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Gender-violence against the female nursing staff of a Brazilian hospital in São Paulo City

ABSTRACT

OBJECTIVE: To estimate the occurrence of psychological, physical and sexual violence among female nursing staff.

METHODS: This is a cross sectional study, conducted with a sample of 179 professionals (50 nurses and 129 nursing aides / nurse technicians) in a general hospital in the municipality of São Paulo, Southeastern Brazil, 2005-2006. A validated questionnaire was applied in face to face interviews with these professionals, conducted by trained interviewers. Psychological, physical and sexual forms of violence were addressed, involving both male and female aggressors who were classified as: intimate partners, family members and other aggressors such as acquaintances and strangers. A descriptive analysis was undertaken, in which the frequency of the occurrence of the different types of violence was calculated with a 95% confidence interval.

RESULTS: The most frequent form of violence was intimate partner violence (63.7%; 95% CI: 55.7;70.4), followed by violence perpetrated by others (45.8%; 95% CI: 38.3;53.4) including patients and people accompanying them, colleagues within the field of health, head nurses, acquaintances and strangers. Family members occupied the third place as aggressors, (41.3%; 95% CI: 34.0;48.9), and the majority of these were fathers, brothers, uncles and cousins. In general, the nursing staff did not seek help frequently when acts of aggression occurred: only 29.7% of those who suffered intimate partner violence; 20.3% whose aggressors were others and 29.3% whose aggressors were family members sought help. Those who did not perceive their experience as a form of violence represented 31.9% of the subjects interviewed.

CONCLUSIONS: The rates of gender violence among female health professionals were important, particularly with respect to violence committed by intimate partners and family members. However, the proportion of these women who sought help was low, considering the fact that this group has a significant educational level.

DESCRIPTORS: Nurses, psychology. Women, Working. Spouse Abuse. Battered Women. Violence Against Women. Domestic Violence. Cross-Sectional Studies.

INTRODUCTION

Violence against women has been considered an important public health and social issue.[8] It is also denominated "gender violence" because it is based on asymmetric power relations between men and women, in which women frequently find themselves in a subordinate situation.[17,21] The most common form

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of gender violence is committed by intimate partners.[a] It is estimated that 20% to 50% of the women in the entire world suffer from physical and/or sexual violence by their intimate partners or companions at least once in their lifetimes.[9]

In Brazil, a multicentric study conducted by the World Health Organization (WHO) revealed the following prevalences[7,19] for 2,128 women from 15 to 49 years: physical and/or sexual violence by an intimate partner at least once in their lifetimes was reported by 29.0% in São Paulo (SP) and by 37.0% in the *Zona da Mata* of Pernambuco (PE), a region with both urban and rural areas in the Northeast of Brazil. The proportion of physical violence by other aggressors was lower (21.0% in Sao Paulo and 13.0% in the *Zona da Mata*), being that the majority of these aggressors were members of the family.

Venturi et al[23] (2004) found rates of 27.0% for psychological violence, 33.0% for physical violence and 13.0% for sexual violence among 2,502 women, 15 years of age and older, in 24 Brazilian states.

Among the main risk factors for violence against women, Jewkes et al[12] (2002) point out: masculine behaviors of control; higher schooling of women, making them critical of male oppression; social stereotypes of men and women based on sexual differences. According to this author, personal experience of violence during childhood or the experience of a close friend or relative may stimulate the reproduction of violent behavior in adult life; other factors stimulating the reproduction of violent behavior would be poverty, besides alcohol and illicit drug abuse.[12]

The repercussions of Intimate Partner Violence (IPV) have been investigated with respect to women's mental, physical, sexual and reproductive health. It may cause stress, fear, physical traumas, gynecological problems and even fetal and maternal mortality.[2,20]

The World Health Organization (WHO)[14] and the Pan-American Health Organization (PAHO)[b] have demonstrated their concern with the issue, given that gender violence has a negative impact on the mental, physical, sexual and reproductive health of women. Approaching the issue of violence against women is becoming the competence of health professionals, for health services are frequently sought out by victims of this type of violence.[24]

Some studies indicate the strategic position of nurses and the nursing staff in dealing with the issue. It is contended that the majority of these professionals are females[6] and that they are the first to approach victims of violence within the health services.[4,18]

Victims of violence tend to sub-inform violence due to their fear of the aggressor, social shame, economic dependence, impunity, lack of specialized services and because the situation they are experiencing is not recognized as violence.[20,c] The difficulty health professionals manifest in dealing with these cases may be related to their own experiences with this type of violence.[10,18,22]

Studies have indicated the occurrence of IPV among nursing professionals. Janssen et al[11] (1998) in a study involving 198 obstetric nurses working in a Canadian hospital, found that 26.9% reported having suffered psychological violence, 14.6% reported they had suffered physical violence and 8.1% sexual violence. According to the authors, the rate of violence committed against these nurses by an intimate partner at least once in their lifetimes (38,0%) was higher than the rate of IPV reported by Canadian women in the population at large (29,0%). Díaz-Olavarrieta et al[5] (2001) identified among 1,150 nursing professionals (283 nurses and 867 nursing aides / nurse technicians) working in Mexican hospitals, that the rates of psychological violence were 40.0% and of physical and/or sexual violence were 14.0% (164).

Violence experienced by health professionals is still not widely investigated throughout the world, thus contributing towards the reproduction of an idealization according to which these professionals would be "immune" to their gender, constituting a gap in knowledge with respect to this issue. The objective of this study was to estimate gender violence experienced by nursing staff, characterizing the aggressors, the attempt to find assistance and how violence was perceived by the victim.

METHODS

This is a cross-sectional study conducted between 2005 and 2006, with nurses and nursing aides/ nursing technicians working in a general hospital within São Paulo City.[d] The sample size was calculated, based on a population of 499 nursing professionals; the estimated prevalence of physical and/or sexual violence was 18.0%, based on a study concerning Mexican nurses, (Díaz-Olavarrieta et al[4] 2001), so as to detect a 5% va-

[a] World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva; 2005. [cited 2006 May 03]. Available from: http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

[b] Organização Panamericana de Saúde. Programa Mujer, Salud y Desarrollo. Modelo integral de atención a la violencia intrafamiliar: desconstruyendo la violencia intrafamiliar. San José, 2001 [cited 2005 Aug 23]. Available from: http://www.paho.org/Spanish/HDP/HDW/integratedmodelsp.pdf

[c] Schraiber LB, d'Oliveira AFPL. O que devem saber os profissionais de saúde para promover os direitos e a saúde das mulheres em situação de violência doméstica. 2.ed. 2003 [cited 2005 Feb 21]. Available from: http://www.mulheres.org.br/violencia/documentos/cartilha_violencia.pdf

[d] Oliveira AR. Violência de gênero contra mulheres profissionais de enfermagem de um hospital geral do município de São Paulo [Master's dissertation]. São Paulo: Faculdade de Medicina: da USP; 2007.

riation, with a 95% level of confidence (95% CI). The calculated sample obtained, including a 20% increase to account for eventual losses, was 187 professionals. The sample also contemplated the estimated prevalence of 20.5% obtained in a Brazilian populational study.[a]

Among the 187 nurses and nursing aides/nursing technicians allotted to participate in this study, three nurses were excluded. In two cases this was due to their refusal and in one case a maternity leave was the motive for exclusion. Likewise, five auxiliary nurses/ nurse technicians allotted to the study did not participate, either due to their refusal (three cases) or because they were on medical leave (two cases). Therefore, there were a total of eight exclusions and the final sample was revised for 179 professionals, being that 50 were nurses and 129 were nursing aides/ nursing technicians.

The study instrument contemplated sociodemographic variables;[b] episodes of violence; the attitude of seeking help and perception of the experience of violence.

The questions concerning violence were based on the instrument utilized by the "Multi-country study on women's health and domestic violence against women".[c] This instrument was granted by the Brazilian coordinators of the WHO multicentric study.[a]

Violence was approached in its psychological, physical and sexual forms, involving both male and female aggressors, grouped together as: intimate partners (by formal consensual unions or dating practices in the present or past), family members or relatives (except intimate partners), and other aggressors such as acquaintances (neighbors, colleagues, chiefs at the hospital) and strangers.

Due to the cultural subjectivity that perpassses this issue, particularly with respect to psychological violence,[14] the term "violence" was not utilized and the episodes were described by concrete acts, so as to increase this study's sensibility:

- psychological violence: insults, humiliation, intimidation or threats;
- physical violence: slap, push, shove, hit with a fist or something that can hurt, kick or beat, choke or use or threaten to use a gun, knife or other weapon against her;
- sexual violence: physically forced to have sexual intercourse, to have sexual intercourse when she does not want because she feels frightened or threatened and being forced to engage in sexual practices considered degrading or humiliating.

When at least one act of any form of violence above mentioned was reported by the interviewee, it was considered violence. Physical violence, occurring in intimate relations was classified as either moderate (slap, push, shove) or severe (punch, kick or beat, choke or use/threaten to use a gun, knife or other weapon).

Each episode of violence that occurred in the twelve months prior to the interview was explored with respect to its characteristics, frequency and the interviewee's perception of the event.

Violence committed by intimate partners and relatives was denominated "violence within intimate relationships". Particularly with respect to IPV, physical violence was considered moderate when, at least once in her life, the interviewee reported that she was slapped, an object was thrown at her, she was pushed, shoved, or shaken up and down and severe when she was punched, kicked, beaten, strangled, burnt, threatened or attacked with a gun, knife or other arms.[7]

During the interview, the act of seeking for help in dealing with the aggression and the places where it was sought were also registered. The perception of violence experienced by the women interviewed was measured, comparing the revelation of the episodes of aggression to the question, "do you consider that you have suffered violence at least once in your life?", that was posed directly after completing the part of the questionnaire dedicated to questions concerning violence.

The sample of 179 women was taken into consideration for all the variables except for those concerning intimate partnerships (frequency of IPV and search for help), in which case only those women who had had an emotional and sexual partnership at least once in their lives, 177 interviewees, were considered.

All data was digitalized in a 2.6 version of the FoxPro software, being double entered and the 13.0 version of the SPSS software was utilized in analysis. Descriptive analysis was conducted, calculating the frequencies of the types of violence with a 95% confidence interval.

Ethical concerns and procedures were present throughout the various phases of this investigation. During the pilot study, care was taken in order to find the best format and site for the interviews. Ethical concerns were also incorporated in the process of training the interviewers (a nurse and a psychologist), who both had previous experience with this theme. Anonymity of the institution and of the women interviewed was

[a] Schraiber LB, d'Oliveira AFPL, França-Junior I, Diniz CSG, Portella AP, Ludermir AB, et al. WHO: Multi Country Study on Women's Health and Domestic Violence Against,Women, Brazil. São Paulo: FMUSP; 2002. (Relatório de Pesquisa para a WHO)

[b] Associação Brasileira de Empresas de Pesquisa. Critério de Classificação Econômica Brasil. [cited Out 20 2005]. Available at: http://www.abep.org/codigosguias/ABEP_CCEB.pdf

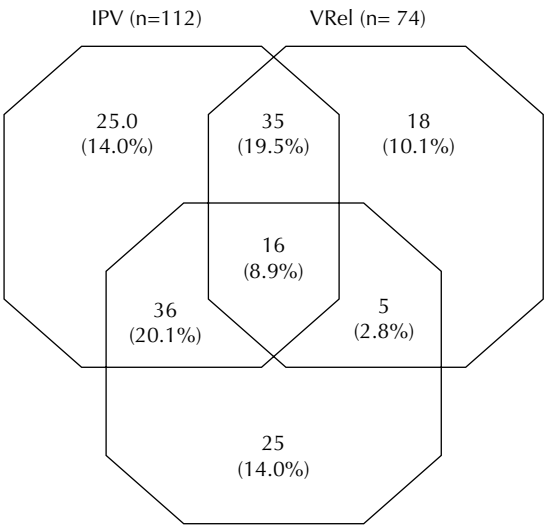
[c] World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva; 2005. [cited 2006 May 03]. Available from: http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

guaranteed and all participants read and signed a term of informed consent. Privacy during the interview was guaranteed as well as liberty to desist at any point. Support and professional assistance were offered to interviewees and it was granted to all who actually solicited it. All women interviewed received a Mini-guide of the Referral Services that attend women experiencing situations of violence in the municipality of Sao Paulo.

This study was approved by the Research Ethics Committee of the School of Medicine of the University of Sao Paulo and its medical center (CAPPesq-320/05) and by the Research Ethics Committee of the hospital where fieldwork was conducted, being register as CEP n. 572/05 in Aug/20/2005. Participants signed the Informed Consent Form, which followed the specific recommendations for research concerning violence against women.[a]

RESULTS

On Table 1, the sociodemographic characteristics of the women interviewed are presented. These women, who represent all sectors of the hospital, were, on the average, 37.6 years old (sd=9.9) and only four professionals had only completed junior high school or had not completed high school (eight to ten years of schooling). In 86% (154) of the cases, women were classified as pertaining to socioeconomic strata "B" and 72 (40.2%) declared they were the "head of their family". Some form of psychological, physical or sexual violence, either by intimate partners, relatives or other aggressors was reported by 160 (89.4%; 95% CI [83.9;93.5]) of the women interviewed.



IPV: Intimate partner violence
VRel: Violence by relatives
VO: Violence by other aggressors

Figure. Distribution of the sample according to types of violence to which they were submitted. Sao Paulo, Southeastern Brazil, 2005-2006. N=179

Table 1. Sociodemographic characteristics of the nursing professionals interviewed in the general hospital. Sao Paulo, Southeastern Brazil, 2005-2006. N=179

Sociodemographic characteristics	n	%
Age group (years)		
20 ├─┤ 29	54	30.2
30 ├─┤ 39	44	24.6
40 ├─┤ 49	53	29.6
50 ├─┤ 59	28	15.6
Educational level* (years of schooling)		
8 ├─┤ 10 (CJH and IHS)	4	2.2
11 (CHS)	114	63.7
12 ├─┤ 14 (ESI)	4	2.2
15 ├─ (CC)	57	31.8
Religion		
Catholic	76	42.5
Evangelical	44	24.5
Kardecism	24	13.4
Does not practice religion	32	17.9
Other	3	1.6
Socioeconomic stratum		
A	16	9.0
B	154	86.0
C	9	5.0
Marital status		
Living with a partner	103	57.5
Dating with sexual relationship	43	24.0
Exclusively affectionate partnership	1	0.6
Does not have a affectionate-sexual partner	32	17.9
Perception of head of the family		
She is the head of the family	72	40.2
Her companion is the head of the family	37	20.7
She and her companion are the heads of the family	37	20.7
Another person is the head of the family	33	18.4

* CJH: complete junior high school; IHS: incomplete high school; CHS: complete high school; IC: Incomplete college; CC: complete college

[a] World Health Organization. Putting women's safety first: ethical and safety recommendations for research on domestic violence against women. Genebra/Programme in evidence for health policy. Publication WHO/EIP/GPE/99.2, 2003

IPV was referred by 112 (63.7%; 95% CI[55.7;70.4]) interviewees and the rates of the different forms of violence and the period when it occurred are indicated on Table 2. Psychological violence was the most frequent form of violence both during the lifetime and in the 12 months prior to the interview, being reported in a total of 105 cases (59.3%). One in every three (33.3%; 59) women reported having suffered physical violence at least once in their lifetimes, being that the severe form of violence was more frequent (54.2%; 32), among the victims of physical violence. Sexual violence, considered severe in all its expressions, was referred by 50 (28.2%) women, being that 41 (23.2%) were reports of forced sexual intercourse.

As to the forms of IPV, the majority experienced these aggressions more than once in their lives: psychological violence (87; 82.9%), physical (37; 62.7%) and sexual violence (45; 90.0%). Reports of the occurrence of the three forms of violence in the 12 months prior to the interview were less frequent.

Thirty three women (29.5%; 95% CI[13.2;25.2]) sought some form of help when they were confronting IPV: 15 (45.5%) sought the police, 11 (33.3%) sought psychological support, 6 (5.4%) sought support from the family and one (0.9%) the hospital itself. There was one loss with respect to this question. Seventy eight women interviewed did not seek any service or any form of assistance when faced with the offense experienced. Among the latter, 19 (24.3%) stated they desired to seek some form of assistance. The kind of support most desired was psychological support, identified by 13 (68.4%) of them. Fear of exposure, lack of time and financial limitations were reported as obstacles to seeking help.

Violence by relatives was reported by 41.3% (74; 95% CI[34.0;48.9]) of the interviewees (Table 3). Psychological violence was the most frequent form identified (54; 30.2%), followed by physical (42; 23.5%) and sexual violence (17; 9.5%). The psychological and physical grievances were recurrent for almost half of

Table 2. Forms of violence by intimate partner experienced by nursing professionals (multiple answers), aged 20 to 59 years, interviewed in a general hospital. Sao Paulo, Southeastern Brazil, 2005-2006. N=179

Form of violence	During their lifetime		In the year before the interview
	n (%)	95% CI	n (%)
Psychological			
At least one episode of psychological violence	105 (59.3)	52.0;67.0	23 (13.0)
1- Has he insulted you or made you feel bad about yourself?	80 (45.2)	37.7;52.8	
2- Has he belittled or humiliated you in front of other people?	57 (32.2)	25.4;39.6	
3- Has he done things to frighten or intimidate you on purpose?	69 (39.0)	31.7;46.6	
4- Has he threatened to hurt you or someone you care about*?	55 (31.2)	24.5;38.6	
Physical			
At least one episode of physical violence	59 (33.3)	26.4;40.8	5 (3.0)
1- Has he slapped you or thrown something at you that could have hurt you?	38 (21.5)	15.7;28.2	
2- Has he pushed or shoved you?	49 (27.7)	21.2;34.9	
3- Has he punched you or hit you with some other object that could hurt you?	16 (9.0)	5.2;14.3	
4- Has he kicked you, dragged you or beat you up?	16 (9.0)	5.2;14.3	
5- Has he choked or burnt you on purpose?	6 (3.4)	12.5;7.2	
6- Has he threatened to use or actually used a gun, knife or other weapon against you?	23 (13.0)	8.4;18.8	
Sexual			
At least one episode of sexual violence	50 (28.2)	21.7;35.5	4 (2.2)
1- Has he physically forced you to have sexual intercourse when you did not want to?	41 (23.2)	17.2;30.1	
2- Did you ever have sexual intercourse when you did not want to because you were afraid of what he might do?	37 (20.9)	15.2;26.6	
3- Has he forced you to do something sexual that you found degrading or humiliating?	32 (18.1)	12.7;24.5	
Physical and/or sexual violence	78 (44.1)	36.6;51.7	8 (4.5)

* Valid for 176 women interviewed

Table 3. Forms of violence by relatives and other aggressors experienced by nursing professionals in a general hospital. Sao Paulo, Southeastern Brazil, 2005-2006. N=179

Forms of violence	Violence by relatives			Violence by other aggressors		
	During their lifetime		During the year before the interview	During their lifetime		During the year before the interview
	n (%)	95% CI	n (%)	n (%)	95% CI	n (%)
At least one episode of violence by relatives	74 (41.3)	34.0;48.9	28 (15.6)	82 (45.8)	38.3;53.4	38 (21.2)
Psychological						
Has any other person insulted, belittled or humiliated you or made you feel bad about yourself at any time in your life?	54 (30.2)	23.5;37.5	21 (11.7)	68 (38.0)	30.8;45.5	33 (18.4)
Physical						
Has any other person hit you, slapped, kicked or hurt you physically or in any other way?	42 (23.5)	17.5;30.4	7 (3.9)	19 (10.6)	6.5;16.1	5 (2.8)
Sexual						
Has any other person forced you to do something sexual against your will?	17 (9.5)	5.6;4.8	0 (0)	7 (3.9)	1.6;7.9	0 (0)

the women that reported them, 48.1% (26) and 50.0% (21), respectively. Although it was less frequent, sexual violence, when declared, occurred more than once in a lifetime for 64.7% (11) of the women who reported it.

The episodes were not recent, having taken place, in the majority of cases, prior to the year before the interview. Psychological violence occurred primarily after they were 19 years old (28; 51.8%), whereas the incidents of physical (66.7%; 28) and sexual violence (82.3%; 14) reported occurred primarily until they had completed 15 years of age.

Father/brothers (men) were the principal aggressors for psychological (37.0%; 20) and physical (57.1%; 24) violence. As to sexual violence, other relatives were more frequently identified such as uncles/cousins (men) (10; 58.8%), however, father/brothers (men) also stood out as common aggressors (7; 41.2%).

Among the 74 interviewees that reported incidents of violence by relatives, 15 (20.3%) sought help: six (40.0%) sought psychological support, four (26.7%) sought help from a relative, one (6.7%) resorted to the police service and another four did not state what kind of support/service they sought out. Among the 59 women who did not seek for help, 18 declared they would have liked to have done so: 11 (61.1%) would have liked to have sought for psychological support, three (16.7%) mentioned the police service, three (16.7%) mentioned family support and one interviewee did not declare what kind of support or service she wished she had sought. Lack of time, feeling ashamed to tell someone about the experience, dismay or discouragement by close relatives, fear of retaliation by the aggressor were the primary reasons mentioned for not seeking help.

Almost half of the women interviewed (82; 45.8%; 95% CI[38.3; 53.4]) reported some incident of violence by other aggressors, as indicated on Table 3.

The episodes of psychological violence by other aggressors were the most frequent form of violence (68; 38.0%), as in the cases of IPV and violence by relatives. They occurred predominantly in the 12 months prior to the interview. However, almost half of the incidents (33; 48.5%) of psychological violence occurred the year before the interview. Aggressions were recurrent during their lifetimes for the majority of the women interviewed and with respect to the three forms of violence: psychological (50; 73.5%), physical (13; 68.4%) and sexual violence (6; 85.7%).

The main aggressors for psychological violence were, in the majority of the cases, male colleagues at work (27; 39.7%) and bosses (16; 23.5%), corresponding to 60.0% and 35.0%, respectively. The principal aggressors in cases of physical violence were patients and people accompanying the patients (9; 47.7%) and strangers (7; 36.8%); in cases of sexual violence these rates were (3, 42.8%; 4, 57.1%, respectively). Colleagues at work and bosses were not reported in any of the cases of physical and/or sexual violence by other aggressors.

Among the 82 women who reported psychological violence by other aggressors, 24 (29.3%) sought some service/support: 11 (45.8%) sought the institution in which they worked, five (20.8%) chose to seek the police service, three (12.5%) sought psychological support, two (8,3%) sought the *Conselho Regional de Enfermagem* [Regional Nursing Council] and one (4.2%) sought religious support. Two women did not reveal the source of support they sought. Nine of the 58 women who did not seek support stated they would have liked to have

done so: six (66.7%) stated they wished they had sought psychological support, two (22.2%) would like to have sought support from the institution where they work and one (11.1%) wished she had sought the police service. The motives for not seeking support were lack of time and fear of retaliation by the aggressor, both of which were also mentioned by women whose aggressors were members of the family. Financial limitations, a motive also mentioned by victims of IPV, was another explanation for not seeking help as well as fear of retaliation from the institution in which they worked.

The rates of overlap between IPV, violence by relatives and by other aggressors were important. Among the 112 women who reported some type of IPV, 52 (46.4%) also reported some form of violence by other aggressors and 51 (45.5%) stated they had suffered some form of aggression from a family member. Considering the entire sample, 16 (8.9%) of the women interviewed declared they had been victims of all three types of aggression (Figure).

Among the 160 (89.4%) interviewees that reported some act of aggression, 109 (68.1%) perceived it as violent. The lowest rate of perception of the act experienced as violence occurred among the women who reported incidents of violence by other aggressors (56; 68.3%). Among the interviewees who replied affirmatively to any of the questions concerning IPV, the perception of the incident experienced as violent was 71.4% (80). For the reported acts of aggression by relatives, 78.4% (58) perceived these as violent.

DISCUSSION

This is the first study in Brazil to approach the theme of gender violence among female nursing professionals. Its potential limitations are the subjectivity surrounding the definition of violence and disclosure bias. Violence, particularly of a psychological order, has a polysemic character, that is, it may assume different meanings depending upon the cultural context of a specific social group.[14] For this reason, the women interviewed were asked objectively about their experiences in this respect, by reference to situations and concrete acts,[14] by means of a questionnaire culturally adapted to Brazil.[a]

As to disclosure, studies have indicated that experiences of violence tend to be underestimated because of difficulties with this respect, since it is a stigmatizing situation, involving shame and fear.[8,9] In this sense, in order to diminish this bias, some ethical and methodological concerns guided the development of this study[b] that are indispensable when approaching women who are living in a situation of violence.

The exclusion of professionals that were on medical leave for a period greater than 15 days may have contributed towards a reduction in the frequencies of violence. In thesis, these professionals would have a greater probability of suffering from violence, since the latter is associated to health problems.[2,9]

The rates of IPV found in the present study are consistent with those found in other national and international studies, presenting similarities, and, in some cases, even higher proportions of violence. However, cultural differences, distinctions in the samples as well as similarities with respect to the instrument utilized in each study should be taken into consideration.

In relation to women in the population at large, the frequency of physical and/or sexual violence (44.1%) presented itself within the limits found by Heise et al[9] (1999). Also, in comparison to Brazilian data,[23,c] the rates of physical/sexual violence and the isolated forms of violence were greater among the nursing professionals from São Paulo.

A possible explanation for this fact is that the greater autonomy of women, based predominantly on work and more years of schooling may threaten the traditional hierarchy of gender, in which men detain greater power than women.[12,a]

When compared to international studies,[5,11,13] particularly among nursing professionals, the rates of intimate partner violence are frequently higher among the professionals from São Paulo. The rate of physical/sexual violence found in this study is more than twice the estimated prevalence utilized in Mexico (18.0%).[5] However, in that study, self-administered questionnaires were utilized whereas in this study a face to face technique was employed. Furthermore, Mexican women may present greater difficulty in verbalizing IPV due to fear of social retaliations.[1]

Violence by relatives presented high rates, particularly with respect to physical and sexual violence during childhood, which may contribute to a greater vulnerability towards IPV in adult life.[3,12,b]

The expressive masculine participation in this type of violence is also indicated by WHO[c] (2005) and reinforces the perception that this is a form of gender

[a] Schraiber LB, d'Oliveira AFPL, França-Junior I, Diniz CSG, Portella AP, Ludermir AB, et al. WHO: Multi Country Study on Women's Health and Domestic Violence Against,Women, Brazil. São Paulo: FMUSP; 2002. (Relatório de Pesquisa para a WHO)

[b] World Health Organization. Putting women's safety first: ethical and safety recommendations for research on domestic violence against women. Genebra/Programme in evidence for health policy. Publication WHO/EIP/GPE/99.2, 2003.

[c] World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva; 2005. [cited 2006 May 03]. Available from: http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf

violence, since men are the main aggressors and women their primary victims. Despite the fact that a large part of the episodes of IPV occurred in the 12 months prior to the interview, their possible sequels may endure for years.

Violence by other aggressors represented the second largest rate of violence. The working environment was the principal *locus* of psychological violence committed, mainly, by colleagues, chiefs, and patients/patients' relatives or friends accompanying them.

Nursing professionals are particularly vulnerable to violence in the working environment, above all in hospital services.[15,16] Their direct and continual interaction with patients and the fact that most professionals are women may contribute towards the greater risk of aggression.[15,16]

In general, nursing professionals were not immune to situations of violence; on the contrary, within the municipality of Sao Paulo, higher rates of violence were found among them than in the female population at large, as occurred in Canada as well.[11] It is possible that the ethical and methodological procedures taken in this study, including the fact that a nurse conducted most of the interviews, contributed towards a higher rate of disclosure.[a]

The rate in which help or support was sought was low (29.7% in IPV; 20.3% in violence by relatives and 29.3% in violence by other aggressors). In IPV, when psychological, physical and sexual violence are conjugated, the act of seeking for help was more frequent, in accordance with the WHO findings[b] (2005). Fear, shame with respect to the situation, and lack of time were the motives more frequently alleged for not seeking help in the three types of violence being studied, as other studies have also indicated.[c,d]

The lack of recognition of their own experience as violence varied from 21.6% for violence by relatives to 31.7% for violence by other aggressors. Daily violence by close relatives during childhood and by intimate partners in adult life may have contributed to the naturalization and banalization of violence.

One of the conclusions of this study is that the nursing professionals investigated, make up a special group of women, for they occupy important positions in confronting gender violence. In the first place, as women, and, therefore, as possible victims of this type of aggression and also as professionals who care for others, suffering violence in their workplace. In addition, these experiences may have consequences in terms of the health of these professionals' health and may interfere with their work as caretakers as well.[10,18]

Janssen et al[11] (1998) consider that the opportunity to be heard and to voice their lived experiences may represent an important strategy in the management of violence experienced by nursing professionals.

Furthermore, it is vital to instrumentalize professionals with respect to this issue, by elaborating and implementing protocols geared towards integral and interdisciplinary care for clients who are victims of violence.

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[a] World Health Organization. Putting women's safety first: ethical and safety recommendations for research on domestic violence against women. Genebra/Programme in evidence for health policy. Publication WHO/EIP/GPE/99.2, 2003.
[b] World Health Organization. Multi-country study on women's health and domestic violence against women: summary report of initial results on prevalence, health outcomes and women's responses. Geneva; 2005. [cited 2006 May 03]. Available from: http://www.who.int/gender/violence/who_multicountry_study/summary_report/summary_report_English2.pdf
[c] Organização Panamericana de Saúde. Programa Mujer, Salud y Desarrollo. Modelo integral de atención a la violencia intrafamiliar: desconstruyendo la violencia intrafamiliar. San José, 2001 [cited 2005 Aug 23]. Available from: http://www.paho.org/Spanish/HDP/HDW/integratedmodelsp.pdf
[d] Schraiber LB, d'Oliveira AFPL. O que devem saber os profi ssionais de saúde para promover os direitos e a saúde das mulheres em situação de violência doméstica. 2.ed. 2003 [cited 2005 Feb 21]. Available from: http://www.mulheres.org.br/violencia/documentos/cartilha_violencia.pdf

REFERENCES

1. Altamirano RI. La violencia intrafamiliar: los mitos. *Rev Med* Guanajuato. 2000;10(1-2):206-9.
2. Campbell JC. Health consequences of intimate partner violence. *Lancet.* 2002;359(9314):1331-6. DOI: 10.1016/S0140-6736(02)08336-8
3. Christofides NJ, Silo Z. How nurses' experiences of domestic violence influence service provision: study conducted in north-west province, South Africa. *Nurs Health Sci*. 2005;7(1):9-14. DOI: 10.1111/j.1442-2018.2005.00222.x
4. Davidhizar R; Newman-Giger J. Recognizing abuse. *Int Nurs Rev*. 1996;43(5):145-150.
5. Díaz-Olavarrieta C, Campbell J, Cadena CG, Paz F. Prevalence of intimate partner abuse among nurses and nurses'Aides in Mexico. *Arch Med Res*. 2001;32(1):79-87. DOI: 10.1016/S0188-4409(00)00262-9
6. Donoso MTV. O gênero e suas possíveis repercussões na gerência de enfermagem. *Rev Min Enf*. 2000;4(1/2):67-9.
7. García-Moreno C, Jansen HAFM, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women's health and domestic violence. *Lancet.* 2006;368(9543):1260-9. DOI: 10.1016/S0140-6736(06)69523-8
8. Gelles RJ. Public policy for violence against women. *Am J Prev Med.* 2000;19(4):298-301. DOI: 10.1016/S0749-3797(00)00245-2
9. Heise L, Ellsberg M, Gottemoeller M. Ending violence against women. *Popul Rep*. 1999;27(4):1-44.
10. Henderson A. Factor influencing nurses' responses to abused women: what they say they do and why they say they do it. *J Interpers Violence.* 2001;16(12):1284-306. DOI: 10.1177/088626001016012004
11. Janssen PA, Basso MC, Costanzo RB. The prevalence of domestic violence among obstetric nurses. *Womens Health Issues*. 1998;8(5):317-23. DOI: 10.1016/S1049-3867(98)00023-1
12. Jewkes R, Levin J, Penn-Kekana L. Risk factors for domestic violence: findings from a South: African cross-sectional study. *Soc Sci Med*. 2002;55(9):1603-17. DOI: 10.1016/S0277-9536(01)00294-5
13. Kim J, Motsei M. "Womem enjoy punishment": attitudes and experiences of gender-based violence among PHC nurses in rural South Africa. *Soc Sci Med.* 2002;54(8):1243-54. DOI: 10.1016/S0277-9536(01)00093-4
14. Dahlberg LL, Krug EG. Violence: a global public health problem. In: Krug EG, Dahlberg LL, Merc JA, Zwi AB, Lozano R, editors. Report on violence and health. Geneva: World Health Organization; 2002. p.1-21.
15. Love CC, Morrison E. American Academy of Nursing expert panel on violence policy recommendations on workplace violence. *Issues Mental Health Nurs.* 2003;24(6/7):599-604. DOI: 10.1080/01612840305318
16. McPhaul K, Lipscomb J. Workplace violence in health care: recognized but not regulated. *J Issues in Nurs* [Internet]. 2004;9(3) [citado 2008 ago 3]. Disponível em: http://www.nursingworld.org/MainMenuCategories/ANAMarketplace/ANAPeriodicals/OJIN/TableofContents/Volume92004/Number3September30/ViolenceinHealthCare.aspx
17. Saffioti HIB. Gênero, patriarcado, violência. São Paulo: Fundação Perseu Abramo; 2004. (Coleção Brasil Urgente)
18. Schoening AM, Greenwood JL, McNichols JA, Heermann JA, Agrawal S. Effect of an intimate partner violence educational program on the attitudes of nurses. *J Obstet Gynecol Neonatal Nurs*. 2004;33(5):572-9. DOI: 10.1177/0884217504269901
19. Schraiber LB, D'Oliveira AFPL, França-Junior I, Diniz S, Portella AP, Ludermir AB, Valença O, Couto MT. Prevalência da violência contra a mulher por parceiro íntimo em regiões do Brasil. *Rev Saude Publica*. 2007;41(5):797-809. DOI: 10.1590/S0034-89102007000500014
20. Schraiber LB, d'Oliveira AFPL. Violência contra mulheres: interfaces com a saúde. *Interface (Botucatu)*. 1999;3(5):11-26.
21. Scott, JW. Gênero: uma categoria útil para análise histórica. *Educação e Realidade*.1995;20(2):71-100.
22. Thompson RS, Rivara FP, Thompson DC, Barlow WE, Sugg NK, Maiuro RD, et al. Identification and management of domestic violence: a randomized trial. *Am J Prev Med*. 2000;19(4):253-263. DOI: 10.1016/S0749-3797(00)00231-2
23. Venturi G, Recamán M, Oliveira S. (orgs) A mulher brasileira nos espaços público e privado. São Paulo: Editora Fundação Perseu Abramo, 2004.
24. Watts C, Zimmerman C. Violence against womem: global scope and magnitude. *Lancet*. 2002;359(9313):1232-37. DOI: 10.1016/S0140-6736(02)08221-1

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