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ZNAČAJ EDUKACIJE ZDRAVSTVENIH RADNIKA U OTKRIVANJU ŽENA KOJE SU PREŽIVELE RODNO ZASNOVANO NASILJE

Snežana Knežević[1]

[1]Dom zdravlja Kraljevo, Srbija

SAŽETAK

Uvod/cilj: Nasilje nad ženama je svaki vid rodno zasnovanog nasilja koje može da ima za posledicu fizičku, psihičku ili seksualnu povredu žene. Cilj istraživanja je bio da se utvrdi da li postoji razlika u stavovima između zdravstvenih radnika i radnica edukovanih o važnosti otkrivanja žena koje su preživele rodno zasnovano nasilje.
Metode: U okviru ove studije preseka prikupljeni su podaci anonimnim, on-line upitnikom, od 78 zdravstvenih radnika (stopa odgovora 72,9%) koji su edukovani o važnosti otkrivanja žena koje su preživele rodno zasnovano nasilje.
Rezultati: Od 78 zdravstvenih radnika 14,1% su činili muškarci, a 85,9% žene. Između muškaraca i žena nije bilo značajne razlike u odnosu na njihove demografske karakteristike (uzrast, bračni status, dužina radnog staža i stručnu spremu). Muškarci su jedino značajno češće, u poređenju sa ženama, smatrali nedostatak osoblja kao ključni razlog zašto postoje institucione barijere koje onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja. Oba pola od socijalnih barijera za prijavu nasilja izdvajaju: nizak socio-ekonomski status pacijenata (74,4%), kulturološko shvatanje sredine gde živi osoba koja preživljava nasilje (60,2%) i društveni stereotip i predrasude (59,0%), od institucionih barijera: preopterećenost poslom (69,2%), a od ličnih barijera: ograničenost vremenom pri obavljanju svakodnevnog posla (70,5%) i mala ovlašćenja zdravstvenih radnika (52,6%). Muškarci češće smatraju da se nasilje ne prijavljuje, jer žene koje su preživele nasilje moraju da se vrate u isto okruženje i jer se stide i boje osude okoline, a žene jer se nasilje može ponoviti.
Zaključak: Edukacija zdravstvenih radnika/ca je presudna u sticanju znanja i veština o rodno zasnovanom nasilju u cilju pomoći ženama koje su ga preživele. Takođe, potrebno je uključiti veći broj muškaraca u ove vrste edukacija.

Ključne reči: Edukacija, rodno zasnovano nasilje, zdravstvena zaštita

Uvod

Nasilje nad ženama je svaki vid rodno zasnovanog nasilja koje može da ima za posledicu fizičku, psihičku ili seksualnu povredu ili patnju žene, uključujuci i pretnje takvim radnjama, ograničenje ili proizvoljno lišavanje slobode, bez obzira da li se dešava u sferi javnog ili privatnog života (1). Globalni podaci pokazuju da svaka treća žena je iskusila nasilje od strane svog partnera tokom života (2). Najčešći oblik nasilja je psihološko nasilje, zatim fizičko i ekonomsko (1,3,4). Zdravstveni sektor često je prva i jedina instanca kojoj se žene izložene rodno zasnovanom nasilju obraćaju, zbog čega su zdravstveni radnici/ce, u okviru svoje profesionalne delatnosti, u obavezi da doprinesu prevenciji, ranom otkrivanju, dokumentovanju i prijavljivanju nasilja nad ženama. Zdravstveni radnici treba da prednjače u zagovaranju nulte tolerancije nasilja. Da bi u tome bili uspešni, neophodno je da ovladaju odgovarajućim znanjem o rodno zasnovanom nasilju, pruže doprinos u primarnoj prevenciji, da se redovno edukuju, kao i da svoje znanje prenose kako na druge zdravstvene radnike, tako i na pacijente (1,5).

Edukacija zdravstvenih radnika u Srbiji je podrazumevala osnovne i napredne treninge

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THE IMPORTANCE OF HEALTHCARE WORKERS' EDUCATION FOR THE DETECTION OF WOMEN SURVIVORS OF GENDER-BASED VIOLENCE

Snezana Knezevic[1]

[1]Health Care Centre Kraljevo, Serbia

SUMMARY

Introduction/Aim: Domestic violence is any form of gender-based violence that may result in the physical, psychological or sexual injury of a woman. The aim of the study was to determine whether there is a difference in attitudes between male and female healthcare workers about the importance of detecting women who have survived gender-based violence.
Methods: Within this cross-sectional study, data were collected with the help of an anonymous, online questionnaire, from 78 healthcare providers (response rate 72.9) who were educated about the importance of identifying women survivors of gender-based violence.
Results: Of 78 health workers, 14.1% were men and 85.9% were women. There was no significant difference between men and women in relation to their demographic characteristics (age, marital status, length of service and level of education). Men claimed significantly more often, compared to women, that the lack of staff was a key reason why institutional barriers made it impossible to provide assistance in the situation of gender-based violence. There was no significant difference between men and female professionals in relation to their attitudes towards other institutional, as well as social and personal barriers that made it impossible to provide assistance. Both men and women pointed out the following social barriers: low socio-economic status of patients (74.4%), understanding of the cultural environment, where the person who experienced the violence lived (60.2%), and social stereotypes and prejudice (59.0%), whereas the institutional barrier was the heavy workload (69.2%), and personal barriers were the time constraint in performing daily work (70.5%) and the limited authority of healthcare professionals (52.6%). Male healthcare workers claimed more often that violence was not reported because women who had suffered it had to return to the same environment and because women were ashamed and afraid of being condemned by the environment, while female health professionals believed that women were afraid of violence recurrence (68.7%).
Conclusion: Education of health workers is crucial for acquiring knowledge and skills about gender-based violence that will enable them to help women who have survived it. Also, it is necessary to include more male professionals in this kind of education.

Key words: Education, gender-based violence, health care

Introduction

Violence against women is defined as all acts of gender-based violence that result in physical, sexual, psychological harm or suffering to women, including threats of such acts, coercion, or arbitrary deprivation of liberty, whether occurring in public or private life (1). Global estimates indicate that almost one third of all women have experienced violence by their intimate partner in their lifetime (2). Psychological violence is the most common type of violence, followed by physical and then economic violence (1,3,4). The healthcare sector is often the first and only point of access for women who have experienced gender-based violence. Therefore, the healthcare workers are, within the scope of their profession, obliged to report acts of domestic violence, complete the medical documentation, and contribute to the early detection and prevention of violence. Healthcare workers should be the first to promote zero tolerance of violence. In order to be successful, they need to acquire knowledge about gender-based violence, to contribute to primary prevention, to participate in continuing medical education, and to share their knowledge with other healthcare workers and patients, as well (1,5).

pod nazivom „Izgradnja kapaciteta zdravstvenih radnika/ca za planiranje, organizaciju i edukaciju u oblasti rodno zasnovanog nasilja u zdravstvenom sektoru“, koje je, u period 2016-2019. godine, organizovala kancelarija Populacionog fonda Ujedinjenih nacija (UNFPA), u saradnji sa Centrom za promociju zdravlja žena (CPZŽ) i Ministarstvom zdravlja Republike Srbije, a uz podršku vlade Švedske (šved. *Sida - Styrelsen för Internationellt Utvecklingssamarbete*). Obuke su se sprovodile u Vrnjačkoj Banji, Zlatiboru, Beogradu i Kragujevcu. Profesionalce iz zdravstvenih ustanova širom Srbije menadžment je selektovao za edukaciju nakon zvaničnog pozivnog pisma koje je organizator treninga upućivao na službene kontakt adrese (6,7). Glavne teme treninga sadržane su u priručniku pod nazivom „Odgovor zdravstvenog sektora na rodno zasnovano nasilje, Vodič za zdravstvene radnike/ce” (6). Priručnik sadrži materijal obrađen tokom treninga za potrebe edukacije zdravstvenog sektora u oblasti rodno zasnovanog nasilja, a koji je rađen prema poslednjim međunarodnim standardima i vodičima dobre prakse u ovoj oblasti (6). Cilj treninga bio je da se zdravstvenim radnicima pruže neophodna znanja i veštine da budu organizatori, predavači i treneri kolegama u svojim radnim sredinama, kako bi se rodno zasnovano nasilje smanjilo, preveniralo i sankcionisalo, kao i da se zdravstveni radnici osposobe za prepoznavanje i primenu komponenti efikasnog treninga, korišćenjem participativne metodologije, komunikacionih tehnika i modela dobre međusektorske saradnje u zaštiti žena koje su preživele nasilje, zainteresovani da budu edukatori i da dalje organizuju (i akredituju ako žele) obuke za svoje kolege o rodno zasnovanom nasilje.

Cilj ovog rada je bio da se utvrdi da li postoji razlika u stavovima između zdravstvenih radnika i radnica edukovanih o važnosti otkrivanja žena koje su preživele rodno zasnovano nasilje.

Metode

U okviru ove studije preseka obuhvaćeno je 107 zdravstvenih radnika koji su prošli osnovnu i naprednu edukaciju pod nazivom „Izgradnja kapaciteta zdravstvenih radnika/ca za planiranje, organizaciju i edukaciju u oblasti rodno zasnovanog nasilja u zdravstvenom sektoru”. Učešće u studiji je prihvatilo 78 zdravstvenih radnika. Svi ispitanici su kontaktirani *on-line* da popune anoniman upitnik, na imejl adrese dostupne organizatorima edukacija, kancelariji UNFPA i CPZŽ, sa objašnjenjem svrhe anketiranja, učešćem na dobrovoljnoj bazi i izjavom da se njihove imejl adrese neće koristiti u promotivne svrhe. Istraživanje je sprovedeno u periodu od 6. do 12. septembra 2019. godine. Za ovo istraživanje pribavljena je saglasnost tima organizatora edukacije, koji su posedovali bazu podataka učesnika navedenih treninga.

Upitnik se sastojao od 11 pitanja. Prvi deo upitnika se odnosio na socio-demografske karakteristike zdravstvenih radnika (pol, uzrast, bračni status, dužinu radnog staža i stručnu spremu), a drugi je bio sastavljen iz 4 dela. Prvi deo odnosio se na stavove zdravstvenih radnika o socijalnim (7 pitanja), drugi institucionalnim (6 pitanja) i treći ličnim barijerama (6 pitanja), koje onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja. Četvrti deo obuhvatio je stavove zdravstvenih radnika o tome zašto žene ne prijavljuju nasilje koje su preživele. Odgovori ispitanika su sakupljeni u *docs.google.com*, tabela Excel programa, verzija 2010, u kojoj su i analizirani.

U statističkoj analizi rezultata korišćeni su prebrojavanje, minimalna i maksimalna vrednost, aritmetička sredina, standardna devijacija, procenti, χ^2 test i *Yates*-ova korekcija.

Rezultati

U studiju je bilo uključeno 67 (85,9%) žena i 11 (14,1%) muškaraca. Dve trećine ispitanika imalo je 41 i više godina, svaki drugi je bio u braku, 4/5 je imalo radni staž duži od deset godina, a 72,7% ispitanika činili su lekari (tabela 1). Prosečna starost ispitanika je bila 43,7±6,4, a raspon godina se kretao od 30 do 60. Prosečna dužina radnog staža je bila 20,1±6,5 godina.

Između muškaraca i žena nije uočena značajna razlika u odnosu na socijalne barijere koje onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja žena (tabela 2). Oba pola su u preko 50% slučajeva smatrali da su glavni razlozi za socijalne barijere koje

The education of healthcare workers in Serbia consisted of basic and advance training programs titled "Building the healthcare providers' capacities for planning, organization and education in the field of gender-based violence in the health sector", which were organized in 2019 by the United Nations Population Fund (UNPF) in cooperation with the Centre for the Promotion of Women's Health and the Ministry of Health of the Republic of Serbia, with the support of the Government of Sweden (*Sida – Styrelsen för Internationellt Utvecklingssamarbete*). Trainings were held in Vrnjacka banja, Zlatibor, Belgrade and Kragujevac. The professionals from the healthcare institutions in Serbia were selected for this education after the organizer of trainings had sent the letter of invitation to official contact addresses (6,7). The main topics of trainings were included in the handbook titled "The Response of the Health Sector to Gender-based Violence, Guidelines for Health Professionals" (6). The handbook, which was developed on the basis of the latest international standards and guidelines of good practice, contained the material that was analyzed during the training for the needs of education of the health sector in the field of gender-based violence (6). The aim of this training was to offer the necessary knowledge and skills to health workers so that they could be organizers, lecturers and instructors to their colleagues in their work environment in order to reduce, prevent and punish gender-based violence. Also, the aim was to enable the healthcare workers to recognize and apply the components of efficient training, using the participatory methodology, communication techniques and models of good inter-sectoral cooperation, in protecting the survivors of violence. Interested health workers could become educators, organize and possibly accredit the training programs about gender-based violence for their colleagues.

The aim of our study was to determine the difference in attitudes between male and female healthcare workers, educated about the significance of detecting women who have survived gender-based violence.

Methods

A cross-sectional study included 107 health workers, who attended the basic and advance educational training titled "Building health workers' capacities for planning, organization and education in the field of gender-based violence in the health sector". 78 health workers accepted to participate in the study. All respondents were asked via e-mail to complete an anonymous questionnaire sent by The United Nations Population Fund and the Center for the Promotion of Women's Health. The respondents participated voluntarily. The purpose of this survey was explained to them and they were informed that e-mail addresses would not be used for promotional purposes. The research was conducted from September 6th to September 12th, 2019. This research was approved by the organizer, who had the database of all participants of the mentioned trainings.

The questionnaire consisted of 11 questions. The first part of the questionnaire referred to socio-demographic characteristics of health workers (gender, age, marital status, length of service, qualifications), while the second part consisted of 4 domains. The first referred to the attitude of health workers to social barriers (7 questions), the second referred to institutional barriers (6 questions) and the third to personal barriers (6 questions), which made it impossible to provide help in case of gender-based violence. The fourth domain included attitudes of health workers towards the reasons why women did not report violence. The respondents' answers were collected using docs.google.com, Excel table, version 2010, and analyzed.

Counting, minimum and maximum value, arithmetical mean value, standard deviation, percentage, χ^2 test and Yates's correction were used in the statistical analysis of results.

Results

The study included 67 (85.9%) women and 11 (14.1%) men. Two thirds of respondents were 41 and older, half of them were married, 4/5 had 10 years of service and more, and 72.7% of them were doctors (Table 1). The mean age of respondents was 43.7±6.4, and they were between 30 and 60 years old. The mean length

Tabela 1. Distribucija ispitanika prema polu, uzrastu i stepenu obrazovanja

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Demografske karakteristike/ *Demographic caracteristics*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Uzrast (godine)/*Age (years)*			
≤40	2 (18.2)	26 (28.8)	
>40	9 (81.8)	41 (61.2)	0.326*
Bračni status/ *Marital status*			
U bračnoj zajednici/*Married*	5 (45.4)	35 (52.2)	
Van bračne zajednice/*Not married*	6 (54.6)	32 (47.8)	0.676
Dužina radnog staža (godina)/ *Years of service*			
≤10	1 (9.1)	15 (22.4)	
>10	10 (90.9)	52 (77.6)	0.542*
Stručna sprema/*Qualifications*			
Lekari/*Doctors*	8 (72.7)	32 (47.8)	
Zdravstveni saradnici/ *Health associates*	3 (27.3)	35 (52.2)	0.226*

*Yates korekcija; ** p vrednost prema χ^2 testu

onemogućavaju pružanje pomoći: nizak socio-ekonomski status žrtava nasilja (74,4%), kulturološko shvatanje sredine (60,3%) i društveni stereotipi i predrasude (59,0%).

Muškarci (54,6%) su značajno češće, u odnosu na žene (6,0%), smatrali da je institucionalna barijera koja onemogućava pružanje pomoći u slučaju rodno zasnovanog nasilja nedostatak osoblja zaposlenog u zdravstvenom sektoru (p < 0,001) (tabela 3). Između muškaraca i žena nije bilo značajne razlike u odnosu na sve druge navedene institucionalne barijere. Oba pola su smatrala da su ključne institucionalne barijere koje

Tabela 2. Distribucija edukovanih zdravstvenih radnika prema njihovim stavovima koje socijalne barijere onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Socijalne barijere koje onemogućavaju pružanje pomoći/ *Social barriers make it impossible to provide assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak jasnih smernica za postupanje/ *Lack of clear guidelines*	1 (9.1)	17 (25.4)	0.235*
Kulturološko shvatanje sredine/ *Cultural environment*	6 (54.6)	41 (61.2)	0.676
Nizak socio-ekonomski status/ *Low socio-economic status*	6 (54.6)	52 (77.6)	0.104
Starosne razlike između zdravstvenih radnika i žrtava/ *Age differences of health workers and victims*	0 (0.0)	1 (1.5)	0.398*
Društveni stereotipi i predrasude/ *Social stereotypes and prejudices*	8 (72.7)	38 (56.7)	0.317*
Religiozna uverenja/ *Religious factors*	1 (9.1)	7 (10.4)	0.159*

*Yates korekcija; ** p vrednost prema χ^2testu

Table 1. Distribution of healthcare professionals in terms of their demographic characteristics

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Demografske karakteristike/ *Demographic caracteristics*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Uzrast (godine)/*Age (years)*			
≤40	2 (18.2)	26 (28.8)	
>40	9 (81.8)	41 (61.2)	0.326*
Bračni status/ *Marital status*			
U bračnoj zajednici/*Married*	5 (45.4)	35 (52.2)	
Van bračne zajednice/*Not married*	6 (54.6)	32 (47.8)	0.676
Dužina radnog staža (godina)/ *Years of service*			
≤10	1 (9.1)	15 (22.4)	
>10	10 (90.9)	52 (77.6)	0.542*
Stručna sprema/*Qualifications*			
Lekari/*Doctors*	8 (72.7)	32 (47.8)	
Zdravstveni saradnici/ *Health associates*	3 (27.3)	35 (52.2)	0.226*

*Yares correction; ** p value according to chi square test

of service was 20.1±6.5.

There was no significant difference between men and women regarding social barriers that made it impossible to help women in case of gender-based violence (Table 2). Both men and women stated that the main reasons for social barriers, which made it impossible to provide help, were the following: low socio-economic status of victims (74.4%), understanding the cultural environment (60.3%) and social stereotypes and prejudice (59.0%).

Men (54.6%) significantly more often, in comparison to women, stated that the

Table 2. Distribution of educated healthcare professionals in terms of their attitudes which social barriers make it impossible to provide assistance in case of domestic violence

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Socijalne barijere koje onemogućavaju pružanje pomoći/ *Social barriers make it impossible to provide assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak jasnih smernica za postupanje/ *Lack of clear guidelines*	1 (9.1)	17 (25.4)	0.235*
Kulturološko shvatanje sredine/ *Cultural environment*	6 (54.6)	41 (61.2)	0.676
Nizak socio-ekonomski status/ *Low socio-economic status*	6 (54.6)	52 (77.6)	0.104
Starosne razlike između zdravstvenih radnika i žrtava/ *Age differences of health workers and victims*	0 (0.0)	1 (1.5)	0.398*
Društveni stereotipi i predrasude/ *Social stereotypes and prejudices*	8 (72.7)	38 (56.7)	0.317*
Religiozna uverenja/ *Religious factors*	1 (9.1)	7 (10.4)	0.159*

*Yares correction; ** p value according to chi square test

Tabela 3. Distribucija edukovanih zdravstvenih radnika prema njihovim stavovima koje institucionalne barijere onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Institucionalne barijere koje onemogućavaju pružanje pomoći/ *Institutional barriers make impossible to provide assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak prostora za privatnost/ *Lack of privacy*	6 (54.6)	23 (34.3)	0.198
Strah za sopstvenu bezbednost/ *Fear for own safety*	1 (9,1)	18 (26.9)	0.371*
Preopterećenost poslom zdravstvenih radnika/ *Overwork of health workers*	6 (54.6)	48 (74.4)	0.255
Neinformisanost o procedurama/ *Lack of information about procedures*	3 (27.3)	20 (29.8)	0.855*
Nedostatak osoblja/ *Lack of staff*	6 (54.6)	4 (6.0)	<0.001

*Yates korekcija; ** p vrednost prema χ^2 testu

onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja: preopterećenost poslom zdravstvenih radnika (69,2%) i nedostatak prostora za privatnost lekara i pacijenta (44,6%).

Između muškaraca i žena nije bilo značajne razlike u odnosu na sve lične barijere koje onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja (tabela 4). Oba pola su smatrala da su ključne lične barijere koje onemogućavaju pružanje pomoći u slučaju rodno zasnovanog nasilja: ograničenost radnog vremena (70,5%) i mala ovlašćenja zdravstvenih radnika (52,6%).

Takođe, između muškaraca i žena nije bilo značajne razlike u odnosu na njihove stavove zašto žene koje su preživele nasilje ne prijavljuju dato nasilje (tabela 5). Muškarci (63,6%) su više u odnosu na žene (40,3%) smatrali da je razlog neprijavljivanju nasilja stid i nerazumevanje okoline, ali razlika nije bila značajna. Muškarci i žene su kao glavne uzroke neprijavljivanja nasilja naveli: da se žene boje ponovnog nasilja (67,9%), povratka u isto

Tabela 4. Distribucija edukovanih zdravstvenih radnika prema ličnim barijerama koje ih onemogućavaju da pružaju pomoć u slučaj rodno zasnovanog nasilja

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Lične barijere koje onemogućavaju pružanje pomoći/ *Personal barriers to providing assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak znanja o nasilju/ *Lack of knowledge*	1 (9.1)	8 (11.9)	0.814*
Nedostatak treninga/ *Lack of training*	0 (0.0)	10 (14.9)	0.731*
Ograničenost vremenom/ *Time constraints*	9 (81.8)	46 (68.7)	0.596*
Zdravstveni radnici u tome ne mogu pomoći/ *Healthcare staff can not help*	0 (0.0)	6 (9,0)	0.109*
I sam/a sam žrtva nasilja/ *Personal experience*	0 (0.0)	5 (7.5)	0.178*
Dati veća ovlašćenja zdravstvenim radnicima/ *Need of increased authorization*	5 (45.4)	36 (53.7)	0.610

*Yates korekcija; ** p vrednost prema χ^2 testu

Table 3. Distribution of educated healthcare professionals according to attitudes which institutional barriers make it impossible to provide assistance in case of gender-based violence

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Institucionalne barijere koje onemogućavaju pružanje pomoći/ *Institutional barriers make impossible to provide assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak prostora za privatnost/ *Lack of privacy*	6 (54.6)	23 (34.3)	0.198
Strah za sopstvenu bezbednost/ *Fear for own safety*	1 (9,1)	18 (26.9)	0.371*
Preopterećenost poslom zdravstvenih radnika/ *Overwork of health workers*	6 (54.6)	48 (74.4)	0.255
Neinformisanost o procedurama/ *Lack of information about procedures*	3 (27.3)	20 (29.8)	0.855*
Nedostatak osoblja/ *Lack of staff*	6 (54.6)	4 (6.0)	<0.001

*Yares correction; ** p value according to chi square test

institutional barrier that made it impossible to provide help in case of gender-based violence was the lack of professional staff employed in the health sector ($p < 0.001$) (Table 3). There was no significant difference between men and women regarding all the other institutional barriers. Both men and women thought that the key institutional barriers that made it impossible to provide help were: the heavy workload of health workers (69.2%), the lack of private space for doctors and patients (44.6%).

There was no significant difference between men and women regarding all personal barriers which made it impossible to provide help in case of gender-based violence (Table 4). Both men and women thought that key personal barriers, which made it impossible to provide help in case of gender-based violence, were the following: the time constraint (70.5%), the limited authority of health workers (52.6%).

Also, there was no significant difference between men and women regarding their attitudes to the reasons why women, who survived violence, did not report it (Table 5).

Table 4. Distribution of educated healthcare professional workers in terms of personal barriers to providing assistance in case of domestic violence

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Lične barijere koje onemogućavaju pružanje pomoći/ *Personal barriers to providing assistance*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Nedostatak znanja o nasilju/ *Lack of knowledge*	1 (9.1)	8 (11.9)	0.814*
Nedostatak treninga/ *Lack of training*	0 (0.0)	10 (14.9)	0.731*
Ograničenost vremenom/ *Time constraints*	9 (81.8)	46 (68.7)	0.596*
Zdravstveni radnici u tome ne mogu pomoći/ *Healthcare staff can not help*	0 (0.0)	6 (9,0)	0.109*
I sam/a sam žrtva nasilja/ *Personal experience*	0 (0.0)	5 (7.5)	0.178*
Dati veća ovlašćenja zdravstvenim radnicima/ *Need of increased authorization*	5 (45.4)	36 (53.7)	0.610

*Yares correction; ** p value according to chi square test

Tabela 5. Distribucija edukovanih zdravstvenih radnika prema njihovim stavovima šta je uzrok da žene koje su pretrpele naselje to ne prijavljuju

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Zašto se ne prijavljuje nasilje kod žena koje su ga preživele/ *Barriers related to the battered woman*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Uporno kriju nasilno ponašanje partnera/ *Hide and endure abuse despairingly*	5 (45.4)	29 (43.3)	0.893
Moraju da se vrate u isto okruženje/ *Turning back to the same environment*	7 (63.6)	43 (64.2)	0.761*
Boje se ponavljanja nasilja/ *Afraid of the repeat of abuse*	7 (63.6)	46 (68.7)	0.986*
Ne znaju dovoljno o svojim zakonskim pravima/ *Lack of knowledge on legal rights*	6 (54.6)	38 (56.7)	0.893
Stide se i boje nerazumevanja okoline/ *Shame and afraid*	7 (63.6)	27 (40.3)	0.263*
Lakše im je da trpe nego da o tome pričaju/ *It is easier to suffer than to talk*	5 (45.4)	25 (37.3)	0.607
Očekuju da budu pitane o nasilju/ *Expect a question about violence*	3 (27.3)	25 (37.3)	0.761*
Drugo/*Other*	0 (0.0)	0 (0.0)	-

*Yates korekcija; ** p vrednost prema χ^2 testu

okruženje (64,0%), nepoznavanje zakonskih prava (58,9%), prikrivanje nasilnog ponašanja partnera (38,5%) i stida i straha zbog osude okoline (43,6%).

Diskusija

Ovo istraživanje je sprovedeno da bi se definisale prepreke za otkrivanje većeg broja žena koje su preživele rodno zasnovano nasilje, promenili stavovi o nasilju nakon sprovedenih edukacija, prepoznali izazove sa kojima se susreću zdravstveni radnici/e tokom svog svakodnevnog profesionalnog rada i da bi se donele preporuke za dalji rad na jačanju uloge zdravstvenog sistema u odgovoru na rodno zasnovano nasilje.

Dugo se smatralo da je nasilje u porodici socijalna i privatna kategorija i tek u poslednje dve decenije ono poprima sve veće razmere i predstavlja važan problem u okviru javnog zdravlja. Rodno zasnovano nasilje je faktor rizika za zdravlje poput zloupotrebe alkohola, pušenja, nepravilne ishrane i fizičke neaktivnosti. Predominantno se odnosi na žene i decu, dok su muškarci ređe žrtva rodno zasnovanog nasilja (5-8).

Procenat ispitanika koji su želeli da učestvuju u našem istraživanju je 72,9% i, u poređenju sa dostupnim istraživanjima gde je učešće ispitanika bilo 20-90% (9-13), može se objasniti relativnom željom ispitanika da znaju više i participiraju u ovoj temi.

U poređenju sa sličnim istraživanjem u Domu zdravlja Kraljevo, sprovedenom 2017. godine, kada su neselektivno anketirani pružaoci zdravstvenih usluga, bilo da su edukovani ili ne, na temu rodno zasnovanog nasilja, procenat ispitanika koji se uključio u istraživanje je bio znatno viši (91,3%) (14). U datom istraživanju procenat ispitanika muškog pola je bio nešto viši (26,7%) i koristili su se upitnici u papirnoj formi.

Rezultati našeg istraživanja vezani za demografske karakteristike ispitanika su u skladu sa nalazima drugih autora, osim dužine radnog staža (13-15). Naši ispitanici imaju u većem procentu (79,5%) više od deset godina radnog iskustva u odnosu na istraživanje u Kuvajtu (55,2%) (10) i u Švedskoj (57%) (13).

Socijalne prepreke

U našoj studiji, zdravstveni radnici (54,6%

Table 5. Distribution of educated healthcare professional workers in terms of personal barriers to providing assistance in case of domestic violence

	Muškarci/ *Men* N=11	**Žene/ *Women* N=67**	
Zašto se ne prijavljuje nasilje kod žena koje su ga preživele/ *Barriers related to the battered woman*	**Broj (%)/ *No (%)***	**Broj (%)/ *No (%)***	****p vrednost/ *p value***
Uporno kriju nasilno ponašanje partnera/ *Hide and endure abuse despairingly*	5 (45.4)	29 (43.3)	0.893
Moraju da se vrate u isto okruženje/ *Turning back to the same environment*	7 (63.6)	43 (64.2)	0.761*
Boje se ponavljanja nasilja/ *Afraid of the repeat of abuse*	7 (63.6)	46 (68.7)	0.986*
Ne znaju dovoljno o svojim zakonskim pravima/ *Lack of knowledge on legal rights*	6 (54.6)	38 (56.7)	0.893
Stide se i boje nerazumevanja okoline/ *Shame and afraid*	7 (63.6)	27 (40.3)	0.263*
Lakše im je da trpe nego da o tome pričaju/ *It is easier to suffer than to talk*	5 (45.4)	25 (37.3)	0.607
Očekuju da budu pitane o nasilju/ *Expect a question about violence*	3 (27.3)	25 (37.3)	0.761*
Drugo/*Other*	0 (0.0)	0 (0.0)	-

*Yares correction; ** p value according to chi square test

Men (63.6%) claimed more often than women that the reasons for not reporting violence were shame and the lack of understanding of the environment, but the difference was not significant. Both men and women stated that the main reasons for not reporting violence were the following: women were afraid of the recurrence of violence (67.0%), they were afraid to return to the same environment (64.0%), ignorance of legal rights (58.9%), hiding the partner's violent behavior (38.5%), shame and fear of being condemned by the environment (43.6%).

Discussion

This research was conducted in order to define barriers to identifying a larger number of women who survived violence, to change attitudes towards violence after the conducted educational programs, to recognize challenges which the health workers face during their daily professional work, and to bring recommendations for further work aimed at strengthening the role of the healthcare system in response to gender-based violence.

Domestic violence was deemed to be a social and private category for a long time, but during the last two decades it has been on the rise and it has become an important public health problem. Gender-based violence is a health risk factor like alcohol abuse, smoking, unhealthy diet and physical inactivity. It is predominantly related to women and children, whereas men are more rarely the victims of gender-based violence (5-8).

The percentage of respondents, who wanted to participate in the research, was 72.9%. Compared to available research studies, in which 20-90% of respondents participated, this could be explained by the fact that respondents' wish to know more and to take part in this topic was relative.

In comparison to the similar research, which was conducted at the Health Center Kraljevo in 2017, when healthcare providers were interviewed randomly, no matter whether they were educated or not in relation to gender-based violence, the percentage of respondents who participated was significantly higher (91.3%) (14). In the mentioned research, the percentage of male respondents was somewhat higher (26.7%) and questionnaires were in the paper form.

muškaraca i 77,6% žena) su nakon treninga smatrali da je najčešći razlog u neotkrivanju žena koje su preživele nasilje nizak socio-ekonomski status tih žena. Ovaj uzrok je nešto ređe identifikovan od strane ispitanika u studiji Kneževića i sar. (14). Takođe, u našoj studiji 54,6% muškaraca i 61,2% žena zdravstvene struke smatralo je da je barijera u prijavljivanju rodnog nasilja zbog kulturološkog shvatanja sredine, a 72,7% muškaraca i 56,7% žena usled društvenog stereotipa i predrasuda. Međutim, zdravstveni radnici bez treninga (njih 57,4%) ukazivali su na nedostatak smernica za postupanje kao ključnim za neprijavljivanje rodnog nasilja (14), dok je u našoj studiji taj procenat iznosio 9,1% za muškarce i 25,4% za žene. Samo jedan ispitanik naše studije smatrao je da su starosne razlike između zdravstvenih radnika i žena koje su preživela nasilje prepreka. Religiozna uverenja predstavljaju kod 9,1% muškaraca i 10,4% ispitanika ženskog pola prepreku u našoj studiji, što je niži procenat nego u studiji sprovedenoj u Kraljevu (14).

Institucionalne prepreke

U našoj studiji 74,4% žena izdvaja od institucionalnih prepreka preopterećenost poslom, kao što je to u studiji Beynon-a sar. (17). Takođe, zdravstveni radnici ženskog pola to češće navode kao prepreku u našoj studiji, nego što je to zabeleženo u sličnim istraživanjima (14,17). U kuvajtskim studijama ovaj procenat je znatno viši (10,16). U našoj studiji čak 54,6% muškaraca smatra da je prepreka nedostatak zdravstvenog kadra, dok je u istraživanju sprovedenom u Kraljevu to navelo 27,8% anketiranih muškaraca (14). Na nedostatak prostora za privatnost ukazuje 54,6% muškaraca i 34,3% žena našeg istraživanja, dok u finskoj studiji (18) to uopšte ne predstavlja problem, a u kanadskoj ovaj problem uočava tek 8,2% ispitanika (17).

Sledeća prepoznata institucionalna prepreka među našim ispitanicima bila je neinformisanost o procedurama (27,3% muškarci i 29,8% žene). U poređenju sa rezultatima istraživanja sprovedenog u Kanadi, gde se 13% ispitanika izjasnilo za ovu vrstu prepreke, naši ispitanici uprkos sprovedenim edukacijama i dalje imaju visok procenat odgovora na ovu vrstu barijere (17). Rezultat implicira da edukacije treba da se sadržajno obogaćuju sadržajem i u određenim vremenskim intervalima ponavljaju. Sistem obrazovanja zdravstvenih radnika je podrazumevao minimalno sticanje znanja iz oblasti nasilja nad ženama. U praktičnom radu nedostaju raznovrsni načini za edukaciju o tome. Nedostaje i odgovarajuća domaća literatura, ali ukoliko postoji lična motivacija dostupna je strana literatura, seminari i mnoštvo informacija na internetu. Kada se neki fenomen ne poznaje dovoljno, očekivano je da se ne prepozna rutinski u svakodnevnom radu (5). Najmanju prepreku u radu zdravstvenih radnika predstavlja strah za sopstvenu bezbednost (24,4%), što je manje nego u drugim studijama (10,16). Kod zdravstvenih radnika koji nisu edukovani strah se češće javlja (čak kod 46,3% ispitanika) (14).

Lične prepreke zdravstvenih radnika

Zdravstveni radnici najčešće navode da ograničenost vremenom (81,8% muškaraca i 68,7% žena) i nepostojanje većih ovlašćenja (45,4% muškaraca i 53,7% žena) predstavljaju ključne prepreke za pružanje pomoći u slučaju rodno zasnovanog nasilja. Ograničenost vremenom navodi se kao važna prepreka, ali u nešto manjem procentu (58,1%), u istraživanju Kneževića i sar. (14), a mnogo je većeg značaja u studijama sprovedenim u Kuvajtu (kod čak 90,6% i 85% ispitanika) (10,19). Nedostatak treninga je prepoznata prepreka u pružanju pomoći od strane 44,9% ispitanika u istraživanju Kneževića i sar. (14), a u našem istraživanju kod nešto manjeg broja (14,9%) zdravstvenih radnika i to isključivo žena. Ovakva situacija ohrabruje, jer najznačajnije aktivnosti na imenovanju, prepoznavanju, identifikovanju i adekvatnom reagovanju na nasilje treba da se odvijaju prvenstveno na nivou zdravstvenih ustanova (5). Trening značajno u tim aktivnostima može da pomogne. Pet ispitanica (7,5%) naše studije je navelo da su i same žrtve porodičnog nasilja, što može biti prepreka u svakodnevnom radu, jer zdravstveni radnik ponovno preživljava sopstveno iskustvo nasilja.

Prepreke u vezi sa samim ženama koje su preživele nasilje

U našoj studiji preko 60% zdravstvenih radnika, odnosno 68,7% žena i 63,6% muška-

The results of our research related to the demographic characteristics of respondents were in accordance with other authors' findings, except the length of service (13-15). Our respondents had more than ten years of service (79.5%), which is a higher percentage in comparison to the research conducted in Kuwait (55.2%) and Sweden (57%) (13).

Social barriers

In our study, health workers (54.6% of men and 77.6% of women) thought that the low socio-economic status of women was the most common reason for not identifying the women who survived violence. The respondents pointed to this cause more rarely in the study of Knezevic and associates (14). Also, in our study 54.6% of male and 61.2% of female health professionals thought that the barrier to reporting domestic violence was cultural understanding of environment, while 72.7% of men and 56.7% of women thought that this barrier referred to social stereotypes and prejudice. However, health workers without training (57.4%) pointed to the lack of guidelines as a key factor for not reporting domestic violence (14), whereas in our study that percentage amounted to 9.1% for men and 25.4% for women. Only one respondent thought that difference in age between health workers and women who survived violence was the barrier. In our study, religious beliefs presented a barrier for 9.1% of male and 10.4% of female respondents, which was a lower percentage in comparison to the study conducted in Kraljevo (14).

Institutional barriers

In our study, 74.4% of women pointed to the heavy workload as one of the institutional barriers, like in the study of Beynon and associates (17). Also, female health workers cited this barrier more frequently in our study than in similar research studies (14,17). In Kuwait studies, this percentage was significantly higher (10,16). In our study, 54.6% of men cited the lack of professional health staff as a barrier, whereas in the study conducted in Kraljevo 27.8% of interviewed men cited this as a barrier (14). The lack of private space was mentioned by 54.6% of men and 34.3% of women, whereas in the study from Finland (18) it was not perceived as a problem, and in the Canadian study only 8.2% of respondents noticed this problem (17).

The next institutional barrier, which was recognized among our respondents, was the lack of information about procedures (27.3% of men and 29.8% of women). In comparison to the results of one research conducted in Canada, where 13% of respondents opted for this barrier, our respondents still had a high percentage of responses to this barrier, despite the conducted educational trainings (17). The result implies that educational trainings should be enriched with contents and repeated at certain intervals. The system of health workers' education included very little contents regarding the field of gender-based violence. Different ways of acquiring knowledge about this field are needed in practical work. There is no appropriate domestic literature, but if personal motivation exists, foreign literature, seminars and a lot of information on the Internet are available. When we do not know enough about a phenomenon, we cannot expect to recognize it routinely in everyday practice (5). The fear for their own security is the smallest barrier to health professionals' work (24.4%), which is less in comparison to other studies (10,16). In health workers, who were not educated about this field, this fear occurs more frequently (in 46.3% of respondents) (14).

Personal barriers of health workers

Health workers state most frequently that the time constraint (81.8% of men and 68.7% of women) and limited authority (45.4% of men and 53.7% of women) present key barriers to providing help in case of gender-based violence. The time constraint is cited as an important barrier, but to a lesser extent (58.1%) in the research of Knezevic et al (14). However, it had a greater significance in the studies conducted in Kuwait (90.6% and 85% of respondents) (10,19). The lack of training is a barrier to providing help, which was recognized by 44.9% of respondents in the research of Knezevic et al. (14), and in our study by 14.9% of solely female health workers. This situation is encouraging because the most important activities regarding defining, recognizing, identifying and reacting to violence should be done at the level of healthcare

raca, smatra da se žene koje su preživele nasilje boje ponavljanja nasilja, dok je u istraživanju Kneževića i sar. ovaj problem identifikovan kod 55,8% svih ispitanika (14). Oko 64% naših ispitanika smatra da je prepreka to što se žene vraćaju u isto okruženje, što je nešto više nego što je zabeleženo u studiji Kneževića i sar. (53,7%) (14) i znatno više nego u studiji sprovedenoj u Britaniji (11%) (20). To ne treba da bude značajna prepreka zbog kompleksnih mehanizama i teškoća izlaska iz nasilne veze/braka. Činjenica je da mnoge žene ostaju u nasilnim vezama. Porodica, prijatelji, susedi, pa čak i stručnjaci, često ne razumeju zašto žene trpe nasilje. Istraživanja i iskustvo pokazali su da žene kao najčešće razloge prihvatanja života u nasilnom odnosu navode one koji se uklapaju u opšte društveno prihvaćene predrasude o nasilju (7,8). Preživljavanje nasilja određeno je kako društvenim shvatanjem tako i brojnim psihološkim/ličnim razlozima. Objašnjenje se, delimično, može naći u dinamici nasilnog odnosa u kojem se smenjuju faze nasilja – kada celokupnu moć poseduje nasilnik, i faza kajanja, „medeni mesec", u kojoj žena ima privid sopstvene moći i kontrole situacije (7,8).

U našem istraživanju 54,6% muškaraca i 56,7% žena je smatralo da žene koje su pretrpele rodno nasilje ne znaju dovoljno o svojim zakonskim pravima, što je skoro 3 puta više u odnosu na rezultate studije sprovedene u Velikoj Britaniji (20). Naši rezultati, kao i rezultati drugih studija (19,21), pokazuju da žene koje su preživele nasilje ne prijavljuju ga zbog stida i straha da ih okolina neće rezumeti. Svaki drugi ispitanik naše studije smatrao je da žene uporno kriju nasilno ponašanje partnera i da zato ne prijavljuju nasilje. Iako je žena preživela nasilje, ona će to iskustvo često negirati. Postoje brojni razlozi za to i profesionalci treba da budu svesni toga i da imaju razumevanje (1). Neki smatraju da je ženama teško da o tome pričaju i da očekuju da o tome budu pitane. Tokom svakodnevnog rada zdravstveni radnici treba da iskoriste terapeutski potencijal i identifikuju nasilje, jasno ga osude, vode empatičan razgovor, ponude kontinuitet u nezi, budu svesni toga da nije njihov zadatak rešavanje tog problema već veština da upute na resurse (1,7,22).

Pitati žene o preživljenom nasilju nije nimalo lak zadatak. Needukovani zdravstveni radnici/ce to često ne rade, jer se boje da će pitanjima uvrediti ženu. *Lewis* i sar. su, u svom radu, 2017. godine, predlagali intersektorske treninge obzirom da je nasilje u porodici multidisciplinarni problem (23). Istovremeno, postaviti pitanje o rodno zasnovanom nasilju je veoma važno, pošto žene čak i kada ne govore same o svom iskustvu očekuju da budu pitane i prihvataju razgovor (7,8). U okviru zdravstvenih ustanova važno je ohrabriti žene da govore o nasilju koje prežive. Ovo se može postići štampanim materijalima koje je potrebno postaviti u čekaonicama, ordinacijama ili na šalterima u zdravstvenim ustanovama. To mogu biti posteri, pamfleti, lifleti i sličan materijal namenjen ohrabrenju žena da govore o nasilju (24,25).

Zaključak

Edukacija zdravstvenih radnika o rodno zasnovanom nasilju značajno smanjuje njihov nedostatak znanja o ovom problemu. Nakon što se upoznaju sa smernicama za postupanje mogu da promene stav i mogu da pomognu ženama koje su pretpele nasilje. Takođe, smanjuje se njihov strah za sopstvenu bezbednost. Nedostatak kadra i prostora za privatnost, kao i preopterećenost poslom su ključne prepreke. Zdravstveni radnici očekuju veća ovlašćenja (status službenog lica).

U treninge/edukaciju treba uključiti više profesionalaca muškog pola, svih starosnih dobi i zaposlene u seoskim sredinama. Zdravstvene ustanove treba da naprave plan stalnog i sistematskog obučavanja zaposlenih sa što većim obuhvatom kroz specijalizovane akreditovane kurseve i treninge. Neophodna je implementacija znanja u svakodnevnu praksu, ali i praćenje njihovih rezultata.

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institutions (5). Training can significantly assist in these activities. Five female respondents (7.5%) of our study stated that they were the victims of domestic violence, which could be a barrier in everyday work, because the health workers go through their own experience of violence repeatedly.

Barriers related to women who experienced violence

In our study, more than 60% of health workers, that is 68.7% of women and 63.6% of men, think that women, who have experienced violence, fear the recurrence of violence, whereas in the research of Knezevic and associates, this problem was identified by 55.8% of all respondents (14). About 64% of our respondents think that one of the barriers is the fact that women return to the same environment, which is, to a certain extent, higher in comparison to the study of Kneszevic et al. (53.7%), and significantly higher in comparison to a study conducted in Britain (11%) (20). It should not be a significant barrier due to complex mechanisms and difficulties in relation to coming out of the violent relationship/ marriage. The fact is that a lot of women stay in violent relationships. Family, friends, neighbors and even professionals frequently do not understand why women endure violence. The research and experience show that the most common reasons for accepting life in a violent relationship are those which fit into the socially accepted prejudice about violence (7,8). Experiencing violence is determined by social, as well as psychological/personal reasons. The explanation may be found in the dynamics of a violent relationship, in which partners go through different phases – when the perpetrator of violence has all the power, and the phase of regret, "the honey moon", when the woman has the illusion of her own power and control over the situation (7,8).

In our research, 54.6% of men and 56.7% of women think that women, who have experienced gender-based violence, do not know enough about their legal rights, which is almost three times more in comparison to the results of one study conducted in Britain (20). Our results, as well as the results of other studies (19, 21) show that women, who have survived violence, do not report it due to shame and fear that the environment will not understand them. Around one half of respondents think that women persistently hide the violent behavior of their partner and therefore, do not report it. Women often deny that they have experienced violence. There are numerous reasons for that, and therefore, professionals should be aware of that and show understanding (1).

Some of them think that it is hard for women to talk about violence and that they expect to be asked about it. During their everyday work, health workers should use the therapeutic potential and identify violence, condemn it clearly, be empathetic listeners, offer continuing care, and be aware of the fact that their task is not to solve the problem but to direct women skillfully to existing resources (1,7,22). Asking women about the experienced violence is not an easy task. Uneducated health workers often do not do that, because they fear that they would insult the woman with such questions. In 2017, Lewis and associates proposed the inter-sectoral trainings because domestic violence was deemed to be a multidisciplinary problem (23). At the same time, it is important to ask questions about gender-based violence because women expect to be asked and they accept the conversation, even when they do not speak about it on their own (7,8). Women who have experienced violence should be encouraged to speak about it within healthcare institutions. This can be achieved with printed materials, which should be placed in waiting rooms, doctors' offices or at the reception desks of healthcare institutions. These can be posters, pamphlets, leaflets and similar materials intended to encourage women to speak about violence (24,25).

Conclusion

The education of healthcare workers about gender-based violence significantly reduces the lack of knowledge about this problem. After the health workers get acquainted with the guidelines they can change their attitude and help women who have experienced violence. Also, the fear for their own safety decreases. The lack of staff and private space, as well as the heavy workload present the key barriers. Health workers expect greater authority (the

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status of authorized officers).

More male professionals from all age groups should be included in trainings/ educational courses, as well as all those employed in rural environments. Healthcare institutions should make a plan of constant and systematic educations of employees through specialized accredited courses and trainings. The implementation of knowledge into the everyday practice is necessary, as well as the supervision of results.

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Autor za korespondenciju: Snežana Knežević, Dom zdravlja Kraljevo, Ulica Jug Bogdanova 110, 36000 Kraljevo, Srbija; e-mail: lesta59@yahoo.com

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Corresponding author: Snezana Knezevic, Health Care Centre Kraljevo, St Jug Bogdanova 110, 36000 Kraljevo, Serbia; e-mail: lesta59@yahoo.com