International Labour Office **ILO** International Council of Nurses **ICN**
World Health Organisation **WHO** Public Services International **PSI**

Joint Programme on
Workplace Violence in the Health Sector

Workplace Violence in the Health Sector

Country Case Study – Brazil

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SUMMARY

RESEARCH REPORT – SECTION A - INTRODUCTION

I - Concept of violence

For the discussion of violence definitions, we used two papers: Minayo and Souza [1] discuss the relationship between violence and health, understanding that this theme is inserted in an interdisciplinary field and collective action; Zaluar and Leal[2] discuss the relationship between violence and education. Our aim is to introduce the discussions in the education field considering its incorporation of Arendt´s concept of violence, i.e., the impossibility of negotiation, the lack of dialogue between the parts in conflict, being either individuals either groups, such as different social classes.

The first authors outline for the complexity of the object " violence ", as it has a lot of meanings and it is controversial. They believe that all the theories present partial visions of the problem. There are aspects studied by several Brazilian authors in the field of Social Sciences:

- The understanding of violence on the marks of socio-economic, political and cultural relationships and the recommendation to make a differentiation by type of perpetrator, victim, location and technology;
- The social inequalities and the economic, social and cultural expropriation would be on the core of the creation of values and parallel codes of the gangues in the urban centres;
- The importance of differentiation between the violence of the dominating classes and the violence of the groups who resist;
- The association of the discussion concerning the violence of the State and the established order;
- The importance of the cultural aspects for the analysis of the phenomena, considering the diversity of the social tolerance to violence;
- The indication of methodological guidelines, considering the dialectics between the abstract form and the concrete reality.

Zaluar and Leal accomplish a review of violence concepts placing them mainly in the field of social sciences and education.

The authors adopted the Arendt [3] paradigm when they mark the differences between power and violence (violence as an instrument and not as an end). According to Arendt, language is not included as an instrument of violence. Language characterises power relations, based on persuasion, influence or legitimacy.

Other Brazilian authors follow the same paradigm:

- Violence as non recognition, annulment or splitting of the other;
- Violence as denial of human dignity;
- Violence as compassion absence;
- Violence as excess of power.

Although incorporating language, these definitions have in common the little space for the appearing of the subject who arguments, negotiates or demands, since this subject is enclosed in the exhibition of the physical force of his opponent or squashed by the outrage of who refuses the dialogue.

Zaluar and Leal also bring to the scene the distinction between conflict and violence. There is no violence in the conflict when there is negotiation, where there is the manifestation of the subject's autonomy.

The authors make a review of the education bibliography area about the representations of poor students' and their educational opportunities. Some of these authors analyse the psychological violence practised by the school against the poor student [4,5] . This aspect present a connection with the item about the role of culture, in this report.

II - Workplace violence

Considering some aspects of social work division, workplace violence has been approached in Brazil by studies that discuss the repercussions of the work over workers' health. There are studies of mental suffering related to work, workplace accidents (intoxication by metals, civil construction, for example), traffic accidents and child-juvenile work[6,7] .

The effects of the productive restructuring over the workers' mental health, especially in the banking sector, are also analysed by some authors in the country [8]. In the same perspective of investigation, there are studies outlining the repercussions not only of the structural adjustments, but also the organisational innovations, having as main effect the impoverishment of work in the public sector of health attendance [9].

Besides, in a microssocial approach, the concept of Moral Harassment in the workplace begins to gain the pages of magazines of wide circulation out of the academic environment, at the moment of the launching of Hirigoyen's book [10]. Translated and published in Brazil in 2001, the book discusses the moral harassment in the family and in the workplace.

As the author puts it:

"For harassment at workplace we have to understand every and any abusive conduct which manifests above all by behaviours, words, acts, gestures, writings that may cause damage to personality, dignity or to physical or psychical person's integrity, jeopardise his job or degrade the work atmosphere".

Dejours[11] has also several of his papers translated and quite divulged among us. This author marks the commonplacement of the suffering and of the unfairness in the workplaces, taking into account the effects of the productive restructuring and of the dynamics of employment in developed countries, which also happens in countries in development. The fear of loss of the employment generates pacts of silence and omission front to unfairness' situations, usually driven to the hierarchical strata of the base.

Concerning to racial discrimination at work, the Interamerican Syndicate Institute for the Racial Equality (Instituto Interamericano pela Igualdade Racial - INSPIR) published the "Map of Black Population in the Work Market"[12] starting from the data of the researches of Employment and Unemployment. The results disclose that the largest proportion of busy people in non-qualified functions is among black workers. As to the access to the functions of direction and planning, which characterise the best salaries and work conditions, and the highest rate of education, black workmen are found in low proportions. Among the black, the higher proportion in duty of direction and planning is in Brasilia – Distrito Federal (15,1%), and the lower in the city of Salvador (5,9%). There are two main issues related to racial discrimination at work: the discrimination at the access to work, which makes the black occupy prioritarily the more disqualifying and noxious functions and the discrimination in the access to promotion, which makes it difficult for the black access the positions of direction and better salaries. Regarding to daily discrimination at work, there are no data but it is assumed that it happens very often, although there are laws which punish those ones who practice discrimination acts, since the Brazilian society, ex-slaverer, still prejudiced [13].

III - Gender and workplace violence

Although there is some discussion cumulated in the domestic violence area, concerning specially the violence against women in the country, there is still some invisibility of violence against women at work, such as sexual harassment.

In the report "Violence against Woman", elaborated by the Feminist National Network of Health and Reproductive Rights (section Pernambuco) [14], the subject of institutional violence is marked emphasising sexual harassment. The recommendations of the World Action Platform of the IVth World Conference about the Woman, of which Brazil is signatory, include the adoption and application of laws against sexual harassment [15] and the creation of programs for elimination of sexual harassment in the workplace.

In research accomplished by the Syndicate of Health Public Workers in the State of São Paulo (SindSaúde - SP) [16] about the conditions of life and work of the female population, we highlight its results as to the perception of discrimination. From the 90.000 workers of this sector, 71% are women. The research was accomplished in the years of 1996 and 1997, having been answered by 1200 women.

Regarding discrimination, it has been observed that over one third of the interviewees had already been felt affected (33%). Of these, 12% affirmed that the most usual ways of discrimination refer to age, social condition and cultural condition, political activities exerted, non-acceptance of patronage, marital status and professional disregard. Next, 5% feel discriminated for the physical appearance and 3% for the race/colour. The same percentile (3%) feel victim of sexual harassment.

These events are somehow linked to an aspect of the relations between gender and workplace violence, specially if we consider the microssocial level. Nevertheless, if we consider other aspects of social and sexual work division, there is a growing literature about violence concerning work conditions.

IV - The role of culture

Regarding the role of the national, occupational and professional culture about the acceptance of violent behaviour, we may report to the sociological and anthropological literature, which supply us with some indications which concern to the national culture:

- The own myth of the foundation of Iberian colonies starting from the European imaginary about the "tropical paradise" [17];
- The image of "gentleman" (homem cordial) divulged until few decades ago among the Brazilians, which point not only for a certain theoretical intolerance with violence but also hide the existence of social conflicts in the country.

V - Existent measures of violence

Regarding health field, its implication in the investigation and action do not only happens for assisting the victims of the social violence but also because it is held responsible for the elaboration of prevention strategies. Some authors write about the effects of violent actions for individuals' health and its implications for the health systems.

Minayo and Souza point that, in Brazil, during the 80's violence was considered the second cause of casualty (29%), being the larger deal referring to traffic accidents and homicides, with small participation of the suicides. For the morbidity, the inaccuracy of the occurrences, the shortage of data, the poor visibility of certain types of violence and the multiplicity of factors do not allow a description which may initially appoint intelligibility to the statistical data.

The construction of epidemiological indicators for the diagnostic of the violence situation is an actual object of discussion to the Rio de Janeiro's Health State Secretary. In its

Conference [18] it has been pointed the difficulty of implementation of policies concerned to health personnel. The sub-notification, misclassification and disparities among the sources of data (ex. health and police as to the qualification of homicides) are some of the problems referring to the quality of data. This is one aspect that needs to be deepened to recognise the researches limits.

However there is not an information system concerned specifically to the violence against health personnel. Contacts with syndicates and professional councils in the health area disclosed to us that a number of denounces emerge in several of them but nothing is accomplished, unless, in some cases, the victim is informed to open a criminal process.

VI - Existing knowledge in workplace violence in the country's health sector

The academic production about workplace violence in the health sector is still a restricted production, taking in account the consulted bases of data [19]. Nevertheless, we can identify some literature which tries to understand the determinants of violence, including the violence against health personnel, and propose some measures of immediate nature.

One of these works on the theme used as theoretical framework the concepts of work process, suffering at work and social violence and had as field work an emergency facility[20]. She used an ethnographical methodology and her main objective was to verify the representations of quality of the attendance provided in the emergency services. The author analysed the professional's relationship with the user and the user's relationship with the health setting. She adopted the concept of social representation, alluded Gramsci, where the representation is based in the notions of common sense and good sense.

That research was inserted in an interinstitutional project, of which participated the Municipal Secretary of Health and the Latin American Centre of Studies about Violence and Health (CLAVES), with the aim to map out the social violence in the emergency services in the city of Rio de Janeiro.

The author pointed out the main effects of social violence on the health system, as the costs with number of beds, location, distribution and degree of complexity and resolutionability.

Concerning the personnel's health situation as victims of violence in their workplace, the author points the anguish related to ethical and moral conflicts at work. Besides, she marks her perception of the increase of voluntary dismissals in recent years due to insecurity and low wages of these professionals.

In the conclusions, the author marks the need of structural reforms which strengthen democracy and social rights of the population, besides punctual interventions. Among them, educational campaigns for decrease of traffic accidents; control over firearms; security's agents' qualification (or vigilant); incentive to these professionals' interaction with other health professionals; supervision to academics, mainly concerning ethical aspects; to increase the information flow for relatives about their patients; suggestion to increase employment of more social assistants in schedules that are not available; beds to support "social cases" beside the social control over health units which assume this type of hospitalisation; investment in the construction of the social consciousness of public servant. She concludes that health personnel are threatened in this social and sanitary context, beside the patients in their search for attendance.

Deslandes [21] discusses the representations and the practices of health personnel in two emergency services in the city of Rio de Janeiro. As in the thesis quoted previously, the author analysed as violence modalities the events classified as "external causes" by the Epidemiological Surveillance (aggression, falls, suicide, mistreatments, etc), also presenting the limits and difficulties to deal with such approach.

The research developed by the author and other partners of CLAVES is not centred on the violence committed against health personnel. When she reports to the specific literature about the theme, especially the Anglo-Saxon, the author considers the verbal abuse as the most frequent kind of violence against the health personnel, in especial in what concerns to nurses.

In the two hospitals studied by the author, it was identified in all the professionals a recent experience (own or among colleagues) of conflicts, menaces or physical assaults involving professionals, patients and relatives. In the interviews, the professionals point as reasons for the patients' assaults:

- Delay considered excessive for the attendance;
- The relatives' wish that their patient be treated in a special way or immediately;
- Perception about the disregard in the attendance;
- Imminence of patient's death.

Besides, the attendance to people wounded by bullets generates the fear of invasions of armed gangs in the physical spaces of the emergencies with consequences for the team, other patients and facilities. According to the author, this fear is not senseless, according to the interviews (doctors, nurses and auxiliary personnel).

Not only in Rio de Janeiro, but also in São Paulo, the description of violence situations against the health personnel has shown the concern with the phenomenon. In a more articulate way, the Doctors' Syndicate of São Paulo (Simesp) developed a research in the geographical area of Great São Paulo, with a sample corresponding to 1,52% of the doctors' population [22].

The results were: threat against physical integrity of health personnel by clients in search of immediate or preferential attendance and rescue of arrested after shooting. Doctors referred to "precarious conditions of security in the work positions", especially in the public sector.

The Syndicate (Simesp) suggested preventive actions based on the conclusion that there is "lack of security" in public units. But what is understood by increase of security? This type of solution for the problem of the violence is questioned by national [23] and international [24] studies in what concern to effectiveness. To places gratings and walls not always results in decrease of assaults, especially verbal assaults. It is not also a solution for sexual or moral harassment.

In synthesis violence in the workplace in the health sector is quite invisible.

There are no cost data. In fact, there was not, until the accomplishment of this research, any organized initiative (neither from the unions nor workers' associations nor employers nor even of the public power) to diagnose or lessen the problem of workplace violence in the health sector. There were some previous initiatives, as the workshop mentioned previously and a research done in São Paulo, by the Regional Council of Medicine, worried about the violence against physicians, but they were exceptions of a general rule.

This research is the first to give visibility to a violence, which is so much felt but even now so invisible. We heard several statements, some of them very touched, expressing the gratitude of the interviewees when knowing that someone was concerned with this kind of problem and allowed them to talk freely about that. They were touched because they could know that those problems are not individual problems, that those problems were not their problem, but a social problem. Knowing that other colleagues suffer with the same kind of problems, finally, they could talk about violence in the workplace.

There are no absenteeism data also. Violence have no registration as cause of absenteeism.

Personnel's shortage is the form as violence has been appearing in the press. However, the personnel's shortage cannot be attributed exclusively to violence. Lack of equipment and consumption material, low wage and every kind of difficulties originated from low financial resources, associated with some kind of corruption and the political use (private) of the public resources. It is necessary to say that many members of the teams working in the frontlines of the health sector are working there because they are strongly committed to the cause of health care

(religious, ideological) and/or they do need this job, due to the employment rates in Rio de Janeiro.

Besides the recognition of violence, we identify that this report could contribute as an important empirical research and as a stimulus to develop the concept of violence in the collective health field of knowledge.

SECTION B (THE INVESTIGATION)

I OBJECTIVES

The objective of the country case studies consists in showing country-specific evidence and practical solutions concerning workplace violence in the health sector. By summarising existing information and analysing newly obtained information the study aims to identify risk factors as well as best practices of anti-violence interventions in the given socio-cultural context. This work will serve as a basis for the formulation of guidelines for prevention and coping strategies targeting issues of workplace violence in the health sector.

II - METHODOLOGY

Quantitative and qualitative methods of research were used. The qualitative material was constituted of focus groups' reports and interviews. The quantitative material was obtained from a confidential survey with standardised questionnaire, answered by 1.569 health personnel.

II.1. Qualitative part

Homogeneous focus groups (4) were carried out with workers' of elementary (1), middle or technical (1) and higher or university(1) level of school qualification, and one focus group of representatives from unions and professionals' councils (1). Interviews were carried out, with a health authority (responsible for the violence program), a labour judge, a state deputy and a representative of the Association of Hospitals from Rio de Janeiro. A presentation of preliminary results was accomplished with representatives of District Councils of Health and a representative of State Secretary of Health.

In another research procedure, we visited the workers' organisations of health personnel (n=18) in order to collect statistics data of violence in the workplace in the health sector, and to know what they are doing to protect workers from the violence. The interviewers were instructed to have a contact to every union and professional council. In this contact the interviewers gave a letter soliciting existing data of workplace violence and inquired the receptionist "what are the procedures of the institution if a member of the professional category come to the council/union with a complain involving a violent incident?".

Besides the theoretical support supplied by OIT/ICN/OMS/PSI, other texts were consulted on the methodology of focus groups (Morgan, 1988; Neto, Moreira, Sucena & Marins, 2001). The coordinators acted mainly in couples. Tape and video recorders were used, but in some cases, just observers' annotations were made.

The focus groups and the interviews followed the same guideline (ANNEX 1), with the objective of obtaining detailed information, as well as to allow a space for reflection and diagnosis by the actors (Demo, 1992). The focus groups were accomplished after the end of the employees' strike, in November 2001. Each participant signed an informed consent form (ANNEX 2).

The health personnel were selected from the University Hospital, according to the experience time (more than 10 years). Letter inviting each one were delivered personally to them or by mail to unions and professional councils, invited participants.

The great social inequality between the elementary, technical and university level groups reflects the social distances between social classes in our society. Because of that the focus group were conducted respecting these differences guarantying homogeneity.

No hospital director attended the invitation for focus group, which accomplished in a strike period in the health public system.

The dynamics of the groups was varied according to the number of participants. Except for the group of intermediary level, it was followed the orientation of the dynamics of the focus group, that is, it was sought the consensus of the group on all subjects presented. In the case of the technical group, the presence of just two people in different moments made the team opt for the individual interview.

Ten employees were invited and six attended the meeting of elementary personnel and two from fourteen invited, the meeting of technical level. In university level's meeting, six persons attended from eleven invited. Three representatives attended the meeting with members of unions and councils although we had invited all the unions and professional councils of the health area by letter (there are 14 unions and 9 professional councils). Several of them answered to the letter but they didn't attend the focus group meeting.

Interviews were accomplished in the interviewees' workplaces. We had no problems to accomplish the interviews, but a certain constraint took place when one interviewee required the presence of his lawyer. These results are therefore of individual perceptions concerning the problem of violence, considering their varied insertions as sanitarian authorities, juridical and legislative representative and an organisation of the private health sector. The analysis of these interviews consider therefore the singularity of the emitted opinions.

We also considered as qualitative material the informal observations of the interviewers' field notebook. All the interviewers were instructed to write down everything they observed in the facilities visits, particularly the personnel's reception to the research and the cases of violence observed or related.

Limits: difficulty of gathering the focus groups, in general with low frequency of people to the meetings. In the case of the managers' groups, although invited, the absence was total.

II.2. Quantitative part

After the study of the distribution of the facilities in Rio's City (ANNEX 3), the team opted to stratify the facilities in eight groups to contemplate into the sample some of the diversity of facilities found in the city, taking into account the scarce time that we would have to conclude the research (table 1).

Table 1: ***Sample facilities by sector.***

	PUBLIC		PRIVATE	
	Total facilities	Sample	Total facilities	Sample
Facilities with hospitalisation	56	3	160	3
Facilities without hospitalisation	101	3	398	Several *
Specialised facilities with hospitalisation	12	2	50	2
Specialised facilities without hospitalisation	9	-	313	1

**Included 32 private offices and 4 clinics.*

The strategy of sampling included three stages. The first one was the selection of the study units. Some typical units were then selected from each group, according to the consensus of the team (table 2 and table 3): a University hospital(A) and a federal general hospital(B) (tertiary level); a state emergency hospital (C)(3 public facilities with hospitalisation); two public specialised hospitals (D and E - an unit treatment of cancer with a home-care service and a psychiatric hospital); two municipal Health Centres and a community health post (F, G and H - centres of primary attention – 3 facilities without hospitalisation); three private units with hospitalisation (I, J and K - a hospital placed in the middle class zone of the city, two units of medium size placed in the poor zone of the city); two private specialised facilities with hospitalisation (L and M - an unit of psychiatry and another specialised in treatment of cancer); an unit specialised in rehabilitation without hospitalisation, a private ambulatory unit (N and O) and 32 doctor's offices and 4 clinics. The ambulance service is accomplished by the firemen. We included four teams that render that type of service.

In the second sampling stage employees were divided into four categories as shown in table 2 and table 3. A sample was then calculated according to the qualification level and administrative level demanded for the professional exercise in his/her work position.

In the third stage, the sample was then distributed, for each level of qualification, among the facilities chosen observing the size of each facility (table 2 and table 3). From each facility we received the list of workers including the setting where he/she works and the professional category, independently of the type of the worker's linkage with the institution (employee, hired of others companies or autonomous). In each stratum of level of qualification, we calculated the number of each professional category proportional to the distribution in the facility, guaranteeing that all the position categories, sectors and professional categories would be represented in the sample. At this stage, of each facility we had the number of people of each professional category to be selected. Each group of research assistants, in each facility negotiated with the administration what people could be liberated in the hour of the visit of the team to fill the questionnaire. The matrix (services x professional category) of the sample distribution in each facility was respected most of the time. The exceptions were due to the absence for vacations or license or mistake in the list offered by the unit. For example, if the only nutritionist of the unit was on vacation, he would be substituted then by other allied professional of same qualification level.

Table 2: ***Distribution of the sample by type of public facilities and level of qualification***

	TYPE OF FACILITY														
	WITH HOSPITALISATION									WITHOUT HOSPITALIZATION					TOTAL PUBLIC
	general facilities					specialised facilities				general facilities					
	A	**B**	**C**	**S***	**POP****	**D**	**E**	**S***	**POP****	**F**	**G**	**H**	**S***	**POP****	**EMERG**	
University	76	81	48	205	17551	10	12	22	1918	14	14	29	57	4528		
Technical and auxiliary	99	99	53	251	22619	10	14	24	1945	14	14	40	68	4746		
Administration	54	77	40	171	11296	10	4	14	1353	12	12	16	40	4116		
TOTAL	229	257	141	627	51469	30	30	60	5216	40	40	85	165	13390	18	870

Table 3: ***Distribution of the sample by type of private facilities and level of qualification***

	TYPE OF FACILITY														
	WITH HOSPITALISATION									WITHOUT HOSPITALIZATION					TOTAL PRIVATE
	general facilities					specialised facilities				general	specialised	Offices or clinics			
	I	**J**	**K**	**S***	**POP****	**L**	**M**	**S***	**POP****	**N**	**O**		**S***	POP**	
University	43	30	30	103	11534	18	4	22	1499	35	60		95	10002	
Technical and auxiliary	67	40	47	154	11419	17	4	21	1467	6	15		21	2488	
Administration	72	18	47	137	9639	15	4	19	1614	---	25		25	4052	
TOTAL	182	88	124	394	32682	50	12	62	4580	41	100	102	243	16542	699

* Sample – size of category in the sample
**Population – size of each category in worker population.

The demographic profile of the sample can be seen in table 4. We don't have the profile of the health personnel in the city to compare.

Table 4: ***Demographic characteristics of the sample***

Sex	N	%
Male	489	31.5%
Female	1061	68.5%
Age (years)		
19 or under	28	1.8%
20-24	184	11.8%
25-29	217	13.9%
30-34	233	14.9%
35-39	240	15.4%
40-44	222	14.2%
45-49	208	13.3%
50-54	136	8.7%
55-59	50	3.2%
60+	43	2.8%
Marital status		
single	545	34.9%
married	636	40.7%
living with partner	178	11.4%
separated/divorced	169	10.8%
widow/ widower	35	2.2%

For the accomplishment of the survey we had the participation of 20 students from the Medical School (14 from the Physiotherapy course and 06 from the medicine course), of the Federal University of Rio de Janeiro. The 20 selected students received 20 hours of training including how to approach the facility's direction and each employee, respecting the autonomy of the subjects, how to apply the questionnaire (assuring the privacy insofar as possible for each one to answer the form – ANNEX 4), the codification and digitations of the questionnaires. Several pre-tests and several adjustments were made in the questionnaire to facilitate its understanding by the interviewees of all cultural levels (ANNEX 5).

The fieldwork was developed according to a sequence of procedures. First the field supervisor had a phone contact with the representative of each facility to know about the interest in participating of the study. After that first contact, a member of the technical team visited the facility to present the project to the management or a representative. Only after the approval of the project by the management, a member of our team conducted the interviewers formally identified, only then they were introduced to the workers and those responsible for the work sections.

In each facility, an explanatory letter was distributed to the workers, occasion when the researchers explained the objectives, procedures, relevance, risks and benefits of the research (ANNEX 6). The subjects which answered the questionnaire (quantitative part of the project) were not requested to sign any term in order to make them feel comfortable about participating or not in the research. The autonomy of the research subject had been explicitly respected but we had a very few amount of refusal.

The difficulties found were several. In several health facilities, the time elapsed between the first contact and the approval was very long, several contacted facilities did not authorise the realisation of the research. The largest difficulties were found in the private net and one of the public facilities refused to participate in the project.

Other difficulties faced in the facilities were: resistance of some supervisors in liberating employees to filling the form, which in some moments delayed the fulfilment of the research; resistance found in some professional categories which alleged no time to answer the questionnaire, although they recognise the importance of this work for them; strike in the public section, first federal and later municipal. The strike in the University and in the federal public service lasted more than 100 days.

Limits: It is important to highlight that although the sample had been selected according to the exposed criteria guaranteeing its representativeness, the few number of facilities could introduce some bias.

- Some diversity of approaches to the interviewees: according to the particularities of each facility, a uniformity of procedures was not possible. It varied from having total agreement with the interviewers' proposals to the managers' imposal related to the form of interviewing. This variability could be responsible for an under registration of reports frequency of violent events.

III - RESULTS:

III.1 The survey results

1- Characteristic of workplace violence in Rio de Janeiro

Workplace violence was classified in 5 different forms: Physical violence, verbal aggression, moral harassment, sexual harassment and racial discrimination.

Forty seven percent of the interviewees informed that they have been victim of one kind of violence at least in the last year. Table 5 shows the frequency of people with violence complaint. Fifty three percent reported none violence in the last year. Two persons, 0.1% informed that they suffered all kind of violence, 27.5% informed aggression of just one type.

Table 5*: Victims by frequency of violence types*.

VICTIMS	Freq.	Percent	Cum
0	836	53.3%	53.3%
1 type	432	27.5%	80.8%
2 types	206	13.1%	93.9%
3 types	75	4.8%	98.7%
4 types	18	1.1%	99.9%
5 types	2	0.1%	100.0%
Total	1569	100.0%	

The most common violence is the verbal aggression with a proportion of people who experimented this violence type in the last year of 39.5%, followed by the moral harassment with 15.2%, followed by the physical aggression with 6.4%, 5.7% were of people who suffered sexual harassment and 5.3% was the racial discrimination proportion. To characterise each violence type concerning to the

frequency of its occurrence the analysis of the results reveals that "sometimes" is the most frequent answer given for all violence types. It is noticed that 0.4% of the target population have been victim of an assault with weapon in the workplace (table 6).

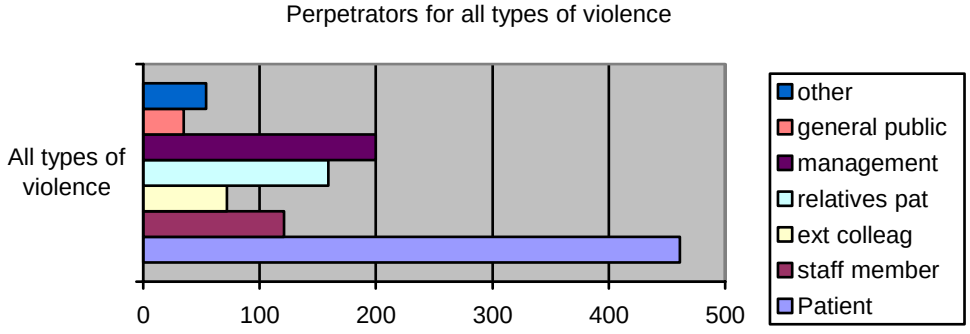
Table 6 - V*iolence victims for violence type – male and female*

Type of Violence	Male		Female		Total	
	N	%	N	%	N	%
Total de interviewees	489		1061		1569	
Physical violence (total)	36	7.4%	65	6.1%	101	6.4%
Phys viol with weapon	3	0.6%	4	0.4%	7	0.4%
Phys viol w/o weapon	33	6.7%	61	5.7%	94	6.0%
Verbal abuse (total)	191	39.1%	430	40.5%	621	39.5%
All the time	23	4.7%	37	3.5%	60	3.8%
Sometimes	116	23.7%	268	25.3%	384	24.4%
Once	48	9.8%	120	11.3%	168	10.7%
Bullying (total)	83	17.0%	156	14.7%	239	15.2%
All the time	9	1.8%	15	1.4%	24	1.5%
Sometimes	48	9.8%	97	9.1%	145	9.2%
Once	22	4.5%	38	3.6%	60	3.8%
Sexual harassment (total)	37	7.6%	52	4.9%	89	5.7%
All the time	7	1.4%	5	0.5%	12	0.8%
Sometimes	18	3.7%	27	2.5%	45	2.9%
Once	11	2.2%	18	1.7%	29	1.8%
Racial harassment (total)	22	4.5%	61	5.7%	83	5.3%
All the time	2	0.4%	6	0.6%	8	0.5%
Sometimes	13	2.7%	37	3.5%	50	3.2%
Once	4	0.8%	15	1.4%	19	1.2%

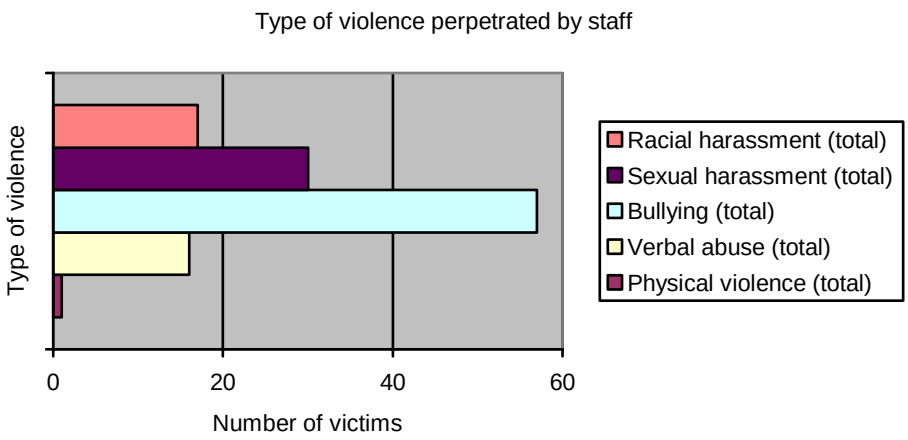
2. Perpetrators related to different forms of violence (who)

To characterise who are the aggressors, we present some graphs that show the number of aggressions (first for any type of violence followed for each violence type) for aggressor type.

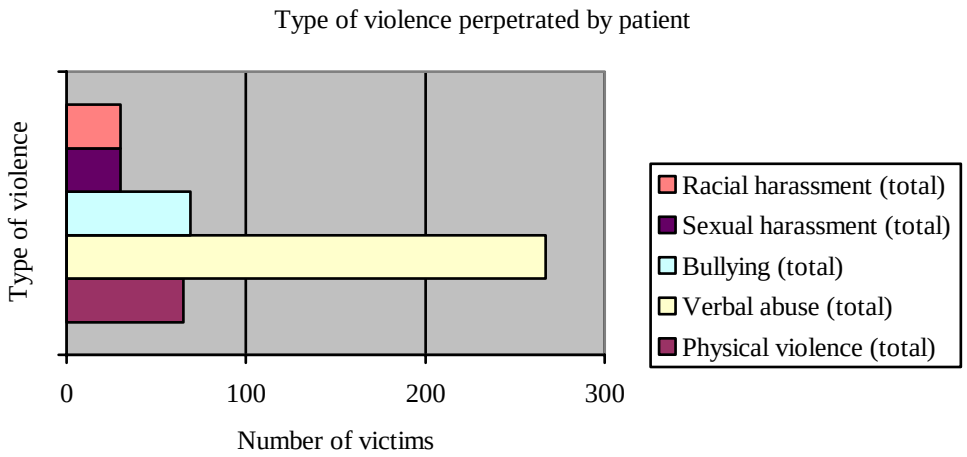
Graph 1



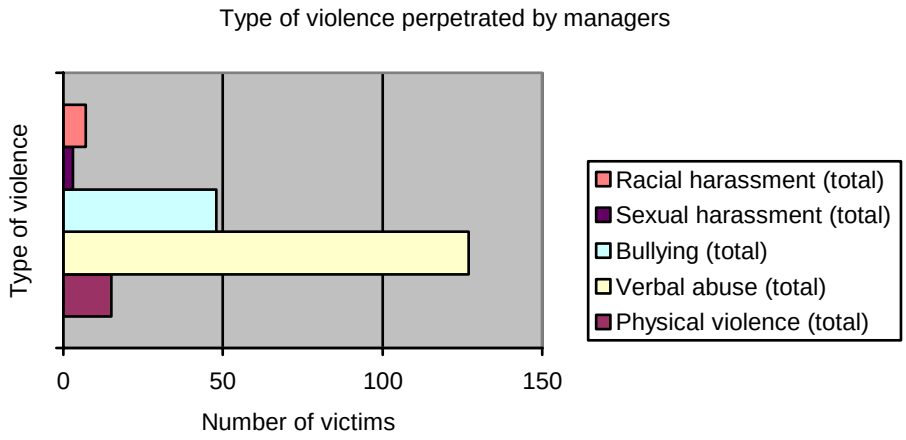
Graph 2



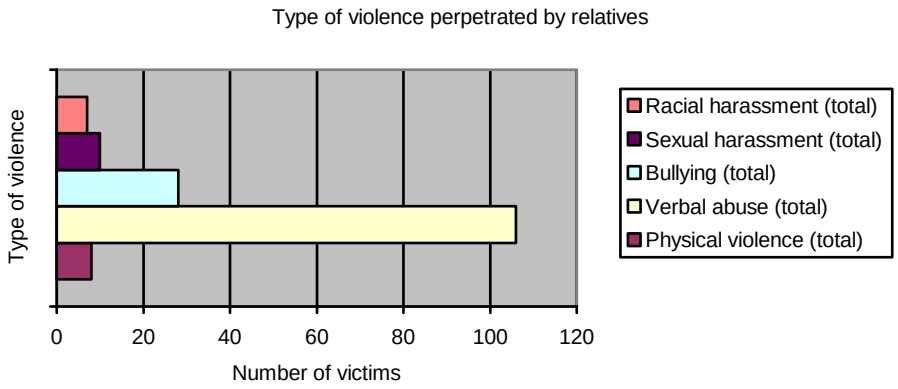
Graph 3



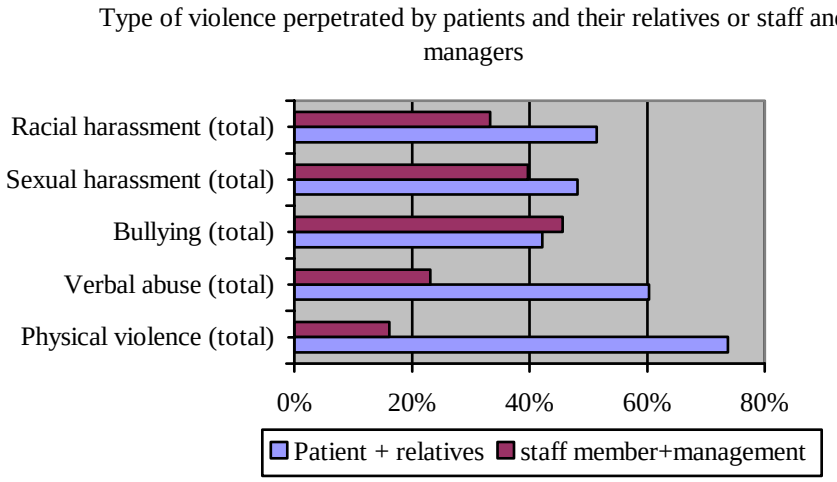
Graph 4



Graph 5



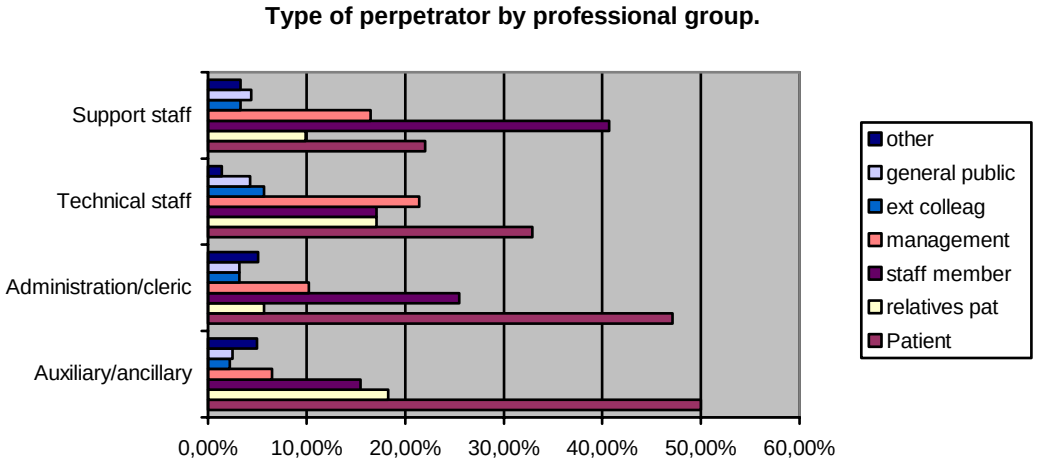
Graph 6



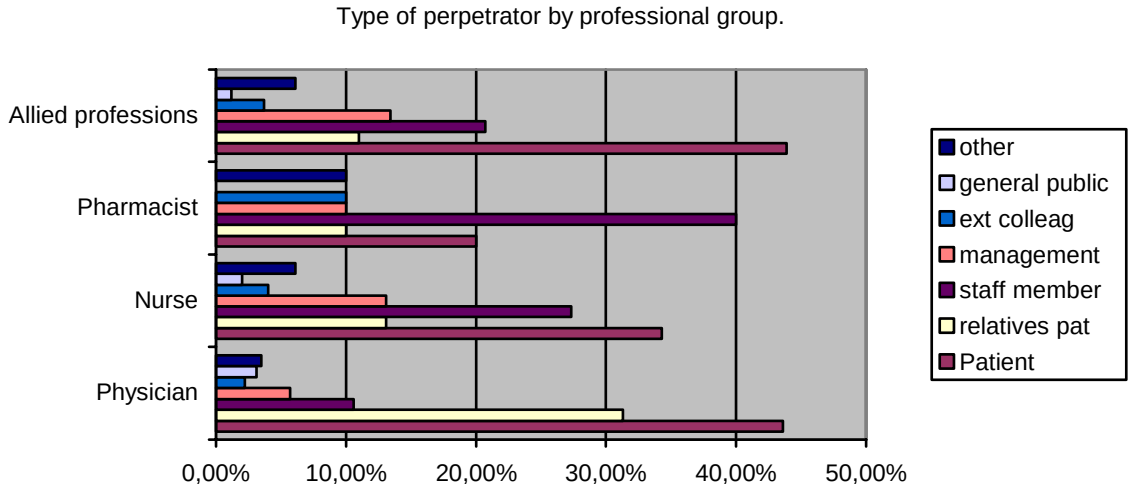
In graph 6 it is interesting to notice that among the aggressions by racial discrimination and by sexual harassment, the group of the services' beneficiaries is the most important perpetrator. Meanwhile, in terms of moral harassment the staff + managers group is one which has the largest relative frequency. In terms of physical violence, patients or their relatives are responsible for 73,74% of all physical aggressions (73 of 99).

Graphs 7 and 8 show the characteristics of the distribution of perpetrators for each professional group.

Graph 7



Graph 8



The distribution of perpetrator type for victim's professional category, patients perpetrated forty four percent of aggressions suffered by physicians, and patients' relatives perpetrated thirty one percent. The sum, 75%, is the service beneficiaries. In the nurses' group if we take the proportion of aggressions by colleagues and bosses, that proportion is 40,4%. For auxiliaries, adding the aggressions by patients (50%) and their relatives (18.3) we have a proportion of 68,3% of aggressions and for staff and bosses that proportion is 22% (table 7).

Table 7- ***Proportion of aggressions practiced by the services' beneficiaries and by the personnel of health (colleagues and bosses) for each professional category***

	Pat+relatives	Staff + administrator
Physician	74.9%	16.3%
Nurse	47.4%	40.4%
Auxiliary/ancillary	68.3%	22.0%
Administration/ Cleric	52.8%	35.7%
Allied professions	54.9%	34.1%
Technical staff	50.0%	38.5%
Support staff	31.9%	57.2%

3. Characteristics of victims)

Age

Questioned how often violence occurs victims, in all age groups, answered more frequently "sometimes" and "once", except for the band 55-59, where the incidence of the answer " all the time " was greater (21,1% - ANNEX 7). People who present greater risk of violence in the last year were between 30 and 39 and between 55 and 59 years (table 8).

Table 8: ***Victims by age group***

	Sample	Victims	%
19 or under	28	12	42.9%
20-24	184	86	46.7%
25-29	217	99	45.6%
30-34	233	117	50.2%
35-39	240	122	50.8%
40-44	222	101	45.5%
45-49	208	103	49.5%
50-54	136	51	37.5%
55-59	50	26	52.0%
60 +	43	14	32.6%

Marital Status

The marital status associated to violence is separated/divorced (table 9). However, we can't consider it as a causal factor for violence.

Table 9: ***Victims by marital status.***

	Sample	Victims	%
Single	545	244	44.8%
Married	636	300	47.2%
Living with partner	178	88	49.4%
separt/div	169	90	53.3%
Widow	35	11	31.4%

Ethnic group

Among the respondents of the question about pertinence to ethnic group (1213 persons), 69,2% belong to the majority group at the workplace and 30,8%, to the minority group. There is a greater frequency of victims in the minority group (52,8%). The minority ethnic group is more affected by racial discrimination (9,7%) than the majority group (3,0%) (table10).

Table 10: ***Victims by ethnic group at workplace***

	Ethnic group at workplace				
	Majority		Minority		RR (p value)
	N	%	N	%	
Sample	840		373		
Victims	390	46.4%	197	52.8%	1.14 ($p<0.05$)
Physical violence (total)	50	6.0%	28	7.5%	ns
Verbal abuse (total)	334	39.8%	166	44.5%	ns
Bullying (total)	133	15.8%	56	15.0%	ns
Sexual harassment (total)	43	5.1%	25	6.7%	ns
Racial harassment (total)	25	3.0%	36	9.7%	2.02 ($p<0.001$)

* ns – no significance.

Gender

For men, larger frequencies are detected comparing to women with relationship to sexual harassment (7,4% - RR = 1.56; $p < 0.05$) and, in smaller degree, with relationship to physical violence (7,4%). The masculine population of this study seems to be more susceptible to suffer this kind of violence (table 11). The men's understanding of sexual harassment or the women's fear in turning public this subject can have been interfering with the differences among genders. This doesn't mean that men cannot be victims of this type of violence, especially considering that there are other sexual orientations besides the heterosexual. The women occupation of management positions in the health sector should also be observed, in relation to the sexual harassment and also to the moral harassment.

Table 11: ***Gender's victims for type of suffered violence.***

	Sex			
	Males		Females	
	N	(%)	N	(%)
Sample	489		1061	
Victims	223	45.6%	501	47.2%
Physical violence (total)	36	7.4%	65	6.1%
Verbal abuse (total)	187	38.2%	425	40.1%
Bullying (total)	79	16.2%	150	14.1%
Sexual harassment (total)	36	7.4%	50	4.7%
Racial harassment (total)	19	3.9%	58	5.5%

Professional group

Considering violence suffered in the last year by several professional groups, the nurses constituted the group with the largest proportion of victims (62,4%) and they have been 1.37 times more victim of any kind of violence last year than other professional categories, considering them all together. Health institutions and health personnel no longer enjoy such a social prestige. Some reasons, considering the public sector of health attendance, are frequently matters in the press denouncing the lack of personnel in the emergencies and hospitals for hospitalisation, the gigantic queue for ambulatory attendance, and the lack of materials resources (equipments and consumption materials as medications).

However, as it can be seen in the table 12 gender is a risk factor: male condition increases the risk of suffering violence for support staff (RR = 1.58; $p < 0.05$). Female condition increases the risk of suffering violence for physicians (RR = 1.26; $p < 0.05$ – for the other professional groups there are no significance).

Concerning physical violence, auxiliary group had 12% of the personnel attacked physically, followed by the nurses' group (9,9% of victims of physical violence) and by the physicians (5,7%).

The groups that presented larger frequencies of verbal abuse, were nurses, pharmacists and physicians. The subjects belonging to the allied professions of medicine presented frequency of 29,9%.

The professionals attacked by moral harassment were nurses, auxiliary personnel and administrative personnel[1]. The second group is the most numerous in the hospitals, they are the main executant members of a care team.

Considering professions, we can notice that physicians report more sexual harassment (8,1%) than other professions.

In terms of racial discrimination, technical staff and support personnel (10,6% and 8,4%, respectively) are the most discriminated.

[1] For a detailed description of these professions in Brazil, see ANNEX 5.

Table 12: ***Victims' percentage for professional group and gender.***

	Male			Female			RR	p-value
	Sample	Victims	%	Sample	Victims	%		
Physician	154	70	45,5%	140	80	57,1%	1.26	p<0.05
Nurse	12	8	66,7%	88	55	62,5%	ns	
Auxiliary	60	38	63,3%	292	150	51,4%	ns	
Administration	52	22	42,3%	146	73	50,0%	ns	
Allied Professions	44	18	40,9%	121	44	36,4%	ns	
Technical	49	21	42,9%	54	24	44,4%	ns	
Support st	57	24	42,1%	120	32	26,7%	1.58	p<0.05

Table 13*: Victims' proportion for professional group and for violence type.*

	Sample	Victims	Physical violence	Verbal abuse	Bullying	Sexual harass,	Racial harass,
Physician	296	150	17	135	44	24	7
		50,7%	5,7%	45,6%	14,9%	8,1%	2,4%
Nurse	101	63	10	55	21	5	5
		62,4%	9,9%	54,5%	20,8%	5,0%	5,0%
Pharmacist	14	7	0	7	2	0	1
		50,0%	0,0%	50,0%	14,3%	0,0%	7,1%
Ambulance	8	2	0	2	0	0	0
		25,0%	0,0%	25,0%	0,0%	0,0%	0,0%
Auxiliary	359	191	43	160	63	16	20
		53,2%	12,0%	44,6%	17,5%	4,5%	5,6%
Administration	200	96	6	87	34	12	13
		48,0%	3,0%	43,5%	17,0%	6,0%	6,5%
Allied profession	167	62	6	50	9	10	2
		37,1%	3,6%	29,9%	5,4%	6,0%	1,2%
Technical	104	46	4	36	15	4	11
		44,2%	3,8%	34,6%	14,4%	3,8%	10,6%
Support st	178	57	5	41	22	9	15
		32,0%	2,8%	23,0%	12,4%	5,1%	8,4%
Other	126	52	7	39	20	5	4
		41,3%	5,6%	31,0%	15,9%	4,0%	3,2%

Hierarchical position

Concerning physical violence (table 14), the staff group incidence is 6,4%, since they are in the front line. Seven people suffered violence by firearm, being 4 employees of the staff category .

The directors' group (senior managers) presents a remarkable incidence as well (11,1%), although there are few people belonging to that category, in our sample (n=18).

Line managers are frequent victims of verbal abuse (43,4%), although the largest incidence in the last year is in the directors' group (44,4%). The violence incidence between line managers is probably due to the fact that they are linked with different and opposite hierarchical levels, often in tension.

Students are the most reached by sexual harassment and racial discrimination (9,5% and 7,1% respectively).

Table 14: ***Victims' proportion for position in the work and violence types.***

	Sample	Victims	Physical violence	Verbal abuse	Bullying	Sexual harass,	Racial harass,
Senior mgr	18	9	2	8	1	1	0
		50,0%	11,1%	44,4%	5,6%	5,6%	0,0%
Line mgr	159	79	7	69	23	7	3
		49,7%	4,4%	43,4%	14,5%	4,4%	1,9%
Staff	905	426	58	361	138	51	50
		47,1%	6,4%	39,9%	15,2%	5,6%	5,5%
student	84	38	4	27	15	8	6
		45,2%	4,8%	32,1%	17,9%	9,5%	7,1%
indep	151	69	8	54	26	8	9
		45,7%	5,3%	35,8%	17,2%	5,3%	6,0%
Other	164	71	10	65	22	5	10
		43,3%	6,1%	39,6%	13,4%	3,0%	6,1%

1481 answered about the position

Time of professional experience

Concerning the time of professional experience and violence types as a whole, the group with more than 16 years of experience and up to 20 are the groups that had more victims in the last year.

Physical violence affects more the group with more than 20 years of experience (8.8%). Sexual harassment is high for the group with 16-20 years of experience. Racial discrimination is more frequent among those who have between 1-5 years of experience (7.4%). This last data corresponds to the largest incidence of racial discrimination against students.

Table 15: Victims by length of professional experience and violence types.

	Sample	Victims	Physical violence	Verbal abuse	Bullying	Sexual harass,	Racial harass,
Under 1 yr	163	53	6	42	14	6	8
		32,5%	3,7%	25,8%	8,6%	3,7%	4,9%
1 to 5	394	194	24	159	63	27	29
		49,2%	6,1%	40,4%	16,0%	6,9%	7,4%
6 to 10	307	136	16	121	41	19	12
		44,3%	5,2%	39,4%	13,4%	6,2%	3,9%
11 to 15	219	111	16	93	35	12	7
		50,7%	7,3%	42,5%	16,0%	5,5%	3,2%
16 to 20	193	103	13	89	36	14	12
		53,4%	6,7%	46,1%	18,7%	7,3%	6,2%
Over 20	284	135	25	114	42	8	11
		47,5%	8,8%	40,1%	14,8%	2,8%	3,9%

Work journeys/Shifts

There is a great variety of modalities of work journeys. In general the nursing personnel work 30 hours (considered part time in Brazil) and the doctors in general work 20 or 40 hours a week, in the part and full time, respectively. In other professions, the professional can have part time in 20 or 30 hours or he/she has full time in 40 hours. Only residents have a superior workload, they have 60 hours of work per week. Temporary workers exist in the public health system in Brazil, but they were not identified in our sample. It is a contractual type that foresees a period of work of 3 months renewable for a maximum of three months.

Sexual harassment is remarkable among workers in part time (6,4%) (table 16).

Table 16*: Victims' per work journey and violence types.*

	full time		part time	
Sample	948		607	
Victims	435	45,9%	292	48,1%
Physical violence	61	6,4%	39	6,4%
Verbal abuse	365	38,5%	248	40,9%
Bullying	146	15,4%	85	14,0%
Sexual harassment	46	4,9%	39	6,4%
Racial harassment	54	5,7%	25	4,1%

Shift work means for doctors the possibility to work during one morning (6 hours), one afternoon (6 hours) and one night (12 hours) performing 24 hours a week, or occupying two shifts of 12 hours, one during daytime and another during the night, or working 24 hours at once.

For the nursing personnel (registered nurses, technical and auxiliary nursing), in general, the shifts are accomplished in a regime of 12 working hours followed by 36 hours of rest. This means to work three days during one week and two days during the following week, not working in the weekends.

Another common possibility of work outline for the nursing personnel is the division of the schedule in 12 working hours followed by 64 hours of rest. In this last case the professional doesn't have rest in the weekends and also performs a work time of 30 hours a week. The other professions, in general, do not work in shifts regime.

The relative risk between work in shift and be victim of any kind of violence, physical or psychological, in the last year, is 1.12 ($p < 0.05$). For each type of violence *per se* there is not statistics significance when compared with work in shift (table 17).

Table 17: Victims for shift work and violence types

	Work in shifts			
	Yes		no	
Sample	857		675	
Victims	418	48,8%	293	43,4%
Physical violence	57	6,7%	39	5,8%
Verbal abuse	333	38,9%	268	39,7%
Bullying	122	14,2%	103	15,3%
Sexual harassment	45	5,3%	37	5,5%
Racial harassment	37	4,3%	40	5,9%

Those who also work in the night shift have larger risk of suffering physical aggression (9.0%). This probably excess of risk could be attributed, at least in part, to social violence commuting to and from work. The association among night shift and being victim of violence (RR = 1.25; $p < 0.001$); physical violence (RR = 1.72; $p < 0.01$) and verbal abuse (RR = 1.32; $p < 0.001$) is significant. For the other violence types the association was not significant statistically. An explanation can be to consider that mobbing, sexual harassment and racial discrimination is not so related to the increase of crime rate in the city.

Table 18: Victims by night shift and violence types.

	work between 18h-07h00s			
	yes		No	
Sample	465		1067	
Victims	252	54,2%	464	43,5%
Physical violence	42	9,0%	56	5,2%
Verbal abuse	221	47,5%	383	35,9%
Bullying	80	17,2%	149	14,0%
Sexual harassment	32	6,9%	52	4,9%
Racial harassment	26	5,6%	51	4,8%

Interaction / Physical Contact

First, there is a very small part of personnel who works in health facilities and who doesn't interact with patients/clients. But it can be said that they are more protected from any type of aggression whatever the violence type to be considered.

Table 19: Victims by interaction with patient and violence types.

	No interaction		Interaction		RR (p-value)
Sample	181		1329		
Victims	45	24,9%	674	50,7%	2.04 (p<0.05)
Physical violence	4	2,2%	92	6,9%	3.13 (p<0.05)
Verbal abuse	34	18,8%	573	43,1%	2.30 (p<0.05)
Bullying	14	7,7%	213	16,0%	2.07 (p<0.05)
Sexual harassment	4	2,2%	81	6,1%	2.76 (p<0.05)
Racial harassment	5	2,8%	72	5,4%	ns

When we consider physical contact with patients/clients, we also observed that for all violence types, there is almost a larger risk for those who have physical contact. But when racial discrimination occurs, there is a larger proportion of victims among the group that doesn't have physical contact with patients (table 20).

Table 20: Victims by physical contact with patient and violence types

	Physical contact		No physical contact	
Sample	886		504	
Victims	458	51,7%	228	45,2%
Physical violence	75	8,5%	23	4,6%
Verbal abuse	385	43,5%	195	38,7%
Bullying	145	16,4%	73	14,5%
Sexual harassment	55	6,2%	27	5,4%
Racial harassment	42	4,7%	31	6,2%

4. Work settings at risk

Before we start with considerations over survey data, it is necessary to have in mind that healthcare workers usually have various jobs. This can affect the results' validity, since the place where the respondent suffered aggression might not necessarily be the place where he/she spends most of his/her working hours (see ANNEX 4 - questionnaire).

The proportion of victims among hospital worker populations is 52% in public services and 44% in private services (table 21). When compared to private services, public services have higher levels of verbal abuse (43.2%), bullying (18.5%) and racial harassment (6.5%). The proportions of physical and sexual harassment victims are similar in both sectors, private and public.

Table 21*: Victims in public and private hospitals, by type of violence.*

	total hosp / public		total hosp / private		RR (p-value)
Sample	634		512		
Victims	329	51.9%	221	43.20%	1.20 (p<0.05)
Physical violence	44	6.9%	40	11.7%	ns
Verbal abuse	274	43.2%	187	54.8%	1.18(p<0.05)
Bullying	117	18.5%	61	17.9%	1.55(p<0.05)
Sexual harassment	37	5.8%	34	10.0%	ns
Racial harassment	41	6.5%	19	5.6%	1.74(p<0.05)

Table 22 shows the proportions of victims in the sectors where they work within the hospitals, and even considering the observation noted above, they represent an approximate map of the violence risk inside city hospitals.

Table 22: *Victims according to work services in the hospital.*

	PRIVATE		PUBLIC	
	SAMPLE	VICTIMS	SAMPLE	VICTIMS
ambulatory	95	52	113	74
		54.7%		65.5%
gral medicine	92	34	65	28
		37.0%		43.1%
gral surgery	40	20	53	31
		50.0%		58.5%
psychiatric	15	10	19	16
		66.7%		84.2%
emergency	57	38	102	77
		66.7%		75.5%
operating room	28	15	24	11
		53.6%		45.8%
intensive care	55	23	29	14
		41.8%		48.3%
management	48	19	72	30
		39.6%		41.7%
specialized	58	28	91	38
		48.3%		41.8%
techn svces	25	11	44	17
		44.0%		38.6%

Support svc	63	16 25.4%	42	21 50.0%
Other	57	27 47.4%	99	50 50.5%

As for the public service, when we analyze violence type for each sector inside the hospital (table 10, ANNEX 8), the rates for racial harassment both in general medicine (13.8%) and general surgery (17.0%) draw our attention.

Inside surgery rooms, the levels of physical violence are impressive (20.8%), while at intensive care units the public sector shows lower rates (3.4%) when compared to the private sector (10.2%).

The management sector in public services also shows lower physical violence rates when compared to the private sector (1.7% and 7.8% respectively).

Support services present a 9.5% rate of racial harassment.

In the private sector (table 12, ANNEX 8), total violence victims rates in hospitals shows a preponderance of verbal abuse, as expected, and with very similar physical violence and sexual harassment rates (7.8% and 6.6% respectively).

At ambulatory services we note high verbal abuse rates (45.4%), bullying rates (15.5%) and sexual harassment rates (14.4% - in public services this rate is 3,5%). In general surgery the rate of physical violence victims is of 12,5% and 15% for bullying. At intensive care, the physical violence rate (10.2%) is similar to the rates found at emergency and ambulatory services.

In support services, although we found lower physical violence rates (2.9%), the proportion of racial harassment victims is 7.9%.

Emergency services

Among interviewed healthcare workers who work in emergency services in the public sector, 75,5% suffered some kind of aggression within the last year. This rate drops to 66,7% when we analyse the private sector. The proportion of physical violence victims in the public sector is 17.6% and 11.6% in the private sector. The bullying rate, 15.9%, is also remarking.

In the private sector, in emergency services, the physical violence rate is 11.6%, and 15.9% for bullying.

During the interview with a legislative representative, he mentioned the large number of threats and all kinds of violence performed mainly by armed drug dealers suffered by healthcare workers while caring for social violence victims.

Psychiatry

It is also important to make clear that in the city of Rio de Janeiro, psychiatry services, both public and private, are offered in specialised hospitals, and therefore cannot be considered a sector within a general hospital.

In psychiatry, we find higher rates for all types of violence when compared to other hospitals, except for sexual harassment rates. We highlight physical violence rates, that affect 47.4% of all workers in that sector.

In the private sector, in psychiatry services, we find high rates for physical violence (46.7% - 7 of 15), verbal abuse (9) and bullying (3). In public sector, psychiatric hospital have even worst rates: 84,2% (16 of 19) of victims, 42,1% (8) of victims of physical violence, 66.7 % (12) of verbal abuse and 4 victims of moral harassment. These can also reflect social violence, since psychiatry services in Brazil are often responsible for roles usually performed by shelters, or even judiciary insane asylum. We found, however, no report of racial harassment.

Health Centres

Table 23:*Victims in public Health Centre, by type of violence.*

	Public Health Centre	
	N	%
Sample	54	
Victims	38	70,40%
Physical violence	4	7,3%
Verbal abuse	36	65,5%
Bullying	11	20,0%
Sexual harassment	2	3,6%
Racial harassment	2	3,6%

Seventy percent of who work in public health centres have been victim of any kind of violence in the last year. Verbal abuse rate is higher than in hospitals (65.5%).

In the private sector, there is only a small number of workers involved in health centre (16).

We need to point that although the sample had been proportional to the distribution of work positions in the health sector, most of respondents answered that he/she works more than 50 % of his/her work journey in a hospital setting, even when he/she was selected because of the link with facilities without hospitalisation.

Concerns with violence

Table 24: ***Professional group by concern with violence***

Victim professional profile	**Very worried**		
	N	%	Respondents
Physician	62	21,2%	293
Nurse	35	35,0%	100
Pharmacist	3	21,4%	14
Ambulance	2	25,0%	8
Auxiliary/ancillary	131	38,3%	342
Administration/cleric	52	27,1%	192
Allied professions (1)	30	19,9%	151
Technical staff	23	23,2%	99
Support staff	47	27,0%	174
Other	34	28,6%	119

Table 24 shows that there are larger percentiles of person very worried among nurses and auxiliary. These are the professional categories more affected by violence in the workplace.

Table 25: ***Health care setting by sector and concern with violence***

	Health care setting					
	Public sector Very Worried			Private sector Very Worried		
	N	%	Resp.	N	%	Resp
Total	234	33.4%	701	149	22.1%	673
Hospital (total)	207	33.1%	626	115	24.8%	463
ambulatory	41	36.3%	113	17	18.3%	93
general medicine	15	23.4%	64	29	33.3%	87
general surgery	19	36.5%	52	9	23.1%	39
psychiatric	11	57.9%	19	7	46.7%	15
emergency	49	49.5%	99	15	27.3%	55
operating room	8	33.3%	24	7	25.9%	27
intensive care	8	27.6%	29	11	20.4%	54
management	21	29.6%	71	12	25.5%	47
specialised unit	26	29.2%	89	7	12.5%	56
technical services	8	18.6%	43	5	20.0%	25
support services	13	31.0%	42	14	23.0%	61
other	29	29.3%	85	11	19.6%	56
Ambulance	5	35.7%	14	0	0.0%	3
Health centre	18	34.0%	53	3	21.4%	14
Community/district	1	100.0%	1	2	9.5%	21
Hospice	0	0.0%	0	0	0.0%	0
Home for elderly	0	0.0%	0	1	0.0%	5
Rehab centre	1	25.0%	4	6	8.1%	74
Other	2	66.7%	3	14	24.6%	57

Approximately a third of all respondents from the public sector shows great concern with violence (table 25). In the private sector this proportion is lower (22.1%)

Among hospital specialities, workers from psychiatry and emergency services show greater concern (57.9% and 49.5%) in the public sector. These are also the most important specialities in the private sector, 46.7% and 27.3% of workers declared themselves very worried, respectively in psychiatric setting and emergency.

5. Contributive factors

In the survey's standard forms, written answers about contributive factors to physical violence mentioned mainly:

- Security measures (alarms, identification, guards or police officers);
- Employee education (professional qualification);
- Lack of dialogue/ communication;
- Low capacity by the health sector/ large demand for health services;
- Lack of respect;
- Lack of information;
- Disagreement by team members .
  A few physical environment factors were mentioned. E.g.:
- Poor lighting;
- Heat;
- Poor infrastructure.

As for psychological violence, a few power or authority abuse practices were mentioned as relevant to triggering psychological violence incidents in the written answers to the survey.

6. Impact on the individual employee / worker

The questionnaire approached the psychological impact of the violence on the victims investigating “how BOTHERED have you been by”:

a) Repeated, disturbing memories, thoughts, does or images of the abuse?
b) Avoiding thinking about or talking about or avoiding having feelings related to it abuses?
c) Being " super-alert " or watchful and on guard?
d) Feeling like everything you did was an effort?

The answers in all items were from the answer "in no way", the most frequent, to "extremely annoyed", the less frequent. This tendency was shown inverted in the following situations: The victims of physical violence, moral harassment and racial discrimination informed, with great frequency that they felt "too much" or "extremely" annoyed with the fact of had became "super-alerts"; victims of moral harassment were also shown "too much" or "extremely" annoyed with the repeated memories of the violent incident.

The numbers of physical aggressions are small (table 26). The injury occurred due to the physical aggression for males in 26,5%of the physical aggressions and for females in 21.9%.

Table 26: ***Injury outcomes for physical violence***

	Victims of physical violence	Injuries as result		Require formal trt for injury	
		N	%	N	%
Male	34	9	26,5%	7	20,6%
Female	73	16	21,9%	8	11,0%

· Consequences in relation to work

Consequences of workplace violence were investigated according two indicators - days of work lost after physical violence and transfer requested after violence episode (physical or psychological).

Transfer solicitation in not frequent among the possible immediate response of victims. Three percent of all victims of verbal abuse or moral harassment used this procedure (table 27).

Table 27: ***Individual response*** **"**transferred to another position" ***per violence type.***

TYPE OF VIOLENCE	**Victims**	***Victims that requested transfer***	
		N	%
Physical violence	101	1	0.99%
Verbal abuse	621	16	2.58%
Intimidation/ Moral harassment	239	7	2.93%
Sexual harassment	89	0	0.00%
Racial discrimination	83	0	0.00%

The information about lost work time after the violence episode was got only in the cases of "physical violence". Of the 101 people physically attacked 12 informed that they had wasted some time of work due to the incident. One of them stayed more than 6 months away from the work, two stayed one or more months away of the work.

Impact on migrant health personnel

When we crossed the migration situation with several violence types we found positive association among migration and to have suffered at least one attack of bullying or sexual harassment in the last year.

Table 28: ***Victims of violence by migration***

	MIGRANT		NO MIGRANT		RR
	N	%	N	%	
	205		1364		
Victim	102	49.76%	631	46.26%	NS
Physical violence	12	5.85%	89	6.52%	NS
Verbal abuse	83	40.49%	538	39.44%	NS
Bullying	41	20.00%	198	14.52%	1.38 ($p<0.05$)
Sexual harassment	19	9.27%	70	5.13%	1.81 ($p<0.05$)
Racial discrimination	15	7.32%	68	4.99%	NS

7 - Individual, institutional and systematic responses to violence

Coping strategies of victims / witnesses (immediate reaction)

It is interesting to notice that the immediate reaction of victims are different according to the type of violence. The victims of physical aggression, verbal abuse or bullying opted more frequently for the answer "reported to a manager" as the immediate answer to the aggressions. This answer can be characterised as an attempt to face the violence inside the limits of the workplace. Considering sexual harassment and racial discrimination, the options more frequently chosen were individual. It seems that these kind of aggressions are more often lived alone (**no action, pretend not happen, told to stop**) in some cases they tell to friend, family or colleague.

Table 29*: Coping strategies of victims (immediate reaction)*

	Physical violence (total)		Verbal abuse (total)		Bullying (total)		Sexual harassment (total)		Racial harassment (total)	
Victims	101		621		239		89		85	
no action	20	19,80%	151	24,32%	65	27,20%	19	21,35%	29	34,12%
pretend not happen	7	6,93%	137	22,06%	64	26,78%	39	43,82%	35	41,18%
told to stop	32	31,68%	194	31,24%	57	23,85%	35	39,33%	14	16,47%
defend phy	30	29,70%	0	0,00%	0	0,00%	0	0,00%	0	0,00%
told friends/fam	21	20,79%	166	26,73%	64	26,78%	20	22,47%	20	23,53%
counseling	7	6,93%	58	9,34%	32	13,39%	4	4,49%	9	10,59%
told colleague	24	23,76%	206	33,17%	82	34,31%	20	22,47%	17	20,00%
reported	44	43,56%	235	37,84%	92	38,49%	10	11,24%	17	20,00%
transferred	1	0,99%	16	2,58%	7	2,93%	0	0,00%	0	0,00%
help assoc/union	1	0,99%	6	0,97%	8	3,35%	1	1,12%	0	0,00%
compl form	18	17,82%	44	7,09%	18	7,53%	1	1,12%	3	3,53%
prosecution	3	2,97%	6	0,97%	4	1,67%	1	1,12%	0	0,00%
compl claim	1	0,99%	1	0,16%	1	0,42%	0	0,00%	0	0,00%
other	14	13,86%	79	12,72%	26	10,88%	6	6,74%	6	7,06%

Table 30 shows the frequency of registration of violence in the workplace. Asked if such procedure exists, 37% answered yes and 71 % of them answered that knew how to use it. That means that 26% of the interviewees knew the system of registration of violent events and also how to use it. When asked if they are encouraged to report violence episodes, 72,4% denied.

Table 30: ***Procedures for the reporting of violence in workplace***

	Reporting procedures		Know how to use		Encouragement	
	N	%	N	%	N	%
Yes	555	36.8%	392	70.63%	396	27.6%
No	535	35.5%	93	29.37%	1040	72.4%
Don't know	418	27.7%				

Institutional responses to violence

Institutional answer as to take any action to investigate the causes of the incident was performed in 19% of all violence episodes. Among those who suffered physical violence 27% knew about any investigation procedure taken by the institution. (when it was an episode of sexual harassment that proportion dropped to 8% and for racial discrimination to 9,2%). Table 31 shows the proportion of the aggressions suffered by health personnel which are investigated.

Table 31: ***Action taken to investigate the causes of the incident***

Types of violence	Investigation
All types of violence	18.86%
Physical violence (total)	26.51%
Verbal abuse (total)	20.49%
Bullying (total)	18.59%
Sexual harassment (total)	8.00%
Racial harassment (total)	9.23%

8- Anti-violence strategies

The survey asked about the existence of institutional anti-violence policies. Themes were presented and the respondent answered whether or not actions in health and safety areas were performed and each violence type. The result, found in table 32, is a higher institutional policy rate for "health and safety" at work. However, in institutional actions by violence type, "NO" and "DON'T KNOW" answers suggest that these are themes of little concern by employers and employees at healthcare services.

Table 32 – *Existence of institutional anti-violence policies, according to respondents*

	Yes	No	Don't know
Health and safety	59.4% (n=787)	24.6%(n=326)	16.0% (n=212)
Physical violence	24.7%(n=303)	46.1%(n=567)	29.2%(n=359)
Verbal abuse	22.3%(n=272)	48.7% (n=595)	29.1%(n=355)
Sexual harassment	17.1%(n=209)	48.0 %(n=586)	34.9%(n=427)
Racial harassment	17.5%(n=213)	47.8%(583)	34.8%(424)
Bullying	20.9%(n=255)	47.3%(n=578)	31.8%(n=389)
Threat	20.6%(n=251)	46.7%(n=569)	32.7%(n=399)

Institutional measures to prevent violence

Among institutional measures for controlling violence presented by the survey, "security measures" have higher visibility for workers and therefore present higher rates. The percentage of workers that say there are no anti-violence measures in their workplace is also striking, 6,5% (n=81), and is something that may reflect an actual lack of measures or a misunderstanding regarding the nature of measures described as anti-violence.

When analysing data for the measures: "patient classification", "*training*", *and* "*human resources development*", we noted that the respondents may not have understood the question, since these would be policies resulting from a reflection about violence in the workplace, something we previously found to be very restricted in our healthcare centres, as shown in table 33.

Table 33*:Prevention measures in healthcare institutions*

ANTI-VIOLENCE MEASURES	YES	NO
Security measures	78,6%(n=1033)	21,4%(n=281)
Work environment improvements	67,2% (n=872)	32,8%(n=425)
Restricted access	49,1%(n=635)	50,9% (n=658)
Patient classification	28,4%(n=358)	71,6%(n=904)
Patient behavior protocols	34,8(n=440)	65,2(n=826)
Restriction of money handling at work	28,7%(n=359)	71,3%(n=891)
Increase in numbers of employees	27,1%(n=343)	72,9%(n=923)
Screening procedures for employees	20,7%(n=260)	79,3% (n= 996)
Special equipment or clothing	50,5%(n=647)	49,5%(n=635)
Work shift change	44,5%(n=567)	55,5%(n=707)
Reduction of time worked without company	15,0%(n=188)	85,0%(n=1062)
Training	19,3%(n=243)	80,7%(n= 1017)
Human resources development	20,8%(n=261)	79,2%(n=992)
None	6,5%(n=81)	93,5%(n=1167)
Other	1,4% (n=17)	98,6% (n=1200)

Existing anti-violence measures in healthcare institutions, according to their employees, vary by sector (public or private). Data from the survey suggests stronger concern in the public sector with violence control measures, maybe due to the sample institutions' location (near urban 'favelas' and drug dealing spots), or due to being emergency units, which receive victims of 'external cause', i. e. traffic accidents, and social violence victims, making violence numbers rise in all categories at healthcare institutions. Besides, all measures dependant on resources allocation are more frequent in private institutions.

Table 34- ***Prevention measures in healthcare institutions by sector - private and public***

ANTI-VIOLENCE MEASURES	Private	A	Public	B	Associated measure- A/B or B/A		p <
Security measures	451	65,1 %	550	74,5 %	B/A	1,26	0,001
Work environment improvements	442	63,8 %	401	54,3 %	A/B	1,23	0,001
Restricted access	274	39,5 %	348	47,2 %	B/A	1,16	0,005
Patient classification	159	22,9 %	193	26,2 %			Não sign.
Patient behavior protocols	191	27,6 %	237	32,1 %			Não sign
Restriction of money handling at work	219	31,6 %	132	17,9 %	A/B	5,73	0,001
Increase in numbers of employees	175	25,3 %	155	21,0 %			Não sign
Screening procedures for employees	106	15,3 %	143	19,4 %	B/A	1,14	0,05
Special equipment or clothing	328	47,3 %	302	40,9 %	A/B	1,14	0,02
Work shift change	263	38,0 %	287	38,9 %			Não sign
Reduction of time worked without company	93	13,4 %	188	25,5 %	B/A	1,4	0,001
Training	107	15,4 %	129	17,5 %			Não sign
Human resources development	128	18,5 %	126	17,1 %			Não sign
None	48	6,9%	27	3,7%	A/B	1,35	0,01
Other	7	1,0%	9	1,2%			

9 - Prevention strategies recommended by respondents

When asked, "To what extent do you think these measures would be helpful in your work setting?", the respondents answered "very much" more frequently for "human resources development", *"training" and "security measures"*. This may reflect the will for these kinds of measures to be implemented more often, since the first two options mentioned above are rare in healthcare institutions. The answers suggest that the workers in the sector believe these measures would have a higher efficiency against violence at work.

High frequencies in options *"restricted access"* and "increase in number of employees" are striking and might be associated with social violence and its direct influence over work settings.

Table 35 - *Efficiency evaluation of anti-violence actions*

MEASURES	Very much	Moderately	A little	None
Security measures	70,0%(n=893)	17,6%(n=225)	6,5%(n=83)	5,9%(n=75)
Work environment improvements	63,3%(n=778)	19,4%(n=239)	8,5%(n=104)	8,9%(n=109)
Restricted access	55,9%(n=665)	18,0%(n=214)	10,8%(n=129)	15,3%(n=182)
Patient classification	45,6%(n=498)	22,0%(n=240)	13,3%(n=145)	19,1%(n=208)
Patient behavior protocols	48,7%(n=501)	20,8%(n=214)	13,7%(n=141)	16,7%(n=172)
Restriction of money handling at work	33,7%(n=344)	12,4%(n=127)	14,3%(n=146)	39,6%(n=405)
Increase in numbers of employees	53,9%(n=637)	16,1%(n=190)	13,9%(n=164)	16,2%(n=191)
Screening procedures for employees	42,0%(n=433)	20,5%(n=211)	15,1%(n=156)	22,3%(n=230)
Special equipment or clothing	46,1%(n=510)	16,8%(n=186)	13,8%(n=153)	23,2%(n=257)
Work shift change	35,7%(n=374)	15,6%(n=163)	15,8%(n=166)	32,9%(n=345)
Reduction of time worked without company	47,2%(n=499)	14,0%(n=148)	12,2%(n=129)	26,7%(n=282)
Training	68,8%(n=828)	16,4%(n=197)	6,2%(n=75)	8,6%(n=104)
Human resources development	73,3%(n=851)	15,2%(n=176)	5,7%(n=66)	5,9%(n=68)
Other	45,5%(n=66)	4,8%(n=07)	2,1%(n=03)	47,6%(n=69)

10 - Measures to reduce violence in the workplace.

Workers' priorities

The following categories reflect the respondents' opinion on the measures they judge important to reduce violence in the health sector.

- Humanization
- Better wages
- Psychological support for employees, patients and parents
- Managerial organization
- Punishment for offenders
- Respect
- Security
- Better work conditions
- Education (social)
- Professional recognition
- Education (training)
- Training
- Funding of social programs
- No measure should be taken

III.2 Qualitative results.

In this section we present the results of the qualitative part of the research. As pointed in the methodology section of this report, in this part we are referring to the material produced by focus group and interviews.

About the meaning of violence

- Poor or insufficient medical and social care for employees (elementary and technical level health personnel) ;
- Salary. Although the three groups of health personnel referred to the low salaries perceived by health workers, in each group the salaries determine different standards of consumption. For elementary level the group made reference to a hard access to private healthcare or immediate access to health services; good nutrition; decrease in quality of life;
- Violence due to “lack of communication” (psychological), specially among colleagues and senior levels(elementary level) or as pointed by a member of technical group the aggressions by colleagues when they smoke inside rooms without windows.
- Discrimination background in work relations, higher incidence of situations that indicate class discrimination(elementary level);
- Other types of discrimination (psychological): patronising(elementary level);
- Understanding of theft (both of public assets and personal belongings) as "physical" violence, based on reports of emotions involved(elementary level);
- Violence “outside” (government neglect for maintenance, quality of food offered, salaries and work conditions; public healthcare privatisation) (elementary level).

- Workload: rates, daily hours, shifts, absences(technical level);
- Verbal abuse by patients and parents (and/or escorts) (technical level);
- Physical aggression by patients/ escorts (story of a slap on a nurse's face) (technical level);
- Feeling of insecurity and fear inside the hospital: fear of possible armed patients; fear of verbal abuse turning into physical violence(technical level);
- Armed robbery and bladed weapons (knives and similar weapons) when leaving the hospital: stories of aggression against colleagues and patients, with occurrence of wounds and death (technical level).

The university level characterised as institutional violence, associated with work relations, including colleagues and patients. There were no consensus among the members of the group about the consolidation of interdisciplinary work inside the hospital. Some of them pointed the discrimination among professionals due to power relations. Patients are seen as victims of a social violence: “The patient arrives already armed with his condition”. need to increase number of employees;

The violence in the health sector appears to the Legislative Assembly as many complaints, such as the ones related to (interview with a deputy):

- firefights in health centres,
- kidnapping of workers from inside their workplace;
- murders of hospital directors;
- murders of union leaders.

These are violence modalities whose main contributive factor is social disorder, according to the Legislative representative. There is no discussion on this issue by the Legislative Power, except for a few people from the health sector. The sole project more directly related to healthcare workers' health mentioned by this representative is a project dealing with custody (of detainees) within hospitals.

Contributive factors

As factors that contribute to increase violence perpetrated by patients in the workplace the group of university level health workers pointed:
(related to the patient-professional relationship)
- lack of commitment of health professionals with the patient;
- need of higher tolerance with patients;
- healthcare service network doesn't work for reference and counter-reference;
- increased demand;
- need to increase number of employees;
- work overload for nurses and other non-physician professionals: “nurses work unhappy”; social assistant highlights diversity of activities and impact on quality.
- Programs for treating specific illnesses, like the Diabetes Program, facilitate communication and can be seen as anti-violence mechanisms, since they are places where there is collaboration and the patient has higher respect.

As factors that contribute to increase violence inside the team in the workplace all focus groups of health workers pointed the relationships with unprepared bosses or senior employees and/or the impossibility to oppose senior employees, as well as the asymmetric relationships inside the health team.

Work conditions were considered as facilitators of violence, more so in issues related to general conditions for work performance (materials) and less in issues related to physical conditions in the work environment (lighting, temperature, toilet facilities) (*health personnel focus groups*).

It is possible to mention, as a common set of risk factors, according to the interview with the Deputy:

- the increasing feeling that anyone can currently be a victim of social violence, traffic/car accidents and other common violence modalities in the city of Rio de Janeiro;
- the lack of a Career and Salary Plan, that causes insecurity;
- Future living on a insignificant retirement payment;
- Nearness to places of risk, specially Emergency Rooms and Health Centres near low income communities ;
- Poor income distribution (inequity).

The context of violence

A formal support network to solve violence issues does not exist in hospitals. E.g.: hospital ombudsman – only for patients and not for employees. However, employees are too submissive by not complaining (*focus group university level health personnel*).

There is no organisational support to victims of violence either physical or psychological; and there is no awareness, by the employees, that they are suffering violence. As for psychological violence, it is not even reported (*interview with a deputy*).

There is a war climate in some neighbourhoods and/or areas of the city of Rio de Janeiro. In these more violent places the government faces great difficulties to offer even the basic social service to the population. Even in hospitals, which are not inside this kind of regions but which are quite close, the government has difficulties to complete teams to work in Emergency Rooms.

- ***Consequences for health sector and society at large***

The theme of violence, most of the time, is treated as a subject of safety. It is clear that association, even after the answering of the standardised questionnaire, many interviewees suggested that the problem could be better solved if there were armed guards inside the hospitals. For many health professionals the solution for the violence in workplaces is more violence, but a defensive violence.

We presented some preliminary data of this research for representatives of local health councils. They said that when the population appreciates positively the health unit they are mobilised to defend it and who works there.

Institutional measures to control the violence

The registration

We did not find, in any place we visited in the course of the research, a specific system for violence report (*field observation*). In general the events were marked in the book of occurrences in the nursing room.

The workers' organisations

All healthcare workers unions were sought by the research team. None of them declared to have any kind of anti-violence strategy to protect their category. Some said that when the accusation involves a colleague of the same professional category as the offender, the person making the accusation is asked to

file an ethical suit against the offender at the council that supervises professional exercise. When the offender is of a different category the process is harder, and, when the offender is a patient, some organisations suggest filing a criminal suit. Since our justice system is very slow and, unlike central countries, impunity is well known, the aggression is rarely put forward. There is not, as stated before, a systematic reflection about violence at Unions in Rio de Janeiro. The only exception might be the physicians union, that has been trying to influence the state government's decision to not to allow detainees to stay very long in public hospital wards.

The health sector has become increasingly concerned with violence in the population, but shows little interest in violence among its staff.

Outside workplaces, in unions and councils, for example, there is not any attendance outline to violence complaints or standardised procedure. When interviewed, the representatives of councils and unions of health sector informed that they receive many informal complaints.

But there is no formal channel for this kind of complaint. Each claimer received the orientation to go to a police station. There, before registering the complaint, the police officer evaluates if the event justifies a complaint-crime (*representative of an union*).

Other interviewees manifested interest in the possibility of an accusation channel, which can give visibility to the violence suffered by its categories in some way. *(representative of a professional council*).

Local level of action - the health facility.

During the fieldwork, a group of physicians in a study unit told us about a formal request asking the director to intensify the control at the entrance. The objective of such measure was to deny the free access of non-workers to the wards. They were been victims of several aggressions and no providence had been taken.

No support mechanism to assist victims of violence in the workplace in the health sector has been instituted. The existent initiatives are some times of concerned colleagues, other times of their chiefs but it does not sensitise the directors of the establishments in such a way that it turns such initiatives into an institutional strategy. Nevertheless, they are timid initiatives.

Municipal and State level of action - the health secretariats.

The State and Municipal Secretariat of Health advisor for Violence Prevention was interviewed. Since this is a pioneer advisory board in Brazil and in Rio de Janeiro, as informed the interviewee, its aim is to prevent violence and accidents of various types: domestic violence, violence against children and adolescents, against women and elderly people, as well as accidents in work and domestic settings. There isn't a specific action dealing with violence in work settings in the health sector, neither there is information on the issue at state level. Violence incidents are usually identified locally and receive individual juridical counselling, when asked by the employee (interview).

The contribution of legislative power

The deputy interviewed told us that there is very few actions accomplished by the legislative power. He mentioned the career plan and the project of deal with custody inside hospitals of examples of what can be done.

"... there aren't any discussions about this, generally, in the legislative area. Some people linked to healthcare areas have this concern. We are ... calling for a better work on violence, we prepared a law project about custody inside hospitals. They were cancelled, it's true, but still those patients are not sent to penitentiary hospitals. The legislative power can also act for better income division, to lower social exclusion levels, and with a few projects that can help healthcare workers".

"We are trying to discuss a salary/ career plan as a way to decrease violence. That means acting, turning incidents that are not of compulsory notification, like cases of aggression against women, against healthcare workers, all of this is part of the legislative agenda. "

"For example, when I was director of a Hospital, I made an administrative change, in which every punishment for senior workers had to go through the evaluation of the employee association, and that caused an uproar in the hospital, because even tertiary level professionals in the commission itself did not want their internal juridical problems to be discussed or assessed by workers of secondary / elementary levels."

The contribution of the Labour Court

Interviewed a judge of the Labour Court she shows what she thinks about violence in the workplace and what kind of process she uses to judge.

"...I never judged a case of violence between employer and employee, though there indeed is a very high hostility between them, when they arrive at the hearing, one hates the other, but because the other did not pay what he had a right to get ..."

"we could talk of psychological violence, I think it applies more to the countryside in Brazil, in the northeastern region, even in the south we hear about what could be considered slave work, that still exists..."

"...I judged cases of that, one of them from X company, I can't remember the person very well, she was a sewing woman, putting fasteners in X' bras, and was constantly called stupid for being of a class that doesn't need to read or write, semi-illiterate, they only need skills on the machine, they don't even have to know how to sew, and they have to complete a lot of pieces every minute, since production is very high, and they are called stupid, idiot, you are not able to produce so there is a lot of this, specially in lower classes, so the lower the cultural level, the higher is, let's put it this way, the humiliation he has to face..."

"... because now we work with sectors where it is very easy to steal, what happens is that in security companies men have to work absolutely naked under the uniform, no shorts or underwear, only the uniform, the socks and the boots, so as not to be able to hide the money they deal with, and then they have to undress in one room and get their clothes in another room to be able to leave...".

Despite the reduced number of focus group and interviews, the results of this part brings to light a lot of questions, particularly what can be considered as violence, and what varied institutions have been doing concerning violence in the workplace in the health sector. A lot of questions arisen in this part of the research can be better explored in others researches. The role of the republic's powers in the control of workplace violence and the notions people have of psychological violence, the limits of what they think to be moral harassment or sexual harassment are examples.

V - DISCUSSION

Concerning violence definitions and its types

Definition of violence, as conclusion of the qualitative part of the research, must include as violence also the disrespect to the contracts and established agreements. This kind of violence could be called institutional violence. Difficulty to access justice, fear of reprisals and the absence of procedures of collective defence (as syndicate association or similar) make violence a trivial theme, making the subject work until be very tired or carry out tasks for which he/she has not qualification. The low wages in public and private sectors, the worst work conditions and the coexistence of multiple types of work contract are examples of how this violence is revealed.

Another example of this kind of violence in our country is the non-payment of wages, as marked by the judge interviewee, which is not recognised as violence.

About moral harassment

Differently of sexual harassment and racial discrimination, the term moral harassment, in Brazil, is in an embryonic stage of discussion in juridical, academic, syndical and managerial areas. This is mainly due to a difficulty to establish which behaviours associated to this violence type because of the complex net subjectivity in the workplace and the restricted diffusion of this notion which reach only middle and high class in the country.

The occurrence of veiled menaces, emission of contradictory and divergent prescriptions with attribution of guilty to workers and other psychological mechanisms of annulment, are elements present in moral harassment as in sexual harassment.

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WHO ARE THE VICTIMS?

From the results we can trace a profile of the aggression victims among the health workers. If we took the aggressions without considering the type of suffered aggression, we can consider that the violence reaches men and women faintly, of all the age groups and marital status. In what he/she refers to the ethnic group, it is different, the violence reaches more the minority group, once he/she is victim of racial discrimination, besides all the other violence types that reach both minority and majority groups with relationship to the race. With relationship to the activities carried out by the professionals, they compose the victim's profile the work in shift and at night, working with patient, especially with physical contact, and, to be nurse or auxiliary nurse.

WHERE ARE THE VICTIMS?

A few issues related to the Rio de Janeiro health sector organisation must be pointed out, and are elements of the health work context deeply related to the violence lived in the services.

In Brazil there are a few different health services options: the public service (largest network), services linked to health insurance companies (private) and strictly private services. In Rio de Janeiro can be found the largest network of public hospitals.

Each of these divisions has aspects that characterise it as for work contracts, waging and type of contract. In the public sector, only recently the salary for a university level employee at the State Health Secretariat, was raised to US$ 500. Before that, a physician, working 20 hours a week, and a psychologist, working 30 hours a week, earned around one hundred dollars a month each. At the Ministry of Health, these professionals earn less than 700 dollars a month with similar working hours. With a few exceptions, the private sector does not pay much better salaries.

Among these university level professionals, physicians and, in a smaller degree, nurses, have access to individual alternatives (multiple jobs) that allow them have a better "quality of life". However, the situation is worsening, such as when institutions or employers hire cooperatives of professionals, specially physicians and assistant nurses. Temporary contracts (six months maximum) are also emerging as a contractual alternative in the public sector.

Other more collective alternatives have been tried through informal agreements with university level workers in public health facilities. These agreement sometimes reduce the contractual work journey as for example, a contractual shift of eight working hours, five times a week can be reduced to eight hours three times a week. These alternatives are forms of compensation according to the level of exposure to violence, the distance between work and home, the general conditions level at work (like lack of basic materials – bandage material, drugs etc) and salary.

We call "worsening" the current ways of employment through contracts with cooperatives or contracting companies, where employees have reduced working rights, such as no right to holidays or days off, health insurance and no stability. Many times higher salaries compared to stable employees mean a difference in working hours.

The inequities between consequences of joblessness and an unequal globalisation process, when comparing central and peripheral countries, such as Brazil, is pronounced: the State protection of the Brazilian population is very poor. These consequences are felt not only in the health care work area, but also in the distress and the diseases due to poverty that flood increasing numbers of people into healthcare services. Healthcare workers, aware that social issues cannot be treated with medicine, show visible distress.

Although not very known, complementary actions to State duties through individual initiatives by healthcare workers can be found in health services, such as donations of food, clothes, toys and books, and even transportation payment between states (see, for example, Isto É, a Brazilian Magazine, of March 20, 2002).

This kind of sympathetic response to social violence does not seem to be hegemonic in health services. The violence framework is worsened by the healthcare workers' attempt to survive multiple jobs, which, together with the conditions exposed above, have worsened the quality of services offered to the population.

In private services, specially in hospitals where one finds services of higher complexity, there are various possible work contract options. Cooperatives can be responsible for in-hospital services (e.g. intensive care, neonatal intensive care) through a kind of lease of hospital facilities or by maintaining available specialist teams. Hired shift workers and hospital daily workers are, usually, responsible for maintaining hospital services. University level professionals can be hired by the hospital (shift workers,

for example) or simply use hospital services and get directly paid by the patient or by the insurance company.

As presented in the methodology chapter, the selection of facilities embraced all the types of establishments according to the stratification made. However, inside of each stratum an infinity of characteristics could not be taken in consideration because of the limited number of establishments in the sample. Besides, we didn't get approval of any hospital in the wealthy zone of Rio, as well as we opted for not including in the sample any establishment in area with high crime rates, for not exposing our research team to risks. Thus, particularly for the private establishments it is probable that the violence incidence here presented is underestimated.

Because of these multiple job situations and social context in the health sector, the limited number of facilities in the sample and the multiple jobs that workers have, we must consider with caution the results of violence comparing the public and private sectors.

WHO ARE THE AGGRESSORS?

As pointed in the results, it can be identified two great groups of aggressors: one composed by the patients and their relatives - the beneficiaries of the health service, and other group composed by the work colleagues and managers - the health team. This is a classification that helps to understand the violence so that it can be controlled.

WHAT ARE THE CONTRIBUTIVE AND PREVENTIVE FACTORS?

We can organise the contributing factors in those of general order, that depend on public policies and those related to work process and its immediate context. The factors of general order are, for example, education for the population (in the sense that lack of school increase the cultural distance between the attended population and the personnel of health, specially them who have university level), more employments, less poverty (lack of employment make stressed people ask for assistance and a great number of sick people), efficient policies of safety.

Factors directly related to the production process of health facilities:

For the violence perpetrated by the beneficiaries we can group together a series of contributive factors already presented in the results (qualitative part and survey). In a first attempt of classification of those factors we can consider:
- related to the crime rate - invasion of the health facility by criminals in search of treatment, robbery, kidnapping or revenge, as well as occurrence of shootings and lost bullets in the workplaces and in the itineraries work-home.
- reaction of the users to the violence of the services - to classify aggressions as reactions is an attempt of understanding the reasons of its occurrence so that it can be undertaken effective actions in its combat. Thus, we can consider in this group:

- factors related to the organisation of health services that leaves a significant part of its users awaiting attendance, or offers attendance with low capacity to solve the health problem, or there are lack of materials and equipments for an attendance of good quality or lack of personnel for an adequate accomplishment of the attendance to the users or also there is a lack of technical training to health personnel.

- factors related to the relationship of the services with the users as the absence of channels of the communities' participation – there is a lack of communication between health personnel and patients (from how to move inside the health facility to explanations concerning his/her pathology);
- factors related to the precarious mechanisms of control for the ethical exercise of health professions (nowadays, in Rio we have programs of humanisation of the health attendance in development that have as basic principle the user's recognition as autonomous person independently of his/her precarious social conditions) – there is lack of humanity in treating patients and also there is lack of respect to patient's autonomy

In relation to the violence practised by colleagues and managers, there is a concentration of violence of the types moral harassment, sexual harassment and racial discrimination. From the results of the research emerged contributive factors (qualitative part and survey) that can also be classified in those:

- related to the individual characteristics - there is lack of training for leadership's exercise
- related to the institutional violence – there is lack of respect to labour rights and syndical agreements, unhealthy conditions of work;
- related to the work organisation - there is low wages; unemployment menace; insecurity concerning retirement; trainees in excess taking the place of graduated professional, several types of work contract living together in the public sector, with different wages for same functions; lack of replacement of personnel's losses (abandonment of employment because of low wages and retirement); work overload and work intensification.
- related to power relations and power abuse inside the health team – there is lack of consensus inside health teams, lack of discussion spaces to deal with conflicts inside the team
- related to the invisibility of the violence (registration lack, lack of spaces of reflection, discussion and negotiation). Impunity Stress-

Prevention factors

In our city there is not many experiences of strategies to decrease violence in workplace in the health sector. Some presented recommendations were:

- To narrow the relationship between health personnel and the surrounding community.

  One of the pointed factors was the participation of the community in the life of the hospital, with the intermediation of community's health councils, or enlarging the negotiation channels between the community's interests and the possibilities of the local health system.

- Enlarging of discussion spaces

  Space of discussion means a place and a time of a regular workday to be used for discussion of the theme. This is not a trivial subject in Brazil because opportunities for discussion are rare among colleagues, specially if the theme is related to work and its organization. Time for meeting is not foreseen in the planning of a service, in general. In the area of mental health, there are exceptions where those spaces are more frequent.

WHAT ARE THE CONSEQUENCES OF THE VIOLENCE?

Work relations, violence and distress

Considering work relations between employees and bosses, a few issues related to moral or sexual harassment are noted, as well as racial harassment, which can all be an important source of discomfort and distress at work. As we could see in the results presented before, the most frequent immediate reactions of victims is “no reaction”, “tried to pretend it never happened”, “told the person to stop” or “told friends/family” what means that victims tried to deal alone with the aggression and its psychological consequences. This can mean that social support inside the workplace, which is based on work relations is absent. Without cohesion in the work team, the distress is the attempt consequence of aggressions.

This research do not investigated specifically the possible psychological consequences for victims, but with its results is clear the necessity of more investigations on this subject.

- ***Impact on service delivery for patients and clients (quality of care)***

Although it has not been inquired directly in the questionnaire, the impact on the services is very important. Often in Brazil the press disclose personnel's shortage, either as consequence of low wages, shortage of material resources and lack of infrastructure or as a consequence of the fear of violence. Such denouncements are particularly significant to certain violent regions and neighbourhoods of the metropolitan region of the State of Rio de Janeiro.

There is a public hospital in Rio de Janeiro with a regular home-care service. They did a multi-professional workshop to discuss a principle: “care to not exclude”. This expression has a double sense: to offer health care recognising everyone’s right to access health service and to be careful for not allowing the fear of violence among the health team exclude a segment of the population from health services.

In this last sense, we received several statements concerned with the difficulty of organising teams for that kind of care. It has been tried several strategies with the objective of assure protection to the team when it is suppose to work in areas controlled by drug traffic.

WHAT ARE THE REASONS

The invisibility

Outside workplaces the victims should direct their accusations to the judiciary. As the interviewed labour judge informed, the labour justice does not receive that kind of complaints for trial. The competence of that kind of trial is of the Criminal Court.

Besides the lapse of a formal channel to drive violence complaints, other reasons were given for the non registration of complaints of violence at workplaces in the focus groups, interviews and in informal chats during the field work.

There are many differences of treatment of violent events according to the violence type. Physical violence is much more visible because it has a penal expression (it is a crime which is foreseen in the Law), it is also more unacceptable and recognised, by the population, as a crime. The under-registration in that case has as reasons the discredit in justice and fear of the wish for revenge. If the aggressor is a person

that is daily with the victim, like a work colleague (independently on the professional category or position that he/she occupies), the tendency is that the event is maintained among four walls and meets a domestic solution.

Tolerance is considered as one of the reasons for the under-registration. In a city where violence is marked intensely by a great number of homicides, of policemen's and outlaw's physical aggressions and also characterised by the manliness culture, there is a lot of tolerance to aggressions. In workplaces the person who complains or denounces aggressions, mainly psychological, would be considered as a weak person, a worthless person.

Recently, Lacerda (2002) carried out a research with leaders of Unions who acts in the black movement and found out that most of them understand that the role of Unions in the fight against racism is restricted to support the black movement and that they are not supposed to be involved directly in this fight. It is not a union fight – it is a fight of the black movement.

In synthesis, because of all stated before, and although violence in general has been being a subject of discussion in each corner, there is not any channel where the workplace violence in the health sector can be registered and turned visible, mainly the psychological violence.

In the field of public health, violence is still restricted to the consequences of the crime rates in terms of morbidity and mortality, or to the domestic violence (children and women). However, there are few studies that move the main focus of study towards the workplace and there examine the phenomenon of the violence.

VI - CONCLUSIONS

This research was the first to investigate violence in an embraced way, that is, involving various types of violence. About the survey, despite of our caution to not introduce any bias to not distort the results, the limited number of facilities and the limited sites of the city, in one hand, could represent a limit in this study. In other hand, this is the first survey with a great number of respondents and we can say that at least 47% of the health personnel in Rio’s city have been victims in the last year.

This report could show a detailed diagnosis of workplace violence in the health sector.

About the definitions of violence, its limits, its classification this study could put in light some questions as the institutional violence among workers in our country but it reflects also de embryonic stage in which the reflection about the theme of workplace violence met us. In this sense, the divulging of this results will be the trigger to turn visible all kind of violence in the workplace. More qualitative studies are necessaries to go deeply in this reflection.

The results presented here do not exhaust the possibilities of analysis of the research data, this is a first analysis and other papers will come soon.

Research on the possible actions that can be taken to control violence, particularly in the local level, is a very important way to reach successful initiatives. In other hand, specific research on the psychological impact of violence must be also carried out.

VII - RECOMMENDATIONS

Firstly, in Brazil, it is necessary to recognise the violence, in the sense of not denying its existence and for best verify its magnitude. In that investigation process it was the first time that the subject of the violence was placed in the health sector as a worthy subject of discussion. Not the subject of the general violence, that discussion is trivial among us: It concerns to safety's policy and the fear felt by every citizen because of the high crime rate in the city of Rio. Violence in the workplace had never been a discussion theme. With this research, violence in the workplace in health sector begins to have some visibility and, as everything beginning, it is necessary some care for not take as absolute those results. That care have some reasons: it is not sufficient established what may be considered as violence; moral harassment just begins to be understood; people still afraid of speaking of violence. That research is the first step to begin to think in the subject of violence. For workers and their organisations as well as for health authorities that subject appeared for the first time on that moment. It is necessary to give name to all types of violence and to reflect on all those types. The first step is to guarantee the register.

The second step is to stimulate every facility, and every health setting to create a space of reflection about violence for all kind of person involved, directly or indirectly, in health care. That is to think about what can be tolerable inside each team and what they would call violence. And then, in another step locally, the health personnel would establish procedures to deal with violence, the inner violence and the violence perpetrated by beneficiaries of the health system.

> In Brazil, we are only beginning to reflect about the theme of violence. We need to call the Judiciary, the Legislative, and the Executive in the areas of education, health, social action, labour, public security to sit all together to find ways to protect people who are suffering all kind of violence in the workplace in the health sector.

BIBLIOGRAPHY

1- Minayo, M.C.S. e Souza, E.R. de. Violência e Saúde como um campo interdisciplinar e de ação coletiva [Violence and health as na interdisciplinary field and collective action].Hist. Cien. Saúde, nov. 1997-fev. 1998 vol IV, nº 3.
2- Zaluar, A . e leal, M.C. Violência Intra e Extra Muros [Violence inside and outside walls] Ver. Bras. De Ciências Sociais. São Paulo, 2001:vol.16, nº 45
3- For this distinction, see Arendt, H. – Sobre a Violência (About Violence).Rio de Janeiro: Relume-Dumará, 1994, Cap.2.
4- Cruz, S.H. Representação de escola e trajetória escolar. Psicologia; 8(1): 1-14. USP, São Paulo, 1997.
5- Silva, A.M.M. Educação e Violência: qual o papel da escola?. http://www.dhnet.org.br/educa/redeh/aida1. 1999.
6- Tambellini, A . T. E Câmara, V. de M. A temática Saúde e ambiente no processo de desenvolvimento do campo da Saúde Coletiva: aspectos históricos, conceituais e metodológicos {Health and environment in the process of development oh the Collective Health field].Ciência e Saúde Coletiva, 1998:3(2):47-59.
7- Asmus, C.I.F. Avaliação do Processo Produtivo em Mineração de Diamantes e suas Repercussões sobre a Saúde dos Adolescentes Garimpeiros [Evaluation of the productive process in diamonds mining and its repercussions over the health of teenagers miners]. Tese de Doutorado, Rio de Janeiro: COPPE/UFRJ, 2001
8- Palácios, M. (1999) Sofrimento psíquico e trabalho: um estudo de caso sobre o sofrimento psíquico dos trabalhadores e suas relações e o trabalho de caixa em uma grande empresa estatal bancária [Mental suffering and work: a case about the teller´s mental suffering and its relations with their job in a big bank state company] Tese de Doutorado. Rio de Janeiro, COPPE/UFRJ, 1999.
9- Loureiro dos Santos, M. Cuidado paliativo e Organização do Trabalho: a conepção na atividade de técnicas e auxiliares de enfermagem [Palliative care and work organisation: the conception in the activity of nursing] tese de Doutorado. Rio de Janeiro: COPPE/UFRJ, 2001.
10- Hirigoyen, M.F.Assédio Moral: a violência perversa no cotidiano [Moral harassment: the wicked violence in daily life]. Rio de Janeiro: Bertrand Brasil, 2ª ed., 2001.
11- Dejours, C. A loucura do Trabalho: um estudo de psicopatologia do trabalho [The madness of the work:study psychopathology]. São Paulo: Cortez/ Oboré, 2ªed., 1987.
_____ A banalização da injustiça social [The banalisation of social unfairmess] Rio de Janeiro: Ed. Fundação Getúlio Vargas, 1999.
12- DIEESE (Departamento Intersindical de Estatística e Estudos Sócio-Econômicos) e INSPIR (Instituto Sindical Interamericano pela Igualdade Racial)- Mapa da população negra no mercado de trabalho [Map of the black population in the work market].outubro de 1999.
13- Lacerda, L. Hoje é dia de preto [Today is black´s day]. Texto apresentado para a qualificação no mestrado em Saúde Coletiva. Rio de Janeiro: NESC/UFRJ, 2001.
14- Rede Nacional feminista de Saúde e Direitos Reprodutivos da Mulher – Regional Pernambuco . Dossiê Violência contra a mulher [Report violence against the woman], www.redesaude.gov.br
15- See, for example, the Brazilian Penal Code and the law number 10.224, of may 15th , 2001(www.senado.gov.br)
16- SINDISAÚDE – SP. Pesquisa sobre o perfil da mulher trabalhadora na saúde [Research about the profile of the work woman in the health secotr]. SINDSAÚDE- SP/CEERT, 1999.
17- Buarque de Holanda, S.. Visão do Paraíso [Vision of paradise]. São Paulo: Brasiliense, 6ª ED. 1994.

18- SES/RJ Epidemiologia da Violência: Informação para a Ação [Seminar: Epidemiology of violence: information for the action] seminário promovido pela Secretaria de Estado Saúde (SES/RJ)e Viva Rio/ ISER. Rio de Janeiro, 29-27/09/01, 2001.
19- SCIELO, BIREME, LILACS.
20- Skaba, M.M.V.F. O vício da adrenalina: etnografia da violência num hospital de emergência [The addiction od adrenaline: ethnografy of violence in na emergency room] Dissertação de mestrado. Rio de janeiro: FIOCRUZ/ENSP, 1997.
21- Deslandes, S.F. Violência no cotidiano dos serviços de emergência:representações, práticas, interações e desafios [Violence in the daily life of the emergency services: representation, practices, interactions and challenges]. Tese de Doutorado. Rio de Janeiro: ENSP/FIOCRUZ, 2000.
22- SIMESP. Violência contra médicos [Violence against phisicians]. Dr! São àulo, maio de 2000.
23- Deslandes, 2000. Op. Cit.
24- Van der Spuy, E.; Rontsch, R.; Marais, S. Crime and Violence in the workplace: effects on health workers. (s/d)

ANNEX 1
Guideline for the focus group and interview

Which concept do you have about violence?

Was there any increase in your concern with the violence?

What violence type is more frequent?

Who is more vulnerable?

Who are the aggressors?

Which factors do more contribute?

Which are the main consequences for the subject?

And for the work atmosphere?

Which are the people's main answers?

Does any type of support exist for the violence victims in the institution?

Do you have any suggestion for this support?

Does any type prevention exist to the violence? How?

Do you have some recommendation for this?

ANNEX 2

UNIVERSIDADE FEDERAL DO RIO DE JANEIRO
CENTRO DE CIÊNCIAS DA SAÚDE
NÚCLEO DE ESTUDOS DE SAÚDE COLETIVA
WORKPLACE VIOLENCE IN THE HEALTH SECTOR

Freely Given and Informed Consent

You are being invited to participate on a project of research " Workplace Violence in the Health Sector ". This research seeks to characterise the workplace violence the health professionals are exposed and to facilitate the development of effective strategies to minimise the violence and its consequences on those professionals' health.

The International Labour Office, the International Council of Nurses, the World Health Organization and the Public Service International are co-ordinating and sponsoring the project that will be accomplished in 7 other countries. The Centre of Studies of Collective Health (NESC) of Federal University of Rio de Janeiro is the responsible institution for its accomplishment in the city of Rio de Janeiro, under co-ordination of Dr Marisa Palácios.

In order to know this reality, one of the research activities is the accomplishment of several focus groups for discussion of this theme. Focus group is a technique that seeks, through the group discussion (of 6 to 10 persons), to arrive to what the group thinks on a certain theme. In our research we will select several groups according to some characteristics: group of users of the health services, authorities of health, managers, lawyers, employees, occupational health personnel, etc. The group for which you are being invited is the group of _____.

The discussion dynamics will be such that all the participants will be stimulated to express their opinions freely concerning the violence in the workplace in the health sector as well as the determinants, its consequences and action strategies to lessen the problem. The meeting will be co-ordinated by a trained member of the research team and will also have a reporter chosen also in the project team. The meeting will take about two hours and will be tape-recorded.

That type of approach seeks to obtain more information on the violence in the health sector and it facilitates that a larger number of people can interfere directly in the understanding of that phenomenon.

The research project was evaluated by the Ethics Committee on Research of NESC and gets the approval. In case you need more information, please contact us on the telephone - 99975677 (Marisa Palácios) or 25626224 / 25626223.

The participation in the research protocol is entirely volunteer, you will participate in the focus group only if you want to do. You won't be annoyed if you don’t participate. We inform that the participants won't be identified and everybody can be absolutely sure that no name will be linked to any speech guaranteeing total secret of the rendered information. No name in any moment will be disclosed.

This research will bring more information about the violence, its consequences and its determinants in the health sector. Besides, we hope that the research outcomes can aid each health facility and the competent authorities on the elaboration of programs to minimise the occurrence of violence and its damages on physical and mental health.

_____
Profa. Marisa Palácios / Research Coordinator
(CRM/RJ-52-42010-5) / (Matr.UFRJ: 0136405)

I, _____ declare that I read, I could remove my doubts, I understood and I agree in participating on the research. I will bring a copy of this term with me.

_____

ANNEX 3

HEALTH SECTOR OF THE CITY OF RIO DE JANEIRO.

Rio de Janeiro is a great city; it has 5.598.953 inhabitants (estimate for 1999, according to IBGE). It is the second largest city of Brazil. It has 1518 health settings in activity. The available data for characterization of those units and work positions provides of two sources of information:

1) AMS - Inquiry on Medical Sanitary Attendance - that is a national census of all the establishments of health, accomplished by the IBGE - Brazilian Institute of Geography and Statistics. Here we will work exclusively with the data relative to the city of Rio de Janeiro.

2) DATASUS - System of information of the Health Ministry. We will be working with two sources: SIA (Ambulatory Information System) and SIH (Hospital Information System).

Characterization of the health units

The Brazilian health system is called Single Health System (SUS). It is a public and free health system, which embraces the whole country. The system is organized in a different form in each district. The principles that orient the system organization are integrality and decentralization of the health actions, and equity. Public and private units (the late through the hiring of its services) constitute the system.

According to the Federal Constitution, the public health facilities have priority to give health coverage to the citizens. Therefore, in Rio de Janeiro, the Municipality's Secretary of Health uses the installed capacity of the state and federal hospitals, including the university hospitals. Soon after, if necessary, it hires services of philanthropic institutions and finally, it uses the offer of the private institutions. The admission of the population in the system is always made through the first level units or, in cases of medical urgency or failing of the first level units, through the emergency rooms of the hospitals.

Health facilities

Rio de Janeiro has 1518 health facilities distributed between public and private sectors.

Table A1.1: Facilities per sector

Sector		N
Public	Municipal	106
	State	32
	Federal	31
Private	Contracted - SUS	105
	Private (pre-paid plans, others)	1244

According to the attendance regime:

Table A1.2: Facilities per attendance regime

Attendance regime	N
With hospitalisation	270
Without hospitalisation	797
Support services to the diagnosis and therapy	451

Those diagnosis and therapy support services was excluded from the sample once they are small and very specialized establishments (laboratory of clinical analysis, radiological clinics, etc.). We will be limiting the health units to those that accomplish clinical attendance and hospitalisation.

Health units with hospitalisation

To have an idea of how is the network of hospitals of the Single Health System, the table A1.3 shows the distribution of the number of beds according to the nature of the administration (total of 270 health units):

Table A1.3: Number of bed by sector

Public	Federal	4.807
	State	3.481
	Municipal	3.600
Private	Contracted by SUS	5.806
	Private (pre-paid plan, others)	7.066
Total		24.760

We can observe the greater importance of the public system, which has a larger concentration of beds on large hospitals.

Health units without hospitalisation (first level units)

Distribution of the number of offices according to the type of the unit. There are 797 units.

Table A1.4: Beds by sector

SECTOR		N
Public	Federal	1.384
	State	719
	Municipal	1.332
Private	Contracted by SUS	475
	Private (pre-paid plans, others)	3.183
Total		7.093

Health units with and without hospitalisation - distribution of work positions.

Health units with and without hospitalisation - distribution of work positions according to the type of the unit (total of units– 1087):

Table A1.5: Work positions by sector

SECTOR		LEVEL OF QUALIFICATION			
		University	Technical	Elementary	Administration
Public	Federal	9.595	8.538	5.452	3.452
	State	5.620	6.507	3.415	1.093
	Municipal	8.640	9.263	4.526	3.948
Private	Contracted by SUS	4.026	3.940	1.956	1.924
	Private (pre-paid plans, others)	19.009	10.525	7.249	5.095
Total		46.890	38.773	22.598	15.512

We verify, then, the proportion of SUS' offering of health services (installed capacity) and of work positions, in Rio de Janeiro. It represents 71,5% of the beds, 55,1% of the offices, 59,5% of the work positions of superior level, 72,8% of the positions of work of technical level, 67,9% of the positions of work of elementary level, 67,2% of the work positions of administrative personal.

The data on production of health services are relative to the Single System of Health. Its system of official information includes data of all the procedures at all levels of attendance.

Data consolidated by the Health Secretary of Rio de Janeiro inform that the production of the first level units linked with SUS in this city, in the year of 2000 was of 55,5 million procedures. From these, 50,5% were specialized procedures while 39,1% referred at a basic attention and 10,3% to the procedures of high complexity. Of the total procedures that were accomplished, 51,7% were in district units, 23,9% in the state establishments, 6,1% in the federal ones, 10,1% in the University hospitals; 4,1% in the philanthropic entities and 3,4% in the private companies.

The hospitals production, relative to the hospitalisation of the year of 2000, it is distributed as follows: 38,6% in the municipal establishments; 16,9% in the University Hospitals, 16,5% in the State ones; 13,4% in the contracted private hospitals, 7.9% in the philanthropic ones and 6,8% in the federal hospitals. With relationship to the specialty that refers the hospitalisation, we found the following distribution: surgery - 30,0%; obstetrics - 22,3%; medical clinic - 20,9%; psychiatry - 13,7%; paediatrics - 7,9%.

Table A1.6: Types of units of the first level network of SUS

Types of facilities		Public	Private
Clinics	Units	50	24
	Offices	1.110	240
Health Centre	Units	53	9

	Offices	348	31
Specialized clinic	Units	1	34
	Offices	3	65
Offices at hospitals	Units	61	18
	Offices	1.464	152

Source: Datasus, apr.2001

Table A1.7: Beds per type of unit that compose the hospital net of SUS.

	Type of facilities								**Units**
	chronic/out of therapeutic possibility		Psychiatry		Rehabilitation		Total		Total
	No.	%	No.	%	No.	%	No.	%	
Public	940	8,60	1.926	17,70	57	0,52	10.899	100	59
Private	959	14,94	2.519	39,24	72	1,12	6.419	100	39
University	58	2,55	159	6,99	4	0,18	2.275	100	11
Total	1.957	9,99	4.604	23,50	133	0,68	19.593	100	109

Source: Datasus, apr.2001

1. In spite of the dimension net of health units of the Single Health System, the problem of access to the services is still a serious one. In 1998, according to the available data of the Ministry of the Health, 12,6% of all the deaths at Rio de Janeiro happened without the individuals has had medical attendance. The access difficulties are not of geographical origin. The city of Rio de Janeiro, in spite of its great geographical extension, has a reasonably distribution of its units. The difficulties can be attributed to different reasons, being most related with the human resources in health. Low wages and bad distribution of human resources with great dispersion in the most outlying and poor areas of the city can more frequently represent the reasons associated to this bad distribution of the human resources in the health sector. With an insufficient remuneration, the graduated employees of the public service are compelled to have other jobs, being, in some cases, linked to more than 4 jobs.

ANNEX 4

EDUCATION AND QUALIFICATION OF THE PROFESSIONALS WHO PARTICIPATED IN THE RESEARCH

The participants in the research are professionals who act in the health sector with different functions and education. For the best understanding of Education in Brazil, we present the specific legislation of the Ministry of Education and Culture, who classifies three different levels in the following way:

1 - ELEMENTARY LEVEL – Schooling is compulsory between the ages 7-14 for all population. It does not include professional formation.

2 - MIDDLE LEVEL - It is not compulsory. Some schools have technical schools where students acquire a professional qualification according to different knowledge areas and its minimum duration is 03 years;

3 – HIGHER EDUCATION LEVEL - they are considered university courses, and their duration is between 04 to 06 years.

Some professionals of higher education level who participated in the research contributed directly to the diagnosis, treatment and rehabilitation of the users of health services. They are: Physicians, Dentists, Physiotherapists, Psychologists, Nutritionists, Music Therapists, Social Workers, Nurses, Fonoaudiologists, Pharmacists and Biologists.

Professionals of technician and elementary professional levels also participated from the research. The professionals of elementary level are supposed to possess the complete elementary education level, but it is not compulsory. Some of them have direct contact with the patient and receive training courses before starting their activities, as the auxiliary nurses. Other professionals of elementary level don't have a demand for specific formation, as the serving maids who work in the wards.

The professionals of technical level are those who reached the secondary education level. This last education level can admit a professionalisation. When it happens, the student is enabled for a specific activity, as the technical nurses, laboratory technicians, physiotherapist technicians, x ray technicians, etc.

Professionals of the administrative area were also selected to participate, these personnel possess different educational levels, that is to say: elementary, middle and higher, according to several functions of bureaucratic nature or support. Within these professionals we can mention engineers, system analysts (higher professional level); telemarketing operators, administration technicians, accountants, receptionists (middle professional level); lift operators, serving maids, cleaners (elementary professional level).

Considering the context of education in Brazil, we point out the difficulty for children in getting vacancy in schools, constant crisis concerning low salaries and formation of teachers, besides insufficient income of the majority of the population to maintain their children studying, as some of the problems we are not going to analyse here. Although it is compulsory, elementary level of education is not easily obtained either by children who live with their families nor by children who live in the streets. Elementary education is a right of the whole population but it has not got yet the desired accomplishment.

ANNEX 5
UNIVERSIDADE FEDERAL DO RIO DE JANEIRO
CENTRO DE CIÊNCIAS DA SAÚDE
NÚCLEO DE ESTUDOS DE SAÚDE COLETIVA
Research Protocol: "Workplace Violence in the Health Sector"

Dear worker,

It is a pleasure inform you that this unit was chosen to participate in a research that seeks to characterise the workplace violence to which the health sector personnel are exposed and to facilitate the development of effective strategies to minimise the violence and its consequences on those professionals' health.
The International Council of Nurses, the International Labour Office, the World Health Organization and the Public Service International are co-ordinating and sponsoring the project that will be accomplished in 7 other countries. The Centre of Studies of Collective Health (NESC) of Federal University of Rio de Janeiro is the responsible institution for its accomplishment in the city of Rio de Janeiro, under co-ordination of Dr Marisa Palácios.
This is a first contact to inform you that in the next two months our research team will be visiting your workplace requesting the collaboration of everybody. Each member of our team will be identified with an identification card with his/her name, the research title and the responsible institution (NESC-UFRJ). Only few employees (15 - 20%) of the unit will answer to the research questionnaire. We will select a random sample from the list of the health sector personnel in this unit. Those 15% will be requested to answer the research questionnaire. As the work in the health sector is teamwork, we are requiring the collaboration of everybody to guarantee 30 minutes for the sampled personnel to answer the questionnaire.
The research project was evaluated by the Ethics Committee on Research of NESC and obtained the approval. In case you need more information, please contact us on the telephone - 99975677 (Marisa Palácios) or 25626224 / 25626223.
The participation in the research is entirely volunteer; you will only answer the questionnaire if you agree with the research protocol. You won't be annoyed if you don't want to participate. We inform also that the participants won't be identified and everybody can be absolutely sure that no name will be linked to any questionnaire guaranteeing total secret of the rendered information. No name in any moment it will be disclosed.
This research will bring more information about the violence, its consequences and its determinants in the health sector. Besides, we hope that the research outcomes can aid each health facility and the competent authorities on the elaboration of programs to minimise the occurrence of violence and its damages on physical and mental health.
The team would appreciate to do a presentation and a discussion of the outcomes of the research in your unit.
Thank you very much.

Respectfully,

_____
Dr. Marisa Palácios
Research Coordinator(CRM/RJ-52-42010-5)
(Matr.UFRJ: 0136405)

ANNEX 6

FOCAL GROUP DESCRIPTION:

Material collection was performed in October-November 2001.
A4.1) Healthcare workers
A4.1.1) Elementary level (waitresses, watchmen, elevator operators, boiler technicians).

- *Definition of violence: Asked what violence is to them, the answers were:*

- Poor or insufficient medical and social care for employees;
- Salary: references to hard access to private healthcare / immediate access to health services; good nutrition; decrease in quality of life;
- Violence "with words" (psychological), specially among colleagues and senior levels;
- Violence due to "lack of communication" (psychological), specially among colleagues and senior levels;
- Discrimination background in work relations, higher incidence of situations that indicate class discrimination;
- Other types of discrimination (psychological): patronizing;
- Understanding of theft (both of public assets and personal belongings) as "physical" violence, based on reports of emotions involved;
- Violence "outside" (government neglect for maintenance, quality of food offered, salaries and work conditions; public healthcare privatization).

The following were identified as the main problems:
Hospital assault by individuals carrying firearms, thefts and robbery;
Bullying due to supposed patronizing.

A4.1.2) *Secondary level (X-ray technicians, nurse assistants and technicians, for example)*

Concept of violence
Workload: rates, daily hours, shifts, absences;
Verbal abuse by patients and parents (and/or escorts);
Physical aggression by patients/ escorts (story of a slap on a nurse's face);
Aggressions by colleagues (smoking inside rooms without windows);
Feeling of insecurity and fear inside the hospital: fear of possible armed patients; fear of verbal abuse turning into physical violence;
Verbal threats and threat of physical violence;
Armed robbery and bladed weapons (knives and similar weapons) when leaving the hospital: stories of aggression against colleagues and patients, with occurrence of wounds and death.
deficiencies in medical/ social care.
The following were identified as the main problems:
Physical aggression by patients and escorts, resulting in fear of aggression with firearm;
Verbal abuse by patients and escorts.

A4.1.3) *Tertiary level (1 physician, 1 psychologist, 1 social assistant, 1 physiotherapist, 1 nurse and 1 nutrition expert)*
Definition of violence:

Institutional violence: associated with work relations, both between colleagues and patients; there is no consensus about the consolidation of interdisciplinary work inside the hospital; e.g. discrimination among professionals: power relations; threats by patients: "The patient arrives already armed with his condition"; different frustrations for each category; lack of commitment with the patient; need of higher tolerance with

patients; healthcare service network doesn't work for reference and counter-reference; need to increase number of employees; increased demand;
External insecurity (quick kidnapping);
Life condition of patients, suffering, privation;
Salary policies
Work overload for nurses and other non-physician professionals: “nurses work unhappy”; social assistant highlights diversity of activities and impact on quality.
A formal support network to solve violence issues does not exist. E.g.: hospital magistrate – only for patients and not for employees. However, employees are too submissive by not complaining.
In the physician's opinion, the communication channel works better in the wards than in any hospital. This, however, is not unanimous, as stated by the physiotherapist: "It is not a common thing, the nursing staff facilitating communication in the team”.
Programs for treating specific illnesses, like the Diabetes Program, facilitate communication and can be seen as anti-violence mechanisms, since they are places where there is collaboration and the patient has higher respect.

Recommendation:
In the physician's opinion, a better salary is a way of being acknowledged
Ethical commitment by the workers
Enhanced formal channels
Enhanced exchange of information
The psychologist suggested employees were given training courses

A4.2) Health authorities

The State Secretariat of Health advisor for Violence Prevention was interviewed. Since this is a pioneer advisory board in Brazil and in Rio de Janeiro, its aim is to prevent violence and accidents of various types: domestic violence, violence against children and adolescents, against women and elderly people, as well as accidents in work and domestic settings.

There isn't a specific action dealing with violence in work settings in the health sector, neither there is information on the issue at state level. Violence incidents are usually identified locally and receive individual juridical counseling, when asked by the employee.

A4.3) Management (general and intermediate)

There was an effort to perform focal groups with hospital and healthcare center directors that took part in the confidential survey. However, after previously agreeing, the directors did not attend the group. It must be taken into account that the group was scheduled during a local healthcare service strike.

For an initial assessment of the problems faced by management levels, we will use a text written by researches at the Escola Nacional de Saúde Pública - National Public Health School (ENSP/FIOCRUZ/MS). The work done by the authors and presented in the text aims to “make it possible for managers to think about and explore their experiences on organizational dynamics, focusing specifically on change processes, uncertainty of results, the emotional, imaginary and unconscious dimensions within the organizations”. (Sá & Azevedo, 2001). We will highlight the perceptions and representations by public hospital directors on violence at healthcare work settings.

A feeling of "misgovernment and impotence" was identified, as well as difficulty to act as an authority;
Lack of control over the way the hospital works;

Lack of recognition by central levels;
Rejection by the management team;
Feeling of threat (of being replaced) due to the high level of political approach to public management;
Invasion of hospitals by criminals carrying firearms;
Physical and verbal threats to physicians caring not only for patients victims of social violence, but also due to the increasing demand in overloaded services;

As for intermediate management (Medical Division Directors, Clinical Directors or similar), the difficulty of finding people willing to accept these jobs due to the extreme devaluation of that management level was pointed out (Personal communication, Creuza Azevedo, 2001).

A4.4) Judge

An interview with a judge was performed. Following is a transcript of a few excerpts of the interview.

Excerpt 1:
"...I never judged a case of violence between employer and employee, though there indeed is a *very high hostility between them, when they arrive at the hearing, one hates the other, but because the other did not pay what he had a right to get, and because of that he is hungry, he faces hardships, he stops getting paid, cannot pay the rent, his bills, so he arrives wanting to kill the boss, but not really, only with a lot of anger, that's all. We don't hear about one hitting the other."*

Excerpt 2:
"we could talk of psychological violence, I think it applies more to the countryside in Brazil, in the northeastern region, even in the south we hear about what could be considered slave work, that still exists, that is, we call it (inaudible), which is almost a (inaudible)..."

Excerpt 3:
"...a lot of drought, people working day and night, like contracted farm workers, children working with toxic agents, violence not only in the sense of a threat, of having to work, like the workers who are not capable of leaving a farm, work day and night, don't earn a thing and think they owe the boss."

Excerpt 4:
"...I judged cases of that, one of them from De Millus company, I can't remember the person very well, she was a sewing woman, putting fasteners in De Millus' bras, and was constantly called stupid for being of a class that doesn't need to read or write, semi-illiterate, they only need skills on the machine, they don't even have to know how to sew, and they have to complete a lot of pieces every minute, since production is very high, and they are called stupid, idiot, you are not able to produce so there is a lot of this, specially in lower classes, so the lower the cultural level, the higher is, let's put it this way, the humiliation he has to face..."

Excerpt 5:

"... because now we work with sectors where it is very easy to steal, what happens is that in security companies men have to work absolutely naked under the uniform, no shorts or underwear, only the uniform, the socks and the boots, so as not to be able to hide the money they deal with, and then they have to undress in one room and get their clothes in another room to be able to leave...".

A4.5) Health Legislative Commission

About violence affecting healthcare workers:

"We are treating violence against healthcare workers. There are many types of violence, when speaking of Rio de Janeiro ..."

1 – *"The healthcare worker is the individual working with the product of violence, all types of violence end up in the hands of the healthcare worker... Healthcare workers that work in emergency sectors are often threatened by people linked to drug dealers, someone who is in detained, handcuffed in the wards, they suffer in the wards, all kinds of violence for being treating violence, the product of violence."*

2 – *"Besides that, violence is present in the work of healthcare workers, he has no guarantees of his future, lives in tremendous stress. There isn't a single doctor, specially a nurse that a know of, working in emergency services, that hasn't been in a situation where a person arrives, someone who's been in a car accident, and the worker runs to see if it's someone in his family."*
"Nowadays we don't have a salary and career plan, a normal career, we know that in a while, for some reason, we'll be retiring, if we get to the age, if we don't die from violence before that, and, retiring, we'll be exposed to a new type of violence, of surviving with retirement income."

3 – *"Another kind of violence is suffered by people who work in healthcare units, in a basic healthcare unit, you work inside a community where firefights constantly take place. Some workers have come here, to the Assembly, to complain, because they were kidnapped from inside their own work places, ... , the director of Rocha Faria Hospital was murdered when going home from work ... the Union leaders Edna and her husband were murdered because they defended healthcare workers. So what we have are various levels of violence."*

About violence concepts used in the research:

"I totally agree, there are many threats. Sometimes you suffer a violent aggression by the person you report to, but that is not written down [there are no records on it]."
"Today, for example, exactly in November 2001, we are living a moment of fight for better salary and work conditions in Rio de Janeiro ... Healthcare professionals suffer a hidden and conjured violence."

About legislative contribution to lower violence levels in the health sector.

"... there aren't any discussions about this, generally, in the legislative area. Some people linked to healthcare areas have this concern. We are ... calling for a better work on violence, we prepared a law project about custody inside hospitals. They were cancelled, it's true, but still those patients are not sent to penitentiary hospitals. The legislative power can also act for better income division, to lower social exclusion levels, and with a few projects that can help healthcare workers".

"We are trying to discuss a salary/ career plan as a way to decrease violence. That means acting, turning incidents that are not of compulsory notification, like cases of aggression against women, against healthcare workers, all of this is part of the legislative agenda. "

"For example, when I was director of a Hospital, I made an administrative change, in which every punishment for senior workers had to go through the evaluation of the employee association, and that caused an uproar in the hospital, because even tertiary level professionals in the commission itself did not want their internal juridical problems to be discussed or assessed by workers of secondary / elementary levels."

About the existence of some kind of support for physical or psychological violence victims in work settings

“That is something left out of the agenda, it doesn't exist! I don't know of it!”

Suggestion for actions.

“... a lot of times it seems there are aggressions we cannot see, I think the path would be to deepen these discussions in all sectors, starting with the public service, where it is easier to happen”.

About the existence of institutional measures to fight physical or psychological violence.

“No, I can't see that happening, there isn't a political will to do this.”

Suggestions of strategies to fight violence

We have to discuss this again through a program, for example, work medicine, even this area faces hard obstacles to do this, I think we have to reopen the discussions in work settings based on what this physical or psychological violence means, they are so many times left aside, I think the big change would be if people would fight for their rights, if everyone could discuss this, in meetings, congresses, at work, like a psychological CIPA, specially because people don't know they are suffering violence. If we don't make them wake up and see what is going on, something that only an Executive Act can solve, the aggressors won't want to do it and the people suffering the aggressions don't know they are suffering. To put this forward for daily discussion in work settings is important.