Sexism against women among primary healthcare workers

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Abstract *The objective of this study was to research the existence of sexism against women among primary healthcare (PHC) workers and to identify associated factors. This was a cross-sectional study in which 163 PHC professionals of both sexes participated, all of whom were aged over 18 and had completed their primary or secondary education. The Gender Stereotyping and Ambivalent Sexism Inventory questionnaires were used. The average scores were more than 50% of the maximum score: Gender Stereotyping – 53.8%, hostile sexism – 58.2%, benevolent sexism – 64.1%. The average scores stratified by sociodemographic variables were higher. Significant differences in the hostile sexism score were found for sex (men scored higher than women), religion (higher scores for evangelical Christians) and among those who drank alcohol. For benevolent sexism, differences were found for schooling (greater scores for those who had only completed their primary education), religion (higher scores for evangelical Christians and Catholics) and area of work (greater for those working in general services). The stratification of the Gender Stereotyping scores did not point to significant differences. Sexist prejudice was found to exist for hostile sexism, benevolent sexism and gender stereotyping. This finding could have a negative influence on the service-user relationship, leading to greater inequities in health as a result of gender inequality.*

Key words *Women's health, Sexism, Health inequality, Healthcare staff, Health services*

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Introduction

Violence against women is considered to be a significant public health problem for a wide range of reasons: the seriousness of the physical, mental and social consequences; the high rates of morbidity and mortality that, according to the WHO, reach epidemic proportions[1]; the great suffering that is caused; and the high costs incurred by the health system. Violence is largely motivated by gender prejudice and discrimination, which impede the drawing up and execution of effective strategies for addressing it[2]. These factors can lead to undesirable situations in the health service practices. The Brazilian National Policy for Integral Care to Women's Health even highlights that "questions of gender should be considered as one of the determinants of health when it comes to drawing up public policies"[3].

Gender identity impacts on the perception of being a man or woman or how the person identifies, based on the social roles that are attributed to the masculine and feminine gender. It is a social and cultural construct that is different to sex, which relates to a biological condition, whereby the anatomy of the body will define masculine or feminine sex[4].

A stereotype is understood to be "a process in which an impression is formed, made up of a collection of emotional, moral and instrumental evaluations that are established with regard to an individual. This collection has the capacity to influence the perceiver in his or her relations with the social world"[5]. While sexism is "a collection of stereotypes relating to appearance, acts, talents, emotions and one's appropriate role in society, related to gender. Although this can also involve stereotypes of men, it more frequently reflects prejudices against the feminine gender"[6]. There are two, ambivalent dimensions to sexism: the hostile and the benevolent. The former is the manifestation of prejudice against women in an explicit fashion, "demonstrating beliefs and practices that are typical of people who consider women to be inferior to men, as well as the expression of antipathy and intolerance in relation to a woman's role as a figure of power and decision making". Benevolent sexism is displayed in the form of attitudes that apparently are not prejudiced, and that are expressed in a manner that is subjectively positive, ascribing to the woman an identity that is dependent, fragile, and sensitive and that requires attention and protection from the man[7]. These displays of prejudice are associated with factors such as gender[8,9], schooling[10,11], an

affinity with conservativism, Christianity[12], and the consumption of alcohol and illegal drugs[13].

Sexist and gender stereotyped views held by health professionals can lead to discriminatory and prejudiced practices. Deeply held prejudices and the repetition of inequalities related to the construction of gender identities can be found in the daily operations of health teams[5]. These constructions are reflected in the shortcomings of health services for women that can prevent them from receiving essential care and in turn limit teams from providing integral care to users[7]. Gender identities govern not only health professionals' attitudes, but also their ways of acting and facing problems. It is important to note that these identities are the result of a historical and ideological process that hold the masculine individual to be the central reference across society[5]. Inequality between genders includes "differences between men and women that are unnecessary, unfair and avoidable in relation to their opportunities to enjoy a healthy life and the probability of becoming ill, incapacitated or dying from preventable causes"[14].

Just as different populations are exposed to various types and levels of risk, women and men are also exposed to different patterns of suffering, illness and death, as a result of the social organization of gender relations. Women encounter barriers and inequities of access to the health system. It is common for them to face difficulties in obtaining support for contraceptive methods, as well as prenatal and postpartum care[15]. In the same way, health services generally are not capable of providing an adequate response to situations of violence, either in the family or other realms[5]. It is not uncommon that in cases involving violence against women, "the victim is blamed for the attack, and the prejudice displayed by health professionals itself is the cause of a second offense against the woman"[16]. Health workers should be equipped with the appropriate procedures to carry out their activities, particularly in situations involving violence against women, guaranteeing confidentiality and access to specialist services for physical, mental and legal care[1]. In addition, studies have shown that hospital care for people of the female sex is not equal to that provided to men, both in terms of the correct procedures and the quality with which those procedures are carried out[1,17,18].

The Family Health Strategy is considered to be the entrance point to the Brazilian Unified Health System, SUS. This strategy aims to establish links between health professionals and users

by delineating specific territories and the populations therein. The strengthening of this relationship allows for issues which are important to the health sector but which previously had been overlooked to be addressed, as is the case of domestic violence[19]. Such violence may damage all areas of the family, but its principal victims are women[20]. The SUS directives indicate that primary healthcare services are responsible for the first contact in cases involving violence against women. It is therefore essential to understand the perceptions of health professionals about the social construction of gender identities and violence against women, so that their actions in health might be developed and honed on finding solutions. The detection of sexism and other stereotypes and prejudices held by health workers, as well as understanding their causes, are both fundamental to ensuring that women's health needs are better acknowledged and addressed by health professionals. The existence of sexism and gender stereotypes by professionals from the Family Health Strategy may exacerbate cases involving violence against women, rather than lead to more humanized and integrated solutions.

The objective of this study was to research the existence of prejudice against women among primary healthcare workers and to identify associated risk factors.

Methods

Design

This was a quantitative, exploratory, transversal and analytic study.

Location

Municipal Family Health teams from the Pouso Alegre municipality in Minas Gerais State of Brazil. This is a medium-sized municipality situated in the south of the state with an estimated population of 140.000 inhabitants. The primary healthcare services involved in the study were provided across 19 different health units which between them contained 252 professionals and on average provided coverage for 47% of the municipality's population.

Study population and sample

The study population involved professionals from the Family Health Strategy who were selected on the basis of the following eligibility criteria: being a municipal worker, working in a Family Health Team, responsible for carrying out a health service function, be in contact with the general public, have primary or secondary schooling, to be active in the position (i.e. not to be off work due to health problems, for personal reasons, retirement etc) and agreeing to participate in the study. Those who had tertiary education were not included in the study as they will be involved in a later phase of the research. The sample was made up of 163 health professionals, which represents 64.7% of people working in the sector (n = 252). 89 people did not take part in the study, of whom 17 were refusals and the remaining 72 did either did not meet with the eligibility criteria or could not be found.

Research tools

Three research tools were used to collect data. In the first instance, a protocol for sociodemographic and health data was used. The second tool was the Gender Stereotyping questionnaire which measures gender stereotypes in the context of relationships and responsibilities; it is in the public domain and was created by Gunter and Wober[21], validated by Foshee and Baumann[22], and has a Brazilian version that was developed by Eufrásio[23]. The tool is made up of seven closed items with four possible responses, each of which garners different scores when chosen: Completely agree (4 points); agree (3); Disagree (2); Completely disagree (1). The scores for answers to Question 7 are inverted. The greater the final score, the greater indication of a stereotyped attitude, with the highest possible score being 28.

The third instrument was the Inventory of Ambivalent Sexism that was originally developed by Glick and Fiske[24] and adapted and validated for Brazil by Formiga et al.[25]. The inventory is made up of 22 items and evaluates prejudice in two areas of sexism: hostile (11 questions) and benevolent (11 questions). The respondent should indicate the degree to which he or she disagrees or agrees with the content, using a five point Likert-style scale as follows: 1 = Completely disagree; 2 = Disagree; 3 = Unsure; 4 = Agree; and 5 = Completely agree. The items involve either positive or sexist affirmations. The higher the score, the greater the level of sexism, with the highest score being 55 points for each area. The scales do not propose a definitive cut-off point. For this instrument, the higher the scores, the greater the level of prejudice.

Procedures

The researchers visited the municipal primary healthcare services and entered into contact with the research participants. They held meetings at each one of the health units wherein they explained the study objectives and methodology, then invited the staff who could be included in the research to participate. The sample was made up of those who agreed to participate by signing a free, prior and informed consent form. The questionnaires were read out and participants were asked if they understood each question. If any doubt arose, the researcher would read the question again until the individual indicated that they had understood. The meanings of the questions themselves were never explained in order that the researcher did not influence the response. When there were no more questions, the participants themselves completed the questionnaires in the following order: 1 – Sociodemographic and health questionnaire; 2 – Gender stereotypes; 3 – Ambivalent sexism inventory. The research tools were applied in an isolated and quiet room with no interference from third parties. At the end of the period, the researcher checked that all questions had been answered and requested respondents to complete any items that had not been completed.

Database and statistical analysis

The results of the questionnaire were added to an Excel database, and the statistical analysis was carried out using SPSS 17. For the description of the quantitative variables, (average and median) central tendency and dispersion tendency (standard deviation) were used. The categorical variables were described in proportions. When the distribution of the variables was normal during the central tendency analysis, the t-test or analysis of variance (ANOVA) were applied. For non-parametric variables the Mann-Whitney or Kruskal-Wallis tests were used; and the Kolmogorov-Smirnov test was used to demonstrate adhesion to normal. Statistical significance was set at $p \leq 0.05$.

Ethical procedures

The research followed the directives of the National Health Council's resolution number 466/2012 and was approved by the Research Ethics Committee of the Universidade do Vale do Sapucaí.

Results

The sample was mainly made up of women (89%), of whom 58.9% were aged over 35. The majority of workers had completed their secondary or technical education (78.5%). 79.8% of respondents identified as white, while 70.6% were Catholic and 77.9% had a partner. More than half of the workers (54.0%) lived in a different neighborhood to the one in which the Health Unit was located; 52.1% lived with their spouses and 20.9% with their parents. The majority of professionals held positions in healthcare (69.9%), while the remainder worked in administration or in support services. All respondents had direct contact with service users. 94.5% of respondents earned up to a maximum of five times the minimum salary, with 71.1% holding their current position for at least a year, with 97.5% carrying out their services in urban areas. A total of 38 health professionals were smokers (23.3%) and 43 (26.4%) consumed alcohol (Table 1).

The average score in the Gender Stereotypes questionnaire was 15.07, which represented 53.8% of the maximum possible score (Table 2). There were two items for which the average score was below 50% of the maximum possible score: one relating to men pushing women around and another relating to physical aggression. Five items scored more than half the possible points and the two that scored over 70% related to affirmations that men who show an interest in women are after sex and women look for romance. In the

Table 1. Sociodemographic and health variables.

Variable	n	Percentage (%)
Sex		
Female	145	89.0
Male	18	11.0
Age range		
18 to 35	67	41.1
Over 35	96	58.9
Schooling		
Primary education	35	21.5
Secondary or technical education	128	78.5
Skin color		
White	130	79.8
Other	33	20.2
Religion		
Catholic	115	70.6
Evangelical Christian	41	25.2

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Table 1. Sociodemographic and health variables.

Variable	n	Percentage (%)
Other	7	4.3
Marital status		
Does not have partner	36	22.1
Has partner	127	77.9
Residence		
In the neighborhood where you work	75	46.0
Other	88	54.0
Lives with		
Parents	34	20.9
Other family members	19	11.7
Spouse	85	52.1
Alone	19	11.7
Other	6	3.7
Type of work		
Healthcare	114	69.9
Administrative	28	17.2
General services	21	12.9
Family income (as a multiple of the minimum wage)		
Zero to three	75	46.0
Four to five	79	48.5
More than five	9	5.5
Time in position		
0 to 5 months	13	8.0
6 to 12 months	34	20.9
13 to 36 months	40	24.5
More than 3 years	76	46.6
Location of work		
Urban	159	97.5
Rural	4	2.5
Smoker		
Sim	38	23,3
Não	125	76,7
Drinks alcohol		
Yes	43	26.4
No	120	73.6
Undergoing treatment for a health condition		
Yes	25	15.3
No	138	84.7
Regular use of medication		
Yes	55	33.7
No	108	66.3

Sexual Ambivalence Inventory (Tables 2, 3 and 4) the average score for the Hostile component was 32.03 (58.2% of the maximum score). The great majority of items for this measure received a score that was more than half of the maximum possible, with the only exception being the affirmation that women interpret innocent remarks as being sexist, with the example being "sometimes it is right for a man to hit a woman". The question that scored the highest (73.7%) was the one that stated that there are very few women who get a kick out of teasing men by seeming sexually available and then refusing male advances. Most scored between 50% and 70%. The questions relating to benevolent sexism received an averages score of 35.23 (64.1% of the maximum), and included seven questions that scored more than 60% of the maximum total, with four of these scoring more than 70%. Just the one score was below 50% of the maximum ("In a disaster, women ought not necessarily to be rescued before men").

Table 3 shows that among the scores for hostile sexism when stratified by sociodemographic variables, declaring one's religion to be 'other' (i.e. neither Catholic or Evangelical Christian) received the lowest average score, representing 49.6% of the maximum possible. The highest score was for those individuals who had only completed primary education, scoring 67.3% of the maximum for benevolent sexism. When the average scores were categorized by sociodemographic variable, they all scored more than 50% of the maximum possible, with the one exception mentioned above.

Table 5 shows that Gender Stereotypes are not significantly associated with any sociodemographic or health variable.

Hostile sexism (Table 4) was associated with sex (p < 0.001), with men scoring more than women. When this variable was stratified by sex and race, white men were found to have an average score (37.1; DP = 7.3) that was greater than that scored by white women (31.5; DP = 5.8); a finding that was statistically significant (p = 0.01). The averages scores for non-whites were also greater among men (p = 0.03). When white men were compared with non-white men, no significant difference was found, nor was the case for women. Hostile sexism was also significantly associated with religion: evangelicals were found to be the most likely to be hostile sexists, followed by Catholics, then 'other' (p = 0.048). This type of behavior also prevailed significantly (p = 0.025) among alcohol drinkers (score = 33.84) compared with other workers (score = 31.38). Other variables including age range, schooling, self-declared color, marital status, residing with spouse, type of role in the health services, income, time

Table 2. Average score and percentage of maximum score by variable for the Gender Stereotyping and Ambivalent Sexism Inventory questionnaires.

Tool and Questions	Average Score	% of Total	Median
Gender Stereotyping	15.07	53.8	15.0
1. Most women like to be pushed around by men	1.48	37.1	1.0
2. Most women like to show off their bodies	2.70	67.5	3.0
3. Most men want to go out with women just for sex	2.85	71.3	3.0
4. Most women enjoy romantic affairs with men	2.94	73.5	3.0
5. Most women depend on men to get them out of trouble	2.22	55.5	2.0
6. Sometimes it is right for a man to hit a woman	1.39	34.8	1.0
7. Men and women should have equal responsibility for bringing up children	1.48	63.0	1.0
Ambivalent Sexism Inventory			
Hostile sexism	32.03	58.2	32.0
Benevolent sexism	35.23	64.1	36.0
1. No matter how accomplished he is, a man is not truly complete as a person unless he has the love of a woman.	3.36	67.2	4.0
2. Many women are actually seeking special favors, such as hiring policies that favor them over men, under the guise of asking for "equality."	3.15	63.1	3.0
3. In a disaster, women ought not necessarily to be rescued before men.	2.45	49.1	2.0
4. Most women interpret innocent remarks or acts as being sexist.	2.37	47.5	2.0
5. Women are too easily offended.	3.33	66.5	4.0
6. People are often truly happy in life without being romantically involved with a member of the other sex.	2.60	51.9	2.0
7. Feminists are seeking for women to have more power than men.	2.83	56.6	2.0
8. Many women have a quality of purity that few men possess.	3.37	67.5	4.0
9. Women should be cherished and protected by men.	3.99	79.8	4.0
10. Most women fail to appreciate fully all that men do for them.	2.91	58.3	3.0
11. Women seek to gain power by getting control over men.	2.69	53.9	2.0
12. Every man ought to have a woman whom he adores.	3.57	71.4	4.0
13. Men are complete without women.	3.19	63.8	4.0
14. Women exaggerate problems they have at work.	2.63	52.6	2.0
15. Once a woman gets a man to commit to her, she usually tries to put him on a tight leash.	2.89	57.8	3.0
16. When women lose to men in a fair competition, they typically complain about being discriminated against.	2.78	55.6	2.0
17. A good woman should be set on a pedestal by her man.	2.96	59.3	2.0
18. There are actually very few women who get a kick out of teasing men by seeming sexually available and then refusing male advances.	3.69	73.7	4.0
19. Women, compared to men, tend to have a superior moral sensibility.	3.51	70.2	4.0
20. Men should be willing to sacrifice their own well-being in order to provide financially for the women in their lives.	2.70	54.0	2.0
21. Feminists are making entirely reasonable demands of men.	2.75	55.1	3.0
22. Women, as compared to men, tend to have a more refined sense of culture and good taste.	3.53	70.6	4.0

Question 7 has been inverted; the question in the original survey read: Feminists are not seeking for women to have more power than men. Hostile sexism: 2, 4, 5, 7, 10, 11, 14, 15, 16, 18, 21. Benevolent sexism: 1, 3, 6, 8, 9, 12, 13, 17, 19, 20, 22.

Table 3. Average scores and percentage of maximum scores for Gender Stereotyping, Hostile Sexism and Benevolent Sexism by sociodemographic and health variables.

Variable	Gender Stereotyping		Hostile sexism		Benevolent sexism	
	Average	%	Average	%	Average	%
Sex						
Female	15.02	53.6	31.41	57.1	35.41	64.4
Male	15.44	55.1	37.06	67.4	33.78	61.4
Age range						
18 to 35	15.1	53.9	32.67	59.4	35.82	65.1
Over 35	15.04	53.7	31.58	57.4	34.82	63.3
Schooling						
Primary education	14.71	52.5	31.63	57.5	37.03	67.3
Secondary or technical education	15.16	54.1	32.14	58.4	34.74	63.2
Skin color						
White	14.98	53.5	31.97	58.1	35.22	64.0
Other	15.39	55.0	32.27	58.7	35.27	64.1
Religion						
Catholic	14.97	53.5	31.86	57.9	34.96	63.6
Evangelical Christian	15.39	55.0	33.32	60.6	36.76	66.8
Other	14.86	53.1	27.29	49.6	30.86	56.1
Marital status						
Does not have partner	14.51	51.8	32.5	59.1	34.97	63.6
Has partner	15.2	54.3	31.9	58.0	35.31	64.2
Residence						
In the neighborhood where you work	15.44	55.1	33.12	60.2	35.88	65.2
Other	14.75	52.7	31.1	56.5	34.68	63.1
Lives with						
With spouse	15.02	53.6	31.78	57.8	35.27	64.1
Alone or with others	15.12	54.0	32.31	58.7	35.19	64.0
Type of work						
Healthcare	15.11	54.0	31.94	58.1	35.06	63.7
Administrative	15.32	54.7	33.25	60.5	35.57	64.7
General services	14.52	51.9	30.9	56.2	35.71	64.9
Family income (as a multiple of the minimum wage						
Zero to three	15.23	54.4	32.25	58.6	36	65.5
Four to five	14.9	53.2	31.71	57.7	34.72	63.1

of service and smoking did not show any significant differences.

In Table 4, benevolent sexism is found to be significantly associated with a number of variables: level of schooling, where those with only primary education had scored highest; religion, where evangelicals scored higher; type of work in the health sector, whereby those who worked in general services were found to be the most benevolent sexists. Other sociodemographic variables showed no statistical differences for this measure.

Discussion

The elements that make up the sociodemographic profile of this sample are consistent with those characteristics found among health professionals in other studies[26,27].

There are no predefined cut off points for the three scales used (gender stereotypes, hostile sexism and benevolent sexism); rather, the authors advise that the higher the score, the greater the level of prejudice. In this research, all scores were high, pointing to the existence of prejudice

Table 3. Average scores and percentage of maximum scores for Gender Stereotyping, Hostile Sexism and Benevolent Sexism by sociodemographic and health variables.

Variable	Gender Stereotyping		Hostile sexism		Benevolent sexism	
	Average	%	Average	%	Average	%
More than five	15.22	54.4	33	60.0	33.33	60.6
Time in position						
0 to 5 months	15.23	54.4	33.62	61.1	34.31	62.4
6 to 12 months	14.94	53.4	31.21	56.7	33.65	61.2
13 to 36 months	15.48	55.3	31.27	56.9	35.77	65.0
More than 3 years	14.88	53.1	32.53	59.1	35.82	65.1
Location of work						
Urban	15.04	53.7	31.99	58.2	35.26	64.1
Rural	16.25	58.0	33.75	61.4	34	61.8
Smoker						
Yes	15.37	54.9	32.61	59.3	35.45	64.5
No	14.98	53.5	31.86	57.9	35.17	63.9
Drinks alcohol						
Yes	15.37	54.9	33.84	61.5	35.79	65.1
No	14.96	53.4	31.38	57.1	35.03	63.7
Undergoing treatment for a health condition						
Yes	14.4	51.4	31.76	57.7	36.16	65.7
No	15.19	54.3	32.08	58.3	35.07	63.8
Regular use of medication						
Yes	14.93	53.3	31.75	57.7	35.55	64.6
No	15.14	54.1	32.18	58.5	35.07	63.8
Total	15,07	53.8	32.03	58.2	35.23	64.1

against women among health workers. The highest averages were found for the benevolent sexism component. This may be because the indicators represented "positive attitudes that are apparently not prejudiced against women, demonstrating paternalistic sentiment which sees the woman as a fragile person who requires attention, but who can also complement a man"[28]. The damaging effects of hostile sexism are not open to question, while there is less social recognition of the negative consequences of benevolent sexism.

For the analysis using Gender Stereotypes, no statistically significant differences were found when the scores for each item were stratified for sociodemographic variables. Nonetheless, these stereotypes were present, since the scores were high (all but one scored more than half of the maximum score), irrespective of the stratification that was carried out. Sexism and Gender Stereotypes increase the risk of violence against women[6,28]. The health sector often witnesses abuse, mistreatment, negligence, abandonment, delays, disrespect, a breakdown of trust, neglect of another's autonomy, and the carrying out of painful and unnecessary procedures that affect women[29]. Health sector workers can cause damage and prejudice to health sector uses and to the overall functioning of the health system. Health sector professionals who want to carry out their work in a way that is effective and humanized, showing interest, sharing dialogue and being resolute, need training to deal with subjective social issues that are prevalent in service delivery. Primary healthcare and the Brazilian Family Health Strategy are based on the attributes of access, long-termism, integrality, coordination, cultural competence[30], receptivity and social bonds[31]. Where sexism and prejudice is rife, these qualities are not attainable particularly since the largest proportion of those who access primary healthcare are women[32].

Stratification by sex of Gender Stereotyping is an interesting case in point. Both men and women scored highly with little significant difference between them. This fact shows that both sexes demonstrate gender stereotypes. Stereotypes regarding the feminine are more common among men, but can also occur among women[8,9].

Table 4. Average and median scores, standard deviation and p value for Hostile and Benevolent Sexism by sociodemographic and health variables.

Variable	Hostile sexism				Benevolent sexism			
	Average	Standard deviation	Median	p	Average	Standard deviation	Median	p
Sex				< 0.001*, ES				0.239*
Female	31.41	5.83	31.00		35.41	5.52	36.00	
Male	37.06	6.68	37.00		33.78	5.68	35.50	
Age range				0.269*				0.260*
18 to 35	32.67	6.23	32.00		35.82	5.45	37.00	
Over 35	31.58	6.11	31.00		34.82	5.60	35.00	
Schooling				0.612*				0.013*SS
Primary education	31.63	4.89	31.00		37.03	4.36	37.00	
Secondary or technical education	32.14	6.48	32.00		34.74	5.75	35.00	
Skin color				0.801*				0.964*
White	31.97	6.15	31.50		35.22	5.39	36.00	
Other	32.27	6.33	32.00		35.27	6.22	38.00	
Religion				0.048**, SS				0.020**SS
Catholic	31.86	5.76	32.00		34.96	5.53	35.00	
Evangelical Christian	33.32	7.12	32.00		36.76	4.93	37.00	
Other	27.29	4.11	27.00		30.86	6.91	33.00	
Marital status				0.606*				0.750*
Does not have partner	32.50	6.39	33.00		34.97	6.26	35.50	
Has partner	31.90	6.12	31.00		35.31	5.35	36.00	
Lives with				0.584*				0.929*
With spouse	31.78	5.93	31.00		35.27	5.30	36.00	
Alone or with others	32.31	6.44	32.00		35.19	5.83	35.50	
Type of work				0.405**				0.024**SS
Healthcare	31.94	6.13	36.00		35.06	5.60	36.00	
Administrative	33.25	7.25	36.00		35.57	5.90	36.00	
General services	30.90	4.58	36.00		35.71	4.97	36.00	
Family income (as a multiple of the minimum wage)				0.767**				0.207**
Zero to three	32.25	6.53	32.00		36.00	5.29	37.00	
Four to five	31.71	5.77	31.00		34.72	5.67	35.00	
More than five	33.00	6.93	32.00		33.33	6.23	36.00	
Time in position				0.468**				0.226**
0 to 5 months	33.62	7.02	33.00		34.31	4.96	33.00	
6 to 12 months	31.21	6.06	30.00		33.65	6.28	34.50	
13 to 36 months	31.27	5.29	31.50		35.77	4.41	36.00	
More than 3 years	32.53	6.50	32.00		35.82	5.76	36.00	
Location of work				0.574*				0.654**
Urban	31.99	6.17	32.00		35.26	5.57	36.00	
Rural	33.75	6.65	32.00		34.00	4.76	32.00	
Smoker				0.513*				0.787**
Yes	32.61	7.14	31.00		35.45	5.70	36.00	
No	31.86	5.86	32.00		35.17	5.52	36.00	
Drinks alcohol				0.025*, SS				0.444**
Yes	33.84	6.52	34.00		35.79	5.43	36.00	
No	31.38	5.93	30.50		35.03	5.60	36.00	
Total	32.03	6.17	32.00		35.23	5.55	36.00	

*t test   **ANOVA SS Statistically significant.

Table 5. Average and median scores, standard deviation and p value for Gender Stereotypes by sociodemographic and health variables.

Variable	Average	Standard deviation	Median	p
Sex				0.699*
Female	15.02	2.51	15.00	
Male	15.44	2.71	15.00	
Age range				0.841*
18 to 35	15.10	2.00	15.00	
Over 35	15.04	2.85	15.00	
Schooling				0.102*
Primary education	14.71	3.21	15.00	
Secondary or technical education	15.16	2.32	15.00	
Skin color				0153*
White	14.98	2.52	15.00	
Other	15.39	2.59	15.00	
Religion				0.772**
Catholic	14.97	2.57	15.00	
Evangelical Christian	15.39	2.45	15.00	
Other	14.86	2.48	16.00	
Marital status				0.699*
Does not have partner	14.51	2.99	15.00	
Has partner	15.20	2.38	15.00	
Residence				0.074*
In the neighborhood where you work	15.44	2.26	15.00	
Other	14.75	2.71	15.00	
Lives with				0.172*
Spouse	15.02	2.32	15.00	
Others	15.12	2.75	15.00	
Type of work				0.992**
Healthcare	15.11	2.13	15.00	
Administrative	15.32	3.23	14.50	
General services	14.52	3.40	16.00	
Family income (as a multiple of the minimum wage)				0.477**
Zero to three	15.23	2.76	15.00	
Four to five	14.90	2.36	15.00	
More than five	15.22	1.99	15.00	
Time in position				0.656**
0 to 5 months	15.23	2.28	15.00	
6 to 12 months	14.94	2.19	15.00	
13 to 36 months	15.48	2.46	15.00	
More than 3 years	14.88	2.76	15.00	
Location of work				0.204*
Urban	15.04	2.55	15.00	
Rural	16.25	1.26	16.00	
Smoker				0.545*
Yes	15.37	2.66	15.00	
No	14.98	2.49	15.00	
Drinks alcohol				0.521*
Yes	15.37	2.74	15.00	
No	14.96	2.45	15.00	
Undergoing treatment for a health condition				0.132*
Yes	14.40	2.58	14.00	
No	15.19	2.51	15.00	
Regular use of medication				0.774*
Yes	14.93	2.43	15.00	
No	15.14	2.59	15.00	
Total	15.07	2.53	15.00	

* Mann-Whitney Test   ** Kruskall-Wallis Test.

This finding may suggest that female users face discrimination even in situations in which they seek health services and choose to be treated by professionals of the same sex.

It is nonetheless important to remember that the Gender Stereotypes scale is made up of seven items and is unable to evaluate the overall complexity of this construct. The tool provides results with limited precision that serve to screen information[28], and should therefore be treated with caution.

The results of the Hostile Sexism questionnaire showed that both men and women had scores that pointed to the presence of prejudice, although the men were considerably more hostile than the women. Studies have shown an association between sexism and racism[33,34]. The fact that the majority of workers are white could also be a contributing factor towards the detection of hostile sexism in men and women. However the stratification of score for hostile sexism by sex and color did not show differences between white and non-white men, nor between these same groups of women. It was not possible to detect any inter-relations between sexism and racism in this study on account of the complexity and multidimensional nature of this construct[34]. The instruments used here were not intended to address these questions. Another factor that should be taken into consideration is the ethnic composition of the population of service users, which is probably different to that of the research participants, with a higher proportion of non-white, which may influence the results.

When it comes to hostile sexism, there were significant differences depending on the religion that was practiced by the health professional. While both Catholics and Evangelicals scored highly, indicating a position of hostile sexism, those who declared their religion to be 'other' scored slightly below half the possible number of points. Studies have suggested that religions provide spaces in which sexist and unequal relations between women and men can be replicated in favor of men[35]. Mickoleajc e Pietrzak[12] found a relationship between the Catholic religion and the presence of benevolent sexism, but not of hostile sexism, different to this study. In Brazil, Catholics and Evangelicals traditionally hold conservative values with regard to family, sexuality and morality[11]. Afro-Brazilian religions tend to show greater respect for the values and beliefs of their followers[36,37].

People who consume alcohol regularly scored significantly higher for Hostile Sexism compared with non-consumers. This finding supports the view that alcohol use is a factor that can lead to hostile sexism[13,38]. It is also associated with violence against women[39].

Of all the constructs, Benevolent Sexism held the highest scores, which were generally above 60% of the maximum possible score.

The results suggest that respondents from all sociodemographic categories can be considered to display benevolent sexism, although there were statistically significant differences in three of them: schooling, religion and type of work. There were no differences between men and women, a result that is consistent with those of other studies[10,40]. As discussed for the other constructs, both men and women were found to be benevolently sexist.

The lower the level of schooling, the greater the degree of benevolent sexism[10,41]. Those health workers with primary schooling were significantly more prejudiced than those with secondary or technical schooling.

As was the case for hostile sexism, the particular religion was associated with benevolent sexism, but with higher scores. Catholics and Evangelicals scored more highly, which points to greater levels of benevolent sexism among Christian groups, compared with others. This is generally considered to be due to the greater degree of conservativism among such groups[12].

Health staff working directly with healthcare were found to be significantly less benevolently sexist that those who worked in administration and general services. This may be associated to the greater level of schooling of this first group or be due to the fact that they receive more training, or have greater contact with users which may lead them to have more humanist motives. But in spite of the statistical difference, they all scored highly, being greater than 60% of the maximum possible. The first contact that a user generally has when she or he arrives at a primary healthcare service is with reception staff, although this function may be the responsibility of people from the administrative area. In both cases, the demand of the service user may potentially give rise to prejudice and the receptionist's attitude may be sexist, which is against the rights of health, of humanized care and of respect.

Study limitations

There were some limitations to this study. If the constructs that were researched were to be pub-

licly acknowledged, this may result in censure and embarrassment. Some workers may choose not to give an honest answer to a question for fear of being condemned as prejudiced, since sexist attitudes are socially unacceptable and may lead to criticisms. Research into behaviors that are deemed worth of reproach or that are illegal may have inaccurate results and statistical biases. However, there is very little research in the literature about how such limitations might be assuaged. In order to address this risk, the researchers carried out a full explanation of the research objectives and methodology before applying the research instruments, and insisted upon the guarantee of confidentiality. In addition, the questionnaires were completed by the respondents themselves, in a quiet place where other people would not disturb them. The respondent always replied on an individual basis, therefor avoiding any kind of intimidation or embarrassment, either on the part of the respondent themselves or of a third party who might try to influence the answers. Crömbach's alpha was also used for the statistical analysis in order to measure the reliability of the results.

Any generalization of the results was done so with a degree of caution, given that the study was carried out in a medium-sized municipality in the southeast of Brazil, and that prejudice against women can take many different forms in the country's various regions. More information could be added to the results if other factors were taken into consideration such as the level of experience or training of the health professional. It was also difficult to make direct comparison with other studies, since this is an area that has received little attention from other studies.

Conclusions

The results of this study show that health professionals display Gender Stereotypes, as well as Hostile and Benevolent Sexism. They are associated with variables that show that these phenomena are present in broader social situations, of which health services are just a part, and as such are questions that need to be addressed by the whole of society.

The existence of prejudice against women in the health services is unacceptable under any circumstances. Its occurrence in primary healthcare practice is also unacceptable since it worsens existing inequities. Health workers themselves may become the cause of problems. Individuals who are sexist or who employ stereotypes are unable to assume an ethical role when it comes to the protection of users of the Brazilian public health system, SUS, as they do not carry out their responsibility to "protect living beings and entities against threats that might cause irreversible damage to their existence"[42]. Populations that include women or those who are victims of violence and other confrontations will be exposed to attitudes that are harmful and hostile with prejudices in the mental, physical, moral, spiritual and citizen spheres.

The findings of this study have given rise to the possibility of carrying out further research. New aspects of the research could be given attention, such as giving voice to users, and addressing issues about the development of health practices, the existence or not of continuous education, work relations, social acceptance and other questions, thereby delving deeper into the issues raised here.

Public policies that are antisexist and that focus on the health sphere should be established in the short-term and should involve the condemnation of prejudiced attitudes on a daily basis, and continuous education of health workers in this area.

Collaborations

M Mesquita Filho worked on the study conception and design, analysis and interpretation of data, article write-up, critical revision and approval of the final version for publication. ABC Rocha, MB Brito, SR Oliveira and TF Marques worked on the study conception and design, and on the collection, analysis and interpretation of the data. CCQ Pereira was involved in writing the article, its critical revision and approval of the final version for publication.

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