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Public health program based on the evidence of nursing for prevention and assistance of gender-based violence in collaboration with specialized personnel and community members.

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Synopses

Background: In Venezuela community health nursing directs its care actions toward individuals, families and community. During these encounters and consultation gender violence is observed in women clients of university health centers. However cultural values, lack of guidelines and training in nursing staff represent an obstacle for prevention and assistance of the problem.

Objective: To explore opinions about gender violence in nursing staff and members of the community.

Method: The study was carried out with a qualitative design using semi-structured interviews and focus group discussion in Valencia, Carabobo State, Venezuela. The participants were selected by convenience sample n=7 nurses of two primary health centers of Carabobo State University and n=72 women clients of these centers. The interviews and focus group discussions were recorded, transcribed and afterwards /stored in the software Atlas ti version 6.2. Discourse analysis was used for the interpretive process.

Results: Meaning of gender violence was a significance category and became very obvious as values of traditional gender model guided the nursing practice and women life. In comments were repetitive the perceptions of gender violence as normal behavior into familiar relation. It was verified that (43%) nurses and (47%) women clients of university health centers were victims of any kind of gender violence during their life. In matter of assistance and prevention of gender violence from university health center was obvious lack of training in nursing staff and absence of guidelines to nursing intervention. Nurses confirmed that most of cases detected keeping without registration in medical history form. Suggestions in matter of gender violence assistance from women clients of university health centers were included.

Conclusion: Is necessary carry out quantitative studies to know prevalence of gender violence, as well as their clinical and socio-demographic characteristics. To prove the validity and effectiveness of the proposed intervention model through its implementation in university health centers.

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1. Background

Historically the conception in which male gender is related to force and power and female gender to weakness and submission based on religious, familiar, social and cultural arguments led to copying behaviors in which women's health and dignity have been compromised. Over the time gender violence remained invisible and was taken as something natural. It was not until 1993 through of a pronouncement about the Elimination of Violence against Women where "gender violence was classified worldwide as public health and human rights problem" (Velzeboer et al., 2003). This pronouncement was a catalyst for what different nations observed the problem of gender violence and initiated to working out policies that contribute to a treatment applied under the principles of equity, independence, autonomy and respect toward women. In the same document the United Nations Organization (UNO) defined gender violence as:

> "Any act of gender-based violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (UNO, 1993).

The most important elements stated in this definition are related to all those ways in which a relationship of power is imposed and persisted, where women's submission to the male gender is increased, revealing the different harms that can be caused to women, from restrictions on citizenship exercise to death. This circumstance not only affects the women themselves but also endangers the healthy development of their children. Regardless of the opening showed by organizations and governments of the world, changing a patriarchal conduct of thousands of years has been a hard task. Nowadays women in different cultures around the world are still victims of gender violence and other kinds of discrimination. In this sense, worldwide statistics that show the situation of gender violence from epidemiological point of view are used. Some significance findings were obtained from the world report on violence and health realized by World Health Organization (WHO):

> "One out of every three women has been beaten, coerced into sex or abused in her lifetime and that anywhere from 10 to 69 % of surveyed women mentioned to have been physically assaulted by their partner at some point of their lives. Also, available data suggest that in some countries one in four women report sexual violence by an intimate partner, and up to one-third of girls report forced sexual initiation. Hundreds of thousands more are forced into prostitution or subjected to violence in other settings, such as schools, workplaces and health care institutions." (Krug et al., 2002).

Regarding femicides in general, the third International report partner violence against women -statistics and legislation- performed in 2006 contains data from 44 nations, in this study was reported:

> "The country ranking by number of women killed per million women in 2006 indicated that the countries with the highest prevalence rates are those from Central and South America: a) 129,43 in El Salvador; b) 92,74 in Guatemala; c) 51,32 in Lithuania; d) 49,64 in Colombia; and e) 434,64 in Honduras" (Sanmartín et al., 2010).

The results showed that in Latin America women death for violence against women more than others countries participants in the study. It could suggest inefficiency of services concerning health, legal and social protection to solve the problems that have to do with women. Additionally, in Latin America and the Caribbean was analyzed in a comparative study with the data from twelve countries. This research showed the following results about gender violence:

> "Among 17-53% of women ever married or in union reported ever experiencing physical or sexual violence by an intimate partner. Moreover, in all countries, a majority of women who experienced physical violence in the past 12 months also reported emotional /abuse, ranging from 61- 93%" (Bott et al., 2013)

It is a reality that in Latin America prevail a beliefs system where women, in this conception, are devalued by making her target of physical, emotional, psychological abuse, in addition to impediment to free participation in social, economic and political life of the communities. Evidences of the problem in Venezuela showed during 2008 that "the district attorney's office received 101.705 reports and in the first quarter of 2009 the received reports were 22.606" (Álvarez, 2008). The cases contain threats and psychological, physical, sexual, emotional, financial and patrimonial damages.

However there is a low percentage of trials leading to women's physical integrity might be jeopardized, that turns Violence against Women into one of the crimes that has higher under-registration given to victim's fear to report. Moreover the same author affirmed:

> "It is known that only in the capital city of Venezuela two women die each ten days victims of violence, and 37 women, two of them pregnant, were killed in the first quarter of 2008" (Álvarez, 2008).

Even so, the information is not reliable since the commissioned institutions to publish do not publish or in public area they do not have updated statistical studies for their spreading. From political point of view, Venezuela signed in Beijing its adherence to the platform for actions to the development of women, assuming with it high-level commitments. This led to the activation of organizations and committees that started

the related tasks with: definition of integral public policies referring to violence towards women, “carrying out of studies on domestic violence, creation of free or low-cost integral services, legislation that adapts to International treaties, media awareness” (Ramirez and Mejías, 1999).

Such effort made possible the specification of very important achievements referring to legislation for the Control of gender violence over the past ten years. This is the case of the Fundamental Law on Women’s Right to a Violence-free Life (LODMVLV, 2007). There is evidenced a noticeable improvement in the legal framework for the protection of Women’s Rights, as not only physical violence in its different degrees but also a total of nineteen ways of gender violence against women were classed.

One of the big contribution of this law is that it specifies carefully all that what may cause a physical, sexual, psychological, emotional, labor, financial damage or suffering, arbitrary deprivation of liberty, as well as threatening to carry out such acts, furthermore, it contains in its principles innovative measures concerning to violence prevention, the treatment of abuse victims and punishment of aggressors. Despite of the intention to provide women protection and to satisfy international agreements, our country still shows problems to overcome violence against women. The country report Venezuela realized by Organization of Americans States (OAS) confirmed among the obstacles in gender violence is to visualize the problem since the country counts on very weak initiatives.

> “The report cannot provide a clear view of the problem of violence against women in the country as they only provide very general, without any data disaggregated by age, marital status, ethnicity, education level, and relationship with the perpetrator. Just let you know the number of complaints by type of violence, but not the end result i.e., processes, sentences handed, condemns the aggressor or dismissal” (OAS, 2012).

On other hand, the Ministry of Health has submitted statistical studies on attended cases of Domestic Violence, but they are not articulated nor systematized. Way beyond the no coordination of registered information, a limitation that impedes the problem visibility is the cultural silence of victims and society together. “This silence causes the normalization of the problem” (Álvarez, 2008). The present inflexibility in such roles in gender relation locates women in a situation of subordination that relative to violence disable them to react accurately determining their behavior by fear, shame, denial and feelings of guilt.

According to Bolivarian Gender Observatory there are normative and administrative mechanisms for “integrate assistance (legal, medical, psychological and social) to

victims and survivors of interpersonal, intra-familiar, extra-familiar and gender-sexist violence" (Ministry of Women, 2010) principally, in the field of sexual and reproductive health of women. Despite this in health team is evident lack of training and indifference. In this sense in a case study was mentioned "they see gender violence cases as outside the purview of their mission" (Guedes et al., 2002). Sample of this statement are the obtained results of a carried-out research in the Central Hospital of Maracay, Aragua State, where was proved that:

> "Among 90% of the asked obstetrics and gynecology residents were unaware of the Law of Women's Right for a Life free of Violence and 56% of the same asked group were unaware of the official regulation for the integrated assistance of sexual and reproductive health as well as the recommendations of the World Health Organization" (Silva and Torres, 2009).

About the community health nursing practice, in Venezuela this specialist staff directs its actions towards health promotion, illness prevention and study of risk factors in individuals, families, groups and communities. These actions include daily contact with the population through health services offered by primary health centers of the Carabobo University. During these encounters and consultation violence including gender violence was observed but the absence of register, lack of guidelines, lack of training and perception of gender violence as private problem represented an obstacle during prevention and assistance of gender violence. In this sense community health nursing should be trained because in the professional practice was evident that women have difficulty to admit that they are battered. In this respect during reviewing of Latin-American's literature was found:

> "The problem of violence corresponds to a structural problem that is expressed by behaviors and attitudes based on sexist beliefs that tend to emphasize the differences supported on gender stereotypes preserving control structures that are arisen from them" (Corsi, 2006; Sciortino and Guerra, 2009).

It is on this point where the problem of gender violence comes to be considered by women and for the rest of the society as something normal and unalterable. To carry out this study, it was decided to use as scenario two university health centers called Nuestra Señora de la Luz and El Concejo which identify themselves to be administrative units created to provide primary health assistance services to the population belonging to the zones Naguanagua and Miguel Peña of Carabobo State. Additionally these university health centers are resorts where teachers and students of the Health Sciences Faculty realize educational activities. The qualitative approach with gender perspective was a way to identify the institutional and communal needs for the prevention and assistance of gender violence as well a challenge for nursing staff to create interdisciplinary networks in matter of gender violence.

1.1 Theoretical framework and state of the art

This section extends the overview about gender violence as a problem that affects public health and human rights. Being in contact with the phenomenon under study was observed the complexity around gender violence. It demanded a revision of different approaches in consequences specific explanations from medicine, nursing, psychology, education and juridical sciences were used.

1.2 Theoretical Contributions

It was organized in three broad thematic areas: Gender as a category in health analysis, Consequences of gender violence and Regulatory framework for women's protection and care. About the regulatory framework was used Latin-American and Venezuelan information in order to show particular characteristics.

1.2.1 Gender as a category in health analysis

Sex is a term that defines the biological characteristics of women and men, on the other hand gender is considered as a constant construction of the identity of both. On this particular the famous statement "one is not born, but rather becomes, a woman" (Beauvoir, 1949) makes reference to the relative and unfinished nature of gender definition. In this sense, an approximation of gender meaning is the following definition:

> "Gender is a category constructed socially, historical and culturally. Unlike female and male, femininity and masculinity are not empirical concepts. Gender is the - very deeply rooted - social institutionalization of sex difference. It points out social characteristics, but simultaneous and, fundamentally, it constitutes a conceptual system, an organizing principle, a code of behaviors whereby it is expected that people organize their lives, being females or males and they behave feminine or masculine" (Santa Cruz and Femenias, 1994).

From this perspective, gender is a category of scientific analysis that studies and reflects on the subjectivity of males and females in different societies and historical moments, their positions to the relationship of dominance, the access to resources, services or benefits and the repercussions of these factors during their daily development. Its implementation in health science allows considering gender as a determinant health factor and the psychosocial determinants of gender as a risk factor.

> "These gender determinants are those roles assigned to women and men by the cultural model of gender, the previous attitudes of those gender imperatives to carry out, the necessity to answer to models and ideals of gender and the psychic positions of femininity and masculinity, subjectively constructed starting from those

> internalized models. They are relationships and attitudes of dominance/subordination, and activity and passivity of sex" (Velasco, 2008).

The meaning of being a woman or a man considering the constructions or replies of behaviors in different spaces of society varies according to the characteristics of each culture. The power is another variable that direct these modes of subjectivity and the relations between genders.

> "In every place where there is power, it is exercised. No one is the owner or holder, knowing that it is exercised in a certain direction; we do not know who has it but we know who does not" (Foucault, 2001).

The link between power and gender relations, demarcates the control of some people over others. In this sense, traditional gender model includes behaviors that are based on a social organization.

> "It requires the sexual division of labor supported by the patriarchal system of gender relations, based on hierarchical relationships and power / subordination of a man to a woman" (Velasco, 2009).

This last statement integrates the concepts androcentric, patriarchy and gender hierarchy, which fits in with the institutionalization of a social imaginary biological superiority of a man, in which there is absolute control over a woman and their family. Within this scheme, there is the concept of a man as the only who is able to direct the moral, education and social behavior of their family. Activity carried out by the woman as wife, mother, housewife and family caregiver is a role assigned by her biological characteristics, in addition she is unvalued. Elements of this model still remain in force in Latin America and the Caribbean region; even provide the guideline for deciding on contraceptive use, consumption of food within the household, access to education and work, among others. In the case of the use of methods for the control of Sexually Transmitted Infections (STIs) gender stereotypes hamper the adoption of preventive measures. "Condom use for a man is under male control, according to traditional standard, it is difficult for a woman to negotiate safer sex" (Kendall and Pérez, 2004). This type of inhibitions can lead to risky behaviors to the health of both. Another example is the difference of food habits in girls and boys, specifically implemented by indigenous people in Oaxaca, Mexico:

> "A boy needs more time for breastfeeding to get stronger and be healthier because in the future he is the responsible for the support of his family, on the contrary a girl remains at home" (Gil-Romo and Díez-Urda, 2007).

The aforementioned is a wrong construction of femininity and masculinity and this situation affects the personal development, health and quality of life in a woman since childhood. A problem for girls and women in rural areas of Peru is the low educative

level, a research shown the following “scholar dropout in teenagers due to the process of learning several skills to be acquired at home as cooking, knitting, caring for livestock, etc., distracting them from the formal learning” (Oliart, 2004). Similarly, the WHO and Pan-American Health Organization confirmed:

> “Girls begin to help their mothers at an early age, often indefinitely postponing their education, and in many cases preference is given to education of children” (PAHO-WHO n.d).

The above exposed is “a symbolic system, which assigns meanings, value, individual prestige or discredit in society” (Comesaña, 2004). Despite of, there are differences among urban, rural, ethnic and socio-educational level of Latin American countries; our region has increased women's access to formal education.

> “The women access to tertiary education and its culmination increased, in particular women had access mainly in professions in the field of education, health and services” (UNESCO, 2007).

Indeed, it is evident in the total population increased participation of women in education, workplace and community. However, this has not been enough to overcome the subordination of Latin American women.

> “Even among individuals with similar education levels, women tend to have lower paying jobs than men, also confirmed that 25% of employed women work more hours than they deserve by law” (UNPD, 2010).

All this without counting the time they spent doing the housework or community activities; what is double or triple heavy workload. Certainly, the transfer of values plays a significant role in the construction of these models referred to the social roles of gender.

> “The gender stereotypes are not necessarily fulfilled, but they serve as a standard that has influence on judgment, on social evaluation, on the own image and self-esteem, for as much as it restricts the potentials of people by stimulating some behaviors and suppressing other, in function of its sex” (Centro Nacional Género y Salud, 2005).

The existence of imbalance concerning the use of power, information and procurement social resources, making decisions, taking responsibilities and expectations cause what we know as hierarchical differences in gender giving the origin of the different aspects in conditions of health and life of quality between women and men. That explains why it is important to include this point of view in the health care sector to identify its impact in the process health-disease and so avoid the differences that may systematically harm the members of each society. Nevertheless, to achieve this ideal it is important to confront us with the subjective construction and the significance that

gives the health care sector as well as the community in general to feminine and masculine activity. Emphasizing in the health care sector, the aforementioned demands a change in the mainly biologist assistance. It is necessary that the professionals of this area assume ways of assistance in which gender is considered as "a psychic and social factor that determines health or constitutes a factor of risk and vulnerability in people" (Velasco, 2009). A critic realized to health system researchers affirmed:

> "When services are performed to satisfy women's needs these services are designed from a masculine point of view, so they cannot respond to women's own specific expectations or concerns. As a result, health services for women tend to focus on their reproductive function and overlook the other functions" (Sen et al., 2005).

A model from health sciences that combines perfectly with this demand and currently upholds the line Gender Analysis as health determinant is the bio- psychosocial model. This approach the necessity to use the psychosocial perspective as a means to examine a disease:

> "Faced with the necessity and the challenge to broaden the approach to disease to include the psychosocial without sacrificing the enormous advantages of the biomedical model, which had become a cultural imperative in today's society" (Engel, 1977).

In this model is proved how diseases that belong to paradigms of "somatization" and "mental" disorder can be analogous, and how the biomedical model is adopted insufficiently by not considering the complement system of the person in treatment which is: psychological, social and cultural factors.

> "The most essential skills of the physician involve the ability to elicit accurately and then analyze correctly the patient's verbal account of his illness experience. The biomedical model ignores both the rigor required to achieve reliability in the interview process and the necessity to analyze the meaning of the patient's report in psychological, social, and cultural as well as in anatomical, physiological, or biochemical terms" (Engel, 1977).

From the health field this point of view constitutes a reference that offer guidance to health sciences and especially to nursing professionals to understand the trends that currently support health approach with gender perspective.

1.2.2 Gender Violence implications for Women's Health

Violence is the premeditated use of power or brute force to threaten or hurt another person or a community. "Either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment or deprivation" (Krug et al., 2002). In terms

of gender violence can be categorized as an interpersonal form of commonly occurring violence it affects especially to feminine population and represents a serious problem that damages categorically their physical and mental health (UNO, 1993; Velzeboer et al., 2003). The complexity around gender violence makes difficulties to present an exact typology. However, in this study was convenience to use the following definition:

Physical violence: it involves the intentional act to affect the body of another person through the deliberate use of force. There is a risk in which a person could be physically damaged, even if in the real case there are no injuries (Flury et al., 2010; Spiwak et al., 2013). In gender violence it is the most evident form because the consequences are difficult to recognize by victims.

Sexual violence: it is a type of physical violence that involves the mistreatment or the control of another person sexually. This activity may be physically forced, or accomplished through coercive tactics. It could present between partners as Sexual violence can take the form of forced and unsafe sex to performance of certain sexual acts with other people. The incest referred to sexual abuse occurring within a family group, more often during childhood or adolescence. It is perpetrated by a relative in a position of family trust (Steven, 2002; Campbell et al., 2008).

Psychological and emotional violence: this form of violence includes negative verbal communication and it serves to undermine the victim's confidence but also includes intimidation, threats and isolation (Walker, 2009; Flury et al., 2010; McMahon et al., 2009). The aggressor uses "tactics to get the control over the victim causing a state of fear, panic, terror, submission and dependence" (Garcia, 2005).

The way as displays gender violence causes harm to the physical, psychological and social integrity which in many cases are irrevocable. If the person that is perpetrating the violence is a (current or past spouse, other intimate partner, or former partner) is known as Intimate Partner Violence. On other hand, Family Violence: could be physical, sexual or psychological, it takes place between family members. Another type is the violence between individuals who are not related falls under Community Violence (Krug et al., 2002; Devries et al., 2010).

Other impositions in which women are victims of gender violence correspond to tactics or manipulations done during everyday life by intimate partner, dominating and controlling behaviors are displayed in order to take the control over other person (Bourdieu, 1990; Johnson, 1995a; Johnson and Ferraro, 2000b); these conducts are imperceptible involving a rather low level of violence (Johnson and Ferraro, 2000b). It

represents an imbalance in gender relationships that may arise in the intimate sphere (family) or in the public sphere (educational, in the workplace, political, economic, health, etc.). From this perspective, the main objective of the attacker is not exactly to cause harm to the victim but to create subjugation and dependency in order to reaffirm the masculine identity strongly registered in a traditional gender model. Moreover, in gender perspective has been developed different contributions that offer explanations about the origin of gender violence. In this study was used ecological model in which are presented the associate factors with violence inflicted by the partner. Authors affirmed that:

> "There is not only one explanation of the problem as its origin is multi-causal" i.e., it is influenced by social, economic, psychological, legal, cultural and biological factors that contribute to the incidence and severity of violence against women" (Heise et al., 1999).

They defined the factors which are acting in four different fields:

> "**Individual perpetrator:** Being a male, witnessing marital violence as a child, suffering an absent or rejecting for a father, being abuse as a child, alcohol used. **Relationship:** Marital conflict, male control of wealth and decision-making in family. **Community:** Poverty, low socioeconomic status or unemployment, associating with delinquencies peers, isolation of women and family. **Society:** Norms granting men control over female behavior, acceptance of violence as a way to resolve conflict, notion of masculinity linked to dominance, honor or aggressions, and rigid gender role" (Heise et al., 1999).

It is indicating that the interaction takes place between them. Similarly, the researchers affirmed that it is added that the interaction of these factors may behave in given moments not only as a risk but also protection factors. Health Researchers observed the effects violence had on women and described these effects as:

> "Non-fatal Outcomes in the Physical Health: Injury, functional impairment, physical symptoms, poor subjective health, permanent disability, severe obesity. In the Chronic Conditions: Chronic pain syndromes, irritable bowel syndrome, gastrointestinal disorders, fibromyalgia. In the Mental Health: Post-traumatic stress, depression, anxiety, phobias/panic disorder, eating disorders, sexual dysfunction, low self-esteem, substances abuse. In the Negative Health Behaviors: Smoking and drugs abuse, sexual risk-taking, physical inactivity, overeats. In the Reproduce Health: Unwanted pregnancy, STIs/HIV, gynecological disorders, unsafe abortion, pregnancy complications, miscarriage/low birth weight, pelvic inflammatory disease. Finally, the fatal Outcomes are: Homicide, suicide, maternal mortality and AIDS-related" (Heise et al., 1999).

Having as Nursing worker gender sensitivity and consciousness about this problem, underreporting and inattention of this problematic may be overcome in the health sector.

1.2.3 Regulatory Framework for Women´s Protection and Care

In Latin-America was celebrated the Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women. It represented for the American countries a commitment to approach effectively with the violence against women. It was laid down the protection of women in public as well as in private sphere emphasizing that every woman has a right to fully exercise “her civil, political, economic, social and cultural rights, and may rely on the full protection of their rights” (OAS, 1995). The parties identify and acknowledge that when violence is used against women it eliminates the exercise of rights

With the intention to satisfy the international resolutions and agreements assumed by the Venezuelan state in gender-related matters and the participation of several Venezuelan organizations interested in making visible and giving solution on the problem of gender violence, it was facilitated the inclusion in the public agenda of matters with regard to women’s protection and development. This favored the creation of several organizations for the formulation, implementation and evaluation of public policies, as well as the instrumentation of social programs, plans and projects aimed at the protection, assistance and empowerment of women. Referring to the Organic Law on the Right of Women for a Life Free of Violence (LODMVLV, 2007) it can be assured that it is a legal instrument set up to respond to the state of injustice in which a lot of women are affected in our country. Becoming evident as in article 3 of the law mentioned above; the protection of the right to life, dignity, physical, psychological, sexual, patrimonial and legal integrity of women victims of violence is covered in public and private sphere. Women victims of violence require receiving full information and suitable advice to their personal situation. In addition to this Law in its article 57 is contemplated for health team the obligation to report to the competent authorities within the next twenty-four hours of cases detected. Likewise, the referred article describes the penalties for the health personnel that fail to fulfill this obligation. Another national legal document that provides protection to girls, who are targets of sexual violence, is the Organic Law for the Protection of Children and Adolescents (LOPNA, 1998) contents include series of articles that criminalizes offenses against this population and includes legal obligations from health professionals to report cases detected.

Also, it is necessary to refer to the Official rule for the integrated assistance of sexual and reproductive health (Ministry of Health, 2003), designed in order to provide assistance toward women from gynecological and obstetric point of view. It includes some measures to give answer to women and families victims of physical, sexual and

psychological violence from health centers. Some of the projects which operate in line with the principles of this rule are: Project Mother; Breast-feeding Program; Nationwide system to distribution of contraceptive medicaments; Protocol for obstetric emergencies; and Prevention, assistance and responsibility of teenage pregnancy. The existence of these strategies has responded to health problems related to women's sexuality and reproduction, but a latent shortcoming in our country is exactly that women's health is still described in accordance with sexual and reproductive health. Being limited the understanding of women's health-disease process throughout its vital process and its interrelation with gender determinants. Despite the existence of laws and rules still being in force as far as it corresponds to gender violence we are confronted with this situation: under-registrations, emptiness, doubts, ignorance and approach to violence against women without a gender view.

1.3 State of the Art

This section will show evidence of Gender Violence. The main sources of review were journal articles. References were obtained after the query in the PubMed search engine. Similarly, two pilot studies conducted in Venezuela were cited. They were done in order to test categories selected and methodology. The general information was gathered through simple inquiry in virtual space using descriptors: domestic violence and women's health, intimate partner violence and violence against women. Initial findings were derived from the following criteria

a. Quote studies of science nurse or medical field that related to the main analytical categories of this investigation.

b. Getting research findings that could be compared with the final product of this qualitative study.

The first research was realized by (Fugate et al., 2005) titled: "Barriers to Domestic Violence which Helps Seeking Implication for Intervention". Data for this study was acquired from the Chicago Women's Health Risk Study. Interviews were conducted with over 490 women in hospitals and public health centers to gather and analyze responses from women who did not seek interventions. Examinations of these responses reveal common patterns like the magnitude of violence and the ability to end

an abusive relationship. Furthermore, the responses provide a ground to understand why these women did not seek intervention.

The following study realized in Brazil by (da Fonseca et al., 2009) titled: “Domestic violence against women from the perspective of the community health agent” discusses views of actors that took part in the intervention process at the primary level and associated practices established at the basic level. It attempts to examine views in daily care delivery with the aim of training workers in this particular field. Ideology as social product and gender violence as social construct stood in as theoretical-methodological references. A questionnaire consisting of 30 thematic statements composed using the Likert scale was used to gather data about violence against women during the care delivery context. Sample information contained data of 17 women between the ages of 22 and 50. The results revealed findings that highlighted the ideology of male domination in terms of gender violence and also highlighted significant inconsistencies that exist in the care practice. Lack of readiness by the professionals dealing with such scenarios became quite apparent. It is vital to promote discussion on this particular issue to establish measures to ensure care and safety of women.

Another study by (da Fonseca et al., 2010) called “Violence against Women is a research based on police reports in Itapevi City located in Sao Paulo Brazil”. The aim of the study was to examine cases pertaining to violence against women as reported and recorded by the Police Station’s for Women’s Defense to restructure the processes that women had to undergo in order to point out the offenders. The research itself was very descriptive and was conducted in the metropolitan region of Sao Paulo, Brazil.. PSWD data was gathered from police reports collected from neighboring cities. The statistics were observed for this information. According to findings threats (42%) and physical injury (49%) were the most common types of violence faced by victims aged between 20 and 49 years. 97% of these offenders were women who maintained an intimate relationship with the victim. Alcohol induced violence accounted for 25% of total violent scenarios. The findings indicated that women victims of domestic violence had a lot of different kind of additional problems as spending their own resources investing their time, money and others without receiving the expected institutional protection.

On other hand, (Abramsky et al., 2011) realized the research titled: “What factors are associated with recent dating violence?” The research was carried out by the World Health Organization and its aim was to highlight factors that frequently cause risk of

partner violence. The methodology provides detailed analysis of data collected from several countries included in the World Health Organization's study on women's health and domestic violence that had occurred between the years 2000 and 2003. Data collection included the application of standard household questionnaire designed with open and closed questions. The total population was a little over 24,000 and consisted mainly of women between the ages of 15 and 49 years old selected at random. The findings proved that alcohol abuse, wife beating, and frequent domestic abuse increased the likelihood of abuse among adults whereas marriage and education offered protection.

The following research, realized by (Vives-Cases et al., 2011) was titled: "The effect of intimate partner violence and other forms of violence against women on health." This particular research examined the effects of violence among intimate partners along with several other forms of violence against women. The aim of the research was to observe whether violence negatively affected a women's health Data gathered after interviewing over 13000 women at the Spanish National Health Survey in 2006 showed degrading physical and mental health. Results also proved that violence among intimate partners is the most common form of violence against women in Spain. As compared to other violent offences intimate partner violence was observed to be the most frequent form of home based violence. Use of psychotropic drugs was more frequent with intimate partner violence than any other form of violence against women.

The study realized in Venezuela by (Medina et al., 2011) titled: "Subjective constructions of gender violence, contributions to the prevention of the problem". This study focuses on the understanding of perceptions that are established between sexes about gender violence. Thus the aimed was to explore the subjectivities built by women and men about gender violence in order to promote prevention initiatives that contribute to quality of women life. It is a qualitative research with gender-perspective, the techniques for data collection were a direct observation and on a focus group discussions. The total population consisted of 7 women and 5 men, all community members of El Rincón in Valencia, Venezuela. The systematization of the data is handled by Atlas ti 6.2 and the phase of reasoning the discourse analysis was used. The results showed naturalization of the problem, double victimization, consent of patriarchal culture, censorship of women who do not exhibit behavior consistent with the traditional female role and recommendations about to the prevention of gender violence.

The next research titled: “Critical trajectories of female victims of gender violence: discourse analysis of women and staff professionals” in Porto Alegre, Brazil was realized by (Meneghel et al., 2011) this qualitative study aims to describe the trajectories of female victims of gender violence in Porto Alegre, Brazil. The methodology included in-depth interviews with women and staff, attempting to show the critical situations of women when they made the decision to seek professional help. Authors interviewed 21 women victims of gender violence and 25 professionals, including law enforcement officials, health and social workers, and nongovernmental organizations. The women’s trajectories in the services were mapped, identifying facilitating factors and obstacles in the process of breaking with gender violence. The victims reported: pressure by professional staff to return to their marriages and police inefficiency in providing protection. The discourse of law enforcement officials and health and social workers showed a range of different concepts regarding violence, medicalization of violence, and network fragmentation. Also, it was noted that in the health field, the teams interviewed did not feel able to provide comprehensive care to women in situations of violence.

In Sweden by (Sundborg et al., 2012) was realized the study titled: “Nurses' preparedness to care for women exposed to Intimate Partner Violence (IPV)” and observed the impact of violence on a woman’s health The research attempted to examine the readiness of nurses and their ability to provide care to women who had been victims of intimate partner violence. Data was collected using questionnaires filled out by nurses at public health care centers. Logical regression examination was used to test relationships and it was found that the sample response rate stood at almost 70%. Results further indicated that nurses lacked the training when tested for readiness. Only 50% of the interviewed nurses asked their patients about violence while the other half simply referred them to a doctor for treatment. A part of being ready to treat victims of intimate partner violence is to obtain knowledge on their own and develop the ability to identify such victims/situations. In conclusion, improvements are needed in both levels individual and organizational.

The research by (Keeling and Fisher 2012) titled: “Women’s early relational experiences that lead to domestic violence.” According to the authors several offenders of domestic violence frequently formed relationships and repeated their violent behavior with the new partner. With their manipulative methods they are able to dominate their partner and frequently subject them to the violent ways. The study was conducted from a feminist’s standpoint and highlighted the narratives of 15 women who spoke about their transition to a violent relationship from a loving one. The research

revealed three tactics called commitment, vulnerability and the princess effect employed by male offenders in the initial stages of a relationship. The aim of these practices was to threaten with violence and suppress their victims.

The study by (Azevedo et al., 2012) titled: “Narratives of intimate partner violence practiced against women.” The study included women between the ages of 15 and 49 residing in an economically unpredictable sector of the Brazilian State Capital for being victims of intimate partner violence. A qualitative approach called the Collective Subject Discourse or CSD for short was adopted by the researchers. Between February and July, about 200 women reported that they frequently experienced violence in their lives. Using the CSD technique the discourses were categorized by similar violence under 7 major groups consisting of 395 keywords.1) i) IPV Engineering (N = 114;58.5%); ii) Rape of vulnerable sex (N = 77; 39.5%); iii) Silent or silenced violence (N = 43; 21%); iv) Years of Suffering (N = 43; 21%); v) New time despite the suffering (N = 39; 20%); vi) Talking about violence (N = 35; 18%); Violence is a language (N = 34; 17.4%). Under the title of IPV Engineering, three reports of highest occurrence are present in details in this research. The narratives unraveled the extent of violence suffered by women and revealed multiple aspects of violence in intimate relationships.

Finally other study by (Medina et al., 2013) titled: “Focus group discussion as a tool to study gender relations in an urban community members”. It was a qualitative research with gender perspective aimed to illustrate the usefulness of Focus Group Discussion in the study of factors influencing gender relations, based on the conceptions of urban community members. The methodology included focus groups with n=5 women and n=5 men members of the community Tazajal in Valencia, Venezuela. In the stage of reasoning was used discourse analysis. Results showed: Gender relations based on the traditional gender model represent a risk to physical and mental health of the group being studied. Demonstration of manhood, individuality and promiscuity in the male gender put them in such a risk. In female gender submissiveness may trigger low self-esteem, blaming and mental suffering. Conclusions: This study describes Focal Group Discussion as an effective tool during the exercise of community nursing because this kind of technique promoted dialogue and exchange with community members.

1.4 Summary

The practical implications of this theoretical framework and state of the art consisted. First, to guide the research process according to the form as it was addressed

previously. Second, contrasting the different explanations of the phenomenon with outcomes found in this study. In the section theoretical contributions were used theories, conceptual models and reports from relevant authors or organizations in order to extend the explanation about the feminine role expectations from Latin-American culture, repercussions of gender violence in health, and the state role to assist victims of gender violence. Specifically, investigations outlined in the state of the art, presented key elements that will be compared with the results obtained in this study. They are:

a) The imaginary constructions about socio cultural characteristics of femininity and manhood in which prevails idea those women are fragile, submissive and imperfect (da Fonseca et al., 2009; Medina et al., 2011). Similarly, it was significance finding out the influence of gender stereotypes in the everyday life and health (Medina et al., 2013) as well as the risk factors that increase prevalence of intimate partner violence (Abramsky et al., 2011).

b) It was noted the negative impact of lack preparedness professional, guidelines or protocols in the face of situations to provide assistance to offend women. It was observable not only in health system but also justice; this aspect could be triggering a second victimization (da Fonseca et al., 2009; da Fonseca et al., 2010; Medina et al., 2011; Sundborg et al., 2012).

c) The understanding of intimate abusive relationships from perspective of gender violence victims and feelings of that impede them seeking help i.e. hassle, fear, confidentiality, or tangible loss of partner (Fugate et al., 2005; Keeling and Fisher, 2012; Azevedo et al., 2012). Other element to contrasting the findings concerning to victims of gender violence are the consequences in mental health (Vives-Cases et al., 2010; Meneghel et al., 2011).

d) It was tested the convenience of methodological approach using participative techniques in order to encourage dialogue and exchange with community members. It was useful in the searching of values, beliefs and mandates that perpetuate the practice of traditional gender model into communities (Medina et al., 2013).

Limiting factors in results of the search were observed. About papers published a minority of these researches showed gender violence from Latin-American context and most of Latin-American's articles published in PubMed were available in Portuguese language because of, they were done in Brazil.

2. Objective

Explore opinions about gender violence in nursing staff and women clients of university health centers to identify the institutional and community needs in matter of prevention and assistance.

The problematic situation brought us to face the following questions: What is the meaning of gender violence by nursing staff and women clients of university health centers? What is the opinion of nursing staff about their professional practice in relation to prevention and assistance of gender violence? Which contributions should be considered from study group to define nursing interventions referring to prevention and assistance of gender violence?

3. Materials and methods

3.1 Research design

The present study corresponds to a qualitative research with a gender perspective since it aims to explore the experience and meaning of gender violence from the realities of women and nurses which are the studied subjects. In fact, to understand the phenomenon under study feminist assumptions and public health were incorporated. In this regard, the feminism applied to research establishes a framework for understanding, analysis and critiques of male domination, the patriarchal organization of society and limitations within the construction of feminine identity.

Its development in different areas of knowledge allows classing it as a valid and accepted tradition for the realization of studies related to women and gender. In this sense, a researcher in this field expressed “it had contributed in particular to debating about the reflexivity, the subjectivity and the otherness” (Goldsmith, 1998). Also Routledge afirmmed “the feminist perspectives may be used to develop a body of knowledge in health for and about women” (Routledge, 2007).

Particularly, gender perspective had been used in public health to develop health planning, intervention and research. This has made visible the way how women live, get sick and die. In this regard Velasco identified the development of three successive lines in the health field. The first of these lines is the “movement of Women’s Health”; the second line includes “gender concept and gender inequalities in health”; and the third line incorporates “gender analysis as determining factor for health and disease by social gender factors as well as subjective factors and identities of gender” (Velasco, 2009).

Therefore, the gender perspective has been selected as the appropriate analytical category to understand the meanings attributed to gender violence from the experience of the nurse staff and women clients of university health centers.

3.2 Scenery

The fieldwork has been carried out at the university health centers “Nuestra Señora de la Luz” and “El Consejo”. These are administrative units that report to the Extension Head office of the Health Sciences Faculty, Carabobo State University. These health centers have been created with the intention of providing primary care services to the internal and external university community in the zones Naguanagua and Miguel Peña in Carabobo State.

3.3 Selection of groups under study

It was investigated in two different groups, on one hand, the nursing staff that worked in university health centers (Carabobo University) and, on the other, women clients of these university health centers. The sample decision was guided for the free participation and saturation of the information.

The ethical aspects were observed according with Venezuelan Bioethical and Biosafty Code (Bioethics Code, 2002); the participants were informed about the objectives of the research, applying techniques and tools, duration of meetings and signing of the informed consent to take part in the research.

3.3.1 Selection of nursing staff

At the time of the study the universe was composed by a population n=12 nurses that worked in the healthcare centers “Nuestra Señora de la Luz” and “El Consejo” of Carabobo University. The total participants were n=7 nurses of both healthcare centers. The selection criteria of the individuals under study were nursing professionals, gender female, academic level Advanced Technician, Bachelor or Master of Science in Nursing, have at least one (1) year of working experience in the healthcare centers.

3.3.2 Selection of women clients of university health centers

At the time of the study the universe was composed by n=47,822 women currently in their reproductive years hailing from Naguanagua and n=132,147 women in their reproductive years belonging to the zone Miguel Peña (Foundation of Carabobo State Institute of Health- INSALUD, 2010). A total of n=72 women took part in the focus

group discussion. The considered selection criteria were being female, over age 17, living in selected zones (Naguanagua or Miguel Peña) and being client of the university health centers.

3.4 Information saturation

The number of participants was determined after reaching the cutoff point where no new inputs for the research emerged. It means that there is a redundancy of information and the informants did not indicate anything different to what has already been said. It consists in seeking that a sample is representative, “not on a morphological level (on the level of superfluous description) but on the sociological level” (Camacaro, 2010).

3.5 Data collection techniques

3.5.1 Semi-structured interview

In using semi-structured interview it was investigated about the carried-out activity by the nursing professionals regarding assistance and prevention of gender violence in the healthcare educational centers of University Carabobo. The quality of this technique was useful because its flexibility enabled free questions where situations and experiences by the participants could be appreciated that were unplanned for the study of the phenomenon and were crucial in the analytical phase. In this sense, the purpose of the interview in a qualitative research is “obtaining descriptions of the lived experiences by the people that were interviewed” (Martinez, 2006) in order to achieve reliable interpretations of the meaning that the phenomena have described. The verbal exchange was characterized for being private and amiable, allowing fruitful interactions with the interviewees. The conversations were recorded and stored in voice files using a digital recorder and the interview duration fluctuated between 20 and 50 minutes.

3.5.2 Focus group discussion

The aim of the focus group strategy was to encourage a talk in conjunction to capture stories where the experience of the women participating in the research were disclosed, it represents “the reality of things” (Weber, 1964). On other hand, focus group discussions are compatible with the feminist epistemological framework because they keep to a minimum the distance between researchers and participants. “It allows multi-vocality (many voices are heard) during the research process.” (Madriz, 2000; Rodriguez et al., 2011) A vital condition to carry out focus groups was the close relationship to achieve an environment of trust that allowed the participants during the

debate to express their ideas, thoughts and experiences about gender violence. A total of seven (07) groups were formed in the different communities and the number of participants of each focus group discussion was ten (10) or twelve (12) people. All the testimonials were recorded and stored in voice files using a digital recorder and the meeting duration in the different focus group discussion ranged between 60 and 120 minutes.

3.5.3 Non-participant observation

It was a complementary technique used in semi-structured interviews as well as in focus group discussion, appropriate to register the body language of the individuals under study. Particularly enriching in focus group discussion was the presence of an observer in each group. This person carried out the written descriptions about the emotions and the dynamics of the conversations that turned out to be crucial in the process of giving meaning to the information. This process is defined as the process that "empowers the observer to describe existing situations using the five senses, providing a -written picture- of the situation under study" (Erlandson et al., 1993).

3.6 Principle of authenticity in research

At the end of the data collection process all narratives have been transcribed in Microsoft Office Word 2007. Only in the case of the semi-structured interviews, the documents were sent to the participating nurses by e-mail for their review, it was useful to clarify several doubts that emerged during the transcription process of the narratives. It constituted a guarantee that in the research the information was given how real experiences by the group studied. In this regard it was complied with the principle of authenticity in qualitative research (Alvarez-Gayou, 2003). Another factor that provided authenticity to the study was the presence of external observer in the course of the focus group discussions, the obtaining of an observation record and the subsequent discussion with colleagues about the experience strengthened the analysis from the same view was discovered. It only can be observed when a debate occurs among several researchers giving rise to the well-known triangulation in research.

3.7 Data Processing and Analysis

The interpretation of data was an analytical process based on elements of Mayring's approach. It was useful to present a coherent explanatory and logical organization of all parts of the phenomenon under study. This method of information analysis puts forth three procedures that can be executed independently or in combination depending on

research question (Mayring, 2000; Kohlbacher, 2005). These techniques are as follows:

a) Summary: efforts to shorten the content in a way that preserves its meaning and helps create material which reflects the meaning of the original content. In order to accomplish this content is usually reduced and paraphrased.

b) Explication: is the process of detailing and explaining the content. A lexico-grammatical definition is provided initially which is followed by narrow and broad context analysis.

c) Structuring: The aim of structuring is to extract a specific form of content from the original material. This is where the content is deduced according to scaling and form. The first step involves the formation of units to carry out analysis. After this comes the establishment of structure and defining of features belonging to the system. Consequently definitions are communicated and rules for coding are mentioned. Locations are identified in lieu of first appraisal of the material and in the next phase managed and evaluated. If required the entire system of categories is revised which demands a review of the material. Last stop is the processing of results obtained. (Mayring, 2000; Kohlbacher, 2005).

In the practice, this study includes two **analytical units**, nursing staff and women clients of university health centers. In this respect, developing of content analytical units was established through links between research question, object and theoretical framework. Moreover, each unit of analysis was studied separately. Forward, to know about the characteristics of analytical units was necessary the process of **categories definition** it took two ways:

First, deductive categories determined, it was created with category formerly expressed theoretically discussed features of analysis which are linked to the text (Mayring, 2000; Kohlbacher, 2005). To get a precise material classification categories of pilot studies were integrated (Medina et al., 2011; Medina et al., 2013) as well as elements of gender analysis. The categories referred to nursing staff and women clients of university health centers were socio-demographic data and meaning of gender violence. The category play role in gender violence assistance only was applied in nursing staff.

Second, inductive categories development, they were derived in close proximity of the material to express them in shape of the material (Mayring, 2000; Kohlbacher, 2005). The word “material” is about transcriptions of interviews and focus group discussions. In particular this process allowed in the conceptual level reducing the complexity of the material under analysis. In this research the principal object was to explore what gender violence means for participants. A way to understand this meaning was to know the participants opinion that were living under gender violence and it was not prior regarded in this study.

The dynamic during communicative process -interviews and focus group discussions- did in some nurses and women clients of university health centers to identify themselves as victims of gender violence. This originated the following categories: influence of gender based violence, victims of gender violenc and the category suggests improving gender violence approach. This last category was observed only in women of the university health centers.

About **revising of the categories**, deductive categories were reviewed with the prior category system and inductive categories were reviewed using the material. For this research, both types of categories were adjusted during the whole analysis process in order to draw upon the richness of evidences or material. Thereby, it allowed a reflexive and intuitive exercise to reduce, expand or redefined the categories (Amezcua and Gálvez, 2002; Martínez, 2004). In fact, it improved understanding of life experiences with gender violence and its meaning.

The **feedback loops** was continuous during the interpretation of the results; also it was a way to data reliability and validity. Additionally, the software Atlas ti version 6.2.23 was used to organize the transcriptions of interviews and focus group discussions. This turned out to be a practical tool during the exploring meaningful segments of large amounts of data, definition of categories, making notes, comparing the frequency of categories doing in flexible and systematic way. On the other hand, to socio-demographic data analysis Excel program was applied.

3.7.1 Description of deductive categories determined for qualitative data analysis

Socio-demographic data

a) Aged

b) Marital status

c) Highest level of education

Meaning of gender violence

a) Normalization of the problem: this category gathers expressions through which gender violence come to be seen as normal into gender relations.

   Rule coding: It is evident in victims and no victims' expressions where acceptation in the use of violence to resolve partner conflicts exists; silence of the violence situation; the aggressions are minimized; gender violence does not look such a public health problem.

b) Double victimization: this category gathers expressions through which women get entire blame for the violence situation.

   Rule coding: Opinions from participants where the victim is blamed for being battered or raped, experiences in which victim face obstacles into the family, justice system or health to formulate the reporting, negative experiences in which justice system minimize the severity situation.

c) Acceptance of traditional gender model: this category gathers expressions through which is approved inequity in the distribution of child-care tasks and chore responsibility.

   Rule coding: Participants share or practice beliefs about women's submission and dependence, feminization of household chores, women are principal responsible for child-rearing and household chores, agreement with lack of cooperation by male in household chores and tolerate abuses on behalf of ideal family.

Nursing role in addressing gender violence

a) Gender violence cases detected: this category gathers expressions through which nursing staff confirms the detection of physical abuses, sexual and psychological in women clients of university health centers during consultation.

   Rule coding: Victims spoke with nursing staff about their violence situation, nursing staff questioned directly about gender violence, nursing staff found

during consultation signs that suggested gender violence, descriptions about consequences in health of women affected.

b) Approach of gender violence: this category gathers expressions through which nursing staff identified their skills and knowledge in prevention and assistance of gender violence.

   Rule coding: Nursing staff described educative actions implemented in the prevention of gender violence; training and knowledge received about official regulations for the assistance of gender violence as well as abilities during the assistance of cases.

c) Available guidelines: this category gathers expressions through which nursing staff described existence of procedures into university health centers to assistance and prevention of gender violence.

3.7.2 Description of inductive categories development for qualitative data analysis

Victim of gender violence

a) Dominance and control: this category gathers expressions through which participants described being under control of a dominant couple without physical aggression or threat.

   Rule coding: Participant describes experiences where she felt lack of independence to make decision by herself, dominant couple took the control on the other partner (friendships, clothing or time, decides how thinking, feeling or behave).

b) Physical violence: this category gathers expressions through which participants are or had been slapped, dragged, beaten up, kicked, choked or injured.

   Rule coding: Participant describes experiences where she is or had been physically abused from their partner, ex-partner or another relative with the aim of keeping the control over family members; aggressor has caused hurt with objects, weapons or his hands.

c) Psychological violence: this category gathers expressions, through which participants are or had been threatened, degraded or humiliated.

Rule coding: Participant describes experiences where she is or had been victim of constant critic, ridicule, blackmail, coercion or disrespect in front of other people or at home. Aggressors may be partner; ex-partner or another relative. Aggressor has threatened to hurt or kill someone e.g. woman, relatives, sons or himself.

d) Sexual violence: this category gathers expressions through which participants are or had been victims of sexual assault.

Rule coding: Participant describes experiences where she is or had been forced to have sex, the perpetrator may be stranger or couple; participant was victim of sexual abuse at the hands of close relatives (incest).

Impact of gender violence

a) Fear: this category gathers expressions through which participants living in constant afraid of their partner.

b) Low self-esteem: this category gathers expressions through which is detected in participants decrease in self-assessment.

c) Mental suffering: this category gathers expressions through which victims of gender violence show signs of depression, hopelessness, unhappy and lack of meaning to existence.

Suggests improving gender violence approach

a) Community Prevention: this category gathers expressions through which women clients of university health centers suggested educational activities and awareness campaigns to reduce gender violence.

b) Community Participation: this category gathers expressions through which women clients of university health centers suggested ways to integrate members of the community in prevention and assistance of gender violence.

c) Intervention in gender violence: this category gathers expressions through which women clients of university health centers suggested ways to improve the assistance of gender violence cases.

4. Results

This chapter will show the results of data analysis. First, the explanation of socio-demographics aspects using descriptive statistic, it was complemented with presentation of data on a table. Second, the participants' stories collected during interviews and focus groups were allocated in the categories classification. The interview and focus groups' passages were written in cursive and to identify participants intervention was used the following abbreviation:

- Interviews (I1, I2, I3, I4, I5, I6, I7)
- Focus Groups of the zone north university health center "Nuestra Señora de la Luz" (FN1, FN2, FN3, FN4) Focus groups of the zone south university health center "El Concejo" (FS5, FS6, FS7). To identify the opinions from participants into the focus groups added -P with the number of participant, e.g. (FN1-P1).

4.1 Socio-demographic characteristics

In the aged of the sample, the median age of the n=7 nurses was 34.28 years (SD 7.88 range: 26-47 years old); n=05/07 (71.4%) were aged between 25-44 years old, and n=02/07 (28.6%) were aged 45-64 years old. About n=72 women clients of university health centers, the median age was 36.5 years (SD 15.98 range: 17 to 68 years); n=29/72 (40.3%) were aged 25–44 years, n=22/72 (30.5%) were aged 17-24 years, n=12/72 (16.6%) were aged 45–64 years, and n=09/72 (12.5%) were aged >65 years old.

In the group of nursing staff marital status married / living with partner was predominant n=04/07 (57.1%), n=02/07 (28.6%) expressed being divorced or separated, and single n=01/07 (14.3%). Similarly, in women clients of university health centers the status married / living with partner report higher rates n=45/72 (62.5%), single woman were n=17/72 (23.6%), women divorced / separated were n=06/72 (8.3%), and widow n=04/72 (5.6%).

In the highest level of education the totality of nursing staff n=07/07 had college graduate level. About women clients of university health centers n=49/72 (68.1%) had less than high school, n=19/72 (26.3%) high school graduate, n=03/07 (4.2%) some college, and n=01/72 (1.4%) college graduated. (See table 1).

Table 1 Socio-demographic characteristics of participants

	Nurses		Women	
Total	07		72	
Predictors	**No.**	**(%)**	**No.**	**(%)**
Age				
17-24	-	-	22	(30.5)
25-44	05	(71.4)	29	(40.3)
45-64	02	(28.6)	12	(16.6)
65 + years	-	-	09	(12.5)
Marital Status				
Single	01	(14.3)	17	(23.6)
Married / living with partner	04	(57.1)	45	(62.5)
Divorced / Separated	02	(28.6)	06	(8.3)
Widow	-	-	04	(5.6)
Highest level of education				
Less than high school	-	-	49	(68.1)
High school graduated	-	-	19	(26.3)
Some college	-	-	01	(1.4)
College graduated	07	(100)	03	(4.2)

Found: Interviews and focus group discussion.

4.2 Meaning of gender violence

In this section nurses' interviewed and women participants in focus groups were asked about the meaning of gender violence, participants' narratives are presented in each of sub-categories.

4.2.1 Normalization of the problem:

Nurses

n=4/7 nurses expressed opinions in which gender violence does not look such as a public health problem of obligatory intervention. During these interviews nursing staff known gender violence could generate serious consequences in women and families but they do not identify themselves as a resource to offer support and advice to the victims of gender violence.

I3: two girls were sexually abused by their grandfather. Generally, it happens in rural zones but it does not look as a serious problem because it is culturally accepted. I worked in a rural zone and I know how it is.

I4: I said these kinds of clients should find professional support.

I5: Each woman has her life; gender violence, I think is an intimate problem.

I7: There are many women who talk about their difficulties at home and this is very common. These clients come to seek assistance from the nurse but that is not a health problem.

Women

n=43/72 women participants in focus groups discussion admitted keeping in silence or doing nothing in a situation of gender violence as the main reason they are thinking that it is a way to solve problems into family sphere.

Interviewer: What does the community or the neighbor do when a woman is abused?

FN3-P6: Nothing. Nobody does anything. I hear but I do nothing. Before I ran to help my neighbor but now I do nothing.

FN3-P7: After the fight the couples reconcile themselves but the others became into their enemies.

FN3-P5: Sometimes women tell their husbands: "My neighbor told me that I must denounce your abuse" after that the victim husbands become into enemies. The best way to solve problems is to solve them into their own home. It is a way of living.

Other opinions collected in focus group revealed minimization of the problem.

FN1-P2: People ask me, why are you interested in our problems? And the answer is, it is not your problem, it is a private problem. For that reason I say nothing.

FN2-P5: I have a son who he batters his wife but only when he is drunk and into his home.

FS5-P7: When my husband says that he wants to kill me, I tell my sons not to worry. I do not want my sons to feel angry against their own father.

FS5-P10: I am agreed; a woman must endure all her husband.

FS6-P3: I know a case, the grandfather was abusing his granddaughter, she was eight years old, one of his sons found them, the girl's mother knew about it but either the mother or the family did not act. They were silent they did not say anything ever. If they do nothing, no one gets involved. That is completely private.

FS7-P5: We live in a sexist society and women are already adapted to violence. This problem will be always present.

FS7-P9: A person can hear screams and beatings but sometimes no one can get into the family problems.

4.2.2 Double victimization:

Nurses

In this sub-category are presented testimonies in which nursing staff mentioned lack of confidence in institutions (justice system), the victim (woman adult) gets entire blame for being battered or harassed, and proneness to be suspicious of women victims of gender violence. A total n=5/7 nurses in the course of interviews expressed their ideas why they prefer no implicate during professional exercise with this kind of clients.

Interviewer: What will you do if a client wants to report physical violence or sexual?

I2: I do not get involved in legal things because I feel it is not safe for me. I do not feel confidence in our justice system. They do not give warranty our protection.

I3: I have made denunciations but I feel bad when law fails and the offender goes free, our system does not help.

I4: Sometimes women are living in violence because they want it. I think when a woman does not give motives to harassment, it should not happen and I am not excusing the violence.

I6: Only if I have legal evidence I would do the complaint. If a woman says "I was abused" I do not know if it is true.

Women

Opinions from clients of university health centers were closely comparable with nursing staff appraisals'. In total 29/72 women indicated as main barrier into the justice system, indolence from agents these negatives experiences describe a second victimization; traditional precepts were visible, women must remain together with their partner at the expense of anything. Moreover, they criticized severely women who are victims of gender violence.

FN2-P11: We have a justice system that endorses impunity for the worst crimes. Do you think they take a simple complaint from the woman who was battered by her husband?

FN3-P4: When I denounced my husband, the police sided with him.

FN3-P9: My parents told me: "You must to do all that your husband ask you for" neither one should divorce because it is a sin.

FN3-P1: They have never complained about husbands and I believe that they are enduring all because they do not want to be along. My oldest cousin has three sons, the other has two sons and the last one has a baby. So, I think they want to be batter, they don´t feel embarrassed.

FN4-P5: it means, all of us (women) are masochists, we do not feel ashamed, we like violence and that's the truth about us.

FS5-P3: Some women make a complaint, sometimes the things go well but sometimes they do not receive protection from the agents, if someone does not have a stroke or is almost dead, they do not take the complaint.

4.2.3 Acceptance of traditional gender model:

Nurses

n=6/7 nurses described their thinking about sexual division of household chores into the family in getting the satisfaction of traditional gender role expectations.

Interviewer: Could you tell me how your life or your routine is at home?

I3: I get up at 4:30 am; I prepare breakfast and lunch for my family. I start my work from 8:00 am to 5 pm. I am at home about 7:30 pm. I always do dishes, and I complete some household chores. Logically, I get a little help from my daughter but if she is doing her homework, she does nothing. I cook dinner, and then I check out my children's homework because there are many things they do not understand and I must clarify to them. I support them, sometimes at 11:30 pm and I still working with them on the computer.

Interviewer: What is the household chore of your partner?

Observation: She remains in silence a few seconds. She was thinking confused.

I3: Nothing, he does not anything. He has not any chores.

It was obvious the primary role is occupied by female gender in the domestic sphere. The total of participants in this group were professionals and workers; during interviews two nurses expressed that their partners (men) were unemployed and these partners stayed long time at home resting and watching T.V. or spending their time with friends drinking alcoholic beverages. However it was observed that nurses more often have the major family responsibility. This feminization of household chores, child care as well as tolerance of abuse in order to keep paternal figure into the home is exemplified in others passages of nurses interviewed.

I1: I do everything. Of course, my husband helps me in the tasks that are for a man. He washes the car, cleans the garage and waters the plants.

I2: I as a woman, I do all household chores. There are a few men who cooperate in this kind of task, because it is of natural order. I think most of the men follow this guideline.

I3: I have many reasons to break this relationship, but my life is governed for something what is called sense of family. I want my sons grow up with their father.

I5: I get up at 4:30 am, I am the only one who cooks, cleans the house, my husband helps me monetarily but he helps a little in household chores. He is a very lazy person.

Women

n=43/72 women clients of university health centers just over half expressed their agreement with practices of traditional gender role; in some passages women identify themselves as responsibly in the reproduction of these patterns. Also, in others descriptions women talked about their incapacity to involve their partner in household chores because it could produce a disfavor reaction in them i.e. physical or verbal violence. To demonstrate the dynamic of conversation between participants during the discussions, it will be showed an extract of interchange.

Interviewer: Could anybody tell me how the division of household chores or child care at home is?

FS5-P5: I think. Women are guilty about the lack of man cooperation in household chores. We allow them to do nothing. For example sometimes my husband was unemployed and he always had free time. I worked very hard for a long time, after my work when I returned home the only thing I want to do was to rest but I had to start doing the housework. I felt completely tired but I could not ask him for help because he was able to hit me. My sons are like him. They do not hit their women but they do not help at their own homes.

FS5=P6: But I think. We are guilty when our sons do not follow the right way, if a woman is employed; mothers cannot be with their sons. Our place is at home. A lot of women are working because their families need money and it is a problem to a woman because men do not know how to take care of their children neither to do household chores. Observation: Focus group participants share these opinions.

FS5=P8: I think, men are not less or weak when they are helping in household chores. Nowadays, women are working and men are at home because they do not find employment. So, nothing happen if a man cares a child or does household chores, but we are living in chauvinism and sometimes women are chauvinism too, for example I have sons and daughters and I have said them only girls made household chores because, I thought boys could become in homosexuals, those were my thoughts because I learnt it from my family.

Similar appreciations were observed in participants of others focus groups discussions analyzed.

FN4-P5: I am employed but I am responsible for household chores and children care, it is very hard. Sometimes I carelessness my own health, I know it.

FS7-P2: I wake up at 5:00 o´clock every day, I prepare breakfast, I cook lunch for my husband and sons and I do others household chores, then I take a shower, I dress myself and I go to work. I prefer to do all by myself to avoid problems with my husband.

A minor n=08/72 participants expressed opposite experiences, they described agreement between partners in the division of chores at home and some women have dedicated their life to domestic work as a free election.

FN2-P6: I do not feel identify with this problem, I cannot say anything because it is totally unknown to me. I am a retired secretary, I am married. I never have children. I have a wonderful relationship with my husband; we share all in our life; work, money, rest, household chore and friends.

FN2-P8: My husband and I are live in peace. We share household chores, and children care.

FN1-P4: I taught my children to do household chores. I was always a housewife but I was not subjected, I am free, and when I am tired, sick or sometimes I do not want to do chores, my husband takes my place.

An overall interpretation: Meaning of gender violence was a significance category to know how the problem has been understood by people in order to interact with their beliefs system. During analyses, this became very obvious as strong values of traditional gender model were presents in the collective imaginary that guided the nursing practice and women life. Comparing the participants' opinion about the problem, the meaning of gender violence was influenced by conceptions of patriarchal culture. In comments were repetitive the perceptions of gender violence as normal behavior into familiar relation. It might suggest a legitimation of aggression against women, with the existence of ideas what are transferred from the social to individual thinking.

This explains why agents from institutions (justice system and heath) neighbors, as well members of family undervalue, minimize or ignore gender violence. Furthermore, participants and victims themselves even tended to blame women for what happened. The ideology of most participants limited them to certain roles where women are responsible of household chores and children care, they are absolutely available for all members of family, for men could be impossible their implication in domestic aspects. According with conceptions of the women role and the imaginary construction about men are unable to cook, or to care is the reason for what barriers exist in health sector and community to overcome the problem.

4.3 Nursing role in addressing gender violence

In this section nurses interviewed were asked about protocols or guidelines available in these health centers to offer victim’s support as well as actions implemented by nursing

staff from university health centers in the prevention and assistance of gender violence. The descriptions are presented for each of sub-categories.

4.3.1 Gender violence cases detected:

Nurses

n=07/07 nurses of university health centers confirmed the detection of cases during their professional practices; in some passages nurses commented that some clients of university health centers were victims of physical, sexual, and psychological violence. Also, during interviews they narrated the consequences on health of women affected i.e., injures, malnutrition, abortions, unwanted pregnancy, fear and mental suffering.

Interviewer: Did you find gender violence cases during consultation?

I2: I have detected cases of direct gender violence, violent attacks by women's husbands. Once, it was a case that the man was an alcoholic and he threats her with death. She always felt fear.

I3: I found a case, the husband hits her and he does not give money to food. The woman is extremely thin and emaciated. She and their children look very bad they are underfed.

I4: I had a case it was a young woman, her husband attacked her. She was wounded. She did not want to say what had happened but then when I was asking about the situation to the client to know how she was wounded, she told me that her husband assaulted her with a piece of glass of a window and she began to cry.

I6: I have attended a lot of cases of physical and sexual violence in girls and teenagers.

4.3.2 Available guidelines:

Nurses

In this sub-category are presented testimonies in which n=01/07 nurse described procedures established in one of the university health centers to prevention and assistance of gender violence. The nurse expressed the educative actions were executed in schools. Children, teenagers and teachers were objective population.

I6: We are doing preventive activities in primary and secondary school; these schools belong to communities that are influence area of the health center "El Concejo". We have agreement and permanent communication with counseling department and teachers. We conduct workshops and educational sessions aimed to teachers and scholars.

About assistance of gender violence, the nurse identified two different ways to detect the cases; one of them is during consultation and the other through workshops in the

school. Children or teenagers mentioned their violence situation to teachers. Then, they search support with health team (Adolescent pregnancy program).

I6: Violence cases detected in the school population are identified through preventive approach. I think. The educational activities permit self-reflection. Sometimes scholars themselves identified as victims and they communicated it to teachers. Then, we received notification from school, we take care to confirm the diagnosis, we orient the victim and family members to take over the next step, referring the case to the law. We have two lawyers working in this health center. So, these cases are handled jointly; in health history attached legal report for the healthcare team knows the client's situation.

On the other hand, most nurses n=06/07 in this study expressed unknowing about the existence of guidelines established in university health centers to offer prevention and assistance to gender violence victims. It is exemplified in others passages.

I1: I have not worked with gender violence prevention. I usually work with themes as arthritis, psoriasis, vaccinations and prevention of diabetes or high blood pressure because of they are programs available in this health center.

I2: To find a protocol to offer assistance of gender violence victims. It is very difficult, it does not exist.

I3: When I find gender violence cases, I follow my own criteria. I usually do that I think is right. I did not receive training to offer assistance to victims here; we do not have guidelines to these types of cases.

I4: In this health center I perform educational sessions in diseases that are in time of epidemic. I also give information on vaccinations and issues concerning the care of children.

I5: Well, here works a group of lawyers but I do not know what protocol is followed when there are such cases.

4.3.3 Approach of gender violence:

Nurses

During interviews n=01/07 a nurse carried out educative activities; she expressed it was no exactly to prevent gender violence but family violence. The nurse took into consideration some elements about equality relations, respect and cooperation between partners in order to promote peaceful solution to conflicts in the family living. In addition, this nurse commented to have received training in the gender violence topic. At the following it will be showed extracts of interview.

I6: I had done workshops about sexual education in primary and secondary school. Normally the participants are teenagers; in these workshops I spoke them about self-

esteem, project of life, cooperation and peaceful solutions to conflicts into the family. Later, I told them about male and female reproductive systems, sexually transmitted infection and pregnancy prevention.

Interviewer: Did you receive any training on gender violence assistance?

I6: Yes, I did. I am specialist in Adolescent's Health and there we learnt a little bit about this topic but I think the most important training is the experience that I have won in this program.

Interviewer: Could you tell me what you know about Organic Law on the Right of Women to a Life Free of Violence?

I6: I know this law; it has a lot of articles that protect the rights of women. The law avoids abuses against women, it is new to me. I believe that we meet the standards of women's rights with our work and experience. But, the totals of cases in our program are teenagers or children and so we used Law of protection to children and adolescents to handle physical, psychological or sexual violence, most of cases are female but we assist male too.

Interviewer: Could you tell me what this law precise to health team when gender violence is detected in children and teenagers?

I6: To give health and legal assistance at clients.

Interviewer: Did you have cases in which victims are women adults?

I6: Well, sometimes children or teenagers are victims of violence, and the mother too but it is different.

About assistance of gender violence, the experience and skills of this nurse n=01/07 during consultation was different in comparison with the others, because her actions showed potentials that could be used in the definition of guidelines to organize assistance of the victims.

I6: In the course of anamnesis at the Adolescent pregnancy program where I work, I ask the clients about their partners and I have learned to recognize when a patient has a problem with violence. I believe face to face contact, empathy and skills in communication are important. Very often when I examined clients I have detected cases with physical and sexual abuses. It is necessary to develop assessment skills. Of course, our tasks as nurses are only nursing care, the preventive aspect or educational focus.

Others passages from n=06/07 nurses interviewed revealed they miss training to treat victims of gender violence.

I2: I did not have read about this topic. I would like to know more about gender violence.

I3: I have not received this kind of training. I think. It is necessary because sometimes we have clients with gender violence and I do not know what I should do.
I5: I do not know.
I7: I have listened but I do not have studied this topic because it does not belong to my area of attention.

An overall interpretation: It was observable presence of gender violence cases in both university health centers as well as immediate effects on women's health. Nursing staff identified children, teenagers and adults' women as affected population. Despite the fact that in Venezuela legal obligation exists for health team to share information with authorities on gender violence cases (LODMVLV, 2007) a minority of nurses in this study has implemented this measure to help victims. Also, it was confirmed most of cases remained without registration in medical history form. Another observation, nursing staff has more determination to provide protection to victims of violence if they are children or adolescents than adults' women.
An explanation for this conduct is the cultural beliefs it was analyzed in the category meaning of gender violence. Similarly it was clear the lack of guidelines besides lack of training in nursing staff with a particular focus in gender perspective, as consequence gender violence crimes still remain under-reported. Guidelines from one of university health centers are based on the norm to offer protecting the physical and emotional integrity of violence victims (infantile and young population). A brief description of strengths and weakness observed for gender violence assistance from this program will be given. It was suitable a) collaborating inter-professionals, utilizing the expertise of other disciplines for the benefit of their clients; b) Skills and diligence in members of team work; c) Reporting of cases diagnosed; c) Recurrent preventive actions; and d) Linking with school and justice system. About weakness detected.
The strategy being performed in relation to educative actions includes conceptual elements of life skills and gender approach; but apparently nurse was not aware of it; she just did it. So, it has been clear a) A Limited continuous technical training in both health centers; b) A poor scientific information exist on the efficacy and impact of strategies; and c) Unknowing of others nurses about activities carried out in Adolescent pregnancy program.

4.4 Victims of gender violence

In this section nurses' interviewed and women participants in focus groups described spontaneously dominant behavior from their partners and revealed the presence of

violence episodes during their everyday life. Narratives are presented in each of sub-categories. In total n=03/07 nurses and n=34/72 women experienced different kinds of gender violence. In order to present these results in total number of cases and percentage 37/79 participants of this study were victims of any kind of gender violence; it is (49%) of the total participants. These totals are only participants who say during the interview and focus groups they have been victims of one type of violence. Although, it was observed with relative frequent, that some women experienced multiple types of violence simultaneously.

4.4.1 Dominance and control:

Women

In this sub-category n=06/72 participants described typical signs of an abusive relationship; women spoke about being under control of a dominant couple. They commented experiences such as ownership sense on women, emotional manipulation, isolation and specific gender roles.

FN1-P3: I want to study but my husband does not allow me.

FN3-P6: I lived it. I remember my former partner; he made me to wear cloths as a man. He made me dress sports pants with wide shirts. I never said anything because I did not like that he became jealous. I did not want to confront him. I could not visit my family, my mom did not visit me and he did not want that I had friends.

FN4-P3: My husband tells me: you are responsible for everything at home in a very bad way.

FN4-P4: When I go out home I try not to wear t-shirts without sleeves, shorts or skirts because my husband feels very jealous.

FS7-P2: I did not finish either my studies or work because my husband did not allow me to do it. My husband calls me every moment to know everything I do. Sometimes is very difficult for me to make the cytology and medical control.

FS7-P9: I do not do things for me because I must ask my husband for permission, if I am going out he always feels misgiving. He asks me, where I am going, what time I am coming back, or you better wait for me I will go with you. In case I go along he calls me and asks me every time, where I am, why you do not tell me. I seldom leave home, only the necessary because I do not like to have problems with my partner.

4.4.2 Physical violence:

Nurses

n=01/07 nurse during interview narrated several physical assault from their partner.

I3: I remember well the first time he hit me, I was pregnant. You are doing this interview to know my performance, but I feel like a patient in a violent situation.

Women

n=20/72 women were victims of physical violence and the aggressors were partners, ex-partners, sons or grandsons. During discussion in focus groups older women (n=04/09 aged > 65 years) participants in this study commented their stories of abuses in which sons and grandsons learnt violent behavior against woman and learnt also to justify their behavior.

FN1-P5: I have a problem, my husband beats me, I am living full of fear.

FN1-P6: My grandsons 31 and 32 years old hit me, and they hit my daughter too.

FN3-P2: In 32 years of marriage, of course we have lived physical violence. Observation: Participant commented it as a normal situation.

FN3-P4: I lived this situation with my husband, first he started with offenses, he forced me to do the household shore when I was sick, and when I did not do it. He threatened me, until the strokes came one day. He hit me like I was a man.

FN4-P5: The early years of marriage were very hard because physical violence was present.

FS5-P1: when my husband got mad against me, he hit me; he dragged me on the floor as if I were a rag.

FS6-P4: He hits me when he is upset, but I also hit him to defend myself. Once he bit my hand, at the same time I was choking him so he stopped biting me.

FS7-P3: I remember I was eight days after giving birth to my daughter. My husband came home drunk and beat me. I only cried and bleed because I had lost several teeth; I never knew why he hit me.

FS7-P7: I have endured beatings; I have endured physical, emotional and sexual abuse. Observation: She remains in silence a few seconds and then she continued the comment. Yes, I can say, he abused me sexually. I have been sexually abused and I have been sick for that.

4.4.3 Psychological violence:

Nurses

n=02/07 nurses in this study are or have been victims of psychological violence. Descriptions collected over the course of interviews showed wiles, disrespect, humiliating, harassment or constant death threats.

I2: My husband violated me, it was not a physical violence what he did to I, it was psychological violence. I had lots of suffering without receiving a single stroke.

I5: My ex-boyfriend is harassing me and threatening me with death. Once, my husband and I were in church. He (ex-boyfriend) arrived with a gun and told my family that he would rather kill me to stop me of being with someone else.

Women

n=05/72 women commented experiences in which the hitting was not involved, but behavior and language was used to damage the victim by touching their self-value. During discussions in focus groups women expressed feeling of fear and anxiety for death threats.

FS5-P8: Violence is not only stroke, there is another type as verbal violence and I am living it. He yells at me, insults me, scares me and haunts me.

FS5-P2: Always he yells, threats, scares and chases me.

FS7-P1: He tells me: I will kill you.

FS7-P6: At home lives my son, my ex-partner and my two grand grandsons. My son arrives drunk at home and he mistreats us with his words, he tells us contemptuous. He tells to my grand grandson who is 10 years old "when you will grow up you will be a homosexual and a parasite" he says to me "you are raising a parasite". My ex-partner when I cook and feed the children he starts screaming saying: "I have no obligation to feed the children of your granddaughter". Then my grand grandson tells me "do not worry Grandma, I do not want to eat". They only yell, threaten, humiliate and tell me the worst things.

Observation: She remains in silence a few seconds and continue saying.

I want that somebody help me with these people, because I suffer so much, because I do not know what to do.

Observation: Participant began to cry desperately.

4.4.4 Sexual violence:

Women

n=03/72 participants were victims of sexual abuses; n=02/03 from these women were married; they expressed their feelings of dissatisfaction with forced practices from their couple.

FS7-P5: When I was five years old I was sexually abused by my uncle, and I can say that it changes life.

FN1-P8: I must have sex just when he wants it; if I do not do it, he begins verbal abuse.

An overall interpretation: Within the context of an intervention proposal to prevention and assistance of gender violence, the meaning of gender violence was complemented

with experiences in which nurses and women clients of university health centers were victims. In this section they expressed spontaneously being under different types of gender violence. While some women suffered "explicit violence" there was evidence of "underground violence" (Meneghel et al., 2011) which is not physical violence that goes unnoticed and is due to the stereotypes that subordinate women.

That is the sub-category dominance and control represented by couple desires apparently insignificance without hitting or threats, “the exercise of power was characterized by using multiple control tactics” (Dobash and Dobash, 1979). It was showed in the results, women narrated their experiences with constant checking, controls and deprivation of their own needs, i.e., renounces life projects, dependence and submission. In terms of escalate use of violence could be a prognostic of risk, which means early phase of extreme violence episodes or consequences in women’s mental health.

Physical violence was the most frequent abuse in participants and the most obvious dangerous; although they recognized that their situation was abusive, they have endured long time and the reasons for what they continued together with their partners or abusive relatives (sons or grandsons) were discussed in category meaning of gender violence. In some participants psychological aggressions were recognized by them and death threat was more frequent conduct from aggressors being in the case of a nurse an attempted real homicide.

About the women sexually abused, they were living the demand from their partners to have sex although they do not want it. Another modality: they were forced by partners to do sexual acts they do not seem or they have been forced sex by physical force. Despite of women mentioned one type of violence; over course of data analysis were detected (81%) victims suffered several types of violence simultaneously. Three nurses reported own experiences with Gender Violence. This might be a problem, because own experiences that have not been taken care could cause inability to care for clients.

4.5 Impact of gender violence

This section collects expressions of participants affected by gender violence that indicated impact on their mental health. In total n=03/07 nurses interviewed and 34/72 women clients of university health centers.

4.5.1 Fear:

Nurses

In total n=01/03 nurse victim of death threat revealed emotional state of fear.

I5: Always I live with this feeling inside me even when I am on the street, I am aware of those who are around me because I feel afraid that something might happen to me. Once I tried to denounce him but the police asked me his identification card number but because I did not know it I could not proceed with the complaint.

Women

Similar experiences were collected in passages from focus groups discussions in total n=25/34 victims of different kinds of gender violence expressed their emotional state characterized by fear, panic or terror, they expressed feelings of uncertainty or worry. Most of victims manifested living in fear constantly and they described punctual situations in which their panic feeling was present with more intensity and how this emotional situation triggered physical symptoms. This sub-category was more evident in victims that suffered extreme violence.

FN2-P11: I always feel fear to report because institutions are indifferent to face this problem.

FN3-P6: I feel fear with men violence because they threaten with killing the family.

FS5-P7: Sometimes we have our crisis and I feel really scared when my husband is coming at home from work. For example: when I see that it is 6:00 pm I begin to tremble with cold like I was in a freezer because he hits me for everything that I do or say.

FS7-P2: I feel afraid to take the decision of leaving my partner. I always talk about that with my daughter; I feel fear of the consequences because I know he is not going to be quiet.

FS7-P3: I reported my husband last week I felt panic. I was without eating and sleeping for a week, we were called by the police when I faced him I could not speak a word I saw him and I began to tremble.

FS7-P4: Fear and cowardice, that was what kept me trapped into violence situation for many years. For fear I left my house with nothing, we do not hand out material possessions I left my house only with my clothes.

PS7-P5: The experience of sexual abuse is the most terrible thing that a woman can support but the worst is when you have in your mind that others could suffer the same. Normal people feel bad when they see girls are sexually abused, but when we are older and see that other girls live something worse it hurts much more if you have already had that experience. Observation: Participant is a teenager 17 years old.

FS7-P7: At bedtime I trembled a lot, I felt my heart was going out; I always was very scared I really felt panic.

4.5.2 Low self-esteem:

Women

It was observed in n=05/34 women victims of gender violence phrases that compromised their self-confidence and self-assessment. It suggests that circumstances and experiences with gender violence have affected beliefs about themselves negatively.

FN1-P5: They (husband and husband relatives) have treated me like garbage. I feel like garbage. Observation: She remains in silence a few seconds and began to cry.

FS5-P3: I thought if he has an affair is just because I am good for nothing.

FS5-P5: Now, I have another husband but what I lived before was a disgrace I felt lesser, I was unhappy. Honestly I did not feel like a person, I felt like an animal because he abused me all the time, I endured a lot of hits.

FS5-P8: When you have these problems, you feel worthless and that makes you lose the strength to act.

FS6-P7: I am feeling like an incompetent woman to face life alone.

4.5.3 Mental suffering:

Nurse

In total n=02/03 nurse presented feelings of unhappy over the course of interview she narrated how these symptoms affected her life. Also they needed psychological or psychiatric therapy for overcome her emotional problem.

I2: Affairs with other women, he undervalued me. He seems like he was a victim and he talked to me like it was my guilt, he lied to me. It was horrible, this relationship was very heavy. My mind was confused, I felt empty of right feelings that is why I had psychology therapy. Nowadays I feel better but sometimes my feelings go down.

I3: When my family needs me much more for the violence situation. I felt empty with no answers at all I just felt pain. I went to a psychiatrist.

Women

n=19/34 victims of gender violence showed signs of depression, hopelessness, unhappy and lack of meaning to existence. Most of women expressed this suffering.

FN1-P5: I feel unhappy Observation: Participant began to cry.

FN4-P4: I felt pain in my soul, torment. Just now I am separated but I have not peace.

FS5-P7: I have done many things. I have humiliated myself when he is aggressive I implore him I knell on my knees and implore my husband "please we need the separation" and he answers: First, I kill you. The only thing keeps me going on are my sons but I feel my soul is dead. Observation: Participant was crying.

FS7-P6: The life is horrible Observation: Participant began to cry.

The others participants expressed similar phrases; this was also together with emotional displays such as crying, sadness, anger or emotional numbing.

An overall interpretation: Feeling of anxiety, worthless, distrust in itself and hopelessness persisted indefinitely in the life of victims affected by gender violence what impeded their well-being and the development of normal activities in daily living. These warnings suggest symptoms of depression or psychological distress (Vives-Cases et al., 2010; Keeling and Fisher, 2012). Specifically in the sub-category fear was observed as intimidation used by the offender to build anticipation of harmful consequences (Azevedo et al., 2012). Principally fear and practice of values from patriarchal culture explained the fact for what the most of women in this study remained for a long time in abusive relationship. A limiting in this research fragment was related to the technique used focus group, talking about consequences on women's mental health, because gender violence operates with escalates of abuses, and the psychological aspects preferably must be examined deeply through interviews or others scales available.

However it was positive that women revealed their repressed feelings; a group of these participants said they had never spoken in detail about the abusive relationship. It could interpret as an effect of isolation. Thus, this practice of group communication functioned in participants as an escape valve. Also the dynamics raised in these focus groups allowed some victims to understand the following: they are not the only ones with this problem, the abuse is a crime not a normal situation, the mental symptoms are consequences of abuse and woman needs to become in active part to resolve the situation together with professional support.

4.6 Suggests to improving gender violence approach

In this section women clients of university health centers were asked about recommendations to improving gender violence approach, answers will presented in each sub-category. In total were collected n=51/72 opinions from material.

4.6.1 Community Prevention:

Women

In total n=33/51 women clients of university health centers commented the importance of educational activities to reduce gender violence. From participant's points of view to development educative activities is necessary spread about existence of the Organic

law on the right of women to live free of violence whose content is unknown to the most participants as well as an office that receive complaints. During discussion they affirmed that getting information about this law is a way for protecting themselves against violence and these educative activities should involve women and men. About others topics suggested: Integrating in content of culture of peace; Control of aggression in family relationships; Self-esteem; Communication skills; and Consequences of violence in women's lives.

FN3-P2: Diffusion of the law, because many of us do not know the contents of law and men should see that this law exists and when they read the consequences for a man who is abusive they will have more respect if not for women at least for the law. The information should not be just for women should include men. We need the state to face the problem responsibly; they must see that law is applied so when you report, it is possible to obtain protection, it cannot be that the state does not fulfill that function.

FN3-P7: We need education.

FN3-P8: Women need people to help them overcome this problem. We need educational activities for young and adult women, because sometimes younger are blackmailed by the aggressor.

FN3-P10: The most important thing is to know the law in order to defend ourselves because it can happen to anyone. Education is needed.

FN4-P3: I think that a school for parents should exist where boys and girls could learn how to control an aggressive situation including husband, children and myself as a woman. We alone do not learn in everyday life to live peacefully, we need specialist guidance.

FS5:P3: I say that workshops should be organized for women to learn how to increase their self-esteem, because that is lack of self-esteem. Then I think we should do more events like these meetings, with solutions for people.

FS6-P3: Educational activities about violence should be made in the communities and explanations about consequences of abuse in a woman's life.

FS6-P7: We must have guidance on family living, learning to share with others, communication skills to develop our relationships with people; especially into the family.

FS7-P8: Guiding people because they never know how to solve the problem. People do not know places to report. Neighbors often do nothing because they do not know what to do.

FS7-P2: That is true; we need education because many people are desperate. They do not know where to go. Women feel their hands are tied.

FS7-P9: Having good communication between family members, learning to solve problems peacefully.

FS7-P5: Doing educational activities not only to inform women also men.

4.6.2 Community Participation:

Women

In total N = 06/51 women clients of university health centers expressed their opinions on the importance of community involvement in the prevention and assistance of gender violence. Similarly, it was discussed strategies to encourage participation in the population. The key points of the proposals: a) Sensitization of community leaders and the general population, b) Greater involvement in the problem by existing community organizations, in Venezuela they are community councils in Spanish “Consejos Comunales” c) Establishment of a committee to provide protection to victims of gender violence was another possibility suggested; d) Agreements between the university health center and community councils, and e) Agreements with members of the communities a mechanism for screening and referral of cases to the university health center.

FN3-P4: Here you need people to help women change their thinking to stop masochism, people who do not feel afraid to report.

FN3-P2: The community must show its solidarity with the problem, but only when a woman asks for help because when she did not ask for help no one can do anything, it is a family problem. I think the community council should also collaborate and they should go homes and talk with men too they will not beat their wives. The commune council should warn to men if violence recurs a report is made. They should function as justices of peace.

FN3-P10: As a community leader I want more information on the subject, and increased communication between University Health Center and the four community councils that work in this area because only one community council is working with the health center.

FN4-P5: Doing meetings like this makes agreements, and where there is not a community council creating a committee for helping women.

FN4-P1: I think it is good idea what you said (referring to the former Participant) to meet several persons and agree are ways to help the victim of violence, this group can give council and then can take it to the health center for professional guidance.

Observations: The proposal discussed in the focus group No.4 on the creation of a committee to provide protection for women was well received by other participants.

FS7:P5: I think it is very important that we support each other and that the community is prepared to provide protection for these types of cases. A person needs the help of people who are nearby such as our neighbors, but community should recognize that this is a serious problem.

4.6.3 Intervention in gender violence:

Women

In this sub-category n=12/51 women clients of university health centers expressed their opinions about the necessary measures to provide better care to victims of gender violence. The proposed strategies are based on the necessity to address gender violence cases from health centers through care health and legal advice. Participants commented another need which is the qualification of a multidisciplinary team; that might be available in each university health center as well as batterer intervention. The following passages showed expectations from women's point of view.

FN2-P11: While there is not a procedure in hospitals and primary care centers where the woman receives health care immediately and processing the complaint, I think that is not going to change.

FN3-P3: It must run a legal consulting within the health center. It would be good because now even the physician does not want to write the report when received battered women. He says: she must go to Carabobo Hospital, in this center she finds a forensic report and then she goes to prosecution.

FN3-P9: In the health center must have psychology service and legal advice.

FN4-P1: In the health center should run a counselor team. Professionals trained to tell women how to get out from the problem and which are the places to make the complaint.

FN4-P3: I live in this community and I think that many women need help. They have no knowledge, lacking information on the subject. They do not know the places to complain. In this health center there is no qualified staff, there is no presence of a staff that help neighbors in solving that problem. My experience as a community leader is that children come home for help, they desperate look for it and say: "Mrs. Rosa runs to my home because my dad is hitting my mother". So, for that I say we need this service; we need a trained staff to answer people as soon as possible. There should be professionals who give legal guidance to help them to make the decision to report, because these women are very submissive, they always misunderstand love for their husband and they endure everything.

FN4-P7: In the health center should have a group of professionals trained in such cases, to guide women on what to do when there is a situation of violence. I think

should have lawyers, nurses, psychologist and counselor. This service is very important because it would help to reduce the abuse of women. People would have more knowledge on the subject, i.e. when communities achieving a link with the health center and the justice system, it reduces the procedure and women would feel more protected when they make the complaint. People would be better informed about the procedures when a complaint must be made.

FS5-P7: I think, it is very important to provide a counseling service to aggressive men. Assistance for women victims of violence is always necessary but men also need help and guidance.

FS6-P1: There should be a group of trained professionals who give attention not only for women. I think, they should give attention to a man who acts in a wrong way.

FS6-P4: I think, it would be helpful if there is a service to report the aggression at the health center.

FS6-P5: It takes a trained team because this problem needs medical, psychological and legal advice. People need guidance.

FS7-P6: I would like that a team came as a surprise to my house with the police, nurse, doctor, social worker, school teachers. Surely a lot of women want the same thing that the man did not notice that a person is making the complaint. I want that a team ask my grand grandchildren also they can call the mom (granddaughter) the older children know very well the abuses that are happening at home. They can answer all these questions, and those men who live with me (ex-partner and son) heard it is bad abusing children and women. I think, the complaint should not be solely the responsibility of women.

An overall interpretation: Educational activity was the suggestion with greater consensus during discussions in the focus groups. Participants agreed that population need a change in thinking and behavior in relation to gender violence. Similarly, they expressed their belief that this change can be achieved through awareness campaigns and empowerment. “Community participation” was suggested as a social control strategy implemented through existing organizational structures within communities.

In Venezuela this function would correspond to the Community Councils and in communities where there is not this organizational figure, participants suggested creating a committee for the protection of women victims of violence.

They said that this effort should be coordinated with the health center and other institutions responsible in order to transforming these actions in higher welfare. In other opinions collected participants identified that domestic violence must be understood in the collective consciousness as a problem that affects the values of community life. It

will encourage members of the communities to seek solutions with a group view and creating of their own changes. In results of the subcategory “intervention in gender violence” participants expressed important needs base on experiences living by themselves.

First, presence of a qualified multidisciplinary team working in coordination with the justice system this requires a legal advice service within the university health centers. Once again referring to the findings of the category “nursing role in addressing gender violence” was determined that one of the health centers under study has this service and they provide assistance to girls and adolescents victims of gender violence which has facilitated the management of these cases. This becomes an advantage because it would be possible to adapt the services available to the necessities of the population with existing resources.

Second, it was suitable batterer intervention suggested because it will extend the perspective about integral assistance of gender violence which stays incomplete with the unique victims approach. And the contribution from health sector could be direct to psycho-educative intervention and assistance of mental health problems. This last subcategory also showed how several victims who feel afraid are unable to act for themselves and they demanded intervention from a professional team just this finding is consistent with the finding debated in the category “nursing role in addressing gender violence” about the legal obligations of the health team after identifying cases of domestic violence.

However, values of traditional gender model from patriarchal culture, normalization of gender violence, lack of training in health team and lack of guidelines in mater of prevention and assistance is transforming in barriers that impede to offer real protection to women that are victims; it threatens women health and life. The finding in this study confirmed the existence of institutional and community needs in matter of gender violence.

Knowing the characteristics of primary health assistance services among which stand out continuity, completeness and participation, it is indisputable that the contribution of university health centers “Nuestra señora de la Luz” and “El Concejo” may become very significant, since it constitutes the most suitable space for prevention, early detection, and support of gender violence cases. On this point, the importance is to make the health teams constantly aware, provide them with training regarding to work with a gender perspective, promote professional cooperation in health team, legal obligations, mechanisms for screening and report, protection services available, and the inclusion of community organizations.

5. Discussion

This research complements the understanding of gender violence; the explanation of findings will be offered in two key points. First, the analysis of participants' opinions about the meaning of gender violence showed that values of the traditional gender model were shared and practiced by nursing staff as well as women clients of university health centers. It made them to tolerate sexist beliefs, be victims of different abuses into the familiar life, and develop symptoms that impact negatively their mental health. Second, opinions from nursing staff about their professional practice in relation to prevention and assistance of gender violence reveled needs in health centers such as cross training in nursing staff and definition of guidelines.

In the categories hierarchy the meaning of gender violence was the factor with more influence on personal, familiar, community and institutional decisions what becomes in barriers that should be considered in planning the implementation of strategies to assist and prevent gender violence. It is in line with the findings of other studies (Kendall and Pérez, 2004; da Fonseca et al., 2009; Medina et al., 2011; Medina et al., 2013). The discourse of participants revealed the replication of values that become in references or modus vivendi of a collective. Nursing staff is a part of this society and, if health team has not received training with gender perspective is compressible the execution of sexist practices into health institutions. The meaning that participants gave to gender violence was reflected in several contexts.

The normalization of violence into partner relationship is a problematic area that was observed not only in women clients of university health centers but also in nursing staff. It could be explained as is persisting into belief systems a conviction about men have right to discipline members of the family (Velasco, 2008) and it could include the use of different kind of aggressions in order to demonstrate their manhood. Concerning to double victimization, I first evaluated the current opinions from nurses; they explained the reasons why they considered that is not useful providing attention at victims of gender violence in aged adults, principal comments were "women want violence"; "refusal on legal issues"; and "lack of confidence in justice system". One of these nurses explained an experience with two patients (girls and sisters) victims of incest and how the judgment favored the aggressor (grandfather) even if sufficient proves were offered.

On other hand, the opinions from women participants in focus group discussions did not differ in comparison with nurses. They estimations affirmed "women want violence"; "ideology of male domination"; and "lack of confidence in justice system". In many

cases they tried to report this problem and they were rejected by justice system. Referring to this point, which was appreciated by nurses and women, a study by (Meneghel et al., 2011), showed that the victims were pressure by professional staff or relatives to remain with their marriages. In the case of justice system victims expressed inefficiency in providing protection.

A convenient indicator to measure acceptance or reject of traditional gender model is to know how household chores and parental responsibility are shared into the family. Nurses and women described their activities in everyday life; in most testimonies both groups took the primary role into home to respond expectative about a woman in front of the domestic life -implicit imposition because it is what society wait-; but in other cases this aspect was a compulsion resolute from partner -explicit imposition in which partner used tactics base on power to allocate women in this place-; this is supported by others studies realized in Latin-America (Kendall and Pérez 2004; Gil-Romo and Díez-Urda, 2007; Oliart, 2004; PAHO and WHO, n.d).

In the collective perception remained the idea that men are unable to develop this kind of domestic activities. It was frequent in women and nurses overload of activities because despite of partner were unemployed and they were at home, they did not show cooperation. As seen in other studies, women dedicated a few hours to sleep and rest (Silva and Torres, 2009). This sexual division of responsibilities at home involves lack of cooperation by male in child care and household chores. These behaviors turn into an obstacle to promote healthy lifestyles and welfare family members (Silva and Torres, 2009; Medina et al., 2013).

Referring to the victims' category of gender violence, in the totals percentage of cases were shown that (43%) nurses and (47%) women clients of university health centers were victims of some kind of gender violence during their life. The different forms of violence were perpetrated most frequent by partner or ex-partner, but also gender violence was done by relatives (son, grandsons and uncle). These results were consistent with the study by (Vives-Cases et al., 2011) in which was showed that "Intimate Partner Violence -perpetrated by partner or ex-partner- is the most prevalent type of violence against women in Spain".

Besides, it was evident that the meaning of gender violence as one of causes to women remaining with abusive partner. During the analysis of testimonies was shown women minimizing the aggression and did not seek help. It is congruent with the study realized by (Fugate et al., 2005) in the total percentage of responses:

> "Among (82%) of the abused women did not contact an agency or counselor; (74%) of the women did not seek medical care following an incident (62%) did not call the police and (29%) of the women did not talk to anyone else, such as family and friends about the incident".

The study realized by (da Fonseca et al. 2010) agreed that "malicious physical injury (49%) and threats (42%) were the most frequent types of violence". It was consistent with my findings in the total of gender violence victims n=37/72 it was observed most frequent physical violence (57%) next to psychological violence (19%) of participants affected. Similarly, threats were the tactic often used by perpetrators into psychological violence. About sexual violence was observed that married or living cohabitation women were prone of these assaults; in the case of single woman aggression came from a relative (uncle). It was similar to affirmations by prior authors (Stevens, 2002; Campbell et al., 2008).

Dominance and control displayed one again conducts of traditional gender model in which violence is apparently inexistence but the consequences affected to women in matter of personal development. It was evident that women renounced their projects (employ and education) but also other freedoms (friendly, style to wear and independence) testimonies of women showed a controller partner that required to know exactly all that women make during the day. The results observe in the category dominance and control were consistence with studies realized by (Bourdieu, 1990; Johnson, 1995; Johnson and Ferraro 2000; Keeling and Fisher, 2012).

About the consequences in mental health the total of victims n=34/72 showed some warning sign such as fear, low self-esteem and mental suffering; the most frequent symptom between participants was fear it was present in (76.4%) of victims. It is relevant with the conclusions by (Azevedo et al., 2012) in the category "silent or silenced violence" was focused on the perception a climate of constant terror:

> "It presents a woman who lives with fear. The continuity of violence is clear in the speech of women. Even in the absence of formal relationship with the couple, the fear persists, and a sense of vigilance and care accompanies these women".

In addition to the aspects related to consequences in mental health, I identified low self-esteem (15%) in the total of expressions analyzed as well as mental suffering (62%). Women's shown in different moments during their speech a poor self-esteem, these expressions contained clear messages in which they felt less than others persons. In participants were observed expressions that reflected feelings very marked of sadness and hopelessness. These results make victims obviously vulnerable. It was

comparable with findings by others internationals authors (Fugate et al., 2005; Keeling and Fisher, 2012; Azevedo et al., 2012).

Among the themes explored the second important finding was related to the needs observed into the health centers to provide prevention and assistance in matter of gender violence. About guidelines and protocols was verified in totals percentage of opinions (85%) of nursing staff does not know the existence of procedures into university health centers to the approaching of these cases. They affirmed also most of cases detected during consultation or in urgent services remained without registration in the medical history form neither these clients victims of violence received no advice or follow-up. In this line the study realized by Sundborg and collaborators affirmed:

> "The majority of the nurses working in primary health care were found to be quiet unprepared to provide nursing care to women exposed to Intimate Partner Violence. Consequences might be treatment of symptoms but unidentified abuse and more and unnecessary suffering for these women. They lacked organizational support e.g. guidelines, collaboration with others and knowledge regarding the extensiveness of Intimate Partner Violence" (Sundborg et al., 2012).

This lack of information on guidelines and protocols were accompanied by unknowing about legal obligations in gender violence detection with vulnerable population; social and legal services available; procedures established in the official standard for care in sexual and reproductive health; as well as ways of approach to the victims.

This fact revealed a deficiency in mater of gender violence training into the health sector. This point represents a barrier to achieve the goal of offer protection from health institutions to gender violence's victim; it was also discussed by others authors in national and international studies (Guedes et al., 2002; Silva and Torres, 2009; da Fonseca et al., 2009; da Fonseca et al., 2010; Medina et al., 2011; Sundborg et al., 2012).

Nurses who had detected cases of gender violence during their professional practice and decided to take actions to offer help to the victims reported that they were missing training because in the practice they followed their own criteria. It was what they considered right. They expressed their feeling sorry for victims especially, if they were children. It is comparable with the study realized by da Fonseca and colleagues in which they affirmed:

> "Understanding and feeling sorry for the abused of a woman presented a position that tends to be appropriated, probably a result of humanization in the field of nursing" (da Fonseca et al., 2009).

The only nurse who reported to have taken instruction about gender violence topic commented that the training was received during her post grade studies. In the interview was noted unknowing in normative issues. She neither made a correct handle of the theoretic aspects. However in the practice she did an appropriate approach in the following areas: preventive activities; implications of others actors in detection of cases; diagnosis and counseling.

Furthermore, her communication skills with victims of gender violence were positive; she commented that it was developed through the practice. The interventions done by this nurse were in line with the principles of bio psychosocial model that could be integrated in the professional activity to provide assistance to victims of gender violence (Engel, 1977)

Even though some nurses in one of university health center under study specifically “El Concejo” reported there were not available guidelines to gender violence assistance. This fact is not totally precise because there were available guidelines to the approach of this problem in girls and adolescents population. In this sense, was marked absence of cross training, this lack of information about services available showed a deficiency that impact negatively to clients.

The policy implemented in university health center “El Concejo” about legal advice into health center; linking with justice system and creation of multidisciplinary network was not comparable with others studies because this is an inedited experience. It represented a strong point to elaboration of the proposal and the inclusion of adult’s women population who are remaining without attention. Also, this prior initiative might be used to reply in university health center “Nuestra Señora de la Luz” where it was clear a total absence of guidelines to the approach of gender violence.

The experiences narrated for the specialized personnel (nursing staff) and community members (women clients of university health centers) shown clearly the barriers that impede to offer protection for victims of gender violence. They were mainly the practice of values or beliefs from the traditional gender model, lack of a systematic training in nurses interviewed and the lack of guidelines to the assistance of gender violence cases.

In this sense, the results found in this study were taken as contributions to define a proposal for nursing intervention in matter of prevention and assistance of gender violence.

6. Summary

This section will discuss the implementation of activities in prevention and assistance of gender violence. This implementation implies a reorganization of the services in university health centers. An advantage of the health center, “El Concejo,” is the availability of a multidisciplinary team to support children and adolescents who are victims of gender violence, and only minor adjustments to this structure are needed to meet the new requirements. The office of legal counseling at this university health center ensured a link to the judicial system and social services. The team must receive cross-training to improve collaboration and clarify the duties and guidelines for the nursing staff.

The preventive component is based on the needs of the population, which were assessed through focus groups. Preventative services should include two activities. First, education and prevention involve offering general information to the population to minimize risk and strengthen protective factors. These activities require training volunteers who will work in the field: teachers (primary school, high school) and scholars, as well as community members (members of community organizations, natural leaders or any member of the wider community). Second, this distribution of information should be complemented with research to establish the scope and effectiveness of educational programs in different populations. At this point, it is also important to conduct studies on perceptions of gender violence to demonstrate the existence of a change in attitudes.

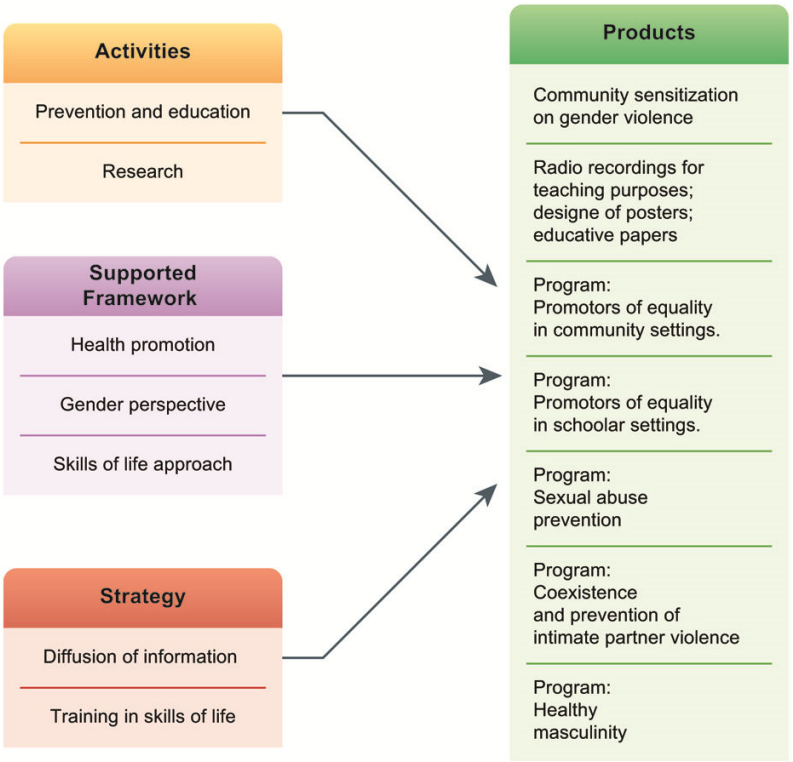
The programs for health promoters recommend implementing social control mechanisms to detect and report violence to the relevant authorities. These programs also should provide training to establish connections among promoters, health providers and social services with the aim of ensuring emotional and physical health of victims. The preventive component will include elements of several theoretical frameworks from a) health promotion as the procedure that enables individuals to improve their health through essential community participation (Centro Nacional Género y Salud, 2005; Garcia, 2005); b) a gender perspective that introduces critiques of the patriarchal organization of society (gender stereotypes and roles) as well as the limitations of the construction of female identity (Centro Nacional Género y Salud, 2005; Camacaro, 2010) and; c) a life skills approach that combines human development, behavior and learning.

The competencies of the life skills approach are: “self-awareness; empathy; assertive communication; interpersonal skills; emotion handling; decision making; critical analysis; problem solving; tension and stress management” (Mangrulkar et al., 2001).

In relation to the insertion of these competencies, prior experience from “El Concejo” was considered (see the sub-category approach of gender violence).

About the strategies will be included: a) the diffusion of information with the objective of increasing knowledge about the social and health consequences of gender violence, and the clarification of values to develop a critical view of the problem demystifies erroneous beliefs within the collective; b) training in life skills that focuses on the development of protective factors through personal and aptitudes to produce behaviors that allow effective problem management and meet the requirements and goals of everyday life. These strategies are implemented through online courses, meetings with community members, workshops and seminars. (See figure 1)

Figure 1



Plan to preventative actions

The assistance component is based on population needs and on the experiences at the university health center, “El Concejo”. The population’s needs were assessed through the testimonials of women in focus groups. Adjustments were also based on international programs and recommendations (WHO and PAHO, 1998; Salber and Taliaferro, 2000; Blanco and Mendi, 2005; Hellbernd et al., 2005). The intervention involves specific actions by nursing staff and professional collaboration. The nursing staff is critical to achieving strong collaborations with the justice and social services

systems and to ensure the safety of the victims and the health team. This model of assistance involves four steps.

The step I, diagnosis, implies the identification of a victim or potential victim. Detection could occur in urgent care services, during consultation, during preventive activities or following client referral from a health promoter. During this step, the nurse employs her communication skills, including: a) active listening (helping the person feel free to speak, allowing time to explain the situation, watching body language, letting go of distractions); b) non-judgment (avoiding personal perjury; trying not to become irritated; understanding that these women are in a vulnerable situation, may feel hesitant to make a decision, and require time and advising); c) simple language (producing a short and comprehensible message, avoiding to use of technical language); and d) empathy (trying to understand what the woman says; understanding the woman's point of view, waiting to offer an argument that respects the point of view and beliefs the other person in the event disagreement). Risk assessment provides an evaluation of the danger level facing the victim. The severity of the case determines whether an immediate report must be filed to ensure the victim's protection, but some cases require more time to prepare her to take action when lethal consequences are not involved. However, exact criteria -this means standards for reporting an incident- must be discussed with the multidisciplinary team before implementing this model of assistance.

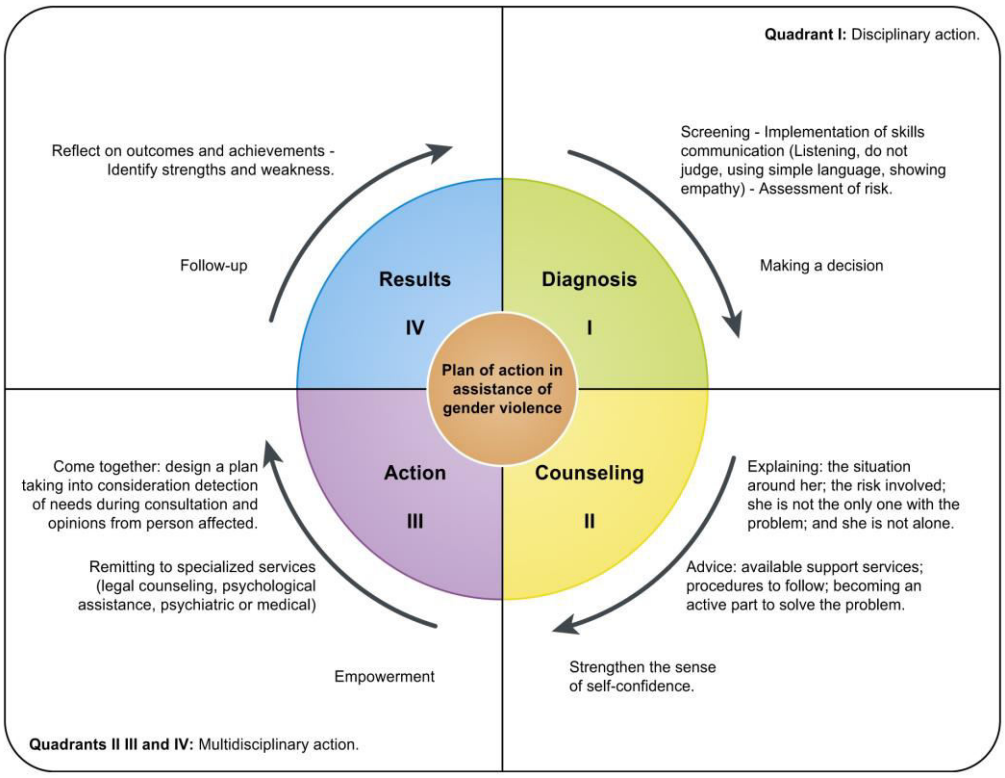
The step II, counseling, requires the nurses to support a victim in making important decisions, to provide a clear explanation of the situation as well as outlining possible short- and long-term consequences of particular decisions. Previous research and the results of this study demonstrate that women are immersed in "guilt, doubt and fear" (Fugate et al., 2005; Meneghel et al., 2011; Azevedo et al., 2012). These feelings highlight the importance of ensuring that the victim does not feel that she is the only one with this problem and that she does not feel alone. The nurse advises about the available services, legal proceedings and medical procedures that may follow. The victim will have to be actively involved in future action to solve the problem. Taking action requires strength and self-confidence as well as the knowledge that there are tangible options to resolve the situation. During these procedures, the case must be recorded in a medical history form. Despite the designation of the step II as a discipline specific action, professional collaboration is not prohibited during this step. Counseling is a key step requiring availability and expertise of the nursing staff.

Steps III and IV involve multidisciplinary coordination. Collaboration requires the design of a plan that addresses the needs identified during the consultation and that considers the opinions of the person affected. Nursing staff refers a victim of gender violence to specialized services (legal counseling, psychological assistance, psychiatric or medical

care). The empowerment model includes short educational sessions to provide information and improve understanding of the problem and strengthen the person. Information is available in group sessions (workshops, presence seminaries) or individual sessions (online courses); the content of the educational intervention includes life skills and gender perspectives.

Results, the last step, occur when the victim analyzes the outcomes of an educational intervention. Somerville and a colleague affirmed that reflection-on-action involves carefully re-running past events in the mind (Somerville and Keeling, 2003). Reflection might be guided by a nurse by adapting of “stimulus" questions proposed by these researchers. This reflection provides a way to examining the impact of educative actions in everyday life. Reflection is also part of emotional support, and it provides an opportunity to re-establish goals, as well as to identify strengths and weakness. Following-up with a victim of gender violence is a complex activity, which requires close collaboration (physicians, nurses, social workers and psychologists) to address their psychological, emotional, and social problems. (See Figure 2)

Figure 2



Plan of action in assistance of gender violence

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Theses

1. The meaning of gender violence was the factor with more influence on personal, familiar, community and institutional decisions according to discourse of participants.
2. Lack of training and guidelines into university health centers become in barriers to warranty protection to victims of gender violence.
3. Lack of quantitative studies to know exactly what proportion of women clients of health centers in the Carabobo University suffer domestic violence, as well as their clinical and socio-demographic characteristics.
4. The implementation of associative strategies with other professionals and the participation of the community contribute to improve detection, registration and follow-up in gender violence.
5. The implementation of a training program to health team is required in order to clarify duties; improve disciplinary collaboration; and design protocols to nursing staff.
6. The population demands of nursing staff an active role in gender violence assistance. It involves early detection, registration of cases, support, referring to specialist services, and follow-up.
7. The population demands of nursing staff an active role in gender violence prevention using their core competencies in health promotion and illness prevention, nursing can empower communities through awareness campaigns.
8. During the practice of Community Health the use of participative approaches - focus group methodology- facilitates a dialogue with the community; it allows understanding their needs and providing an insight into clients' satisfaction with the services available.
9. It is necessary to prove the validity and effectiveness of the proposed intervention model through its implementation in university health centers.

ANNEXES

INTERVIEW 5

UNIVERSITY HEALTH CENTER "EL CONCEJO"

Discussion time: 00:21:06

Age: 31 years old.
Occupation: Nurse
Degree: Senior Technician in Nursing Sciences.
Exercise time job: 6 years.

1. **Interviewer: Could you describe the activities that take place in this University Health Center?**

Nurse: I am senior technician in Nursing. I work in different areas of this health center. I assist physicians in consultations; I care patients for example control of blood pressure, weight and height in children and adults. Also I performed the pregnant history form; I apply vaccination in the area of immunizations, I write the immunization reports, I go to the epidemiology unit district and I search vaccines that we need in this health center. I do the wound care to patients who need it. I administer oral medications, intramuscular or intravenous injections to patients as well.

2. **Interviewer: What is gender violence from your opinion?**

Nurse: I suppose, it involves the behavior of a person. I think it is the behavior of a person at home. For example, if you live with aggressive parents or relatives then this behavior or conduct is transmitted to other members of the family.

3. **Interviewer: In case of gender violence cases or violence-against women. What is the protocol to assist the clients or patients in this University Health Center?**

Nurse: Well, here works a group of lawyers but I do not know what protocol is followed when there are such cases.

4. **Interviewer: Could you describe any experience with this kind of patients?**

Yes, I have an experience, my personal experience. I had a stepfather and I lived every day the fight from my stepfather against my mother. I remember and I feel pain. **Observation: The nurse stays silent few seconds and then began to cry.** I remember well, my mother was pregnant and he tried that she lost her baby. I saw how he threw my mother against the wall and he hit my mother very hard in her stomach, he wanted an abortion. **Observation: She tried her self-control but she continues crying.**

5. **Interviewer: I know. It is very hard for you. Do you want to stop the interview?**

No, I do not. I can follow no problem.

6. **Interviewer: Please tell me about your work. Have you any experiences with this kind of patients or clients?**

We have few cases. Days ago I had a patient, she was battered by her partner but she simulated to be happy. I know exactly how it is because I lived violence at home during my childhood. I saw how my mother was battered from my father and then from my

stepfather. I know very well the situation. Women look well, happy and calm but the opposite is true.

7. **Interviewer: What did you do with the patient?**

Nurse: I was a child, I covered in my room and I heard beating and crying. Ever was the same. I closed the door of my room to be safe because it scared me a lot. I remember once my mother was into her room with the door close. The door was safe but my stepfather kicked so hard and he opened the door. […]**Observations: The nurse answered but she was doing reference to her familiar experience.**

8. **Interviewer: Is possible for you to recognize a victim of gender violence during consultation?**

Nurse: I think, I could diagnose it if the patient has injuries in her face or arms. Probably they would look sad. I am not sure. I remember a case during consultation; the patient was on the gynecological examination bed and after her exploration the physician said "you are expecting a baby" at that time the patient began to cry and she told us that she frequently was battered from her partner. She said "he is very aggressive if I am expecting a baby". The patient said that she lost others pregnancies as a result of the physical violence. Sometimes the patients tell us during consultation what happen in their private life.

9. **Interviewer: What do you know about the Organic Law on the Right of Women to a Life Free of Violence?**

Nurse: I do not know what this law pronounces because I have not read it. I have heard something about the law. I know very supportive to the mother, children and adolescents. Man is moved and he keeps on the last place.

10. **Interviewer: What are the legal obligations for the health team in the Law?**

Nurse: I do not know.

11. **Interviewer: Do you have reported any cases of gender violence or violence against women?**

Nurse: No, I do not do it. Once I had a case of violence. It was violence against child from her mother. The mother was very cruel, she kicked her girl, and she hit her with a broomstick. The neighbors were indignity for the conduct of this mother. However I did not the report. I did not know what I must to do. We do not receive instruction for assist violence cases.

12. **Interviewer: What do you think about women victims of gender violence that do not report their partner?**

Nurse: Each woman has her life; gender violence, I think is an intimate problem. Women feel fear and they have precaution to do not revel familiar problems in public. Also they feel fear because of these women do not anything. Probably they think that they could be batter again. They feel fear that the abuse becomes extreme dangerous.

13. **Interviewer: The Official Standard for Comprehensive Sexual Health and Reproductive some criteria are established for the care of domestic violence, and sexual violence. What is the involvement of nursing in such cases?**

Nurse: I do not know.

14. **Interviewer: Did you assist any case of sexual abuse?**

Nurse: No I did not. I had not cases of sexual abuse; in this health center one of my colleagues has worked with such cases but I just do not know the protocol when these kinds of cases come.

15. **Do you another opinion in relation to this topic?**

Nurse: A personal experience with my ex-boyfriend. I worked in a private hospital and at that time the nurse coordinator told me “a policeman wants to see you, but he is crying and he says that you are a bad, liar and manipulative person”. She observed that his conduct was not normal and she recommended me to leave the Hospital. Then she returned to her office and talk with him. It gives me the opportunity to get away. For this situation I lost my job, colleges doubted about me. They did not know if it was true or false. He ruined my reputation in my work place. He (ex-boyfriend) is harassing me and threatening me with death. Once, my husband and I were in church. He (ex-boyfriend) arrived with a gun and told my family that he would rather kill me to stop me of being with someone else. Always I live with this feeling inside me even when I am on the street, I am aware of those who are around me because I feel afraid that something might happen to me. Once I tried to denounce him but the police asked me his identification card number but because I did not know it I could not proceed with the complaint.

16. **Interviewer: Where did you go?**

Nurse: I went to police department. I talk to the police to explain the situation, I gave the name of the person (ex-boyfriend) and I said he works here but the policemen ask me the question “what is the number of his identity document” And I said “I do not know”. Then they answered me “We need this number to localize him”. I tried several times but I cannot for me is not easy to find this number. It was about one year ago. I feel nervous and only a colleague to know it. I have not told with the head of nursing staff because I do not want that it will affect my work negatively. Occasionally he (ex-boyfriend) does it, when he remembers me, he starts the searching.

17. **Interviewer: What are the topics that develop in the educational sessions?**

Nurse: The educational sessions are about immunization topics.

18. **Interviewer: Did you perform educational sessions to prevent gender violence?**

Nurse: No, I do not.

Interviewer: Thank you for very much!

FOCUS GROUP 6 - SOUTH ZONE
UNIVERSITY HEALTH CENTER “EL CONCEJO”
Discussion time: 00:57:09

Interviewer: What is for you violence against women?
Participant 1: I think, violence against women is physical abuse.
Participant 2: To complete her answer, I think that is physical abuse toward the partner. My daughter was victim of gender violence from her partner, she lived it a long time, and he hit her but also he raped her. My sister reported him and then he left my daughter. Normally he came drunk at home he sent their children to sleep and then he raped her. He hit her, dragged her hair also she was forced to have sex.
Participant 3: I have relatives (uncle and aunt) that are living in violence situation but sometime it is funny because they mistreat each other. Once they were fighting but it was heavy and my aunt reported him. It allowed putting order at home but right now they are living together again. I think this relationship is like a disease. I do not know if it is true but my uncle said that once my aunt hit herself and she said that my uncle was her aggressor. They are both sick. So I find it funny. They reported but now they are together again. They are together from 20 years ago and from the beginning they had a violent relationship.
Participant 6: I think that violence is not only physical because sometimes words hurt more than blows.

Interviewer: What does the community when a woman is abused?
Participant 5: To ignore the situation. Sometimes, it is better because when I had got advice women did not hear me. Always they do what they want.
Participant 2: If you try to take part in the problem the couples come together and then they are happy but they are irritated with you. You become in enemy of them. I had a neighbor, the man hit her, and it was frequent. Then I talk with her. I suggested report to the police and separation. It was ineffective. They are together again and now they are hostiles with me.

Interviewer: Why victims of violence do not report? What do you think?
Participant 4: Well, sometimes my husband hits me. He hits me when he is upset, but I also hit him to defend myself. Once he bit my hand, at the same time I was choking him so he stopped biting me. Sometimes I want report his abuse but I live far away and it is a problem to me my children need care. When I seek help from my mother. She told me. I cannot to care your sons (two children). I am pregnant right now. This baby will be my third son.

Interviewer: What he does for the children?
Participant 4: He is responsible and it is true. He gives us money for food and clothes.

Observation: The participants stay in silence.
Participant 6: My husband is not violent. They only do not like when I wear a dress or a short skirt. He says me "Please I do not like that you wear so” and I do not have problem to change my clothes.
Observation: The participants look between them and laugh.

Participant 4: I worked at City Hall. I was sweeping streets and he knew well. It was my job and the money was to cover my payments and for my oldest son. Then he told me "I do not want that you work as sweeping". He said me you will have all to you and our family. I left my job. Now I want to study and he does not let me study and I am feeling like an incompetent woman to face the life alone.
Participant 7: In my case I renounced my work. It was in a bakery with my mother in love but after the marriage my husband asked me to leave the work and I did it. Until now I have no problem because it covers everything that I need but I know is better to earn your own money. I have no problem with him, sometimes disagreements but abuse occurs only when we are upset but then we are normal.

Interviewer: Why is existing violence against women? What do you think?
Participant 2: It is because violence is normal for us. The violence is in everywhere.
Observation: Participants listen and remain in silence.
Interviewer: Had the situation for women changed?
Participant 2: I think that today the violence against women is worse than before. There is a lot of hate.
Participant 6: I think now the situation of women is the same than before. Men are the bosses of the families for example they say, you cannot work, you cannot wear so and the woman obeys her husband, the role and the position of women is the same.
Participant 1: We laws but the chauvinism and violence remain in the time. This time and before are the same.
Participant 2: Nobody can eliminate violence against women. That does not change anyone.

Interviewer: What programs do you know to protect battered women?
Participant 3: I think the police department.
Participant 2: Sometimes in City Hall you can report. Also in the Canaima's Module there is a support service to women victims of violence.
Participant 1: I know nothing, I do not know.
Participant 4: Agencies of the judicial system and the prefecture.
Observation: The rest of the participants said they did not know services to protect women. One of the participants interrupted saying:
Participant 3: Once I had a book with the law for women protection but I never read it.

Interviewer: Nowadays women have more freedom. What do you think?
Participant 5: Nowadays a lot of women are working in areas that before were reserved only for men. Women are taxi drivers, bus drivers of trucks, buses collectors.
Participant 2: I have seven years working in a food processor company and I think that I am free because I can go to work. In my work my colleges and I have freedom to speak and express what we feel.
Participant 1: But I think that women have always worked at home because there is always enough things to do for work.
Participant 7: Women are free to wear and speak. We have more freedom now than before.
Participant 6: We have more liberty in the care and education of our sons.

Participant 3: Do you believe? I think it is not real because sometimes men take away the authority of the mother. Despite of some women make the rule at home, sometimes men have the final choice. Ultimately I believe that women have more freedom when we have no husband. **Observation: All the women laugh with the intervention.**

Interviewer: Who wants to tell me what a day in his life: What time you wake up? Who cooks? Who cleans the house? Who takes the children to school?
Participant 7: I wake up at 8:30 in the morning I bathe, I breakfast, watch TV, do the housework, make lunch. Right now my husband and I are living in mother's house with the mother and a brother of my husband. I cook for everyone, because as my husband will not let me work, I have no problem doing chores.
Participant 6: I wake up at 07:00 am; make breakfast, whether to wash laundry bathrooms, sweep the floor as do all the housework, I do, after lunch.
Participant 5: I wake up at 06:00 am, make breakfast, breakfast left my husband at home and go to my work I go at 07:00 and leave at 17:00. My husband works loading boxes in the middle with some Arabs. He goes into work at 09:00 but leaves at 18:30 I go a little earlier than him. When I get home, advance some trades, then I cook dinner and the next day the same routine.
Participant 3: I cook the meals at night and by morning I wake up as 05:00 in the morning I make breakfast, breastfeeding, sleep it and then another little while I sleep until about08:00 am at that time my child wakes up again to eat. I do the housework that's my routine, I always do everything in the house because he arrives tired of working on the street what he wants is to rest at home, he does not want more work.

Interviewer: What do your husband's do at home? Talking about household task
Participant 7: My husband does not household task because he works and studies. So I do not like overloading him. I only ask him organization because he is chaotic at home. **Observations: The participants ask each other: "What man is organized?" And they laugh.**
Participant 6: Well right now I am pregnant and I cannot force, so when I wash the clothes he must to hang the clothes on the line to dry.
Participant 5: Sometimes he help me at home; sometimes he helps me to sweep, to fill the pails of water, removing laundry from the washing machine because I cannot force legs. He helps a few but he helps me.
Participant 4: My husband does nothing at home. I am responsible for all at home and for my children too I do not like imploring him.
Participant 3: Sometimes he helps me for example wash the dishes but he usually gets at home to sleep. He is always very tired because he works very hard.

Interviewer: What do you do when you get sick? Who answers them?
Participant 6: Women never get sick and when a woman gets sick her caregiver is the mother. **Observation: The group of participants supports the comment.**

What do you think about child-rearing? It is an activity for women, men, both?
Participant 2: Child-rearing should be a task for both. But in some case if you are separated I think the kids are better with women. I say it because I raised my five children alone. I do not know if they had been better with my ex-husband but I know

that I never had problems with my children on the street, they were good persons, are married and worker.
Participant 4: I think that women care the children better than men.
Participant 3: It is better for children to be with the mother she is better for this than a man. **Observations: The group begins to laugh for the comment and support the position of the participant.**

Interviewer: Anyone else want to say other opinion?
Observation: The group remains in silence.
Interviewer: Did you feel anytime persecuted by a man, harassed, molested or abused from the sexual point of view?
Participant 5: I have not this experience but my cousin was forced to have sex. The man could not do anything but she was in shock for a long time. The situation was very violent. He pointed with a gun; the man who threatened was a neighbor.
Participant 3: I know a case, the grandfather was abusing his granddaughter, she was eight years old, one of his sons found them, the girl's mother knew about it but either the mother or the family did not act. They were silent they did not say anything ever. If they do nothing, no one gets involved. That is completely private. She is a relative of my husband. They live in a town called Canoabo. Now the grandfather's is visiting his granddaughter, the mother did nothing, the father did nothing and when you see the girl, you know that she looks without self-esteem and she enjoy to move her body in front of men.

Interviewer: What is necessary in health center to support battered women?
Participant 3: Legal advice.
Participant 5: Counseling.
Participant 2: A service to provide protection to women.

Interviewer: How should work it to provide an efficient service?
FS6-P1: There should be a group of trained professionals who give attention not only for women. I think, they should give attention to a man who acts in a wrong way.
FS6-P4: I think, it would be helpful if there is a service to report the aggression at the health center.
FS6-P5: It takes a trained team because this problem needs medical, psychological and legal advice. People need guidance.

Interviewer: What should be the prevention of gender violence or violence against women?
FS6-P3: Educational activities about violence should be made in the communities and explanations about consequences of abuse in a woman's life.
FS6-P7: We must have guidance on family living, learning to share with others, communication skills to develop our relationships with people; especially into the family.

Interviewer: Thank you very much for your cooperation.

Curriculum Vitae

Personal data

Name:	Venus Elizabeth Medina Maldonado
Date of birth:	03.01.1973
Place of birth:	San Cristóbal - Táchira
Nationality:	Venezuelan

Education

1989	U.E Militar (GN) 4 de Agosto San Juan de Colon-Venezuela. Attained degree: High school completed.
1992	University Poly-technical Institute of the National Armed Forces Caracas-D.C. Attained degree: Senior technician in nursing, University level
1996	University of Carabobo, Valencia-Venezuela. Attained degree: Graduate degree in nursing
2007	National Experimental University of “Los Llanos Centrales Rómulo Gallegos” San Juan de los Morros- Venezuela. Attained degree: Master degree in nursing, Specialization in Community medicine.

Professional experience

2002 / to present	University of Carabobo Full-time Associate professor Subject: Nursing in community medicine.

Halle (Saale), 20 January 2014

Venus Medina Maldonado

Independence declaration

I, Venus Elizabeth Medina Maldonado, hereby declare that I have made this work without undue assistance from third parts and without using any helping specified. The other sources directly or indirectly acquired data and concepts are characterized by stating the source.

I certify that I have not taken for the content preparation of this work the paid help of mediation and advisory services (promotion consultants or other persons) to complete. Nobody has received from me directly or indirect monetary benefits for work in connection with the submitted dissertation.

The work has been neither in my country nor abroad in identical or similar form to another authority audit presented. I am aware that I cannot complete the Ph.D. before my graduation certificate or a provisional certificate in accordance with Article 15 of the promotion order was handed out.

Halle (Saale), 20 January 2014

Venus Medina Maldonado

Explanation of previous attempts Promotion

I, Venus Elizabeth Medina Maldonado, declare that I first put the application for admission to the doctoral program at the Medical Faculty of the Martin-Luther-University Halle-Wittenberg. I certify that no previous promotion tests with the same or another dissertation are done.

Halle (Saale), 20 January 2014

Venus Medina Maldonado