Original Article

Gender violence: knowledge and professional conduct of the family health strategy

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Violência de gênero: conhecimento e conduta dos profissionais da estratégia saúde da família

La violencia de gênero: conocimiento y conducta profesional de la estrategia salud de la familia

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ABSTRACT

Objective: To evaluate the knowledge and behaviors of health professionals of units of the Strategies Family opposite gender violence.
Methods: This descriptive study with 53 seven of units of the family health strategy professionals from March to July 2015. Data were collected through a self-administered instrument and analyzed in Excel 2007.
Results: It was observed that the knowledge of professionals about definitions, epidemiology and management of violence ranged from reasonable to good, despite knowing little about the prevalence of violence during pregnancy. Regarding the conduct was evident difficulty in questioning women about violence and its notification. Professionals with shorter assistance and who received training were more assertive results regarding conduct.
Conclusions: It is suggested that educational actions in service be carried out in order to provide subsidies for the professionals' action against cases of gender violence.
Keywords: Violence against women. Family health strategy. Knowledge. Attitude.

RESUMO

Objetivo: Avaliar os conhecimentos e condutas de profissionais de unidades da Estratégia Saúde da Família frente à violência de gênero.
Métodos: Estudo descritivo, realizado com 53 profissionais de sete unidades de Estratégia Saúde da Família no período de março a julho de 2015. Os dados foram coletados por meio de instrumento autopreenchido e analisados no software Excel 2007.
Resultados: Observou-se que o conhecimento dos profissionais sobre as definições,
epidemiologia e manejo da violência variou de razoável a ótimo, apesar de conhecerem pouco sobre a prevalência de violência durante o período gestacional. Quanto às condutas, evidenciou-se dificuldade em questionar as mulheres sobre a violência e sua notificação. Os profissionais com menor tempo de assistência e que receberam capacitação apresentaram condutas mais adequadas.
Conclusões: Sugere-se a realização de ações educativas visando fornecer subsídios para a atuação dos profissionais frente aos casos de violência de gênero.
Palavras-chave: Violência contra a mulher. Estratégia saúde da família. Conhecimento. Atitude.

RESUMEN

Objetivo: Evaluar el conocimientos y el comportamientos de profesionales de unidades de la salud de la familia Estrategias violencia de género opuesto.
Métodos: Estudio descriptivo con 53 profesionales de unidades de La salud de la familia de siete estratégias en el período de marzo a julio de 2015. Los datos fueron recolectados a través de un instrumento de auto-administrados y analizados en el software Excel 2007.
Resultados: Se observó que el conocimiento de los profesionales acerca de las definiciones, la epidemiología y la gestión de la violencia varió de razonable buena, a pesar de saber poco acerca de la prevalencia de la violencia durante el embarazo. En cuanto a la conducta era evidente dificultad para cuestionar las mujeres acerca de la violencia y su notificación. Los profesionales con la asistencia más corto y que recibieron entrenamiento fueron los resultados más asertivo respecto a la conducta.
Conclusiones: Sugieren la realización de actividades de educación en servicio para proporcionar información para el trabajo de los profesionales en los casos de violencia de gênero.
Palabras clave: Violencia contra la mujer. Estrategia de salud familiar. Conocimiento. Actitud.

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INTRODUCTION

Gender violence is a serious public health problem[1], highly prevalent around the world. A study revealed that one in every three women has experienced physical or sexual violence from partners, family members or people with whom they have intimate affective relationships[2].

The consequences of gender violence in women's health lead them to search the closest health centers to their houses, demanding answers[3]. Considering this, Primary Health Care, represented by the Family Health Strategy (ESF), is recognized as an adequate space to welcome women in gender violence situations, since this model of attention has the bond between professional and user as one of its basis, and works with the inclusion of the population of the territory[4].

Gender violence is seen as a health problem by the ES professionals, although is not seen as a priority. The non-existence of a specific program to face this grievance is one of the reasons for the deficit in the reception of this demand[5]. The non-existence of a structured and articulated service network also makes care more difficult[4]. Thus, the investigation of cases of gender violence by the health sector is denied by the professionals, seen as a social issue, under the scope of other sectors. Once the problem is identified, their actions are limited to the treatment of lesions[3].

Therefore, a recognition of violence by health professionals is made much more difficult, and the lack of professional training is a factor that motivates that[6]. The lack of professional preparation, as a result of shortcomings during the education of the professional, or of the absence of service qualification, directly influences actions regarding care in these situations, having as one of its impacts the lack of recognition of the violence that affects many women who look for the service[7].

Caring for women who were victims of gender violence requires the ESF professional to have a perspective and care practices that lean towards gender issues. Knowledge about the health needs generated by female oppression, based on gender issues, should guide the conduct of the team. However, this knowledge is not always present, which directly implicates in conducts that are limited by a biomedical model, and represented by tendencies to treat all problems as medical or psychological[4].

In face of this problem, the guiding question of this study was: What are the knowledge and conducts of ESF professionals regarding gender violence? Its objective is evaluating the knowledge and the conduct of professionals from ESF units regarding gender violence.

METHOD

This is a descriptive and quantitative study, conducted with health professionals from the seven ESF units of a municipality in the northwest region of the State of Rio Grande do Sul, Brazil. The setting of the study included all ESF units in the municipality. Among the actions offered in these units is the assistance to women's health through prenatal and puerperal consultations, breast and cervical cancer consultations, prevention of Sexually Transmissible Infections and family planning.

During the data collection period, these units had a total of 73 health professionals. The inclusion criteria were: being a health professional (physician, nurse, nurse technician, community health agent, dentist or oral health auxiliary) and work in an ESF unit. The exclusion criterion was: being on any type of leave in the period of data collection.

For the final sample, two professionals (2.7%) were temporarily dismissed, five (7.0%) chose not to take part on the research, and 13 (19.3%) did not answer the questionnaire, to a total of 53 health professionals, and a response rate of 74.6%.

A questionnaire was given for the participants to complete, adapted from the instrument used by Vieira and Vicente[8]. For the scale of attitudes, questions from a questionnaire conducted in South Africa were used[9]. The instrument went through translation and transcultural adaptation processes[10]. Questions regarding sociodemographic variables were included.

The questionnaire was tested with two professionals from the Center of Planning and Assistance to Women's Health in the city, and modified to be applied to the ESF professionals. Data collection took place from March to July 2015. The questionnaire was delivered in a closed envelope with directions for each member of the ESF team. The researcher delivered the envelope and explained the Free and Informed Consent Form (FICF). Then, the professionals who accepted to participate in the study signed two copies of it, keeping one and giving the other back to the researcher. After one week, the questionnaire was retrieved.

A descriptive analysis was conducted, regarding the knowledge and the attitudes of the professional regarding gender violence, involving issues such as concept, epidemiology and perception of the professional regarding the subject. Questions about their knowledge had true (T) or false (F) answers, and those about the concept of violence were all true. Regarding epidemiology, the first and the last were: F; the second and third: T; regarding the disclosure of violence, the answers were: T, F, T, F and T; regarding case management, they were: F, T, F, T, T; regarding the sings of instances of violence, the answers were: F, T, F, F, F, T, T, F and T. Regarding the

attitudes, the answers were "agree" or "disagree". Concerning how does the professional feel when approaching themes such as violence, sexuality and drug use, the possible answers were: uncomfortable, at ease, or indifferent.

Data was inserted and analyzed in the software Excel 2007, considering the simple frequency of each variable, and the stratification according to time of work and training in the service for variables regarding the attention. To analyze the knowledge and the conduct of the professionals, scores were elaborated, according to correct, incorrect, or do not know answers. Regarding the correct answers, the following was adopted: < 50% right answers - low knowledge; from 50% to 60% right answers - reasonable knowledge; 61% - 70% - good knowledge; 71% to 80% - very good knowledge; 81% to 90% - great; and >91% - excellent knowledge. Regarding the incorrect: < 50% wrong answers - low knowledge; from 50% to 60% - reasonable knowledge; 61% - 70% - little knowledge; 71% to 80% - very little knowledge; 81% to 90% - extremely little knowledge; and >91% - almost no knowledge. And concerning the do not know answers: < 50% - low knowledge; 50% to 60% - reasonable knowledge; 61% to 70% does not know - little knowledge; 71% to 80% - very little knowledge; 81% to 90% - extremely little knowledge; and >91% - almost no knowledge.

The study respected the norms of the Resolution nº 466/2012 of the National Health Council, and was approved by the Committee of Research Ethics under Protocol nº 909978.

RESULTS

Regarding the characteristics of the participants, the age average was 37.7 years; 88.7% declared themselves to be white; 54.8% Catholics; regarding the marital status, 62.2% were married. According to the instruction level, 13.3% were graduated in nursing; 5.7% in medicine; 3.7% in odontology; 22.6% in other courses (languages and linguistic, public management, biology, pedagogy, physical education and social services); 45.3% had only completed elementary or high school, and 9.4% did not respond.

When questioned about the professional training regarding violence, 83.1% consider it very important and 66.0% state to have received instructions about it at work. When evaluating the feelings of professionals regarding gender violence, it was found that 52.0% felt it was uncomfortable to ask whether the woman was submitted to situations of violence with her partner, and 44% felt the same when asking about illegal drugs. The professionals felt most at ease to ask about smoking (88.0%) and alcohol consumption (58.0%)(Table 1).

Table 1 - Description of the sample according to the feelings of the Family Health Strategy professionals regarding the phenomenon of gender violence during the assistance offered. Palmeira das Missões/RS, Brasil, 2015

How does the professional feel when asking	Uncomfortable n (%)	At ease n (%)	Indifferent n (%)	Has never asked n (%)
About the consumption of alcoholic beverages	15 (30.0)	29 (58.0)	01 (2.0)	05 (10.0)
Whether the user smokes	04 (8.0)	44 (88.0)	01 (2.0)	01 (2.0)
About the sex life of the user	16 (32.0)	18 (36.0)	02 (4.0)	14 (28.0)
Whether the user uses illegal drugs	22 (44.0)	18 (36.0)	10 (20.0)	00 (0.0)
Whether the user experiences violent situations with her partner.	26 (52.0)	10 (20.0)	01 (2.0)	13 (26.0)

Source: Research information, 2015.

Table 2 presents the view and concepts regarding gender violence. Regarding the attitudes, most participants agreed that: the role of the professionals during care for gender violence must be the same that applies for situations where children are victims (65.3%). Most also agreed that: aggression is a problem (98.0%); the use of alcohol and drugs (69.9%) and psychological problems (64.8%) are motivations for violence. More than half (58.4%) did not agree that: social problems are situations that cause violence.

There was some disagreement regarding: whether women who suffered aggression by their husbands were in this situation due to their masochism (83.0%). Regarding the aggressors, there was a disagreement regarding: whether they should be treated with compassion due to emotional disturbances (88.5%); whether a husband has the right to beat his wife (98.1%); whether aggression to women is an intimate and private issue (68.6%). 92.4% agreed that the husbands must be arrested because of the aggression (Table 2).

Table 2 - Description of the sample according to the opinion and professional concepts of Family Health Strategy Professionals regarding gender violence. Palmeira das Missões/RS, Brasil, 2015

Vision and concepts of professionals regarding gender violence:	Agree n (%)	Disagree n (%)	Indifferent n (%)
The role of the professional is the same as in cases where the victims are children.	34 (65.3)	17 (32.7)	01 (2.0)
The aggression must be considered as a problem by the professional at the ESF.	51 (98.0)	01 (2.0)	00 (0.0)
The aggression by the husband is caused by social factors such as unemployment.	15 (28.3)	31 (58.4)	07 (13.3)
The aggression by the husband is caused by alcohol and drug abuse.	37 (69.9)	12 (22.6)	04 (7.5)
The aggression by the husband is caused by psychological problems of the victim.	12 (23.0)	29 (55.8)	11 (21.2)
The aggression by the husband is caused by psychological problems of the husband.	33 (64.8)	13 (25.4)	05 (9.8)
Women physically abused by their husbands stay in this situation due to masochism.	07 (13.2)	44 (83.0)	02 (3.8)
There should be compassion towards the aggressors, since they are emotionally disturbed.	02 (3.8)	46 (88.5)	04 (7.7)
The husbands must be arrested because of the aggression.	48 (92.4)	02 (3.8)	02 (3.8)
It is acceptable for a husband to beat his wife.	01 (1.9)	51 (98.1)	00 (0.0)
The wife's aggression by the husband is a private and intimate issue and as such should be treated.	11 (21.6)	35 (68.6)	05 (9.8)

Source: Research information, 2015.

Data from Table 3 allow for the identification of the knowledge of professionals regarding: gender violence, the definitions of violence against women, about statements regarding epidemiology and the morbimortality rates of violence against women, committed by intimate partners, and about the attitudes and management of professionals regarding the unveiling of violence.

Regarding knowledge about gender violence, more than 80% of professionals showed to know the concept of violence. Above 80% of the statements about violence epidemiology were marked as true, indicating that the professionals have little knowledge regarding the theme. Concerning the prevalence of violence in pregnancy, only 11.8% of the answers were correct, and 50.9% answered not to know. Regarding corporal lesions, 35.3% of the answers were correct and 56.9% were mistaken. Considering the unveiling of violence, little knowledge about the direct approach of the users regarding violence was found, with only 19.3% of correct answers. Most professionals demonstrated to know how they should approach women regarding the violence they had been through (Table 3).

Regarding the management of violence cases, the knowledge of the professionals reasonable to great, with percentage of right answers in questions 1, 2, 4 and 5 that went from 66.8% to 94.2%. Regarding the prescription of tranquilizers/antidepressants, 60.8% did not know or answered the question mistakenly, and 39.2% gave it the correct answer, revealing that, in general, there is little knowledge regarding the theme (Table 3).

In the presence of signs of violence against women, the questions regarding the recommendation of couple's therapy had 81.2% of wrong and do not know answers, while the question involving the suggestion of psychotherapy had 92.4%. Regarding the compulsory notification, 70.5% of the answers were correct, indicating a good level of knowledge about the theme. On the other hand, regarding the notification of the cases, 50.1% of people answered correctly, and 40.9% stated not to know, indicating the need for clarification regarding the execution of the procedure. The amount of wrong answers (97.8%) regarding the use of protocols for the management of violence cases also stood out. In the other questions in this group, the relative number of right answers from the professionals varied from 82% to 97% (Table 3).

Table 3 - Description of the sample according the knowledge of professionals from the Family Health Strategy regarding gender violence. Palmeira das Missões/RS, Brasil, 2015

Knowledge of the professionals regarding:	True n (%)	False n (%)	Do not know n (%)
- Definitions of violence against women			
Violence inside the family and any violence committed by individuals that are or consider themselves to be relatives.	42 (80.8)	04 (7.7)	06 (11.5)
Diminishing, slandering, humiliating and intimidating are variants of the violence committed against women by intimate partners.	51 (96.2)	01 (1.9)	01 (1.9)
Pushes and slaps are types of gender violence.	50 (98.0)	01 (2.0)	00 (0.0)
Being forced to have sexual relationships with an intimate partner is a form of violence.	52 (100)	--	--
Any conduct that configures retention and destruction of objects is considered a moral violence.	46 (90.2)	04 (7.9)	01 (1.9)
- Statements regarding epidemiology and the rates of morbimortality of the violence committed against women by intimate partners			
In most cases the violence is practiced by unknown people.	02 (3.8)	46 (88.5)	04 (7.7)
In few occasions of aggression against women there are corporal lesions.	18 (35.3)	29 (56.9)	04 (7.8)
One of every five women that go to prenatal services state that they suffer abuse from their partners.	06 (11.8)	19 (37.3)	26 (50.9)
Most women who live in a situation of violence in Palmeira das Missões reports to their physician or to another professional.	08 (15.4)	35 (67.3)	09 (17.3)
- In face of the unveiling of a violent situation the professional should			
Approach the patient directly and ask: "Are you being beat at home?"	10 (19.3)	37 (71.1)	05 (9.6)
Avoid approaching the subject unless this is the main complaint of the patient.	16 (30.8)	31 (59.6)	05 (9.6)
Ask if there is anyone with alcohol abuse problems at home and if this person gets violent when they drink.	12 (23.6)	36 (70.6)	03 (5.8)
Ask insistently if the patient experiences violent situations.	12 (23.6)	36 (70.6)	03 (5.8)
Explain that violence against women is very common in the lives of women and say that they ask that to all patients.	37 (71.2)	11 (21.2)	04 (7.6)
- Regarding the management of violence cases			
The professional should ignore bruises or other signs of violence if the patient does not talk about them	02 (3.9)	50 (96.1)	--
The professional should schedule follow-up visits with intervals below 1 month if they suspect the patient suffers violence at home.	49 (94.2)	--	03 (5.8)
The physician should prescribe tranquilizers so the patient can deal with possible problems they have at home.	11 (21.6)	20 (39.2)	20 (39.2)
In cases of sexual violence, the attention should be directed to emergency contraception, STI/aids prophylaxis, and pregnancy interruption according to the law.	34 (66.8)	06 (11.7)	11 (21.5)
Evaluate the risk the woman is under considering the types of aggression and the results of violence.	44 (84.6)	01 (1.9)	07 (13.4)

- When there are signs of violence against the woman committed by an intimate partner, the professional:			
Should advise the woman to leave her partner immediately.	11 (22.0)	27 (54.0)	12 (24.0)
Should propose to the patient the elaboration of a safety plan for her and her children.	41 (82.0)	02 (4.0)	07 (14.0)
Should recommend couples counseling.	22 (51.2)	08 (18.6)	13 (30.2)
Should indicate psychotherapy.	25 (58.1)	02 (4.6)	16 (37.3)
Since the information is confidential, the fact should not be notified.	05 (11.3)	31 (70.5)	08 (18.2)
The professional should comply to the compulsory notification.	22 (50.0)	04 (9.1)	18 (40.9)
Give the phone number of an organization that takes care of women who are victims of violence.	40 (86.9)	--	06 (13.1)
Resort to the protocols for the management of gender violence cases from the MH.	45 (97.8)	--	01 (2.2)
Guide the women victimized by violent situations to look for the Police Station for the Defense of Women.	45 (97.8)	--	01 (2.2)

Source: Research information, 2015.

The characteristics of feeling, knowledge, belief and conduct of professionals, considering the period they have been working in healthcare services, and the previous exposure to trainings on the theme "gender violence", are described in Table 4.

When verifying the information related to the conduct of professionals when confronted with gender violence situations, it was found that working in the health services for less than 10 years indicates a better knowledge of the ways to act towards the user. Also, professionals that received training in service recognized the situations of violence and the conduct that should be followed. It stands out that, among the professionals who have been working in the health services for longer times, one fourth believed that the husbands who assaulted their wives should not be arrested, and that the aggression should not be treated as a problem by the physician (Table 4).

Table 4 - Characteristics regarding the feelings, knowledge, belief and conduct of professionals, considering the period they have been working in health care services and training. Palmeira das Missões/RS, Brasil, 2015

Variable	Time working in health care			Training in the Service			Total n (%)
	≤ 10 years n (%)	> 10 years n (%)	IGN n (%)	Yes n (%)	No n (%)	IGN n (%)	
Confronted with a woman who is a suspected victim of violence, the professional agrees that:							
Aggression towards the women by her husband should be considered and treated as a problem by the physician.	27 (53.0)	13 (25.5)	11 (21.5)	35 (68.7)	12 (23.5)	04 (7.8)	51
Aggression to women is caused by abusive alcohol and drug consumption	22 (59.5)	06 (16.2)	09 (24.3)	26 (70.2)	08 (21.6)	03 (8.2)	37
The aggression to women is caused by psychological problems of the victim.	14 (42.4)	10 (30.3)	09 (27.3)	24 (72.8)	06 (18.2)	03 (9.0)	33
The husbands must be arrested due to the aggression.	24 (55.2)	13 (28.1)	11 (22.9)	31 (64.5)	12 (25.0)	05 (10.5)	48

About the definition of violence against women, the professional believes that:							
Violence inside a family is any type of violence committed by individuals who are or consider themselves to be relatives, united by bonds or affinities.	22 (52.4)	12 (28.6)	08 (19.0)	26 (62.0)	13 (30.9)	03 (7.1)	42
Pushes and slaps are types of gender violence committed against women by their intimate partner.	27 (54.0)	13 (26.0)	10 (20.0)	33 (66.0)	12 (24.0)	05 (10)	50
Being forced to have sexual relationships with an intimate partner is a form of gender violence.	27 (52.0)	14 (26.9)	11 (21.1)	35 (67.3)	12 (23.0)	05 (9.7)	52
Regarding the unveiling of violence, the professionals believes they should:							
Explain that violence against women is very common in the lives of women and say that they ask that to all patients, and then ask: "Have you been abused or beat by your partner?"	18 (48.8)	11 (29.6)	08 (21.6)	26 (70.2)	08 (21.6)	03 (8.2)	37
Regarding the management of violence cases, the professional believes that:							
The professional should schedule follow-up visits with intervals below 1 month if they suspect the patient suffers violence at home.	27 (55.1)	14 (28.6)	08 (16.3)	31 (63.2)	13 (26.5)	05 (10.3)	49
In cases of sexual violence, the attention should be directed to emergency contraception, STI/aids prophylaxis, including pregnancy interruption, as prescribed by law.	18 (53.0)	10 (29.5)	06 (17.5)	24 (70.6)	07 (20.5)	03 (8.9)	34
Evaluate, with the women, the risk they are under, considering the types of aggression and the results of violence.	22 (50.0)	13 (29.5)	09 (20.5)	29 (66.0)	10 (22.7)	05 (11.3)	44
When there are signs of violence against women, the professional believes that they should:							
Propose to the patient the elaboration of a safety plan for her and her children.	20 (48.8)	12 (29.2)	09 (22.0)	28 (68.2)	09 (22.0)	04 (9.8)	41
Recommend couples counseling.	12 (54.6)	06 (27.2)	04 (18.2)	19 (86.4)	02 (9.0)	01 (4.6)	22
Indicate psychotherapy.	13 (52.0)	07 (28.0)	05 (20.0)	19 (76.0)	05 (20.0)	01 (4.0)	25
Suggest that the patient brings the partner in the next time coming to the service, so they can talk.	12 (52.1)	05 (21.8)	06 (26.1)	17 (74.0)	05 (21.8)	01 (4.2)	23

Give her the phone number of shelters and organizations that take care of women who are victims of violence.	20 (50.0)	10 (25.0)	10 (25.0)	30 (75.0)	08 (20.0)	02 (5.0)	40
Resort to the protocols for the management of gender violence cases from the MH.	17 (53.1)	08 (25.0)	07 (21.9)	25 (78.1)	05 (15.6)	02 (6.3)	32
Guide the women victimized by violent situations to look for the Police Station for the Defense of Women.	24 (53.3)	10 (22.2)	11 (24.5)	32 (71.2)	11 (24.4)	02 (4.4)	45

Source: Research information, 2015.
Note: (*) The ignored answers were not considered for the calculation of percentages.

In Table 5, the answers from the professionals regarding gender violence situations are given.

The professionals with the lowest time of service (<10 years) felt more comfortable to ask about the use of drugs and violent situations. Most of them believed that women who are under violent situations have some advantage as a result and therefore accept the situation (Table 5). Considering professionals who had been working on the health care service for >10 years, half of them believed they should not advise the woman to leave the partner and notify the fact. This number was higher among individuals who had received training at work (Table 5).

Table 5 - Behavior of professionals when confronted with situations of gender violence according to how long they work in health care and their training. Palmeira das Missões/RS, Brasil, 2015

The professional	Time working in health care		Training in the Service		Total
	≤ 10 years n (%)	> 10 years n (%)	Yes n (%)	No n (%)	
***Feels uncomfortable when asking women about:**					
Drugs	16 (88.8)	02 (11.1)	16 (72.8)	06 (27.27)	22
Violent situations	14 (77.7)	04 (22.2)	21 (80.76)	05 (19.3)	26
* Believes that women who are under violent situations have some advantage as a result and therefore accept the situation.	19 (65.51)	10 (34.6)	26 (70.27)	11 (29.72)	39
*** Believes that, regarding the management of violence cases, they should not:**					
Ignore bruises or other signs of violence if the patient does not talk about them.	28 (70.00)	12 (24.0)	32 (71.11)	13 (28.8)	50
***Believes that when there are signs of violence against women, they should:**					
Advise the woman to leave her partner immediately.	13 (65.0)	07 (25.9)	17 (70.08)	07 (29.1)	27
Since the information is confidential, the fact should not be notified.	15 (62.5)	09 (37.5)	21 (72.41)	08 (27.58)	31

Source: Research information, 2015.
Note: (*) The ignored answers were not considered for the calculation of percentages.

DISCUSSION

The professionals of this study see gender violence as a demand from the ESF, but feel uncomfortable when asking users about it, and some have never done so. When caring for violence cases, certain health professionals feel inhibited to talk about issues that surpass traditional care conducts[11]. The sensitization for the work from a biopsychosocial perspective of the health/sickness process is paramount[12], considering how complex gender violence is.

The lack of knowledge on how to act leads the professional not to directly approach the subject, even in cases where there is the suspicion of violence[11]. The adequate formation of these professionals is favorable for the detection of gender violence[12]. Another study, developed with nurses in Spain, also unveiled that the lack of adequate formal education in the field is the main difficulty in the identification of these cases of violence[13].

Most professionals see partner violence as an intimate and private issue, and its causes not as results of a social order, but of psychological issues, and drug and alcohol abuse by the aggressor. The use of alcohol and drugs can open the doors for cases of gender violence, as it increases stress and diminishes censorship[5].

The domestic environment is considered to be an intimate space, where privacy is guaranteed, and perhaps that is why violence is a difficult issue to approach for many professionals[11]. Although the means of communication divulge information with notions that gender violence is a social problem, its effects are subtle. In addition, there are professionals whose conservative views reinforce the idea that the problem is private[5].

The professionals in this study believe that the aggressor should be arrested. This measure, prescript in the Law Maria da Penha[14], contributes to diminish gender violence.. For it to do so, women must know the measures prescribed by this law, denounce the aggression and follow up with the police inquiry, accessing the police and justice services. To this end, health professionals, when helping women, should reinforce the importance of this law, whether in health service or in their residence, seeking to empower them regarding their rights.

The participants of the research demonstrated good knowledge about the dimensions: definitions, epidemiology, unveiling, management of cases and signs of violence against women. The inability to direct cases is also attributed to the little to no attention given to gender violence in undergraduate curricula[7]. Therefore, stands out the need to include the theme in the academic graduation and professional training[5].

The low epidemiological knowledge of the professionals from the study may be associated to the difficulty of relating violence to the signs related by women. A lack of knowledge about epidemiology is reported in a small research conducted in Ribeirão Preto[15]. The little knowledge of professionals regarding the prevalence of women who suffer aggression, and the presence of corporal lesions, can prevent the investigation of those who get to the unit hurt due to violence. Physical aggression is the most recognized in health spaces, and still, it is invisible in professional conduct[3].

Most professionals did not know about the high prevalence of violence during pregnancy. Several studies have presented the prevalence of violence during pregnancy, such as the one conducted with 232 pregnant women in prenatal follow-ups, which revealed that 55.2% suffered some type of violence from their intimate partner some time during their lives, and that in 15.5% of the times, such situations took place during pregnancy[16]. In this sense, it should be highlighted that a quality prenatal examination is a potential factor for the attention to women regarding violence situations[17].

Almost half of the professionals did not know that a compulsory notification was required. Even when they have knowledge about it, the non-recognition of violence is a factor that interferes in this especially in veiled cases[15]. When they do not identify the cases, they end up not notifying about the violence, and thus, contribute for its invisibility in the setting of health services[4].

A high number of professionals did not know that they should directly ask women whether they suffer violence. When questioned about the right way to ask women about violence, they prefer an indirect approach, perhaps linked to their fear of offending the user and to the notion that this is a private problem[8]. It is necessary for professionals to improve their violence detection skills, asking triage questions as they normally would[13]. Although most of them do not feel comfortable, they need to include direct questions regarding violence in the routine of the care for women.

Most professionals understand that both women and their aggressors should receive psychotherapy treatment, that women should use tranquilizing medicine to face the situation, and that couple's therapy is an alternative solution to the problem. This perspective of medicalization puts the problem in the field of the normal and of the pathological[4].

Almost all professionals knew that there are protocols in the Ministry of Health to care for women under violent situations, except in cases of sexual violence, which, in this study, was something most of them knew. If, on one hand,

the protocols offer subsidies for the development of actions, on the other, they can be limiting, since "everyone is unique"[15], and therefore they might need an individual approach. Despite these differences, it cannot be denied that the lack of technology to identify and confront violence in the practice of professionals limits the possible actions to biological issues[4].

For the implementation of a protocol, it is necessary for professionals to include, among their practices, technologies that can privilege intersubjective interaction and sensible listening. In addition, it is imperative that they see beyond the biological characteristics of women, considering their insertion in the sociocultural context whose lives and actions are influenced by them[4].

Most professionals knew that they should guide women to make denounces in the police department. To do so, professional training is indispensable, since it allows for health professionals to offer pertinent guidance to these women[18]. In addition, this training can prevent the re-victimization of women, since after it, proper care can be offered[18].

It is clear that professionals with a lower time in the service had a better understanding of the adequate conduct towards the users, and also felt more comfortable questioning them about violence. Half the professionals with more than 10 years in the job believed they should not advise the woman to leave the partner and notify the fact - and this number was even higher among those who received training. This notion can be associated to the idea that notifying is the same of denouncing, and to their lack of knowledge that notification is mandatory. This situation was evidenced in a study about the primary attention services in Belo Horizonte and Minas Gerais[19]. The professionals' belief that they should not advise the user to a divorce might be because they believe that, although they suffer violence, the users do not want to divorce, and the permanence of the women in the relationship is associated to the belief that marriage is a woman's achievement, there also being a supposition as to their social and economic dependence on their partners[5].

CONCLUSION

This study found that gender violence was considered to be a demand by the professionals in the ESF units in this particular setting. However, they did not feel at ease to approach the subject with the users, and some have never asked about this problem.

The participants demonstrated knowledge about the definitions, epidemiology and management of cases of violence. On the other hand, their knowledge was little regarding violence rates during pregnancy. Some professionals believed they should not notify cases of violence against women. They have probably never been informed about the compulsory notification, which contributed for the absence of reports. The professionals who are working in the health service for a shorter period presented better results regarding their actions in cases of violence.

Among the limitations of this study, it should be noted that it presented the perspective of ESF professionals, although there are professionals from other sectors involved in the care for women in a situation of gender violence. Also, the results cannot be generalized, due to the characteristics of the participants and the context of the study, which are singular.

It can be understood that the benefits offered by this study to health and nursing teaching and research consist in offering evidence regarding the knowledge and the shortcomings of the conduct of professionals. These evidences will offer subsidies for the development of educational actions in the health service through intervention studies, as to qualify the actions of the professionals regarding cases of gender violence.

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