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Gender-Based Violence, Perspectives in Latin America and the Caribbean

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Abstract

Introduction: To address the phenomenon of gender-based violence in Latin America and the Caribbean is an issue of epic proportion that reflects the unequal power dynamics created within the binary gender system and is often perpetrated by those with more physical, cultural, or social power and inflicted upon those without. **Method:** Each database was comprehensively searched for MeSH keyword combinations of gender violence (violence against women) or (gender-based violence) with the region of interest (Latin America and the Caribbean) in addition to a third word or phrase regarding health care (health care training, training, health care curricula, curricula, health care professionals). **Results:** After completing this scope review, we have found a widespread call for more comprehensive preparation for health care professionals involved in identifying and addressing gender-based violence. **Conclusions:** Though some research has been conducted documenting the ways in which gender-based violence is managed or not managed by health care providers, Latin America and the Caribbean in particular represent a gap in research on health care tools and their effectiveness in these situations. There is a distinct need for the creation of context-specific protocols for vulnerable and underrepresented groups.

Keywords

violence against women, gender-based violence, Latin America, the Caribbean, health care training, health care professionals

Gender-based violence (GBV) is an issue of epic proportion that reflects the unequal power dynamics created within the binary gender system and is often perpetrated by those with more physical, cultural, or social power and inflicted upon those without. The close association of violence with masculinity has created a dangerous and unjust power dynamic that manifests in forms of violent physical, verbal, or psychological aggression and affects an alarming proportion of the population. Though GBV includes anyone who experiences violence due to their gender, certain groups are more heavily affected. According to one study on GBV, "One in every three women in the world has been beaten, forced to have sex, or subjected to some other form of abuse" (Acosta et al., 2018, p. 2). Generally, it was found between all of these instances that determinants of violence lie in social relations, as violence

> derives from hegemonic social values, which naturalize inequalities between men and women and their roles, giving man greater power in relationships, which often justifies the oppression/submission of women. Therefore, this asymmetry of power in the relations present in society is one of the determinants of gender violence. (Costa et al., 2017)

With this in mind, for this scope review, GBV will be defined to include

> any act . . . that results in, or is likely to result in, physical, sexual or mental harm or suffering . . . including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life. (De Ferrante et al., 2009, p. 288).

Intimate partner violence is a subsection of this epidemic that represents a sizable portion of gender violence and

> For the World Health Organization (WHO), intimate partner violence (IPV) is defined as behavior within an intimate relationship that causes physical, sexual or psychological harm, including acts of physical aggression, sexual coercion, psychological abuse, and controlling behavior, and this setting applies to both spouses and current or former partners. (Marques et al., 2017, p. 2).

The prevalence of this issue coupled with the harmful and lasting effects of its violence make it a matter that requires an adequate response from all levels of society in order to eradicate this hostility and to generate sufficient solutions for the victims of GBV. Often, the health care systems in place attempt to manage these issues by helping victims cope and seek

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security and safety yet they do not have sufficient protocols to effectively identify or halt the issues at hand creating a sense of distrust and stigma around GBV victims (Barros et al., 2015; Marques et al., 2017; Palermo et al., 2014). This puts survivors in even more danger as the institutionalized resources that have been set out to correct these instances fail to do so. There are numerous causes behind this malfunction, including a lack of trust between health care professionals and patients, a lack of understanding or tolerance to their situations, lack of confidence to address the issues of GBV on the part of health care providers and the lack of protocols and resources to systematically provide a framework for coping and safety.

Though some research has been conducted documenting the ways in which GBV is managed or not managed by health care providers, Latin America and the Caribbean in particular represent a gap in research on health care tools and their effectiveness in these situations. Experiences of gender violence and intimate partner violence in Latin America and the Caribbean represented in research to date demonstrate a visible need for better informed health care providers and policies as well as access to services and tolerance particularly for vulnerable groups such as sexual minorities, transgender people, rural women, pregnant people and those with mental health needs. From the data, it is evident that the creation of more specialized and comprehensive protocols for health care professionals is necessary to identify and manage GBV.

The promotion of research and tool creation for health care providers around gender violence in Latin America and the Caribbean will significantly augment an area in which research and resources are lacking and could potentially lead to an increase in trust between patients and providers while simultaneously providing health care professionals with resources to better manage and identify GBV.

Methodology

The original search conducted with the outlined key terms between the years of 2009 and 2019 yielded a total of 251 articles. Descendancy searches produced an additional two articles but neither met the inclusion criteria. After removing duplicate articles, 100 records remained and were title and abstract screened. The full text of 43 articles were analyzed by two authors, of which 26 met inclusion criteria. Only articles that met these criteria were included in the final pool of articles.

Four databases were utilized for the article compilation of this scope review including Pan American Health Organization, Scielo, Scopus, and PubMed. Each database was comprehensively searched for MeSH keyword combinations of gender violence (violence against women) or (gender-based violence) with the region of interest (Latin America and the Caribbean) in addition to a third word or phrase regarding health care (health care training, training, health care curricula, curricula, health care professionals). In the case of Scielo, Latin America was not included in the keyword search as individual countries were selected instead, including Argentina, Brazil, Chile, Colombia, Costa Rica, Cuba, Mexico, and Venezuela.

Articles selected for the final review were empirical studies published in peer reviewed journals in English, Spanish, and Portuguese. Articles regarding GBV, violence against women, and health care professionals' perception of GBV were all included. Articles that focused on GBV in regions outside of Latin America and the Caribbean were excluded to ensure a focused study. All articles were initially screened by reviewing title and abstract, and data were abstracted from the texts that met the inclusion criteria. Articles that did not discuss GBV but included data on other intrafamily violence (child abuse, elder abuse) were not included. Two authors reviewed the full text of each article. In the case of disagreement, a third author was brought in to provide input to reach a consensus.

Results and Discussion

Figure 1 summarizes study characteristics for the 26 articles included in this scoping review, and Table 1 gives a detailed description of all the included studies. The earliest study was conducted in 2009, and the most recent study was carried out in 2018. The majority of the studies were conducted in Brazil ($n = 20$). One study was conducted in both Chile and Colombia. Four studies collected data in multiple countries. Lanham et al. (2019) included participants from El Salvador, Trinidad and Tobago, Barbados, and Haiti. Loría et al. (2014) compared participant data from Costa Rica and Catalonia. Palermo et al. (2014) collected data from 24 countries, including Bolivia, Colombia, and Honduras, and Tran et al.'s (2016) sample included participants from 39 countries, such as Argentina. Regarding study design, the majority of the studies ($n = 18$) utilized qualitative methods; six used quantitative methods; and two used a mixed methods approach. All studies used a cross-sectional design. The sample sizes ranged in size, from eight health care professionals to 284,281 women in multiple countries (Borsoi et al., 2009; Palermo et al., 2014).

Stigma

Of the 26 articles included in the review, eight discussed the stigma placed on victims of GBV (Acosta et al., 2017; Acosta et al., 2018; Almeida et al., 2014; Barros et al., 2015; Diez, 2012; Rodrigues et al., 2014; Schraiber et al., 2010; Signorelli et al., 2013). As a consequence of their stigmatization, it was common for victims of GBV to feel shame and guilt that impeded them from divulging their assaults to health care professionals.

Many authors noted that discussing one's experience with domestic violence is similar to tracking into forbidden territory. Participants explained that discussing domestic violence engendered feelings of discomfort and intruded on personal matters (Acosta et al., 2018; Almeida et al., 2014; Marques et al., 2017; Rodrigues et al., 2014; Schraiber et al., 2010; Signorelli et al., 2013). Specifically, among pregnant women who have suffered abuse, Marques et al. (2017) included the idea of the woman's financial and emotional dependency on

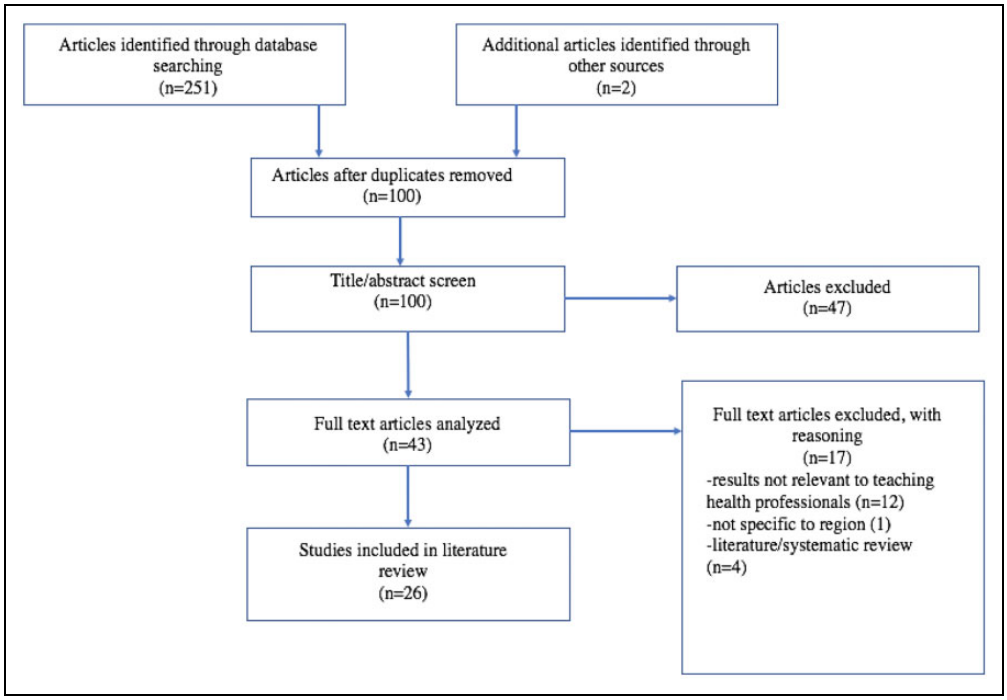

Figure 1. Summary of study characteristics.

their abusive partner. Pregnant women frequently hid their abuse out of fear of losing the support for their future child such as housing, finances, and an additional person to take part in parental care. This exploitative relationship allows the violence against the woman to continue and remain unknown to health care professionals.

Signorelli et al. (2013) described similar feelings of shame and guilt among patients and explained that this lack of communication between patients and care providers prohibits health professionals from administering proper care. Without honest conversation with patients, providers are only able to treat visible, physical wounds, merely addressing one dimension of the healing process. Additionally, Barros et al. (2015) reveals that health care professionals also contributed to the patients' stigmatization, as multiple doctors would not make direct eye contact with their patients and behaved nervously when treating a person who had experienced GBV. Health care providers' further victimization of patients suggests the presence of institutional violence in the health system.

Acosta et al.'s (2018) qualitative study including 100 nurses working at two hospitals in Rio Grande, Brazil indicates that some female victims perceive their violence as a chronic condition and thus naturalize their physical, sexual, and verbal abuse. This naturalization process permits the victim to remain in the perpetual cycle of violence without questioning its unhealthy effects. Furthermore, in some instances, health care professionals have not focused on empowering female victims of GBV, which further maintains the cycle of violence (Diez, 2012).

Trust and Distrust Between Professionals and Patients

Among the studies that analyzed distrust between patients and health care professionals, 11 were conducted in Brazil (Acosta et al., 2017; Acosta et al., 2018; Almeida et al., 2014; Barbosa et al., 2014; Barros et al., 2015; Costa et al., 2017; Marques et al., 2017; Osis et al., 2012; Pedrosa & Spink, 2011; Signorelli et al., 2013; Villela et al., 2011). After hearing the term "domestic violence against women," 36 of the 100 nurses interviewed at two hospitals in Rio Grande, Brazil thought of "physical aggression," 28 identified "fear," and 18 mentioned "humiliation" (Acosta et al., 2018). Because these terms emphasize physical violence, it is evident that physical injuries dominate the health care professionals' conceptualizations of GBV.

Although many patients communicated their distrust in their health care providers, others did note a welcoming and protected feeling once they interacted with medical professionals. In Barros et al.'s (2015) study, many patients revealed that when they received medications or injections, the health care providers communicated the procedures thoroughly to the patients. Costa and Lopes (2012) also found that communication between health care providers and patients encouraged proper treatment of GBV. Additionally, when groups of women suffering from GBV convene and express their needs in a safe space, this stimulates a sense of belonging and worth for victims.

Lack of Adequate Resources

Two studies emphasized that a lack of adequate resources contributed to the quality of care given to patients experiencing

Table 1. Table of Studies.

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Acosta et al.(2017)	Ethical and Legal Aspects inNursing Care for Victimsof Domestic Violence	Qualitative: Semistructured interviews and thematic content analysis	Brazil	34 nurses in 2 hospitals in the city of Rio Grande-RS	To analyze the knowledge of hospital nurses about the ethical and legal aspects of nursing care for victims of domestic violence	The study generated two subclasses: (1) (dis) knowledge of nurses about legal competencies—it observed the confusion between police report and compulsory notification, and (2) (dis) knowledge of the nurses about ethical competences, in which they mention the need for confidentiality, guidance, and privacy in the caring process. Continuing education empowers professionals reflecting the visibility of violence in the health field.
Acosta et al.(2018)	Nurses' Social Representationsabout Domestic ViolenceAgainst Women: A StructuralApproach Study	Qualitative: Free-evocation and semistructured interviews	Brazil	100 nurses in two hospitals in Rio Grande /RS	To analyze the structureand contents of the social representations of nurses about domestic violence against women	1. There is a negative representation with nuclear elements alluding to the forms of violence and their judgment, expressed in "physical aggression" and "disrespect." In the periphery, "fear" reveals both the feelings of professionals and victims against the aggressor, and "submission" is punished as the cause of violence. The possibility of a subgroup with differentiated representation is inferred, in front of the term "verbal aggression" in the zone of contrast. 2. The centralized view of the physical injuries and the blame of the victim can limit the actions of care, therefore it is fundamental to problematize this object with health professionals.
Almeida et al.(2014)	The Object, Purpose andInstruments of the Health Work Process in the Attention toGender Violence in a PrimaryHealth Care Service	Qualitative: Semistructured interviews	Brazil	13 health care professionalsat the Family Health Strategy Unit located in João Pessoa, in the state of Paraíba, Brazil, including a doctor, a nurse, a nursing technician, a dentist, an oral health agent, seven community health agents (CHA) and an appointment marker	To analyze professional practices in the attention to the health of women in situations of violence, identifying the elements of the work process and its relationship with the emancipation of gender oppression	1. Providing comprehensive carefree of prejudice and gender stereotypes is still a major challenge for primary health care professionals, and a reorientation of techniques and knowledge is essential to ensure that violence is recognized for its important social and cultural genesis. In this sense, we highlight the need to qualify professional practices through continuing education, which includes discussions on gender content, with the aim of providing a reorientation of health work in the attention to women in situations of violence. 2. The confrontation of gender violence within services also requires: the development of a work that values the health-disease process in its social interface, privileging not only the biological dimension of illness and medicalization, but the contextof life of women in situations of violence; the establishment of strong interpersonal relationships between professional and user, with closer ties and the recognition of listening and guidance as health care equipment

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Barbosa et al.(2014)	Women, Violence and Attentionin Mental Health: Questionsto (Re) Think the Receptionin the Daily Services	Qualitative: Individual interviews with semistructured scripts	Brazil	19 cases of women in situations of violence with mental disorders and/or passing through the psychosocial care network were selected from two psychiatric hospitals	To know the reception and attention directed to women with mental health demands in the specialized services for coping with violence against women and in the network of psychosocial and hospital care in the city of Natal/RN	1. In the women's care network, users with mental disorders (or with demands on mental health) are understood as a special clientele requiring specialized care. Already in the network of psychosocial attention women in situations of violence suffer from the total invisibility of the circumstances in which they live. The nonacceptance is accompanied and ratified by violent practices: hospitalization for later interview of the life history of the users; predefined clientele in psychosocial care centers; clinical psychological treatment in the psychoanalytic approach, which blames the client for the situation she lives. It is necessary, in this way, to resuscitate the host technology in the policies and devices in question in this study. 2. It is necessary for these policies to be made known and, beyond mere knowledge, they must not reproduce more and more violence in the lives of their users for the sake of attendance by specific demands.
Barros et al.(2015)	The (Un)receptive Experiencesof Female Rape Victims WhoSeek Health Care Services	Qualitative: Interviews, content analysis	Brazil	11 women who experienced rape, monitored in a maternity in the state of Alagoas, Brazil	To know the structure and functioning of health care services from the perspective of women who have suffered rape	1. Health service is permeated by the delays and lack of privacy. Added to the criticism, hospital employees ended up exposing women and propagating the rape so that they were more victimized, unveiling institutional violence. This experience during the care received in health services leads to a revictimization process of these women who already carry the trauma from the rape. This reality points to institutional violence and the need for better professional preparation. 2. Need for better preparation of professionals working at these services and more attention not only to technical procedures, but based on humanization and the reception toward the patients/ victims

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Borsoi et al.(2009)	Actions addressing violenceagainst women at two primaryhealth care centers in themunicipality of Rio de Janeiro	Qualitative: Field observation and in-depth interviews	Brazil	Eight health professionals from Brazil, 2 primary care units in the city of Rio de Janeiro	To investigate and discuss actions for addressing domestic violence within the scope of the Women's Comprehensive Healthcare Program	In both services studied, it can be seen, through reports from health professionals and the observation made, that the demand of women in situations of violence is always implied, that is, it is not this situation that directly leads to health units. The professionals of the two units perceive that the work with the violence does not depend exclusively on the health sector, being necessary the support of an intersectoral network (police, justice, social assistance, education, etc.).
Cortes, et al.(2015)	Caring for Women in Situationsof Violence: EmpoweringNursing in Search of GenderEquity	Qualitative: Descriptive study of interviews, thematic content analysis with gender as an analytical category	Brazil	10 female nurses from the Obstetric and Emergency Care Center of a University Hospital of the South of Brazil and a municipal emergency department	To know the actions of caring for women in situations of violence by nurses in emergency and emergency services and to analyze actions that seek the empowerment of women for gender equity	1. The study shows that it is necessary to constantly seek the development of skills both in clinical practice, through assistance protocols and dissemination of evidence that contribute to advances in the rights and autonomy of women; as well as in the educational, social and gender dimension in order to achieve policies aimed at completeness. 2. The need to implement shelter based on the classification of risk to receive and assess the degree of physical vulnerability and psychological distress of women and family members also emerged.
Costa, et al.(2017)	Rural Women and Situations ofViolence: Factors that LimitAccess and Accessibility tothe Health Care Network	Qualitative: Exploratory descriptive study of interviews analyzed by thematic modality	Brazil	26 professionals from the services of the violence care network of four municipalities in the northern region of Rio Grande do Sul	To analyze the access and accessibility to the network of attention to women in situation of violence, residing in rural contexts, from the discourses of professionals.	1.(Dis) women's information, distance, restricted access to transportation, dependency of the companion, (dis) attention of the professionals to receive the women in situation of violence and (dis) articulation of the network are limiting factors of access and have as consequence facing this problem. 2. Bringing together the services that make up the network for dealing with violence against women and qualifying professionals to accommodate such situations can facilitate access and participation of rural women in these services.
Costa & Lopes(2012)	Elements of Integrality inProfessional Health Practicesfor Rural Women Victims of Violence	Qualitative: Interviews and analyzed according to thematic modality	Brazil	43 participants: 19 community health workers, 14 nurses, 9 physicians, and 1 psychologist	To know and analyze practices of care of health professionals to rural women victims of violence, in the perspective of integral care, in municipalities of the South Half of Rio Grande do Sul. in rural areas	Rural patients in situations of violence are determined as elements of care not only to relational devices, reception, link, and dialogue but also to the construction of collective actions through group activities, recognized as potentiators of health promotion and individual empowerment and collective in the dimension of violent events

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
De Ferranteet al. (2009)	Violence Against Women:Perceptions of MedicalDoctors from PrimaryHealth Care Units in thecity of Ribeirão Preto,Saão Paulo	Qualitative: Semistructured interviews and thematic content analysis	Brazil	14 gynecologist-obstetrician and general practitioners who work in Ribeirão Preto-SP	To verify the perception of doctors working at primary health care units of Ribeirão Preto, state of Saão Paulo, on violence against women perpetrated by intimate partners	All physicians claim to know physical and psychological violence. Some call the latter verbal violence. Sexual violence was the least mentioned in the speeches. Most professionals believe that psychological violence is the most serious, since women themselves find it difficult to recognize it as something harmful to their health, remain exposed for years on end
Diez (2012)	Reports of Primary CareMental Health Teams(APs) about the Approachto Gender-Based Violencein Couples	Qualitative: Semistructured interviews and a content analysis	Chile	11 interviews including two psychologists, two psychologists, four doctors, and three social workers	To analyze if the speeches that the professionals of the APS Mental Health Teams of the Commune of Valparaíso have about the approach they perform on gender violence in the couple present knowledge, ideas or notions based on a gender perspective	There is consensus on how to approach abused women, for all it is very important to generate an empathic therapeutic space, of containment. Multidisciplinary and intersectoral work is valued in discourses. Risk practices to generate revictimization are mentioned. There is no intentionality toward an empowerment from a gender perspective, except in the case of some psychologists
Hasse & Vieira(2014)	How do Health ProfessionalsTreat Women in Situationsof Violence? A Triangulated Data Analysis	Quantitative: Questionnaires; Qualitative: Interviews	Brazil	23 interviews of doctors and nurses working in the Unified Health System of Ribeirão Preto from June to August 2007	To analyze the knowledge of medical professionals on violence against women and the attitudes and referrals made by these professionals	Regarding in-service training to qualify care in cases of violence, only 27% (61) of the interviewees reported having had access to some type of training, and an important difference was found between the training of doctors and nurses, and the latter were more likely to have been trained on duty ($p < .018$). It was also observed that many professionals are unaware of the epidemiological characteristics of violence
Lanham et al. (2019)	"We're Going to Leave Youfor Last, Because of HowYou Are": Transgender Women' s Experiences ofGender-Based Violence inHealth Care, Education, andPolice Encounters in LatinAmerica and the Caribbean	Qualitative applied thematic analysis and descriptive quantitative analysis	El Salvador, Trinidad and Tobago, Barbados, and Haiti	74 transgender women	To document experiences of GBV and transphobia in health care, education, and police encounters	A high proportion experienced GBV in education (85.1%), health care (82.9%), from police (80.0%), and other state institutions (66.1%). Emotional abuse was the most common in all contexts and included gossiping, insults, and refusal to use their chosen name. Participants also experienced economic, physical, and sexual violence, and other human rights violations based on their gender identity and expression

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Loría et al. (2014)	Trends in Public Health PoliciesAddressing Violence AgainstWomen	Qualitative: descriptive and comparative documentary analysis	Costa Rica, Catalonia	13 Health policies and plans in Catalonia and Costa Rica. Principles, strategies, concepts concerning violence against women, health trends, and evaluations	To analyze the content of policies and action plans within the public health care system that addresses the issue of violence against women	1. The priorities and specificity of actions in health care plans were the distinguishing features between the two countries. 2. The common features of the health care plans in both the counties include violence against women, use of protocols, detection tasks, care and recovery for women, and professional self-care. Catalonia does not consider health care actions with aggressors. Costa Rica has a lower specificity in conceptualization and protocol patterns, as well as a lack of updates concerning health standards in Catalonia
Marques et al. (2017)	Strategies for Identification andCoping With IntimatePartner Violence inPregnant Women	Qualitative: Semistructured interviews and thematic content analysis	Braszl	23 primary care nurses	To know the strategies used by nurses of Units of Family Health Strategies for identification and confrontation of violence situation by intimate partner in pregnant women	1. The category: "It is very complex" — actions of identification and coping with intimate partner violence in pregnant women. The physical injuries were the main indication of violence identified in the prenatal consultation. The coping strategies were the referrals to specialized services and joint discussion with the health team. 2. It is pointed out the necessity of organization of a nursing protocol that helps in the identification and classification of risk to exposure to violence, permanent education of these professionals and strengthening of intersectoral actions
Morena et al. (2015)	Subtleness of Gender-BasedDiscrimination ofUndergraduate andPostgraduate Students of aFaculty of Medicine in Bogotá	Quantitative: Questionnaire	Colombia	201 students (170 of graduation courses and 31 of postgraduate studies)	To characterize gender-based violence (GBV) in a Faculty of Medicine in Bogotá DC, which has already been proven in medical schools in other countries such as Japan and Canada	The majority of students perceived this type of violence associated with being a woman (94%), followed by nonheterosexual orientation by 8.5%, religious beliefs (5.1%) and race (3.4%). The most frequent type of violence was the psychological 65.7%, sexual in 35.3% and physical in 6.5%. It was observed that the most frequent response was to ignore the situation (41%), followed by telling a friend (26.8%). The consequences identified were to ignore what happened and act as if this fact had not been presented, followed by the decision to increase their effort in the matter in question.

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Osis et al.(2012)	Violence Among Users of Health Units: Prevalence, Perspective and Conduct of Managers and Professionals	Quantitative: Structured questionnaires and a descriptive analysis	Brasil	14 municipal women's health coordinators, 2,379 users of basic health units, 75 managers and 375 professionals, in 15 municipalities in the state of Sao Paulo, Brazil	To estimate the prevalence of violence in women users of primary health care, if these situations were detected and how they were treated by the professionals of these services	Relevant proportion of users experienced violence in their daily lives, especially by intimate partners. Most women were not identified or approached in these services and did not receive help. Managers and health professionals, while realizing the magnitude of the problem, did not consider basic care prepared to serve these women. The lack of an intersectoral care network to attend women in situations of violence was evidenced.
Palermo et al. (2014)	Tip of the Iceberg: Reportingand Gender-Based Violencein Developing Countries	Quantitative: Survey (performed descriptive analysis and multivariate logistic regressions examining characteristics associated with reporting to formal sources)	Azerbaijan, Bolivia, Cambodia, Cameroon, Colombia, Ghana, Haiti, Honduras, India, Kenya, Malawi, Mali, Moldova, Nepal, Nigeria, Philippines, Rwanda, Sao Tome and Principe, Tanzania, Timor-Leste, Uganda, Ukraine, Zambia, Zimbabwe	284,281 women in 24 countries	To provide bounds for underestimation of reporting of GBV to formal and informal sources conditional on having experienced GBV and characterize differences between women who report and those who do not	Results imply that estimates of GBV prevalence based on health systems data or on police reports may underestimate the total prevalence of GBV, ranging from 11 to 128 fold, depending on the region and type of reporting. In addition, women who report GBV differ from those who do not, with implications for program targeting and design of interventions
Pedrosa & Spink (2011)	Violence Against Women inthe Daily Life of HealthServices: Challenges forMedical Training	Qualitative: Interviews	Brazil	12 interviews with professionals from different health areas, such as nursing, social work, medicine, psychology and nursing technicians were carried out in a public hospital in Ribeiraão Preto	To analyze gaps in medical training and practice on the theme of gender violence	1. The lack of preparation in the academic training for this type of care translates into a lack of professional preparation for SUS (Sistema Único de Saúde) work. 2. Other forms of violence appear in the hospital routine in a more discreet way, sometimes indirectly but are not always included in the scope of care, as in the case of sexual violence. 3. Emotional mobilization in response to violence leads to a multiplicity of feelings, and institutions are rarely able to offer adequate care to caregivers, leaving important consequences for their work routine.
Rodrigues et al. (2014)	The Practice of Family HealthStrategy Workers WhenCaring for Women inGender Violence Situations	Qualitative: Semistructured interview analyzed based on the discourse analysis method	Brazil	25 health care workers from three Family Health Strategy units in a municipality of the state of Bahia, Brazil.	To describe the practice of Family Health Strategy workers when dealing with women in gender violence situations	The results yielded two empirical categories: expression of violence against women due to gender issues, with display of physical and psychological violence by a spouse, and strategies to face up gender violence. The second category displayed that the unit's actions that do not contemplate gender issues and that referrals to assistance services do not receive counter-referrals. We emphasize the need for Family Health Strategy staff to receive qualification for acting in gender violence situations, and for public management to promote a network structure for assistance services.

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Schraiber et al. (2010)	Violence Against Women by Intimate Partners: Uses of Health Services	Quantitative: Questionnaires	Brazil	2,674 women in Municipality of São Paulo, including the Municipalities of Santo André, Diadema and Mogi das Cruzes in Greater São Paulo	To estimate the association between intimate partner violence (IPV) and the use of primary health care services in São Paulo	A prevalence of 59% of IPV was observed regardless of its repetition. The highest number of visits was associated with repetitive IPV, after adjusting the effects of possible confounding variables. Diagnoses and/or complaints of psychoemotional complaints registered more than once in the past year have been associated with IPV, increasing their magnitude with the greatest repetition of violence
Signorelli et al. (2013)	Domestic Violence Against Women and Professional Intervention in Primary Health care: An Ethnographic Study in Matinhos, Paraná State, Brazil	Qualitative: Ethnographic approach: Participant observation, records in field notes, interviews and follow-up	Brazil	15 interlocutors were considered key informants from a basic health unit (UBS) in Matinhos, Paraná, Brazil	To analyze how health professionals attend to such women, problematizing the notion of health care	The research revealed services focused on the following: (1) biologizing precepts, focusing on physical injuries and medicalization, (2) dialogue, active listening, psychosocial issues and establishment of links, highlighting community health agents in this approach. The scarcity of official local structure for the management of domestic violence leads to an activity registered under the host grammar, recommended by SUS, described in the literature, verbalized in UBS but little problematized.
Tran et al. (2016)	Attitudes Towards Intimate Partner Violence Against Women among Women and Men in 39 Low- and Middle-Income Countries	Quantitative:Multistage, cluster sampling technique	Afghanistan, Argentina, Barbados, Belarus, Belize, Bhutan, Bosnia and Herzegovina, Chad, Central African Republic, Costa Rica, Democratic Republic of Congo, Ghana, Iraq, Indonesia, Jamaica, Kazakhstan, Kenya, Laos, Macedonia, Madagascar, Mauritania, Moldova, Mongolia, Nepal, Nigeria, Pakistan, Palestinians in Lebanon, Serbia, Sierra Leone, Somalia, South Sudan, St. Lucia, Sudan, Suriname, Swaziland, Togo, Tunisia, Ukraine, Vietnam	A large nationally representative sample of between 5,000 and 40,000 households was selected in each country	To describe the attitudes of women and men toward perpetration of physical violence to women by an intimate partner, in a large group of low- and middle-income countries	The proportions of women who held attitudes that "wife-beating" was justified in any of the five circumstances varied widely among countries from 2.0% (95% CI [1.7, 2.3]) in Argentina to 90.2% (95% CI [88.9, 91.5]) in Afghanistan. Similarly, among men it varied from 5.0% (95% CI [4.0, 6.0]) in Belarus to 74.5% (95% CI [72.5, 76.4]) in the Central African Republic
Vieira et al. (2009)	Knowledge and Attitudes of Health Professionals regarding Gender Violence	Quantitative: Structured questionnaire	Brazil	221 health professionals in Ribeirão Preto	To evaluate the knowledge and attitude of health professionals regarding gender violence	The majority of interviewees demonstrated positive attitudes, and we can infer that there is good potential for proper management of cases, if they receive training.

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Table 1. (continued)

Author(s), year	Title	Study design	Location of study	Sample	Objective	Key findings
Vieira et al. (2016)	Protocols on the Health Care of Women in Situations of Sexual Violence from the Perspective of Health Professionals	Qualitative: Interviews	Brazil	18 institutions and 140 professionals interviewed in Fortaleza and Rio de Janeiro	To analyze the use of protocols in the health care of women in situations of sexual violence from the perspective of professionals in two Brazilian capitals	1. After organization of the data, the clusters of meaning pointed to the potential benefits of the use of protocols; limits to be faced in the adoption of protocols; and the need for protocol development and professional training. 2. In both capitals, professional qualifications to work with women suffering from sexual violence is inadequate due to the limited coverage of the issue during the undergraduate years of the health care professions and the lack of training in the health services
Villela et al. (2011)	Ambiguities and Contradictions in the Care of Women who suffer Violence	Qualitative: Nonparticipant observation and interviews with professionals	Brazil	21 interviews conducted in two large hospitals, three basic health care units, two specialized women's care stations were included, and three common police stations	To discuss the assistance to women in situations of violence by health services and public security	The assistance to women who suffer violence is marked by ambiguities and contradictions; spaces and workflows are poorly suited to such a sensitive task and the perception of professionals is permeated by gender stereotypes. This suggests that tackling violence against women requires reconfiguring work practices, with permanent education for professionals and changes in work processes

GBV (Barros et al., 2015; Costa et al., 2017). Barros et al.'s (2015) qualitative study including 11 female rape victims in Alagoas, Brazil found that a lack of transportation to health care facilities impeded victims' abilities to access care. The women expressed that doctors had offered psychological examinations for follow-up visits but many were unable to return to the hospital due to distance and lack of access to transportation.

Health care centers also lacked adequate space to serve victims of GBV. Many times, patients overflowed into the hallways because of the lack of space in the waiting rooms and experienced long wait lines because of the hospitals' overpopulation. Women recounted having to wait more than 3 hours for an examination (Barros et al., 2015). Spending extended periods of time waiting for care inflicted greater fatigue on the women who were already experiencing distress.

Along with long wait times and inadequate waiting space, numerous patients described the lack of privacy in examination rooms (Barros et al., 2015). Many patients communicated that their examination rooms included only a curtain for privacy, and they could hear the shuffling of other patients and health care professionals on the other side.

Lack of Adequate Preparation

Ten studies commented on health professionals' lack of preparation to treat GBV (Barbosa et al., 2014; Hasse & Vieira, 2014; Marques et al., 2017; Osis et al., 2012; Pedrosa & Spink, 2011; Rodrigues et al., 2014; Signorelli et al., 2013; Vieira et al., 2009; Vieira et al., 2016; Villela et al., 2011). Hasse and Vieira (2014) found that only 27% of their sample of doctors and nurses had some type of GBV training. In some instances, it was common for health care professionals to only treat patients medically, without viewing them holistically (Signorelli et al., 2013). Although treating patients as medical subjects enables their physical wounds to heal, the mental anguish below the surface remains present for the victims of GBV. Barbosa et al. (2014) specifically emphasizes the lack of dialogue and training around victims with mental health disorders. Health care professionals must receive adequate training on how to actively listen and support patients emotionally in order to appropriately treat patients.

Additionally, doctors and nurses in Brazil explained that they only came into contact with the issue of GBV in their studies when they discussed care of children, adolescent victims of violence, and cases of sexual violence (Pedrosa & Spink, 2011). This narrow scope further emphasizes the need for more comprehensive preparation on these topics during their academic preparation. Vieira et al. (2016) elaborate on the problem of preparation by describing the restrictive protocols by which health care professionals need to abide. These protocols fail to recognize the context of care and do not recognize the importance of caring for the patient's physical and mental health (Vieira et al., 2016). This fragmented approach to care may worsen the patient's health and wellbeing.

Ignorance of Vulnerable Groups

Six articles examined inadequacies in care for vulnerable populations, such as transgender people, sexual minorities, pregnant people, and people with mental health issues (Barros et al., 2015; Cortes et al., 2015; Costa et al., 2017; Costa & Lopes et al., 2012; Lanham et al., 2019; Marques et al., 2017). In a sample of 74 transgender women, Lanham et al. (2019) found that 82.9% of them experienced GBV in a health care setting. Emotional GBV—specifically insults and refusing to call individuals by their chosen name—was the most common form of violence they experienced. This high prevalence of GBV in health care confirms the need for greater education on the treatment of vulnerable populations who experience GBV.

Women living in rural areas also experienced barriers to receiving care (Costa et al., 2017; Costa and Lopes, 2012). Due to a lack of transportation some women were unable to access timely care. Many women depended on their sometimes-abusive partners for transportation, making it difficult for them to travel to health centers without their partner discovering their efforts to seek medical care (Costa et al., 2017). Furthermore, because of the inaccessibility of frequent medical care in some rural areas, many women had little or no knowledge of their rights as patients or as individuals (Costa et al., 2017; Costa & Lopes, 2012). Costa et al. (2017) found that nurses in rural settings must be intentional in clearly communicating with the patient about their rights and the nature of the medical procedures.

A lack of protocol regarding people in situations of violence with mental health issues was also found (Barbosa et al., 2014). Care for all patients was the same from when they arrived to when they left, indicating the lack of personalized and contextual care among vulnerable groups. Health care professionals must attend to patients' individual needs in order for them to fully heal, and a comprehensive mental health protocol will aid in this process.

Limitations

Within this scope review there were several barriers to full inclusivity of all information regarding tools for detection and confrontation of GBV for health care professionals. The 10-year range of the scope review neglects the fact that hegemonic cultural forces behind phenomena like GBV are rooted in long-term cultural norms and thus need to be evaluated over larger periods of time. The fact that most articles pertained to a single country within the purview of the region of interest significantly slanted results to be representative of health care tools and protocols within that country. The fact that only four databases were surveyed also resulted in a smaller pool of initial articles. Additionally, each database had individual search design parameters and thus the methods for generalization of search varied between databases. These variations included differentiations in search terms as certain databases divided results by country and others by region. With regard to search terms, the terms used for this search could have potentially yielded a smaller pool of articles due to specificity of the search.

Final Considerations

After completing this scope review, we have found a widespread call for more comprehensive preparation for health care professionals involved in identifying and addressing GBV. There is also a distinct need for context specific protocols for vulnerable and underrepresented groups. Stigma concerns made it clear that it would be immensely beneficial to enhance privacy measures. Placing greater emphasis on completion of multiple visits and ongoing care and support for victims is another important health care–based method for ensuring quality care.

These are all vital steps in the process of survivor rehabilitation; however, focusing on social determinants of violence may be more beneficial to overhauling GBV at large. To this end, a multipronged cultural approach addressing the positioning of men at the top of the social hierarchy and a realignment of health care professionals' perceptions of underrepresented groups are imperative to the deconstruction of cultural perceptions and actions that force victims of GBV into greater danger.

Within the majority of articles included in this scope review, culture and the gender binary hierarchy, are used as explanations for the prevalence of GBV in Latin America and the Caribbean, and there are several cultural structures that currently act as supports for the privileging of masculine violence over the safety of women and other vulnerable groups. Machismo culture, or the culture of male dominance, exacerbates the acceptance of violence and allows men to feel secure in their decisions to pursue violence. In order to exact any effective change, cultural norms associated with machismo culture, particularly the normalization of this cultural attitude, must be confronted to reflect a more equitable division of gender and power.

Normalization of violence can be directly observed in the actions of health care professionals in this region. In many cases cited throughout this review, the patient's concerns were trivialized by health care professionals as a result of the pervasiveness of GBV and intimate partner violence. This normalization plays a significant role in the quality of the health care these victims receive and the seriousness that both health care professionals and patients regard their situations with. The apparent and willful ignorance and negligence on the part of health care workers toward signs of abuse are equivalent to state and health care sponsored violence. Without the advocacy of health care workers, especially considering that health care professionals are often at the front lines of observation of the repercussions of violence, cultural norms as well as health care procedures and legal statutes will not change.

Culture within the realm of health care professions is as important in determining the reasons why victims do not experience acceptable care as cultural norms of violence. Attitudes of health care professionals are particularly relevant for underrepresented groups such as sexual minorities, people with mental health issues, pregnant people, transgender and nonbinary people, and those living in rural contexts. Inclusion and acceptance of these groups in health care systems is crucial for the elimination of GBV. Prejudice directed toward members of these groups is extremely harmful as these vulnerable groups are often disproportionately affected by violence. Due to diversity of patients in health care contexts there is a distinct need to alter how health care professionals view these groups, especially transgender people, nonheterosexual people, and those struggling with mental health. These groups face additional barriers to health care when professionals diminish their claims, discriminate based on opinion, and practice the continuation of hierarchical norms that privilege a binary heterosexual model. Without a transformation of these attitudes in health care professions, individuals in these vulnerable groups experiencing gender violence are left without crucial resources and support. In order to eradicate GBV and intimate partner violence, protocols specific to the contexts of each underrepresented group are necessary.

While empathetic care and follow-up visits are certainly necessary strategies for the restoration of GBV victims, the fact that all these studies focused on responses to a culturally created public health problem without primarily calling for cultural realignment of both larger society and health care systems makes this a problematic framework to base actions upon. While it is true that even with equitable cultural norms there would still need to be protocols to deal with violence, the fact that the vast majority of these articles are not considerate of prevention is concerning. The prevention of GBV is the responsibility of all members of society; however, health care professionals have a unique position of authority on this issue that should be utilized to readjust cultural norms of male dominance and the normalization of violence. As opposed to frantically attempting to repair damage done by men not only in Latin America and the Caribbean but worldwide, health care professionals should practice a comprehensive approach to GBV and intimate partner violence as part of an epidemic that presents an urgent threat to society and should be addressed with all resources available.

Accountability on the part of perpetrators, in which we include the state, those committing the violence, and a culture that allows for the continuation of these heinous crimes, is absolutely necessary to evaluate the most beneficial methods for the installation of adequate prevention and recuperation protocols within health care contexts when dealing with GBV. Until proper educational, cultural, and legal guidelines are enacted to protect the human right of basic safety for these vulnerable groups, no response from the health care field for this epidemic is enough. These studies place the onus on medical professionals and victims when this issue is societal and thus responsibility rests with every individual to contribute to the cultural prevention of violence. We must also educate the public in order to break the cycle of silence that fails to condemn perpetrators of GBV and intimate partner violence.

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