Readiness for intimate partner violence response: Knowledge, attitudes and practices among healthcare professionals in Santo André, 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 intervention. [5] HCPs are both members of the community and important change agents. Understanding community norms - particularly among HCPs themselves - is crucial to effective IPV response. [6-7] Yet progress within the health sectors of low- and middle-income settings - has been slow to progress. [3,5]

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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.
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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


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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.

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.

Barriers to Action

<table>
<thead>
<tr>
<th>Behavior</th>
<th>Did not ask about IPV</th>
<th>Asked about IPV</th>
</tr>
</thead>
<tbody>
<tr>
<td>Few one on ones (n=84)</td>
<td>*Statistically significant p&lt;.05</td>
<td></td>
</tr>
<tr>
<td>p value .016</td>
<td>Disagree</td>
<td>15.8% (3)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>49.2% (32)</td>
</tr>
<tr>
<td>No privacy (n=84)</td>
<td>p value .031</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>25% (6)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>51.7% (31)</td>
</tr>
<tr>
<td>Fear of offending n=86, p value .095</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Disagree</td>
<td>26.9% (7)</td>
</tr>
<tr>
<td></td>
<td>Agree</td>
<td>48.3% (29)</td>
</tr>
</tbody>
</table>

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