Knowledge and attitudes of healthcare workers towards gender based violence

Conhecimento e atitudes dos profissionais de saúde em relação à violência de gênero

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Abstract

Objectives: There are several public policies to deal with violence against women in Brazil. The literature has reported that healthcare workers find this subject difficult to approach. To improve care in the public health system (SUS) of Ribeirão Preto, a study was conducted aiming to assess knowledge and attitudes of healthcare workers regarding gender violence. **Methods:** A total 278 healthcare workers were contacted and 221 were interviewed using a structured questionnaire. **Results**: 51 (23.0%) were nurses and 170 (77.0%) physicians, 119 (53.8%) males and 102 (46.2%) females, with a mean age of 38.6 years; 200 (90.5%) considered themselves to be white or Asian and 21 (9.5%) black or mulattos. They had an average of 12.5 years of professional practice and 158 (68.8%) had graduated from a public university. About 58.7% had an adequate general knowledge (good and high) about gender violence, which indicates the need to train healthcare workers. Regarding the barriers to identify violence, healthcare workers mentioned the lack of an institutional policy and the silence of women who do not reveal violence. Respondents, especially young women, presented more favorable attitudes towards women living in violence situation. **Conclusions:** Therefore, most of them show positive attitudes toward women living in violence and we infer that they present good potential for appropriate case management if they receive training.

Keywords: Gender violence. Violence against women. Professional training. Attitudes.

Resumo

Objetivos: Várias são as políticas públicas no Brasil para o enfrentamento da violência contra a mulher. Registra-se na literatura que os profissionais de saúde acham o tema de difícil abordagem. Para melhorar o atendimento no SUS em Ribeirão Preto, realizou-se um estudo para avaliar o conhecimento e a atitude dos profissionais de saúde em relação à violência de gênero. **Métodos:** Contataram-se 278 profissionais de saúde, dos quais 221 foram entrevistados utilizando-se um questionário estruturado. Resultados: 51 (23,0%) eram enfermeiras e 170 (77,0%) médicos; 119 (53,8%) homens e 102 (46,2%) mulheres, com idade média de 38,6 anos; 200 (90,5%) consideravam-se brancos ou asiáticos e 21 (9,5%) pretos e pardos. Tinham em média 12,5 anos de vida profissional e 158 (68,8%) eram oriundos de universidade pública. Apenas pouco mais da metade (58,7%) mostrou conhecimento geral adequado (bom e alto) sobre a violência de gênero, o que indica a necessidade de capacitar os profissionais para este atendimento. Em relação às barreiras para averiguar a violência, os profissionais citaram a falta de uma política institucional e o silêncio da mulher que não revela a violência. Os entrevistados, em particular as mulheres jovens, apresentaram atitudes mais favoráveis para o acolhimento da mulher em situação de violência. **Conclusões:** A maioria dos entrevistados demonstrou atitudes positivas e podemos inferir que há bom potencial para o manejo adequado dos casos, se receberem capacitação.

Palavras-chave: Violência de gênero. Violência contra mulher. Capacitação profissional. Atitudes.

Introduction

Knowledge and attitudes of healthcare professionals in relation to gender-violence

The prevalence of violence against women perpetrated by an intimate partner is high in Brazil, according to recent studies. In a study conducted by the World Health Organization (WHO)[1], the lifetime prevalence of physical violence against women in the city of São Paulo was found to be 37.9% and in the *Zona da Mata*, Pernambuco, 35.2%[2]. A similar study conducted in Embu[3], São Paulo, reported that the lifetime prevalence of any type of violence was 33.7%. In a study conducted in 16 Brazilian state capitals, 21.5% of the women reported minor physical abuse[4].

Since the creation of the first women's rights police stations in 1985, violence against women in Brazil has been a target of public policies in various sectors[5-7], which have recognized this as an important health and human rights question. Its high prevalence is evident, along with the need to equip services with adequate resources for offering care and support to women who experience situations of violence, as stated by the Special Secretariat for Women's Policies. In 2005, this body created the National Plan for Women's Policies[7]. One of the aims of this plan was to establish a national policy to deal with violence that would ensure comprehensive, humanized and quality care. In 2007, the National Agreement for Dealing with Women's Violence was created, with the aim of investing in services between 2008 and 2011[8].

These initiatives go back to the commitment signed at the "Belém Convention", the Inter-American Convention for Prevention, Punishment and Eradication of Violence Against Women, by the Brazilian government in 1994, in which implementation of measures for combating violence against women was proposed. Among such actions was a 30% increase in health services providing care for victims, emergency contracep-

tion, abortion as permitted under the law (if the victim so desired) and training for professionals to provide this care[9].

In addition, with the implementation of the "Maria da Penha" Law (no. 11340), on August 7, 2006[5], legal mechanisms to restrain domestic and family violence against women were created.

WHO considers gender violence to be a worldwide public health problem[1]. The National Policy for Comprehensive Women's Healthcare[6] mentions that care within the health services for women who experience situations of violence is extremely important, given that such places are often the only ones sought. The prevalence of violence perpetrated by intimate partners is higher among female health service users, since they seem to repeatedly have a pattern of behavior of greater frequency of health service usage[10], because of the chronic effects of aggression on their health. The common problems described in the literature in addition to physical injuries are complaints of chronic pain (particularly pelvic pain and headache), digestive problems (such as irritable bowel and eating disorders), sexual dysfunction, depression, arterial hypertension and others[11]. However, this violence often goes unrecognized and no type of shelter, care, support or referral is provided. It is generally seen that violence in gender relationships is not accounted for in diagnoses that are made, and it is characterized by healthcare professionals as a problem that is extremely difficult to deal with[12,13]. Studies have shown that professionals' attitudes are often supportive of women who experience situations of violence, but that many professionals feel insecure in handling such cases[14].

Since March 2004, compulsory notification of cases of violence against women attended at public or private healthcare services has been in force in Brazil through law no. 10778 [15]. Because of the recent recognition of the status of gender violence as a health problem, an urgent need to train healthcare professionals has been seen. These professionals need to be capable of recognizing and managing cases of violence. Nevertheless, they generally recognize that they never had classes on this topic or dealt with such cases during their professional training[16]. Studies have affirmed that healthcare professionals tend to consider questions of violence as pertinent to the fields of security and justice[17]; they are fearful of becoming involved in this subject[20], limit themselves to treating the physical injuries[19] and do not receive any education on the subject[20]. It is also seen that, faced with clinical situations relating to violence, healthcare professionals' conduct is characterized by not accepting what is necessary or by making referrals to specialists, which does not always result in an appropriate response to the women's demands[21].

What can be gathered from this type of attendance is that this healthcare is reduced to dealing with the physical-biological effects. It is far from being comprehensive healthcare, which would involve other dimensions such as the social, cultural, legal and psychological aspects. In the light of these questions, a cross-sectional study was conducted with the aim of evaluating the knowledge and attitudes that healthcare professionals in Ribeirão Preto have in relation to gender violence, in order to identify the needs and specific features of a process for training healthcare professionals, given that there are few studies coving this problem [16,21,22,28].

Methods

A questionnaire was applied face-to-face to all nurses and physicians in the internal medicine, gynecology and walk-in clinic sectors in five primary district healthcare units within the Brazilian National Health System (*Sistema Único de Saúde*, SUS) in Ribeirão Preto. The questionnaire covered their knowledge about the definition of violence, certain epidemiological aspects of this subject, perceptions of violence and attitudes relating to gender violence. This questionnaire was an adapted version of an instrument that had been used in another

study conducted among medical residents and medical students[16]. It was based on an extensive review of the literature[12, 23-26], was tested on 13 professionals working in other services and certain changes in the response choices and formulation of the questions were introduced. Data gathering took two months, between August and October 2007, and was carried out by nine interviewers who had been previously selected and trained. The professionals were approached by the interviewers at the workplace and, if they were unable to attend to the questionnaire at that moment, a meeting on another occasion was arranged. If any professionals could not be found, and were not on vacation or on leave of absence, another two attempts to find them were made.

In this paper, we present an analysis on the healthcare professionals' knowledge and attitudes regarding gender violence. The questionnaire included six statements relating to their knowledge about the definition of gender violence, four statements regarding certain aspects of the epidemiology of this topic and one statement dealing with the professionals' perceptions regarding gender violence. For all of these 11 questions, responses of true/false type were requested. One point was awarded for each correct response. The total number of points was summed and a variable called "knowledge of gender violence" was created.

To evaluate the healthcare professionals' attitudes relating to gender violence, 17 statements with an agree/disagree response were used. In accordance with the agreement or disagreement, a mean score was obtained from the statements, such that the higher the score was, the greater the evidence of a positive attitude was. These statements were originally used in another study[14]. Their translation formed part of a process of transcultural adaptation that included two independent translators, back translation and three judges who were considered to be specialists in the subject, in accordance with the proposed methodology[27].

The interviewees' opinions regarding the invisibility of violence as a barrier against healthcare professionals' actions were also analyzed. These opinions were expressed as responses to the question: "In your opinion, why do professionals in your field often not inquire into violence against women that is committed by an intimate partner?"

The analysis sought associations between knowledge/attitudes and the interviewees' other characteristics, using the chi-square test with a significance level of 0.05. For the attitudes, the Mann-Whitney test was used to differentiate the scoring for different groups of characteristics such as sex, age, professional knowledge and length of service.

Results

Contacts were made with 278 healthcare professionals over the study period. Of these, 42 (15%) refused to grant an interview and 15 (5%) could not be found or were on vacation or on leave of absence.

Interviewees' characteristics

Out of the total of 221 interviewees, 51 (23.0%) were nurses and 170 (77.0%) were physicians. There were 119 men (53.8%) and 102 women (46.2%). The mean age was 38.6 years and the median age was 36.5 years. Among the men, the mean age was 39.6 and the median was 38 years, and among the women, the mean age was 34.4 years and the median age was 36 years. Out of the 221 interviewees, 110 (49.7%) were between 24 and 36 years, 57 (25.8%) between 37 and 47 years and 54 (24.4%) over 48 years of age.

With regard to race/color, 200 (90.5%) considered themselves to be white or Asian, while 21 (9.5%) said they were black or mulatto. Regarding religion, 142 (64.3%) said they were Catholic, 60 (27.1%) said they followed other religions and 19 (8.6%) said they did not have a religion.

These professionals had completed their training between one and 36 years earlier. The mean length of time for which they had been in professional practice was 12.5 years and the median was 10 years; 38.5% (85)

had been in practice for less than five years, 19% (42) for between 6 and 14 years, 32% (70) for between 15 and 25 years and only 10.9% (24) for more than 25 years. Most of these professionals (158; 68.8%) came from public universities.

Knowledge about gender violence

Definition of violence

The six statements that conceptualize gender violence are presented in Table 1, together with the results obtained. All the statements (a - f) are true. Most of the interviewees showed that they knew about the concept of gender violence, and the rate of correct responses ranged from 64.2% to 90.5%, although many interviewees (32.1%) showed that they were unfamiliar with the concept. The scores among the 221 interviewees regarding the definition of gender violence (minimum of 0 and maximum of 6) were as follows: 43.4% (96) obtained six points, i.e. correct responses for all the statements; 27.6% (61) gave five correct responses; 16.3% (36) four; 9.0% (20) three; 3.2% (7) two; and only one interviewee (0.45%) gave a single correct response. These scores were categorized as low, medium or high.

Knowledge of the definition of violence was not found to be associated with the sex, color, religion or profession (medicine or nursing) of the interviewees, but it was found to be associated with age. Among the 96 interviewees who obtained the maximum score, 59.3% (32) were in the age group older than 48 years, while among the 28 interviewees who obtained low scores (3, 2 or 1), 64.3% (18) were in the age group between 24 and 36 years ($p < 0.001$). This difference was statistically significant (table not shown).

Table 1 – Knowledge of gender violence and the epidemiology of violence among healthcare professionals at primary district healthcare units, Ribeirão Preto, 2008.

Gender violence (items a - f are true)	True	(%)	False	(%)	Don't know	(%)
a) Violence against women committed by their intimate partners with whom they maintain an intimate affective relationship is gender violence.	142	64.2	8	3.6	71	32.1
b) Violence within the sphere of the family is any violence committed by individuals who are or consider themselves to be relatives through natural ties or through affinity.	200	90.5	11	5.0	10	4.5
c) Scorning, defaming, hurting, constantly humiliating or intimidating women may be considered to be variants of violence against women if committed by intimate partners.	198	90	19	8.6	3	1.4
d) Occasional shoving and slapping are forms of gender violence when committed against women by their intimate partners.	193	87.3	4	1.8	24	10.9
e) Being forced to have sexual intercourse by an intimate partner is a form of gender violence.	198	89.6	2	0.9	21	9.5
f) Any conduct that consists of detention, withholding of rights or destruction of objects, work tools, assets or economic resources is considered to be moral violence.	169	76.5	33	14.9	19	8.6
Epidemiology of violence (items h and i are true)						
g) In most cases, violence against women is committed by unknown people.	1	0.45	213	98.4	7	3.2
h) Injuries to the body are rare in cases of violence against women.	36	16.3	175	79.2	10	4.5
i) One in every five women who go to prenatal services says that they have been abused by their partners.	61	27.6	43	19.5	117	52.9
j) Most women who experience situations of violence in Ribeirão Preto report this to their physician or health professional.	36	16.3	170	76.9	15	6.8

Knowledge about certain aspects of the epidemiology of gender violence

The four statements used to evaluate the interviewees' knowledge about the epidemiology of violence are presented in Table 1 (g-j). Among these statements, h and i are true. Attention was drawn to the lack of knowledge regarding the frequency of injuries to the body among women who suffer aggression (item h). The rate of correct responses to this item among the interviewees was only 16.3%. The same could be seen in relation to lack of knowledge of the prevalence of violence during pregnancy (item i), for which the results were correct responses from only 27.6% of the interviewees and "don't know" responses from 52.9%.

One point was given for each correct response relating to the statements about epidemiology. Thus, 47.0% (104) of the interviewees received no points, 45.7% (101) one point, 6.8% (15) two points and only one interviewee received three points. These scores were categorized as low, medium or high.

Knowledge about the epidemiology of violence was not found to be associated with sex, age, color or religion, but an association with the profession of physician or nurse was found. The difference in the number of points that they obtained in relation to the epidemiology of violence was significant. Among the nurses, 62.7% (32) obtained a low score, while among the physicians, 42.3% (72) obtained a low score (p = 0.035) (table not shown).

Perceptions regarding professional role

The professionals were asked whether their role should include asking about situations of violence against women, and 88.2% (194) of the interviewees said that it should.

This perception regarding profession role (yes/no) did not present any association with age, color, religion or profession, but there was an association with the interviewee's sex. Although only 26 respondents said that their professional role did not include asking about violence against women, 81% (21) of these respondents were male (p = 0.004) (table not shown).

There were only 218 respondents for the question on the invisibility of violence, because three individuals refused to answer it. Thirty interviewees (13.8%) disagreed with the idea that violence is not investigated in healthcare services. Among the professionals who agreed that violence is not investigated, there were various reasons why they agreed with this statement: 30 (13.8%) said that there was no institutional policy establishing such a routine in the service; 25 (11.5%) said that patients did not report such violence; 24 (11.0%) said that the professionals had no interest in this; 23 (10.5%) said that there was a lack of knowledge about this topic; 18 (8.3%) said that this was a topic that was difficult to deal with; 14 (6.4%) said that this was not a subject within the field of healthcare; 12 (5.5%) said that there were problems in the relationships with patients that prevented investigation of violence; 11 (5.0%) said that the professionals were fearful of becoming involved in this subject; and the remaining 25 (11.5%) gave other reasons such as lack of time, insecurity, lack of privacy or not knowing how to answer this question.

General knowledge regarding gender violence

After summing all the points obtained (out of a possible total of 11), the maximum score obtained was nine points and the minimum was three points. The mean was 6.4 and the median was 7.0. Considering all the interviewees, 9.5% (21) were categorized as having very low general knowledge about gender violence (2 to 4 points), 34.8% (77) had low knowledge (5 to 6 points), 34.4% (76) had good knowledge (7 points) and 21.3% (47) had high knowledge (8 and 9 points).

In summary, just over half of the interviewees (55.7%) had good or high general knowledge about violence and only 12.7% (28) were identified as presenting low

knowledge about the definition of gender violence, while 12% (26) said that management of such cases did not form part of their professional role. However, almost half of the interviewees (47%; 104) presented low knowledge about the epidemiology of gender violence.

Categorizing the general knowledge about gender violence as very low, low, good and high, no associations between knowledge about gender violence and the interviewee's sex, age, color, religion or profession were found.

Attitudes relating to the causes of violence

More than two-thirds of the interviewees (68.8%) agreed that aggression towards women by their husbands was caused by social factors such as unemployment and almost all of the interviewees (92,3%) believed that such aggression was caused by abusive use of alcohol and drugs. Only 22% agreed that aggression suffered by the woman at the hands of her husband was caused by psychological problems presented by the victim, whereas 73.3% agreed that this violence was due to the husband's psychological problems (Table 2). Female physicians with less time in the profession presented attitudes that were statistically significantly more positive towards the first of these two statements, while the attitudes of young male physicians were more positive towards the second of these statements (Table 3).

Attitudes towards victims and aggressors

The majority of the interviewees (93.7%) disagreed that it was acceptable for a man to beat his wife, even if he had been provoked (Table 2). Young nurses presented attitudes that were more positive towards this statement, and the difference was statistically significant (Table 3). The majority of the interviewees (92.8%) also disagreed that women who suffered aggression remained in this situation because of their masochism (Table 2). In relation to the mean score, interviewees who were young, with less time in the profession, male and physicians presented attitudes that were statistically significantly more positive regarding this statement (Table 3). The majority of the interviewees (82.4%) disagreed with the statement that violence perpetrated by an intimate partner was an intimate and private matter (Table 2). Younger female nurses disagreed with this statement more strongly, with a statistically significant difference (Table 3).

The majority of the interviewees (87.7%) also disagreed with the statement that husbands who are aggressors should receive compassion because they are emotionally disturbed. The older physicians presented statistically significant greater scores in relation to this statement (Table 3). Many respondents (75.1%) agreed that husbands who are aggressors should be imprisoned. Young nurses presented greater scores of agreement with this statement, and the difference was statistically significant (Table 3).

Attitudes relating to professional roles

The majority of the professionals interviewed (93.2%) considered that it was within the physician's or nurse's role to encourage the victims to get out of the situation of violence. Likewise, they considered their role to include supplying addresses of other places where care could be obtained (96.8%) and being alert with regard to perceiving situations of violence (92.2%). Most of them (93.7%) disagreed with the statement that the physician or nurse should only treat or care for the wounds and not ask questions or give advice to women who had suffered aggression. However, almost half of the interviewees (41.6%) would erroneously not confront the victim if she did not admit that violence was occurring, and most than half of them (58.8%) erroneously believed that prescribing tranquilizers to women who were experiencing situations of violence was correct. Around 30% did not believe that such violence was a medical problem,

Table 2 – Attitudes relating to gender violence among healthcare professionals at primary district healthcare units, Ribeirão Preto, 2008.

	Agree	N	Don't know	N	Disagree	N
a) The role of physicians in cases of victimized women should be the same as the role they perform for victimized children	69.6%	154	1.8%	4	28.4%	63
b) Aggression towards a woman by her husband should be considered and treated as a medical problem.	66.5%	147	2.7%	6	30.8%	68
c) Aggression towards a woman by her husband is caused by social factors such as unemployment.	68.8%	152	6.3%	14	24.8%	55
d) Aggression towards a woman by her husband is caused by abusive use of alcohol or drugs.	92.3%	204	2.7%	6	5%	11
e) Aggression towards a woman by her husband is caused by psychological problems presented by the victim.	22.1%	49	6.3%	14	71.5%	158
f) Women who suffer aggression from their husbands remain in this situation because of their masochism.	5%	16	2.3%	122	92.8%	83
g) Aggression towards a woman by her husband is caused by the husband's psychological problems.	73.3%	162	10.4%	23	16.3%	36
h) Husbands who are aggressive towards their wives should receive compassion because they are emotionally disturbed.	6.7%	15	5.45	12	87.7%	194
i) Husbands who are aggressive towards their wives should be imprisoned because of their aggression.	75.1%	166	6.3%	14	18.6%	41
j) It is acceptable for a husband to beat his wife if he has really been provoked.	0.4%	1	2.3%	5	93.7%	215
l) Aggression towards a woman by her husband is an intimate and private matter.	13.1	29	4.5%	10	82.4%	182
m) Physicians should only treat the wounds and not ask questions or give advice to women who have suffered aggression.	5%	11	1.4%	3	93.7	207
n) If a woman who is suffering aggression loses control, the physician should prescribe tranquilizers.	58.8%	130	9%	20	32.1%	71
o) Physicians should encourage victims to get out of situations of violence.	93.2%	206	3.6%	8	3.2%	7
p) Physicians should supply victims of violence with addresses of other places where they can receive care.	96.8%	214	0.9%	2	2.3%	5
q) Physicians should be alert towards diagnosing violence; for example, investigating whether there are any wounds even if the victim does not report them.	92.2%	174	2.3%	5	5.4%	12
r) Physicians should confront the victim if there is a suspicion of violence, even if the victim/patient does not admit this.	50.7%	112	7.7%	17	41.6%	92

and 28.4% believed that physicians' roles differed according to whether they were dealing with children or women in situations of violence (Table 2).

From analysis of Table 3, it can be seen that young nurses presented higher scores in relation to the statements that healthcare professionals should encourage women to get out of situations of violence, supply addresses of other places where care could be obtained and be alert with regard to perceiving situations of violence, and these differences were statistically significant. The disagreement with the statements that physicians should only treat the wounds and not ask questions or give advice to women who have suffered aggression, and that physicians should prescribe tranquilizers presented greater scores among the women aged less than 40 years. Greater scores were

Tabela 3 – Association between attitudes and certain variables that characterize healthcare professionals at primary district healthcare units, Ribeirão Preto, 2008

Statements	Variables														
	Sex			Age			Profession			knowledge			length of service		
	male	female	p	<40	≥40	p	nurse	physician	p	low 2- 6 pt	high 7-9 pt	p	≤15	>15	P
a) The role of physicians in cases of victimized women should be the same as the role they perform for victimized children.	3.62	3.60	*	3.51	3.73	*	3.76	3.56	*	3.40	3.78	0.0035	3.53	3.72	*
b) Aggression towards a woman by her husband should be considered and treated as a medical problem.	3.57	3.36	*	3.61	3.32	*	2.98	3.62	*	3.17	3.72	0.0002	3.61	3.30	*
c) Aggression towards a woman by her husband is caused by social factors such as unemployment.	3.54	3.51	*	3.57	3.48	*	3.45	3.55	*	3.58	3.48	*	3.54	3.50	*
d) Aggression towards a woman by her husband is caused by abusive use of alcohol or drugs.	4.16	4.12	*	4.18	4.09	*	4.16	4.14	*	4.17	4.11	*	4.17	4.10	*
e) Aggression towards a woman by her husband is caused by psychological problems presented by the victim.	3.57	3.69	*	3.79	3.43	0.0076	3.53	3.65	*	3.60	3.64	*	3.75	3.46	0.0400
f) Women who suffer aggression from their husbands remain in this situation because of their masochism.	4.27	4.24	*	4.42	4.05	0.0001	4.18	4.28	*	4.22	4.28	*	4.40	4.06	0.0007
g) Aggression towards a woman by her husband 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) Husbands who are aggressive towards their wives should receive compassion because 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) Husbands who are aggressive towards their wives should be imprisoned because of their aggression.	3.65	3.85	*	3.97	3.48	0.0012	3.78	3.73	*	3.74	3.74	*	3.90	3.53	0.0128
j) It is acceptable for a husband to beat his wife if he has really been provoked.	4.48	4.67	0.0128	4.63	4.50	*	4.61	4.55	*	4.64	4.50	*	4.61	4.51	*
l) Aggression towards a woman by her husband is an intimate and private matter.	3.79	4.10	0.0309	4.05	3.79	*	4.14	3.87	*	3.87	3.98	*	4.0	3.84	*
m) Physicians should only treat the wounds and not ask questions or give advice to women who have suffered aggression.	4.11	4.47	0.0004	4.38	4.15	0.0189	4.45	4.22	*	4.21	4.33	*	4.35	4.18	*
n) If a woman who is suffering aggression loses control, the physician should prescribe tranquilizers.	2.58	2.97	0.0086	2.90	2.59	0.0273	2.94	2.71	*	2.81	2.72	*	2.82	2.68	*
o) Physicians should encourage victims to get out of situations of violence.	4.17	4.34	*	4.28	4.21	*	4.37	4.21	*	4.29	4.22	*	4.25	4.25	*
p) Physicians should supply victims of violence with addresses of other places where they can receive care.	4.23	4.36	*	4.33	4.25	*	4.49	4.23	0.0069	4.33	4.26	*	4.28	4.30	*
q) Physicians should be alert towards diagnosing violence; for example, investigating whether there are any wounds even if the victim does not report them.	4.15	4.21	*	4.18	4.17	*	4.20	4.17	*	4.10	4.24	*	4.14	4.22	*
r) Physicians should confront the victim if there is a suspicion of violence, even if the victim/patient does not admit this.	3.22	3.08	*	3.13	3.19	*	2.98	1.29	*	3.06	3.23	*	3.15	3.16	*

*=p>0,005

also found among interviewees with high knowledge about gender violence who agreed that violence was a medical problem and that physicians' and nurses' roles in relation to victimized women and children should be the same.

Discussion

Most of the professionals interviewed had graduated from public universities and had had a reasonable level of experience of attending to patients, given the median of 10 years in the profession.

In the present study, an instrument for measuring knowledge was created based on the scientific literature and an instrument for measuring attitudes adapted from another cultural context was used. However, there were no control questions in each domain to check for contradictions or to control for politically correct discourse. This should be taken to be a limitation of this study.

On the other hand, this study enabled verification of the professionals' training needs. Most of them had good knowledge about the definition of violence against women and believed that their professional role included asking patients about situations of violence that they had experienced, but they were unaware of certain important aspects of the epidemiology of violence, as has also been found in similar studies[16,28]. Unawareness among the professionals regarding the high prevalence of violence means that violence remains invisible to healthcare services. Overall, only just over half of the interviewees (58.7%) had adequate knowledge (good or high) about gender violence, and this indicates the need to train more professionals to attend to cases of violence.

With regard to the barriers against investigating violence, attention was drawn to the belief among these professionals that, for there to be better attendance for cases of violence, a protocol for dealing with violence should be established within their work routine. From several studies[8,20,22,28], it has been found that screening protocols are of little use and lead to the risk of ineffectiveness and devaluation when used routinely. Thus, the professionals' lack of awareness was once again confirmed, thereby implying the need for training.

Most of the other barriers presented by the interviewees, such as non-reporting of violence and lack of interest and knowledge among the professionals, differed from those presented in the literature. In the existing literature, the main points mentioned as barriers against investigating violence have been lack of time at consultations and fear of becoming involved in the subject[28]. Women often do not report experiences of violence because they have not been asked about it[13]. Lack of knowledge about the real dimensions of such violence is coherent with lack of interest in and devaluation of the topic.

The percentage of refusals that was found (15%) suggests that there was difficulty in holding interviews during working hours, particularly because professionals working in the walk-in clinic were included in the study. On the other hand, refusal to participate may suggest that low value is placed on this topic, as was found in another study[18].

In relation to the attitudes investigated, it was seen that among the 17 statements, the positive response rate regarding 15 of them was more than 60%. This characterizes the interviewees as having attitudes that were favorable towards sheltering women who were experiencing situations of violence. It can be inferred that since most interviewees presented positive attitudes, they would show good potential for adequate case management, if they were to receive adequate training. More than two-thirds of the interviewees believed that social factors were present in the genesis of violence, along with psychological problems and alcohol and drug use. In a similar study developed in South Africa[14] that originally used these statements, similar results were found: 76.7%, 73% and 96.9% respectively. However, only 22% of our interviewees agreed that women who suffered aggression had psychological problems, while in South Africa, 59% agreed with this statement[14]. In

other words, our interviewees presented attitudes that were more positive than those of their colleagues in South Africa.

Most of our interviewees considered that violence against women was unacceptable and did not blame the women for being in this situation. On the other hand, 13% still argued that this was a private matter and 18% believed that the aggressors should not be imprisoned, thereby showing their lack of awareness of the "Maria da Penha" law. It is important to emphasize that only a small proportion of the interviewees did not believe that interventions in cases of violence were part of women's rights, just as there were few who disagreed with or were unaware of the new legislation on violence against women. The promulgation of the "Maria da Penha" law and its application, along with the different legal and institutional mechanisms for combating violence, is a very recent event within Brazilian society, and this may explain such attitudes.

The interviewees also demonstrated that they had attitudes that were very positive in relation to their professional role in dealing with women who were experiencing situations of violence. Nonetheless, it was notable that two attitudes that seem to be related to case management demonstrated unawareness among the professionals. Firstly, 41.6% of the respondents would not confront the victim if she did not admit that she was in a situation of violence. Confronting the victim is an important step towards removing the invisibility that surrounds violence and getting the woman to ask for help if she is experiencing such a situation[26,28]. Secondly, more than half of the respondents said that it was correct to use tranquilizers, even though it is known that this would aggravate the woman's vulnerability in situations of violence[26].

On the other hand, it seems that there was a certain degree of confusion among the professionals regarding their role. Among 194 professionals who agreed that asking questions regarding gender violence was part of the professionals' role, there were 54 interviewees (27.8%) who did not consider gender violence to be a healthcare problem. This may be explained by the fact that this topic does not form part of the curriculum of medical schools and is therefore not covered as a medical problem. It was only recognized by WHO as a healthcare problem in 1998.

A study conducted in South Africa[14] showed some similarity in relation to our results, but it can be noted that the attitudes towards women in situations of violence in our study were more positive, especially among the younger and female professionals.

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