gender based violence and epidemiology of violence among doctors and nurses, Ribeirão Preto, 2008.

	Correct		Do not know	
	N	%	N	%
a) The doctor (nurse) should ask directly: *"Are you being abused?"*(T)	95	42.9	15	6.8
b) The doctor (nurse) should avoid the subject unless it is a main complaint of the patient (F).	161	72.8	5	2.3
c) The doctor (nurse) should ask if there is someone with an alcohol problem at home and if the person gets aggressive after drinking (T).	197	90.4	8	4.0
d) The doctor (nurse) should insistently ask if the patient suffer violence at home (F).	162	73.3	9	4.0
e) The doctor (nurse) should explain that violence against women is very common in women's lives and s/he should ask to all patients and then ask *"Have you been abused or battered by your partner?*" (T). **check wording to improve**	132	59.7	10	4.5
f) The doctor (nurse) should ignore bruises and other signs of violence if the patient does not disclose them(F).	216	97.7	1	0.4
g) The doctor (nurse) should ask the patient to return within one month if they suspect that the patient suffers violence (T).	176	80.0	9	4.0
h) The doctor should prescribe tranquilizers or ant depressants for the patient to cope with the problems she has at home (F).	177	80.0	11	5.0
i) In the case of sexual violence doctor (nurse) should provide emergency contraceptive, STD/AIDS prophylactic drugs and other necessary medical procedures including pregnancy interruption by law (T)	195	82.3	8	3.6
j) The doctor (nurse) should assess the life risk of the patient according to types of aggression and results of violence (T).	202	91.4	5	2.3
k) The doctor (nurse) should advise the patient to leave the husband immediately (F).	177	80.0	16	7.2
l) The doctor (nurse) should propose a security plan for the patient and her children (T).	176	79.6	15	6.8
m)The doctor (nurse) should recommend couple therapy (F).	61	27.5	36	16.3
n) The doctor (nurse) should recommend psychotherapy (F)	27	12.2	28	12.7
o) The doctor (nurse) should not record the violence because it is confidential information. (F).	154	69.7	21	9.5
p) The doctor (nurse) should suggest that the patient bring her partner with her on her next visit to the health clinic to talk (F).	97	48.9	30	13.6
q) The doctor (nurse) should compulsorily record the case (T).	127	57.5	34	15.4
r) The doctor (nurse) should provide telephone number of organizations and shelters which assist women in such violent situations (T).	195	88.2	12	5.4
s) The doctor (nurse) should use the the Ministry of Health protocol of case management for suspected cases of violence (F)	13	5.9	27	12.2
t) The doctor (nurse) should counsel the woman to go to the police (T)	216	97.7	1	0.4

Table 3 Attitudes toward gender based violence among doctors and nurses, Ribeirão Preto, 2008.

	AGREE		Do not Know		DISAGREE	
	%	N	%	N	%	N
a) Doctor should play the same role in wife abuse as they do in child abuse	69.6	154	1.8	4	28.4	63
b) Wife battering should be treated and regarded as a medical syndrome.	66.5	147	2.7	6	30.8	68
c) Wife battering is caused by sociological (societal) factor like unemployment.	68.8	152	6.3	14	24.8	55
d) Wife battering is caused by alcohol or drug abuse.	92.3	204	2.7	6	5.0	11
e) Wife battering is caused by the victim's psychological problems.	22.1	49	6.3	14	71.5	158
f) Wife battering victims stay in the battering situation due to their masochism.	5	16	2.3	122	92.8	83
g) Wife battering is caused by the husband's psychological problems.	73.3	162	10.4	23	16.3	36
h) Wife bashers should receive sympathy since they are emotionally disturbed.	6.7	15	5.4	12	87.7	194
i) Wife bashers should go to prison for assault.	75.1	166	6.3	14	18.6	41
j) It's OK for a husband to hit his wife if he has really been provoked.	0.4	1	2.3	5	93.7	215
l) Wife battering is a private matter between husband and wife.	13.1	29	4.5	10	82.4	182
m) Doctors (nurses) should only treat the injuries and not query or give advice to battered women.	5	11	1.4	3	93.7	207
n) If a battered woman is overwrought a doctor should prescribe tranquilizers.	58.8	130	9.0	20	32.1	71
o) Doctors (nurses) should encourage the victims to leave the violent situation.	93.2	206	3.6	8	3.2	7
p) Doctors (nurses) should provide wife battering victims with referrals to other agencies.	96.8	214	0.9	2	2.3	5
q) Doctors (nurses) should be on the lookout in diagnosing battering; for example checking injuries against victim's account.	92.2	174	2.3	5	5.4	12
r) Doctors (nurses) should confront the victims/patient if bashing is suspected but she does not admit to it.	50.7	112	7.7	17	41.6	92

Table 4 – Association among attitudes and some variables of doctors and nurses, Ribeirão Preto, 2008

	sex			Age			Profession			Knowledge			Years prof		
	male	female	p	<40	=>40	p	nurse	doctor	P	low 2- 6 pt	high 7-9 pt	p	<=15	>15	P
a) Doctors should play the same role in wife abuse as they do in child abuse	3,62	3,60	*	3,51	3,73	*	3,76	3,56	*	3,40	3,78	.0035	3.53	3.72	*
b) Wife battering should be treated and regarded as a medical syndrome.	3,57	3,36	*	3,61	3,32	*	2,98	3,62	*	3,17	3,72	.0002	3.61	3.30	*
c) Wife battering is caused by sociological (societal) factor like unemployment.	3,54	3,51	*	3,57	3,48	*	3,45	3,55	*	3,58	3,48	*	3.54	3.50	*
d) Wife battering is caused by alcohol or drug abuse.	4,16	4,12	*	4,18	4,09	*	4,16	4,14	*	4,17	4,11	*	4,17	4,10	*
e) Wife battering is caused by the victim's psychological problems.	3,57	3,69	*	3,79	3,43	0,0076	3,53	3,65	*	3,60	3,64	*	3,75	3,46	.0400
f) Wife battering victims stay in the battering situation due to their masochism.	4.27	4.24	*	4.42	4.05	0.001	4.18	4.28	*	4.22	4.28	*	4.40	4.06	.0007
g) Wife battering is caused by the husband´s psychological problems.	3.63	3.61	*	3.66	3.57	*	3.51	3.65	*	3.55	3.67	*	3.64	3.59	*
h) Wife bashers should receive sympathy since they are emotionally disturbed.	4.22	4.09	*	4.10	4.23	*	4.14	4.16	*	4.17	4.15	*	4.10	4.23	*
i) Wife bashers should go to prison for assault.	3.65	3.85	*	3.97	3.48	.0012	3.78	3.73	*	3.74	3.74	*	3.90	3.53	.00128
j) It´s OK for a husband to hit his wife if he has really been provoked.	4.48	4.67	.0128	4.63	4.50	*	4.61	4.55	*	4.64	4.50	*	4.61	4.51	*
l) Wife battering is a private matter between husband and wife.	3.79	4.10	.0309	4.05	3.79	*	4.14	3.87	*	3.87	3.98	*	4.0	3.84	*
m) Doctors (nurses) should only treat the injuries and not query or give advice to battered women.	4.11	4.47	.0004	4.38	4.15	.0189	4.45	4.22	*	4.21	4.33	*	4.35	4.18	*
n) If a battered woman is overwrought a doctor should prescribe tranquilizers.	2.58	2.97	.0086	2.90	2.59	.0273	2.94	2.71	*	2.81	2.72	*	2.82	2.68	*

o) Doctors (nurses) should encourage the victims to leave the violent situation.	4.17	4.34	*	4.28	4.21	*	4.37	4.21	*	4.29	4.22	*	4.25	4.25	*
p) Doctors (nurses) should provide wife battering victims with referrals to other agencies.	4.23	4.36	*	4.33	4.25	*	4.49	4.23	00 69	4.33	4.26	*	4.28	4.30	*
q) Doctors (nurses) should be on the lookout in diagnosing battering; for example checking injuries against victims account.	4.15	4.21	*	4.18	4.17	*	4.20	4.17	*	4.10	4.24	*	4.14	4.22	*
r) Doctors (nurses) should confront the victims/patient if bashing is suspected but she does not admit to it.	3.22	3.08	*	3.13	3.19	*	2.98	1.29	*	3.06	3.23	*	3.15	3.16	*

*=p>0,005