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Research Article

# ATTITUDES OF HEALTH WORKERS IN FAMILY HEALTH CENTERS ON THE INTIMATE PARTNER VIOLENCE AGAINST WOMEN (THE CASE OF MARDIN, TURKEY)

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### ABSTRACT

*The aim of this study was to determine the attitudes and practices of health workers working in Family Health Centers in Mardin regarding the intimate partner violence against women. This study was carried out with doctors, nurses, midwives and health officials working at Family Health Centers in Mardin. The study was conducted with 307 health workers. In this study, socio-demographic questionnaire and Health Care Provider Survey of Intimate Partner Violence (IPV) Attitudes and Practice were used as a data collection tools. The data was analyzed in the SPSS 20 statistics programme. As a result of the study, it was found that the adequacy level of the attitudes and practices of health workers regarding the intimate partner violence against women was low throughout the study. A statistically significant difference was found between the attitudes and practices of health workers regarding the intimate partner violence against women and occupational, gender, education status, workplace, reporting of violence to the police and the social services ( $p < 0.05$ ). It has been determined that health workers are concerned about their own safety and think about possible legal consequences when questioning the violence against women. As a conclusion health workers should be informed and supported with effective trainings on violence against women.*

**Keywords:** *Intimate partner violence against women, family health center, health workers.*

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## **1. INTRODUCTION**

Violence against women can create health and social problems for the individual and the society. Violence against women creating significant health problems such as, physical illnesses for the victimized women, gynecological diseases, alcohol and substance abuse, suicide, psychotraumatic and panic disorders, safe motherhood, family planning, sexually transmitted diseases have a direct impact on many problems such as public health to be considered in terms of is an issue. The first institution where women victims of violence apply for support is health institutions. The approach of the health workers to the victim women in these institutions is important in terms of the fact that women do not conceal the violence and the employees can recognize the violence. As a result of a study conducted in 2001, it was found that the violence against women was reduced by 75% by identifying violence and intervening in violence by health workers in primary health care institutions. However, in recent years, the attitudes of the healthcare workers serving the women who have been subjected to violence and their determination to solve this problem remain limited (Polat, 2017; Kemerli, 2003; Önal, 2003).

In this context, the attitudes of health workers in Family Health Centers providing primary health care services in the family to the intimate partner violence against women and the practices to solve the problem of violence can reduce the incidence of violence, the health of the victimized women and the health of children who witness violence in the family. This will have a positive impact on community health. In this study, it was aimed to determine the attitudes of health workers in Family Health Centers towards their partner violence and their applications to solve the violence.

### **1.1. What is violence?**

Violence is an action by the perpetrator, intentionally committed to harm another person, threatening physical and psychological integrity, causing the victim to experience a devastating fear (Panitch ve Leys, 2009). In Article 2 of the law on the Protection of The Family and The Prevention of Violence Against Women, violence is defined as “any kind of physical, sexual, psychological, or economic attitude or behaviour that occurs in a social, public or private sphere, including the possible actions that result from a person being physically, sexually, psychologically or economically damaged or suffering, threats and pressures against him or her, or the arbitrary obstruction of freedom” (The Protection of The Family and Prevention of Violence Against Women Code, 2012). Violence is defined by the World Health Organization as “the possibility of injury, psychological harm and death in the person subjected to a deliberate threat or reality of physical power or power and the possibility of depriving the person of economic need”. In the World Report on Violence and Health, violence has been examined in three different categories, including the person's own violence, interpersonal violence and collective violence. In the category of interpersonal violence, “domestic violence or intimate partner violence” is defined as violence between spouses or family members, usually at home. It is stated that the life, freedom, body and mental health of the individual in the family is threatened by this violence (WHO, 2002).

### **1.2. Intimate partner violence**

Violence in the family is defined as the physical, sexual, psychological or economic violence that family members exert against each other, damage the physical and mental integrity of family members, threaten their freedom, adversely affect the development of personality and create actions that can cause death in the traditional family unit (Taşçı, 2003). According to the Council of Europe Convention on Preventing and Combating Violence Against Women and Domestic Violence, intimate partner violence against women is defined as “the perpetrator who performs the action, whether or not shared or are sharing the same household as the victim

never had one before, whether or not within the family or within the family unit, spouses, or cohabiting individuals that occur between current or previous physical, sexual, psychological or economic violence” (Council of Europe, 2011). The most common form of this violence is the violence that is applied by men who are with women. Intimate partner violence against women is the most common form of violence against women in the world. Refers to violence between married or unmarried spouses (Ahmad et al., 2017). For this reason, most of the perpetrators are male while the majority of victims of domestic violence are female (Ibiloglu, 2012).

The reasons for the intimate partner violence against women vary according to societies and relationships. Although the cause of violence varies, domestic violence affects both the victim and the perpetrator negatively (Kandemirci and Kağnici, 2014). Although violence is tried to be legitimized in the family where there should be an environment of unity, solidarity, trust and peace, violence is damaging the family structure, exploiting women's human rights and causing violent generations to grow. (Şenol and Yıldız, 2013).

### **1.3. The current situation related to intimate partner violence against women in the world and in Turkey**

According to the World Health Organization's Global and Regional Estimates of Violence against Women (2013), one in three women in the world has been subjected to violence by her husband, 30% of women's physical violence, 35% of women's violence, 29% of women's physical violence in the United States, 36% of women's violence, 25% of women's violence in Europe, and 27% (WHO, 2013). According to the Global Homicide Report published in 2018, 34% of 87,000 women killed worldwide in 2017 were killed by their spouses. In the family, 18% of women killed their husband and 82% of men killed their wife. In the case of female murders in the family, the effect of spouses trying to establish authority over women, gender roles, jealousy, and fear of abandonment, alcohol and drug use, and the denial of women's sexual union is great. The fact that the man witnessed domestic violence during childhood, the level of education and the low income situation also affect women's murders. In Turkey, it was found that the murders of women were mainly related to the relationship between women and men and the behaviour of individuals (UNODC, 2018).

According to the study conducted in Turkey in 2014, the prevalence of psychological violence in women exposed to violence by their partners in Turkey is 44%, the prevalence of physical violence is 36%, the prevalence of sexual violence is 12%, the prevalence of physical violence during pregnancy is 8%, and the Southeast Anatolia region is 41%, 33%, 11% and 9%, respectively. The prevalence of economic violence was determined as 30%. 26% of the women who were subjected to violence stated that they had a health problem due to violence and 33% thought suicide. One in three women who are exposed to physical violence or sexual violence has stated that they are considering committing suicide after violence. This ratio is one tenth of women who have never been subjected to intimate partner violence. Suicide attempts are 5 times more likely in women who suffer from intimate partner violence. 44% of women who are victims of violence did not share their experiences with anyone, while the ratio of sharing violence with their immediate environment was 51% in 2008 and 56% in 2014. After the violence, 7% of women applied to the police, 4% to the health care institution, 3% to the prosecution and 1% to the gendarmerie. 89% of the victims of violence did not apply to any institution or organization. As a result of violence, 85% of women applied to the health care institution were asked for the reason of their illness by the health care worker, 37% were directed to the necessary institutions and 63% were not directed to any institution or institution. 76% of women are satisfied with their approach to health workers (HUNEE, 2015).

As a result of given data above, it is understood that intimate partner violence against women is a widespread universal problem. However, in most cases, women conceal the violence situation and it is assumed that the intimate partner violence rates determined by research do not reflect the actual rates, and the intimate partner violence is more pronounced (Tel, 2002).

#### **1.4. Health dimension of violence against women**

Violence violates the fundamental human rights of women through physical and mental health problems, suicide and death results (Taşkıran et al, 2015). Violence against women is harmful to the family and causes the family to decrease the quality of life of the family, and the physical and mental health of the family members to be damaged. This is reflected in public health and causes violence against women to be a public health problem (Tel., 2002; Chrisler and Ferguson, 2006). At the same time, health expenditures for family members who suffer from violence affect the country's economy. The cost of violence against women is estimated to be \$1.6 billion annually worldwide. In health expenditures, the cost of diagnosis, treatment and medication for women who are victims of violence is €1,800 more than women who are not subjected to violence. Beydoun and his colleagues published in the United States in 2017, health spending for domestic peer violence was \$4 billion per year, physical violence-related health spending was \$2.4 billion, and sexual violence-related health spending was \$1.6 million. For this reason, intimate partner violence against women in the family is a health problem that affects not only women, but also all the family members and hence the society and states in a multidimensional way. It requires multidisciplinary cooperation to prevent it (Korkut and Owen, 2008; Kruse et al., 2011; Beydoun et al, 2017).

Domestic violence causes women to deteriorate their health status, to lower quality of life, to negatively affect physical and mental health and reproductive health and to benefit more from health services. According to Campbell and colleagues, the health problems of women who have been subjected to violence are more than 60% of women who have not been subjected to violence before (Campbell et al., 2002). In Turkey, the overall health status of women exposed to physical or sexual violence by their husbands is twice worse than that of women who have never had any violence (HÜNEE, 2015). For this reason, women who are exposed to the physical, sexual, psychological or economic violence of their partners are twice as often as women who are not violent, and the use of primary health care institutions and emergency services for physical and mental health problems are twice as often as women who are not violent (Beydoun et al, 2017). Late or incomplete provision of the necessary health services to women suffering from peer violence causes the worsening of women's health, loss of limbs, death, reduction of treatment compliance and quality of life, increase hospitalization rate and hospitalization period (Costa et al., 2018). There is a relationship between morbidity and mortality due to the lack of preventive efforts towards the detection and intervention of the intimate partner violence against women in health institutions. Therefore, health workers contribute strongly to preventing violence and reducing morbidity and mortality rates by ensuring that women who are victims of violence have complete access to violence-related services in health institutions (Swalesa et al., 2017).

Women who are victims of violence frequently apply to health institutions because of physical and mental health problems. Women can avoid telling health workers about the violence they are exposed to due to embarrassment, criticism, vandalism and fear of their spouses. In such cases, health workers are aware of the violence even if they do not specify women by taking into consideration the physical findings and behaviors of women during the examination, diagnosis and treatment process through their awareness of violence, education and sensitivity. Therefore, health workers have an important role in preventing violence and reducing its effects within the framework of the intimate partner violence against women

(Yalçın, 2018). According to the article Turkish Criminal Code 280, physicians, dentists, pharmacists, midwives, nurses and other health care providers are obliged to report this crime to the competent authorities without delay in case of any indication that a crime has been committed during the duty. Health workers who do not report the crime or who delay the reporting of the crime will be punished with a prison sentence of up to one year (Turkish Criminal Code, 2004). According to the Law No. 6284 on Protection the Family and The Prevention of Violence against Women, the examination and treatment of women who are victims of violence protected by the measures decision should be done with care without delay by health workers. Health workers should keep confidential information about the effectiveness of protecting the identity, address, or identity of the protected woman and other family members in their records. It is stated that health workers who disclose this information in violation of the law will be punished according to Turkish Criminal Code (The Protection of The Family and Prevention of Violence Against Women Code, 2012).

## **2. METHOD**

The aim of this study is to determine the attitudes and practices of the health workers working in Family Health Centers about the violence against women.

The type of research is a cross-section identifier. The universe of the research is composed of doctors, nurses, midwives and health officers working in Family Health Centers in Mardin. It is aimed to reach all health workers who agree to participate in the study. Therefore, no sampling selection method has been used. In this context, 343 health workers who worked in 69 Family Health Centers in Mardin were reached and 36 people who filled out the survey questionnaire were excluded from the research and the research was conducted with a total of 307 health workers. In the research, the questionnaire used as a data collection tool consists of 3 parts. In the first part there are 16 questions to determine the socio-demographic characteristics of the participants. The second section contains a scenario related to the subject. The third part includes the scale of attitudes and practices of health workers towards women in the field of peer violence, which consists of 42 questions made by the Turkish adaptation (Gezgin, 2011). A total of 42 expressions is a Likert type scale, which is scored from 1-4. Health workers were asked to choose one of the “1: completely agree, 2:agree, 3:disagree, 4:completely disagree” options appropriate to them from 42 statements related to the subject by providing a scenario and reading before the scale. The scale consists of 8 sub-dimensions, including Feeling Ready, Self-confidence, Lack of Control, Ease in Opening the Subject, Professional Support, Obstacles in Practice, Violence Research and Questioning the Results of the Practitioner. Statistical Package for Social Sciences (SPSS) for Windows 20 statistical package was used in the analysis of the data obtained from the study. Statistical significance level was calculated as  $p < 0.05$ .

## **3. RESULTS**

### **3.1. Demographic characteristics of participants**

59.6% (n: 183) of the health workers surveyed were women. Age range were 19 and 68 years and the mean age was  $30.71 \pm 7.36$  years. 42.3% (n:130) of the employees were doctors, 29% (n:89) were nurses, %26,4 (n:81) were midwives and %2,3 (n:7) were health officers. %76,8 (n:236) of the health workers graduated bachelor or master's degree. The working period of the health workers who participated in the study was determined in the range of minimum 4 months and maximum 38 years. 43.3% of the employees have been working in the profession and 67.8% have been working in the Family Health Centers for less than 5 years. Health workers who expressed their working periods in Family Health Centers for 10 years and over (n:2) stated that they had previously worked as a practitioner in the same institution providing

primary health care. 56.4% (n:173) of health workers serve in Family Health Centers in the urban area, %43,6 (n:134) rural area.

While 52.4% of the health workers who participated in the study did not receive training on violence against women during the student period, 61.2% stated that they received training on violence against women during the working life after graduation.

31.3% of the health workers involved in the study had cases of intimate partner violence against women. 11.7% of health workers who experienced violence against women reported the situation to the police, while 7.2% reported the situation to social services. 72.6% of the health workers who participated in the study stated that the violence of any female relative from their spouse would affect their professional life. 43.6% of the workers stated that this would make it easier to identify women who have been subjected to violence. 22.8% of the employees stated that this would cause them to be more concerned, while 3% stated that they had no impact. At the same time, the other 9 respondents stated that this would help them to be more careful and responsive in dealing with the issue and to build empathy.

In the study, 26.9% of the health workers reported that women were concealing and denying violence, 9.4% of the women were afraid of family and community pressure and 8.5% of the women saw violence as normal. 8.5% of the workers stated that criminal sanctions did not give confidence to the woman and that the woman did not report this situation for fear of re-violence. 25.5% of the employees did not express an opinion on the subject.

19.8% of the health care workers who participated in the study suggested that women should be educated and awareness of violence in order to determine the early impact of the violence against women. 14.7% of health workers stated that this situation can be determined by having effective communication with women and 10.7% by analyzing the physical and mental condition of the woman during the examination. 22.1% of employees did not give an opinion on the subject.

When the frequency distributions of scale statements were examined, it was determined that health workers did not routinely open the issue of violence against women (46.9%) in all interviews with the patient, did not directly ask whether the husband hit her (45%), and did not feel blocked (61.6%) in the absence of time to deal with the violence problem. In addition, 58% of health workers (11.4%: totally agree, 46.6%: agree) are concerned about their safety when questioning the violence against women and 78.5% consider possible legal consequences.

### **3.2. Examining the relationship between variables**

The aim of the study was to determine the adequacy level of the attitudes and practices of health workers regarding the violence against women, the attitudes and practices of health workers and their characteristics such as gender, occupation, age, education status, working times in the profession or in the Family Health Center, working areas, the situations of education about violence against women during, the relations between the cases of violence and the cases of violence reported to the police or social service institutions have been examined.

#### **3.2.1. Adequacy of the attitudes and practices of health workers towards the intimate partner violence against women**

When the adequacy level of the attitudes and practices of health workers regarding intimate partner violence against women (Table 1) was examined, it was determined that the lower dimensions of comfort (1,84±0,54) and self-confidence (2,08 ±0,45) were at moderate level. It was determined that the sub-dimensions were lower than the total adequacy level (2.50±0.19).

**Table 1.** Adequacy of The Attitudes and Practices of Health Workers Towards the Intimate Partner Violence Against Women

| Sub-Dimensions                              | Mean |
|---|------|
| Feeling Ready                               | 2,43 |
| Self-confidence                             | 2,08 |
| Lack of Control                             | 2,9  |
| Ease in Opening the Subject                 | 1,84 |
| Professional Support                        | 2,26 |
| Obstacles in Practice                       | 2,92 |
| Violence Research                           | 2,63 |
| Questioning the Results of the Practitioner | 2,49 |
| Total                                       | 2,50 |

\*1: Totally Agree – 4: Totally Disagree

### 3.2.2. The relationship between profession and the attitudes and practices of the health workers on the intimate partner violence against women

The results of the study showed that there was a statistically significant difference in the prevalence of The Lack of Control among health care workers ( $P=0.007$ ) and the prevalence of among The Violence Research and health care workers ( $P=0.002$ ). The Lack of Control of the practitioner was found to be higher in nurses ( $2,81\pm0,38$ ) than doctors ( $2,98\pm0,41$ ). In the Violence Research, it was determined that nurses ( $2.55\pm0.28$ ) researched violence more than doctors ( $2.71\pm0.32$ ). In this study, it was found that there was a general difference between doctors and nurses in terms of intimate partner violence against women ( $p=0.002$ ).

**Table 2.** The Relationship Between Profession and The Attitudes and Practices Of The Health Workers On The Intimate Partner Violence Against Women

| Sub-Dimensions    | Profession     | Mean | p            |
|-------------------|----------------|------|--------------|
| Lack of Control   | Doctor         | 2,98 | <b>0,007</b> |
|                   | Nurse          | 2,81 |              |
|                   | Midwife        | 2,90 |              |
|                   | Health Officer | 2,59 |              |
| Violence Research | Doctor         | 2,71 | <b>0,002</b> |
|                   | Nurse          | 2,55 |              |
|                   | Midwife        | 2,61 |              |
|                   | Health Officer | 2,52 |              |
| General           | Doctor         | 2,53 | <b>0,002</b> |
|                   | Nurse          | 2,44 |              |
|                   | Midwife        | 2,51 |              |
|                   | Health Officer | 2,38 |              |

Analyzed by ANOVA test. (1: Totally Agree – 4: Totally Disagree.)

### **3.2.3. The relationship between gender and the attitudes and practices of the health workers on the intimate partner violence against women**

According to Table 3, the relationship between the attitudes and practices of the health workers in the study and the gender of the was found to be statistically significant Violence Research ( $p=0.007$ ) and the throughout the research ( $p=0.008$ ). Violence Research shows that women ( $2,59\pm0,3$ ) are investigating more violence than men ( $2,7\pm0,34$ ). In the survey, the attitudes and practices of women ( $2,47\pm0,19$ ) regarding the prevalence of intimate partner violence against woman are higher than those of men ( $2,53\pm0,19$ ).

**Table 3.** The Relationship Between Gender and The Attitudes and Practices Of The Health Workers On The Intimate Partner Violence Against Women

| Sub-Dimensions           | Gender       | Mean | p*           |
|--------------------------|--------------|------|--------------|
| <b>Violence Research</b> | <b>Woman</b> | 2,59 | <b>0,007</b> |
|                          | <b>Man</b>   | 2,7  |              |
| <b>General</b>           | <b>Woman</b> | 2,47 | <b>0,008</b> |
|                          | <b>Man</b>   | 2,53 |              |

Independent groups by T-test were analyzed. (1: Totally Agree – 4: Totally disagree)

### **3.2.4. The relationship between education status and the attitudes and practices of the health workers on the intimate partner violence against women**

When it was examined whether the attitudes and practices of health workers regarding intimate partner violence against woman differ according to their educational status (Table 4), there was a statistically significant difference in the survey ( $p=0.046$ ). There was no difference between the learning status groups in the Tukey analysis to determine the source of difference.

**Table 4.** The Relationship Between Education Status and The Attitudes and Practices Of The Health Workers On The Intimate Partner Violence Against Women

| Sub-Dimension            | Education Status         | Mean | P*           |
|--------------------------|--------------------------|------|--------------|
| <b>Violence Research</b> | Health Vocational School | 2,59 | <b>0,046</b> |
|                          | Associate Degree         | 2,55 |              |
|                          | License or               |      |              |
|                          | Post Graduate            | 2,66 |              |
|                          | Expertise In Medicine    | 2,84 |              |

ANOVA test was analyzed. (1: Totally Agree – 4: Totally Disagree.)

### **3.2.5. The relationship between working area and the attitudes and practices of the health workers on the intimate partner violence against women**

When it was examined whether the attitudes and practices of the health workers involved in the study differ according to the settlement of the working area, there was a statistically significant difference in the lower dimension of Ease in Opening the Subject ( $p=0.044$ ). Accordingly, it is observed that the workers in the urban area ( $1,78\pm0,56$ ) are more comfortable in opening the issue compared to the workers in the rural area ( $1,91\pm0,51$ ). Analyzed by Independent groups by T-test. (1: Totally Agree – 4: Totally disagree)



### **3.2.6. The relationship between reporting violence cases to the police and the attitudes and practices of the health workers on the intimate partner violence against women**

When the situation of the health workers who participated in the study reported to the police about the women's violence cases, there was a statistically significant difference in the Self-confidence subscale ( $p=0,025$ ). Employees reporting the situation to the police ( $1.92\pm0.43$ ) are more confident than non-reporting employees ( $2.10\pm0.44$ ). Analyzed by Independent groups by T-test. (1: Totally Agree – 4: Totally disagree)

### **3.2.7. The relationship between reporting violence cases to the social services and the attitudes and practices of the health workers on the intimate partner violence against women**

When it was examined the situation of reporting intimate partner violence cases to social services of health workers, it was found that there were statistically significant differences in Self-confidence subscale ( $p=0,010$ ), Professional Support subscale ( $p=0,005$ ) and throughout the research ( $p=0,020$ ). Employees reporting the situation to social services ( $1,84\pm0,48$ ) are more confident than non-employees reporting ( $2,10\pm0,44$ ). Professional Support subscales are higher in Professional Support skills than those who report the situation to social services ( $1.94\pm0.53$ ) and those who do not report ( $2.28\pm0.56$ ). In the research, according to the employees who report violence against women to social services ( $2.40\pm0.17$ ), attitudes and practices are higher than those who do not report violence against women ( $2.50\pm0.19$ ). Analyzed by Independent groups by T-test. (1: Totally Agree – 4: Totally disagree)

It was not found that the attitudes and practices of health workers on the subject of peer-to-peer violence differ according to age, occupational working time, working time at the family health center, violence education for women in the student period or in the professional life and the situation of encountering a case of violence before ( $p>0.05$ ).

## **4. DISCUSSION AND CONCLUSION**

Intimate partner violence against women is a global problem that affects women, family members and societies, which has lasted many years from the past to the present. It is also an important public health problem that affects the general health status of women who have been subjected to violence and family members who have witnessed violence. One of the health institutions that victims of violence frequently apply to is the Family Health Centre. For this reason, the attitudes and practices of health workers at primary health care centers have an important place in combating intimate partner violence against women, resolving the violence problem, early detection of violence, taking measures against violence, and eliminating the violence against women's health problems.

The Turkish adaptation of the scale of attitudes and practices of health workers towards intimate partner violence against women was carried out by the traveler in 2011. The study was carried out with the doctors, nurses, midwives and health officers working in Family Health Centers, Community Health Centers, Mother Child Health and family planning centers in Izmir. In this study, 67.6% of health workers faced a case of violence against women and 14.6% reported the situation to the police and 7% reported the situation to the social services unit. The relationship between variables was not examined in this study in 2011. In our study, it was found that the situation of reporting violence to the police (11.7%) and social services (7.2%) was low in parallel with the study conducted in Izmir. Turkish Criminal Code 279. And according to the articles 280, although health workers have the obligation to report the violence they face to competent bodies, the majority of health workers did not report. In the same way, 25.5% of health workers and 22.1% of health workers did not express an opinion on

recommendations for early detection of women's peer violence. In this case, it is possible to say that the level of knowledge about the legal obligations of health workers in cases of equal violence against women and their sensitivity to the violence against women is low.

Sarıbıyık (2012) in his study with doctors, nurses and midwives at 28 Family Health Centers in Malatya, he found that health workers were inadequate to recognize the intimate partner violence against women and their attitudes differed by gender and did not differ according to age, occupation and education. In the research conducted by Çatak (2015) in 50 Family Health Centers in Denizli, the diagnosis of the symptoms of violence of doctors, nurses and midwives was partially determined as sufficient. In this study, which was conducted in the Family Health Centers in Mardin, it was found that the adequacy level of the attitudes and practices of the health workers regarding the intimate partner violence against women was low throughout the research. Although health workers are capable of recognizing the signs of violence, the lack of practice of health workers who recognize the signs of violence against women will not help to solve the problem of violence against women. Therefore, arrangements should be made by health managers to increase the adequacy and effectiveness of health workers' practices on intimate partner violence against women.

In the research carried out by Kara and friends in Adana in 2018 with doctors, nurses and midwives at 20 Family Health Centers, it was determined that the rates of the nurses and midwives who receive violence education for women and who face violence cases were higher. Yalçın's study (2018) at Karaman in 74 Family Health Centers doctors, nurses and midwives and Çelik and friends (2015) in Erzurum 18 midwives and nurses in order to prevent violence against women, health workers were trained on gender equality and violence against women, and the level and attitudes of their employees on violence against women were determined to change positively in the fight against violence. 61.2% of the health workers who participated in our study stated that they received Violence against Women in their professional life. However, there was no significant difference between the attitudes and practices of health workers regarding the violence against women and the absence of education or education related to violence against women during the working period ( $p>0.05$ ). This situation is thought to be caused by the content of the violence education for women in different provinces or by the way it is given. The awareness, sensitivity, skills, attitudes and practices of health workers regarding violence against women will increase positively. Violence trainings for health workers providing primary health services by Provincial Health directorates should be increased and the efficiency of the trainings should be evaluated.

According to the findings of this study, health workers are concerned about their safety when questioning the violence against women and consider possible legal consequences. The presence of a risk of violence against health workers causes health workers to think about their safety, avoid investigations that may occur as a result of wrong or wrong practices, avoid compensation and punishment practices, avoid taking initiatives with a defensive approach and ignore violence (Yalçın, 2018). For this reason, health managers should ensure that health workers's working environments are secured through practices that prevent violence against health workers.

In the literature, in researches on intimate partner violence against women, the attitudes and practices of health workers were examined rather than the diagnosis of the signs of violence of health workers. In this case, it is not possible to determine what practices and attitudes of health workers who recognize the signs of violence are and which variables differ according to them. In this study, it was determined that the attitudes and practices of health workers regarding the violence against women were statistically significant and in general inadequate level and that the situation of profession, sex, educational status, working area, violence cases were reported to the police and social service unit. There were no statistically significant

differences in the attitudes and practices of health workers on the subject of intimate partner violence against women in terms of age, working time in the profession, working time in the Family Health Center, education of violence against women in the period of student or professional life.

As a result, it is necessary to increase the adequacy and effectiveness of the attitudes and practices of health workers who play an important role in determining and preventing intimate partner violence against women. To this end, health workers should be aware of and supported by effective trainings on the approach and communication of women in cases of violence against women, legal obligations in cases of violence against women, and in cases of intimate partner violence against women. Violence against women should be increased by health administrators and their research on violence against women who apply to health institutions, education on violence against women and raising awareness on violence, increasing the awareness of health workers about the violence against women should be ensured, health workers should improve working conditions and allocate more time to violence against women should be ensured. Health Care Provider Survey of Intimate Partner Violence (IPV) Attitudes and Practice scale using to determine attitudes and practices regarding intimate partner violence against women health workers and the creation of measures accordingly, the relationship between variables of larger groups, and to study in detail not only the primary health care institutions but also the second and third steps in healthcare institutions in the implementation of the study and data obtained in other provinces to be shared with provincial health directorates, the repetition and elaboration of the scale by other studies will contribute more to the solution of the problem intimate partner violence against women and the literature.

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