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Sexual violence: knowledge, attitudes and practices of Primary Care professionals

Violência sexual: conhecimentos, atitudes e práticas de profissionais da Atenção Primária

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ABSTRACT
To investigate knowledge, attitudes, and practices of Primary Health Care professionals in the care of women in situations of sexual violence. Cross-sectional study, with 359 Primary Health Care professionals. Data were analyzed using descriptive statistics and risk ratio test ($p \leq 0.05$). 71.8% had knowledge, attitudes (72.7%) and preventive practices (92.2%), evaluative (85.5%), monitoring (72.1%) and assistance (46.8%) inappropriate. Professionals with inadequate knowledge were at increased risk for inappropriate attitudes, care practices and monitoring. Among professionals with inadequate preventive, care and monitoring practices, a higher risk for inappropriate attitudes was perceived. Most declared that they had not dealt with cases of sexual violence. Weaknesses were evidenced with regard to the care of women in situations of sexual violence, indicating the need for appropriate professional training, with an emphasis on overcoming the invisibility of the problem.

Keywords: Primary Health Care. Professional Training. Sex Offenses.

RESUMO
Investigar conhecimentos, atitudes e práticas de profissionais da Atenção Primária à Saúde no atendimento à mulher em situação de violência sexual. Estudo transversal, com 359 profissionais da Atenção Primária à Saúde. Os dados foram analisados mediante estatísticas descritivas e teste razão de risco ($p \leq 0,05$). Dos 71,8% apresentaram conhecimentos, atitudes (72,7%) e práticas preventivas (92,2%), avaliativas (85,5%), de acompanhamento (72,1%) e assistenciais (46,8%) inadequadas. Profissionais com conhecimentos inadequados tiveram risco aumentado para atitudes, práticas assistenciais e de acompanhamento inadequadas. Entre profissionais com práticas preventivas, assistenciais e de acompanhamento inadequadas, foi percebido risco maior para atitudes inadequadas. A maioria declarou não ter atendido casos de violência sexual. Evidenciaram-se fragilidades relacionadas ao atendimento da mulher em situação de violência sexual, indicando a necessidade de apropriada capacitação profissional, com ênfase na superação da invisibilidade do problema.

Palavras-chave: Atenção Primária à Saúde. Capacitação profissional. Violência Sexual.

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INTRODUÇÃO

Sexual violence is defined as a sexual act, attempted sexual act, unwanted comments or sexual advances, activities such as human trafficking and others against a person's sexuality using coercion, regardless of the aggressor's relationship with the woman in a situation of violence and the context[1].

According to the Pan American Health Organization[2] (PAHO), approximately one in three women (35%) suffer physical and/or sexual violence by their partner or third parties during their lifetime, and 38% of murders of women are committed by a male partner. In turn, in Brazil, in 2021, 225,455 cases of interpersonal and/or self-inflicted violence were reported, of which 2,668 cases occurred in Rio Grande do Norte[3]. In Mossoró (RN), 75 new cases of sexual violence were registered by the Institutional Program Flor de Lótus – Hospital Maternidade Almeida Castro in 2022[4].

The repercussions of sexual violence are multiple and include physical trauma, sexually transmitted infections (STIs), unwanted pregnancies, depression, insomnia, anxiety, sexual dysfunctions, even very serious cases that culminate in suicide[5]. For these reasons, it is important to have qualified professionals, with a broad view of health, to work with the object in question, which requires knowledge of specific norms and guidelines, appropriation of the concept and how to operationalize the intersectoral network, enabling multidisciplinary action that the problem deserves.

The work of professionals and teams of the Family Health Strategy (FHS) is essential, aiming at assistance, prevention, and health promotion, since the Basic Health Units (BHU) are the main places sought by women in situations of violence. Despite this, these demands at BHUs are not always met immediately and explicitly, appearing more as an implicit demand6. Furthermore, strategies are needed for the early identification of women in situations of sexual violence, involving qualification and professional training, as failure to diagnose or late diagnosis of sexual violence can lead to inadequate procedures and treatments, contributing to increase the morbidity and mortality of women. women in situations of violence[7].

However, despite major advances in public policies on professional qualification, we still see insecurity in the promptness of care for women in situations of sexual violence. The theme is still barely mentioned during graduation, little worked on in health courses and, sometimes, it is presented for the first time to professionals in the practice of the service or on their initiative to seek their own qualification[8].

Considering the above, the current research aimed to analyze the knowledge, attitudes, and practices of PHC/FHS professionals regarding health care for women in situations of sexual violence.

METHODS

Exploratory, cross-sectional study, with a quantitative approach, with FHS professionals in the city of Mossoró, the second most populous city in the state of Rio Grande do Norte (RN) and center of the western region of the state.

Based on the Primary Care Protocols - Women's Health[9], a structured questionnaire was prepared, consisting of 54 items that addressed: sociodemographic information, care protocol, identification of women in situations of violence, reception, ambience and interview, registration, coordination of the care, network and referrals, clinical evaluation and prophylaxis, pregnancy, notification, surveillance and monitoring, specific knowledge and qualification, promotion,

prevention and health education, as well as possibilities and challenges in the care process.

After 17 meetings with the executing team, the concepts of knowledge, attitudes, and practices of professionals in relation to care were constructed, based on the interpretation of the Protocol of Care for Women in Situations of Sexual and/or Domestic/Intrafamilial Violence of Primary Care - Women's Health, MS/ISLEP[10].

Thus, knowledge is the act of knowing a subject so that one can develop the work properly, through the acquisition of information about procedures, norms, guidelines, among other aspects, for the accomplishment of a task. Attitudes are characterized by the positioning/ attitude of professionals in the face of demands and the motivation to solve problems.

The practices are the fulfillment of routines in the services to meet the service demands; follow-up practices are characterized by forwarding, providing support and monitoring women in situations of violence; the evaluative ones deal with the aspects inherent to women in situations of violence, regardless of the adolescents' age and conditions; preventive practices provide information specific to the theme while focusing on prevention and health promotion actions, contributing to a culture of peace; finally, the assistance measures implement the measures that must be instituted in cases of sexual violence against women.

The application of the 359 questionnaires took place from November 2018 to July 2019, preceded by a pilot test at a BHU in a nearby city, which was not included in the survey. The instrument was applied in a printed form or through a self-administered online form, accessed through the participant's own electronic devices, depending on their preference and availability.

The inclusion criteria were: being an integral member of the FHSs (doctor, nurse, dentist, community health agent, nursing technician and oral health); be present at the BHU at the time of the visit/interview; and work in the investigated BHUs. Exclusion criteria were: being away; being absent at three prearranged times; and being a professional linked to the *Mais Médicos* Program.

Data were tabulated in the SPSS program version 20.010 and analyzed using descriptive statistics, followed by association between variables using the risk ratio test, p values ≤ 0.05 being considered significant.

The study was developed in compliance with Resolutions 466/12 and 566/16 of the National Health Council and their complementary ones, being approved by the Research Ethics Committee (REC) of the State University of Rio Grande do Norte (UERN) (Opinion No. 2.511.051 of 02/24/2018; CAAE – 82645518.3.0000.5294) and carried out in accordance with the Declaration of Helsinki.

RESULTS

359 professionals were interviewed, which corresponds to 49.93% (359/719) of those registered in the BHUs. The total number of participants for each variable does not reach the sample of 359 because not all respondents answered all questions (Table 1). The age range of the interviewees ranged from 26 to 85 years old, average of 44 years old, with 88.4% (312/353) being female. As for the professional categories, all were represented, with 49.7% (177/356) being community health agents and 14% (50/356) being nurses. The eastern region had the largest share of participants, 38.1% (136/357) of respondents.

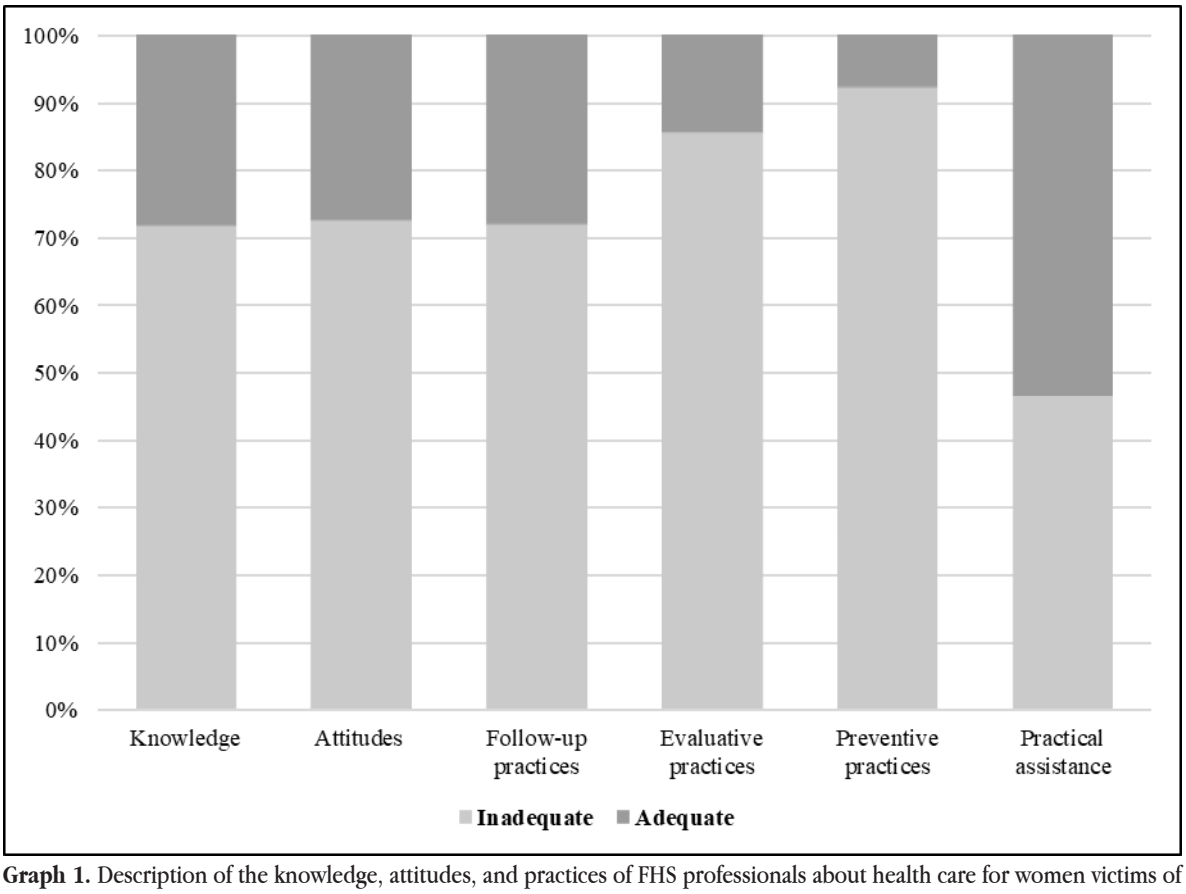
Most professionals, 73% (238/326), had less than ten years of professional experience; and 51.5% (172/334), less than ten years of service in the same BHU.

Table 1. Sociodemographic characteristics of FHS professionals interviewed - Mossoró, RN, 2019

Sociodemographic Characteristics	N	%	Sociodemographic Characteristics	N	%
Sex			**Basic Health Units**		
Male	41	11.6	**(Zone)**		
Female	312	88.4	North	61	17.1
Total	353	100	South	78	21.8
Age			East	136	38.1
Up to 29 years	14	4.6	West	51	14.3
From 30 to 39 years old	84	27.6	Rural	31	8.7
From 40 to 49 years old	124	40.8	Total	357	100
From 50 to 59 years old	72	23.7	**Time working**		
60 or more	10	3.3	**professionally**		
Total	304	100	Up to ten years	238	73
Profession			More than ten years	88	27
Médico	30	8.4	Total	326	100
Nurse	50	14	**Service time in**		
Dentist	24	6.7	**Unit**		
Nursing technician	41	11.5	Up to ten years	172	51.5
Oral health technician	34	9.6	More than ten years	162	48.5
Community health agent	177	49.7	Total	334	100
Total	356	100			

Source: Prepared by the authors with data from the applied questionnaire (2019).

Among the survey participants, the proportion of inadequacy of professionals was 71.8% (258/359) in knowledge; 72.7% (261/359) on attitudes; 92.2% (331/359) in preventive practices; 85.5% (306/359) in assessments; and 72.1% (259/359) were being followed up. Only care practices were adequate for just over half of respondents (53.2%) (Graph 1).



Graph 1. Description of the knowledge, attitudes, and practices of FHS professionals about health care for women victims of sexual violence — Mossoró, RN, 2019
Source: Prepared by the authors with data from the applied questionnaire (2019).

When the existence of adequate knowledge was analyzed in terms of the other dependent variables analyzed, it was observed that professionals with attitudes (RR = 1.524, p < 0.001), care practices (RR = 1.248, p < 0.001) and follow-up practices (RR = 1.248, p < 0.001) = 1.247, p = 0.011) had a significantly higher risk of having inadequate knowledge (Table 2).

Table 2. Association of knowledge about care for women victims of sexual violence with the attitudes and practices of Family Health Team professionals - Mossoró, RN, 2019

(Continua)

Variable	Knowledge		Risk ratio	P
	Inappropriate	Adequate	CI 95%	
Attitudes				
Inadequate	207 (80.2%)	54 (53.5%)	1.524 (1.248-1.861)	< 0.001*
Adequate	51 (19.8%)	47 (46.5%)		
Preventive practices				
Inadequate	241 (93.4%)	90 (89.1%)	1.199 (0.884-1.627)	0.243
Adequate	17 (6.6%)	11 (10.9%)		

(Conclusão)

Variable	Knowledge		Risk ratio	P
	Inappropriate	Adequate	CI 95%	
Evaluative practices				
Inadequate	225 (87.2%)	82 (81.2%)	1.155 (0.930-1.435)	0.144
Adequate	33 (12.8%)	19 (18.8%)		
Care practices				
Inadequate	135 (52.3%)	33 (32.7%)	1.248 (1.097-1.420)	< 0.001*
Adequate	123 (47.7%)	68 (67.3%)		
Follow-up practices				
Inadequate	197 (76.4%)	62 (61.4%)	1.247 (1.051-1.479)	0.011*
Adequate	61 (23.6%)	39 (38.6%)		

* Statistically significant

Source: Prepared by the authors with data from the applied questionnaire (2019).

The risk of professionals developing inappropriate attitudes was significantly higher among those whose preventive (RR = 1.755, p = 0.011), care (RR = 1.163, p = 0.019) and follow-up (RR = 1.413, p < 0.001) practices were inadequate. Those who performed inadequate care practices were also at greater risk (RR = 2.109, p < 0.001) of developing inadequate follow-up practices (Table 3).

Table 3. Association of attitude with the practices of Family Health Team professionals in caring for women victims of sexual violence — Mossoró, RN, 2019

Variable	Attitude		Risk ratio	P
	Inadequate	Adequate	CI 95%	
Attitudes				
Inadequate	249 (95.4%)	82 (83.7%)	1.755 (1.139-2.704)	0.011*
Adequate	12 (4.6%)	16 (16.3%)		
Preventive practices				
Inadequate	229 (87.7%)	78 (79.6%)	1.212 (0.968-1.517)	0.093
Adequate	32 (12.3%)	20 (20.4%)		
Evaluative practices				
Inadequate	132 (50.6%)	36 (36.7%)	1.163 (1.026-1.320)	0.019*
Adequate	129 (49.4%)	62 (63.3%)		
Care practices				
Inadequate	205 (78.5%)	54 (55.1%)	1.413 (1.175-1.700)	< 0.001*
Adequate	56 (21.5%)	44 (44.9%)		

* Statistically significant

Source: Prepared by the authors with data from the applied questionnaire (2019).

Regarding assistance, 78.4% (280) of the professionals reported never having assisted women in situations of sexual violence (Table 4).

The analysis based on the experience of providing assistance to women in situations of sexual violence demonstrated, in turn, that those who never performed it were at greater risk of developing inadequate preventive practices (RR = 1.504, p = 0.022), although they presented lower risk of performing inappropriate care practices (RR = 0.853, p = 0.006) (Table 4).

Table 4. Association of Family Health Team professionals who assisted or not women victims of sexual violence with the variables "knowledge", "attitudes" and "practices" - Mossoró, RN, 2019

Variable	Support for victims of violence		Risk ratio	P
	No	Yes	CI 95%	
Attitudes				
Inadequate	202 (72.1%)	54 (70.1%)	1.022	0.732
Adequate	78 (27.9%)	23 (29.9%)	(0.903-1.156)	
Preventive practices				
Inadequate	204 (72.9%)	55 (71.4%)	1.016	0.806
Adequate	76 (27.1%)	22 (28.6%)	(0.897-1.150)	
Evaluative practices				
Inadequate	265 (94.6%)	64 (83.1%)	1.504	0.022*
Adequate	15 (5.4%)	13 (16.9%)	(1.061-2.131)	
Care practices				
Inadequate	241 (86.1%)	64 (83.1%)	1.054	0.541
Adequate	39 (13.9%)	13 (16.9%)	(0.891-1.245)	
Attitudes				
Inadequate	120 (42.9%)	47 (61%)	0.853	0.006*
Adequate	160 (57.1%)	30 (39%)	(0.762-0.955)	
Preventive practices				
Inadequate	196 (70%)	61 (79.2%)	0.908	0.083
Adequate	84 (30%)	16 (20.8%)	(0.814-1.013)	

* Statistically significant

Source: Prepared by the authors with data from the applied questionnaire (2019).

DISCUSSION

This research demonstrates that inadequate knowledge about the care of cases of sexual violence increases the risk of health professionals having inadequate attitudes, care practices and follow-up. These findings corroborate national[11-13] and international[14,15] studies, which show the negative influence of inadequate knowledge on professional attitudes and practices.

It is noteworthy that most of the professionals participating in our research stated that they had never assisted women in situations of sexual violence. A study carried out in São Paulo shows invisibility and trivialization

as important factors that contribute to the lack of recognition of the problem and, consequently, of its management[16]. Facing the problem as real means rescuing it from invisibility, regardless of the scenario in which it finds itself.

Among professionals who did not assist women in situations of sexual violence, a greater risk of developing inadequate preventive practices was observed, but a lower risk of performing inadequate care practices. The lack of experience and experience leads to the development of inadequate preventive practices, because professionals possibly end up having a low perception of the relevance of their role in caring for women in situations of sexual violence. The biologicist model, more technical, distances this professional from the completeness of the theme.

Evidence points to an association between inadequate knowledge in health professionals and practical problems, such as late referral, poor management of conduct, lack of time for consultations, difficulties in teamwork and referral, lack of control in monitoring[17] and inappropriate psychosocial support[18]. It is possible that there is a relationship between the presence of low or very low knowledge and the development of negative attitudes in professionals — for example, perception of the phenomenon of violence as a social problem and not a health one[12,15].

Adequate knowledge is indispensable in recognizing sexual violence as a public health issue. From the moment that the theme ceases to be recognized as such, it is stripped of its importance, and attitudes cease to be taken, among them: keeping up-to-date mapping and collaboration with bodies and institutions, providing the BHUs with a list of addresses and telephone numbers of the service network, which must be known by all professionals, and activated when necessary.

Vieira[19] showed that health professionals agree with the fact that the implementation of a protocol in their services contributes to better care. Doctors and nurses consider that the protocol is important in care, in the sense of better guiding the conduct[20]. It is important to remember that such technology must be understood in its entirety, so as not to generate weaknesses that could favor the worsening of people's conditions, which would imply an increase in the demand for health services, higher costs, and overload among professionals. BHUs should establish internal service flows, defining the responsibility of each professional in accordance with Technical Standard No. 7,958[21].

Some weaknesses in this qualification date back to graduation, where gaps are perceived in the curricula of the health area related to the topic of sexual violence[20,22-23]. It is important to point out that the academic curricula in this area have not kept up with the speed of advances in the guidelines and norms dictated by public policies in recent years, generating a real mismatch between teaching and the needs of practice scenarios and everything that will be demanded of the professional future.

Properly designed and implemented preventive practices, which pave the way for the implementation of norms, guidelines, and laws, properly instrumented multidisciplinary teams, guided by PHC teaching-service integration, will probably influence the construction of a more dignified, "comprehensive, universal and egalitarian" public health"[21], contributing to a more fraternal and citizen society, in which the culture of peace prevails.

It is necessary to consider both the magnitude of integrating actions and informing people in situations of violence about everything that will be done during the service and the importance of each measure that will be implemented, such as: recording in the local

medical record, day, approximate time, type of violence and number of aggressors, in addition to the general and specific physical examination, the body that carried out the referral and indicate prophylaxis for STIs. These are necessary care practices that must go hand in hand with other practices, helping to ensure adequate attitudes guided by adequate knowledge.

In Curitiba (PR), a study with people in situations of sexual violence, carried out in a university hospital, revealed little preparation of professionals when people reported a long waiting time for care, which did not always correspond to their expectations[24]. Another study, carried out in Fortaleza (CE) and Rio de Janeiro (RJ), pointed out that professionals did not feel like participants in the care setting[19]. Many health workers still consider sexual violence the responsibility of justice and social assistance alone, a factor that contributes to the invisibility of the problem.

Incorporating gender violence as a priority issue in the health sector is essential for the development of adequate attitudes. Resisting the denial that sexual crimes do not represent a public health problem generates numerous consequences in the short and long term for the health of women in situations of violence[5] and those around them. Such a configuration may contribute to underestimating the magnitude of the "sexual violence" problem and its invisibility, sustained within a dimension of gender inequality and social norms. This brings, on the one hand, women who silence the violence of which they were or are victims, and on the other hand, professionals whose ability to suspect and carry out appropriate investigations may be limited by inadequate knowledge.

In turn, monitoring women in situations of sexual violence presupposes the involvement of professionals from different categories and a set of actions to mobilize support and protection mechanisms and care devices. In addition, it highlights the commitment to referral and counter-referral, forwarding, monitoring the evolution of patients and their path, preparing to receive them on return and continuing the therapeutic plan. It is, therefore, a long and complex process, which demands time, knowledge, standardization, and familiarity with the set of elements that characterize teamwork and networking, ensuring continuity of care.

However, the alignment of FHS teams and professionals with the guidelines for care for women in situations of sexual violence poses the challenge of identifying existing barriers and assessing the participation of different factors. Among them is inadequate knowledge, which was an element pointed out in this research. However, the participation of other factors should also be considered, both in relation to professionals and services, in addition to macrostructural aspects, especially in countries where the inclusion of the topic in public policies has recently occurred or whose impact on the provision of care to women in a situation of violence needs to be evaluated[15,18].

Considering training and professional qualification as a priority, in a multidisciplinary and intersectoral perspective, involving workers, management and the community, seems to be a defining strategy in combating the multifaceted theme we studied. This proves to be essential, considering the fact that the present study showed weaknesses regarding the care of women in situations of sexual violence by professionals from BHUs/FHSs in a municipality in western Potiguar.

CONCLUSION

Most professionals presented inadequate knowledge, attitudes, and practices (follow-up, evaluation, and prevention). Only the care practices were adequate in just over half of the

interviewees. Professionals with inadequate knowledge were at greater risk of developing inadequate attitudes and practices (assistance and follow-up).

Developing strategies that motivate professionals to get involved in coping with sexual violence in accordance with national and international guidelines and seeking to strengthen actions seems to be an appropriate path in the constant quest to act appropriately, according to the needs demanded. Also, appropriate professional qualifications are necessary to align with current guidelines and overcome the invisibility of the problem and the traditional healthcare model.

As limitations, this study faced the difficulty of applying the questionnaires due to work overload, difficulty in understanding and lack of priority on the part of professionals, in addition to the difficulty of access in some BHUs. It is suggested that future research be carried out involving managers of all levels of health care, aiming to identify the vision of these professionals, in addition to understanding what are the possible strategies used by the management team to meet the demands of women in situations of violence.

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