

Readiness for intimate partner violence response: Knowledge, attitudes and practices among healthcare professionals in Santo Andre, Brazil



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Background

A growing body of work of promising approaches to responding to Intimate Partner Violence (IPV) has emerged. [1] Building an evidence base and addressing social norms that condone violence are among the strategies that have demonstrated potential.[2-4]

Healthcare providers (HCPs) who directly interact with women have the potential to play a critical role in IPV prevention and response.[5] Yet progress within the health sectors of low- and middle-income settings - has been slow to progress.[3, 5] HCPs are both members of the community and important change agents. Understanding community norms - particularly among HCPs themselves - is crucial to effective IPV intervention.

Community

In Santo André, Brazil - a low-income community of 600,000 in metropolitan São Paulo - suspected and confirmed cases of VAW increased by over 100% between 2009-2013.[6-7] The municipality recognizes VAW as a problem and is a partner in this research.

Methods

- Instrument adapted from the IPPF, Provider Knowledge, Attitudes and Practices (KAP) Survey on Gender Based Violence (GBV).[8]
- The Secretariat of Women's Policies (SPM) selected three public health posts in Santo André for inclusion.
- Data were collected via a self-administered survey.
- Eligible participants include all HCPs providing clinical services within the selected sites; a total of 123 individuals participated.
- Data were double data entered and cleaned using Epi Info 7. Analysis was conducted in Epi Info 7 and SAS using basic descriptive analysis and chi-square tests with Fisher's exact methods ($p < .05$) to account for small cell size.

Purpose

To identify structural and interpersonal barriers to Intimate Partner Violence (IPV) response among Healthcare Professionals (HCPs) working in public health clinics in Santo André, Brazil.

Results

Demographics: 75% of participants were female; 25.4% were community health workers; median age was 40.

Knowledge: 87.4% knew that violence in a relationship tends to increase over time.

Attitudes: Three quarters (75.5%) rejected victim blaming and 69.8% disagreed that IPV was a result of poverty or low education. However, few (22%), felt that it was a man's responsibility to control his sexual behavior.

Practices: Less than half (41%) said that in the past year they asked a woman about abuse or mistreatment.

The top 3 barriers were few opportunities for one-on-one interaction ($n=67$, 77.91%), a lack of privacy (61, 71.76%), and fear of offending women (62, 70.45%).

Behavior		Did not ask about IPV	Asked about IPV
Barriers to Action	* Statistically significant $p < .05$		
Few one on ones ($n=84$) p value .016*	Disagree	15.8% (3)	84.2% (16)
	Agree	49.2% (32)	50.8% (33)
No privacy ($n=84$) p value .031*	Disagree	25% (6)	75% (18)
	Agree	51.7% (31)	48.3% (29)
Fear of offending $n=86$; p value .095	Disagree	26.9% (7)	73.1% (19)
	Agree	48.3% (29)	51.7% (31)

Neither perceived comfort nor perceived role were associated with asking about violence.

Discussion

- Participants demonstrated moderate to high (40.1-92.9%) knowledge on a range of questions about IPV.
- Non-stigmatizing attitudes were observed in most participants.
- A "dose response" was observed where perceived severity of violence prompted a greater likelihood of inquiry.
- Identified barriers were largely structural in nature.
- Limitations included missing data from some questions, a small sample size, and uneven gender distribution. Data may also be limited by social desirability bias.
- Develop and test clinic-based intervention addressing IPV in Santo André (phase 2 of project).

References

- United Nations. Ending violence against women: from words to action. In-depth study on all forms of violence against women. Report of the Secretary-General. New York, United Nations General Assembly, 2006.
- Basile, K.C. & Saltzman, L.E. (2002). Sexual violence surveillance: Uniform definitions and recommended data elements. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.
- Ellsberg M, Arango DJ, Morton M, Gennari F, Kiplesund S, Contreras M, Watts C (2015) Prevention of violence against women and girls: what does the evidence say? Lancet Apr 18; 385(9977): 1555-1566.
- Ellsberg, Mary, et al. "Intimate partner violence and women's physical and mental health in the WHO multi-country study on women's health and domestic violence: an observational study." The Lancet 371.9619 (2008): 1165-1172.
- Garcia-Moreno C et al. (2005). WHO multi-country study on women's health and domestic violence against women: initial results on prevalence, health outcomes and women's responses. Geneva: World Health Organization, 2005.
- Prefeitura de Santo André. (2015). Mulheres de Santo André em pauta: perfil socioeconômico e mapa de violência. Santo André, Brazil: Prefeitura de Santo André, Secretaria de Orçamento e Planejamento Participativo, Secretaria de Políticas para as Mulheres.
- Prefeitura de Santo André. (n.d.) Em Santo André, o mapa da violência doméstica e sexual tem sexo. Prefeitura de Santo André website. <http://www2.santoandre.sp.gov.br/index.php/component/k2/item/948-em-santo-andre-o-mapa-da-violencia-domestica-e-sexual-tem-sexo>.
- Bott G, Guedes A, Claramunt MC, Guezmes A. (2010). Improving the health sector response to gender based violence: a resource manual for healthcare professionals in developing countries. New York: International Planned Parenthood Federation, Western Hemisphere Region (IPPF/WHR).

Acknowledgements

- Emory Global Health Institute
- Emory University Research Committee
- Silmara Conchão, SPM
- Danielle Matias Dantas, FMABC
- Marli Lima