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Review Article

Violence against women and survivors' experiences in Brazilian health services: a qualitative systematic review

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ABSTRACT

Objectives: Violence against women is a global scourge. Yet, the care offered within health services has mostly been explored from the perspective of healthcare professionals, with limited attention to survivors' voices. This qualitative systematic review investigates how women experiencing violence perceive the care provided by primary healthcare services, focusing on both its benefits and challenges.
Study design: The study incorporated a qualitative systematic review.
Methods: A search was conducted in the Scopus and Web of Science databases, identifying 589 articles and reference checking identifying 10. Seven met the inclusion criteria and were analyzed.
Results: Survivors' accounts revealed three overarching themes: the benefits, challenges, and ambivalences of healthcare services. Influential factors included onboarding procedures, the performance of multidisciplinary teams, availability of human resources and training, adequacy of physical infrastructure, awareness of women's rights, and the presence of support networks.
Conclusions: Women identified health services as a primary access point for support and emphasized the importance of empathetic, welcoming care in their recovery. However, they also reported significant challenges, particularly the lack of professional training and poor coordination among services. These shortcomings can contribute to institutional violence, worsen health outcomes, especially mental health, and reinforce gender inequalities.

1. Introduction

Gender-based violence (GBV) is a sociocultural and historical phenomenon that shapes male behaviors aimed at acculturating women, keeping them in subaltern positions, preventing change, and reproducing male dominance.[1–4] As a result, inequalities are naturalized and ideologically maintained.[1–5] The efforts to understand this phenomenon constitute a theoretical-methodological field grounded in feminist movements[6] that approach the issue from a gender perspective.[7–9]

Although the concept of gender-based violence encompasses multiple affected groups, this study focuses on Violence Against Women (VAW), a specific form of GBV that, according to Azambuja & Nogueira,[10] has received greater visibility since the 1990s in political and social debates as well as in public health planning,[10] becoming a concern for the WHO and the Pan-American Health Organization (PAHO).[10–15] Violence Against Women (VAW) occurs across nations, ethnicities, religions, age groups, and social classes, thus being a global issue and one of the leading causes of death among women of reproductive age.[11,12] Moreover, it is frequently manifested as sexual violence (SV), which significantly contributes to female morbidity and mortality, and represents a major public health issue.[16–18]

Its effects may persist for decades and include mental health disorders.[13,14] school dropout, unemployment, and impairments to interpersonal relationships.[11,12] The first World Report on Violence and Health by the World Health Organization (WHO) identified VAW as a global public health and human rights issue.[11,12] The magnitude and severity of its physical and mental impacts[13] make the provision of care, treatment, and rehabilitation for survivors urgent, as reinforced in the 2018 WHO report.[11,12]

Despite strong associations between violence and mental health issues,[13,14] which compromise the self-esteem and autonomy of VAW survivors,[13,14,18–20] fewer than half of WHO's member states offer

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appropriate health services.[11] In 2018, WHO estimated that one in four young women will have already experienced intimate partner violence by the age of 20.[11,12,21] However, only about half of women who survived violence seek help.[11,22,23]

In Brazil, 20% to 60% of women who experienced gender-based violence do not report the assault,[22,23] often due to shame,[20] and only two thirds of women experiencing violence seek care in health services.[17–24] VAW is shaped by relational and intersectional dynamics,[2,21,25–28] with factors such as race, social class, and educational level acting as key determinants.[25–29] For instance, black women with lower education and income are particularly vulnerable to it.[28,29]

Within Brazil's Unified Health System (UHS),[30,31] primary health care is guided by the National Humanization Policy (PNH),[31] which prioritizes dignity, inclusion, and ethics in health care. Brazilian public policies on comprehensive women's health care (PNAISM)[32] similarly advocate for humanized care and quality in health services, emphasizing the importance of training health care professionals for the promotion of welcoming practices and for the protection of women's health.[30,31] The National Policy to Combat Violence Against Women[32] aims to support survivors of violence through programs that combine efforts across the fields of health, public security, justice, education, and social assistance.[31–33] These efforts seek to dismantle gender inequalities and combat discrimination by providing qualified and humanized care to this population.[32,34–36]

One of the core principles of these policies is A*colhimento*, translated into English as welcoming practices.[c] This Brazilian humanization-policy concept refers to the establishment of a therapeutic alliance between the health care professional and the survivor of violence.[20,25,31] It is characterized by qualified and empathetic listening, which promotes physical and emotional safety, essential aspects for building users' trust in health services.[31,32] In this regard, the work of interdisciplinary teams contributes to the quality of welcoming practices,[25–28] whereas poor coordination among professionals and services may compromise care effectiveness.[37,38]

Many studies focus on welcoming practices conducted by health services for violence survivors from the perspective of health professionals.[20,26,30,37–46] However, there is a scarcity of investigations that explore women's own accounts of their experiences when seeking care after episodes of VAW. Considering the intersectional and public health impacts of VAW,[1,2,5,12,25,26,33] it is essential to understand survivors' experiences regarding welcoming practices within health services.[47,48] Given that the violation of autonomy or human dignity also constitutes a form of violence,[33] their narratives as social subjects can help make this violence visible and contribute to the evaluation of public policies.

Based on the concepts of women's autonomy and empowerment, as well as on welcoming practices understood as the empathetic and humanized care provided to survivors of violence,[5,14,20,37] this qualitative systematic review was conducted to explore women's experiences with welcoming practices in Brazilian health services. It aimed to contribute to scientific knowledge and to support the development of effective public policies to address VAW.

2. Methods

2.1. Study design

This qualitative systematic review was conducted and reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA 2020) statement.[49] Moreover, it was guided by the Joanna Briggs Institute methodology for qualitative evidence synthesis.[50]

2.2. Review question and eligibility criteria

The review question was developed using the PICo framework (Population, Phenomenon of Interest, Context), as follows:

- Population: women aged 18 years or older who had survived violence;
- Phenomenon of Interest: survivors' experiences with welcoming practices after VAW episodes;
- Context: Brazilian health services.

Eligible studies included peer-reviewed original qualitative research articles published in English, Spanish, or Portuguese that reported survivor's narratives and experiences of welcoming practices provided within health services after an episode of VAW. Studies were required to include women aged 18 years or older who had accessed health services after experiencing violence.

Studies were excluded if they: (i) included women under 18 years of age; (ii) did not consider women's experiences; (iii) were conducted outside health care settings; or (iv) consisted of clinical trials, experimental studies, reviews, meta-analyses, case studies, conference proceedings, editorials, commentaries, or other non-original research publications.

2.3. Information sources

The Scopus and Web of Science electronic databases were searched from inception to March 2025 to identify eligible studies. In addition, reference lists of included articles were screened using citation chaining to identify additional relevant publications.

2.4. Search strategy

The search strategy was developed to identify studies addressing women's experiences of welcoming practices within health services after violence. Medical Subject Headings (MeSH) and keywords were used; User embracement was included as one of the keywords corresponding to the Portuguese term *acolhimento*. Boolean operators (AND, OR) were applied to combine search terms. An example of the full search strategy, including keywords and search strings, is provided in Table 1.

2.5. Selection process

All retrieved records were imported into Rayyan, where duplicates were removed. Titles and abstracts were screened by one reviewer (BG-S) against the eligibility criteria. The full texts of potentially eligible articles were independently assessed by two reviewers (BG-S and LR). Disagreements were resolved by a third reviewer (CN). During the conflict resolution stage, Rayyan blinded reviewers' decisions to minimize potential bias, in accordance with PRISMA 2020 recommendations.

Table 1
PICo strategy and research question.

PICo Strategy		
Participants (P)	*Phenomenon of Interest (I)*	*Context (Co)*
violence against women	social support	primary health care
domestic violence	psychosocial support	healthcare services
gender-based violence	user embracement	public health
intimate partner violence		

Obtained research question: How do women survivors of violence experience welcoming practices in Brazilian health services?

[c] Although the term "welcoming practices" was chosen to translate "acolhimento" due to its greater clarity in English, it seems Brazilian authors hold a consensus in applying "user embracement" instead.

2.6. Data collection process

Data were extracted using a standardized form within Rayyan and later organized in a table. The extracted data included authors, year of publication, country and state of origin, study design, participant characteristics, and key findings. Data extraction was performed by one reviewer (BG-S) and independently verified by a second reviewer (LR). Any discrepancies were resolved through discussion, and the final dataset was agreed upon by all authors (Table 2).

2.7. Synthesis methods

A thematic analysis was undertaken following the six-phase framework presented by Braun and Clarke[51]: familiarization with the data, initial coding, theme development, theme review, theme definition and naming, and synthesis of findings. Themes were developed through iterative reading and systematic coding, with interpretation guided by the review objectives and the qualitative nature of the included studies.

3. Results

3.1. Study selection

The search, conducted in March 2025, identified 589 records across the selected databases. After export to Rayyan, 141 duplicates were removed. The titles and abstracts of the remaining 448 records were screened, and 333 were excluded for not meeting the inclusion criteria. Subsequently, 114 full-text articles were assessed for eligibility, of which two were included. Among the 112 exclusions, most did not report on survivors' experiences. The reference lists of included articles were also screened, resulting in ten additional records. After full-text assessment, five studies were excluded for not addressing survivors' perspectives and five were included. Overall, seven publications were included in the final synthesis (Fig. 1).

An interesting finding is that all studies included in this review have women as first authors, which contributes to amplifying women's voices.

All studies adopted qualitative designs, and results were analyzed using thematic, content, or discourse analysis. Although two studies also interviewed health care professionals, only the findings related to interviews with women who experienced VAW were considered for the purposes of this review.

Data were analyzed using the thematic analysis approach proposed by Braun and Clarke,[52] enabling the identification of the following main codes: (i) user engagement in health services; (ii) the role of qualified multidisciplinary teams in providing care to survivors of violence; (iii) training of health professionals in gender-based violence; (iv) physical infrastructure and the need for confidentiality; (v) knowledge of women's rights; (vi) availability of support services within the care network; and (vii) family support.

From these codes, three central analytical themes were identified:

(i) Factors that facilitate care and recovery, such as empathy, collaborative care planning, multidisciplinary teamwork, and social and family support;
(ii) Factors that hinder care and recovery, including lack of professional training, inadequate infrastructure, and limited knowledge of women's rights;
(iii) Family support networks and the quality of communication to intersectoral networks were both identified by survivors, whether in their presence or in their absence, as factors that may facilitate or hinder recovery.

These themes informed the central organizing concept: "How do women who survived violence experience welcoming practices in Brazilian health services," illustrated in Fig. 2, which guides the presentation of the study's results.

Table 2
Characterization of the articles by author, region/country, methods and sample.

Authors and Year of Publication	City/State/ Region/ Country	Methods	Sample	Results
(Bacchus et al., 2023)	São Paulo/ SP Southeast Brazil	qualitative, interviews content analysis	−13 HP −2 clinic directors −2 female survivors of DV[a]	• Training enhanced the confidence and skills of health professionals • respond to women's disclosures using a women centered, gender and human rights perspective • emphasized clear roles and collective action within the clinical team. • allocation of resources, monitoring progress and giving feedback
(Baragatti et al., 2018)	Campinas/ SP Southeast Brazil	qualitative participant observation	10 women attending the support group at the Referral Centre	• Severity of injuries, the impact of violence on children, and family support are factors that facilitate survivors' decisions to seek health services. • Survivors often navigate multiple sectors and services before receiving welcoming practices. • Service responses were perceived as insufficient or ineffective by survivors. • welcoming practices as the most effective response for addressing their situation.
(Barros et al., 2015)	Maceió/AL Northeast Brazil	qualitative interviews content analysis	11 victims of SV, treated at the maternity ward	• Understanding survivors' pathways in seeking support from health services • limitations and capacities of health services.
(Batistetti et al., 2020)	Curitiba/ PR South of Brazil	qualitative, interviews content analysis	11 women were victims of SV	• Nursing care perceived as positive by survivors. • protection and support.
(Lettiere et al., 2011)	Ribeirão Preto – São Paulo/ SP Southeast Brazil	qualitative, interviews content analysis	10 women in situations of DV	• Seeking help within one's own social network, including family and friends. • survivors turn to health and judicial services • established social bonds may either hinder coping,

(continued on next page)

Table 2 (*continued*)

Authors and Year of Publication	City/State/ Region/ Country	Methods	Sample	Results
				leaving women vulnerable to further violence • The aggravating factors of violence are insufficiently addressed in the assessment of survivors' needs.
(Oliveira et al., 2005)	São Paulo – São Paulo/ SP Southeast Brazil	qualitative, interviews content analysis	−42 women were victims of SV (13 of whom were attended by services)[a] −29 HP from two services for victims of SV	• Welcoming practices in both services • Difficulty of access due to lack of awareness of available services • quality and effectiveness of welcoming practices provided by a multidisciplinary team • late access services compromising their effectiveness
(Santi et al., 2010)	Ribeirão Preto – São Paulo/SP Southeast Brazil	qualitative, interviews content analysis	10 women in situations of DV	• Seeking help within their own social networks, including family and friends • precedes seeking health services, which often depends on the perceived severity of the situation • does not always result in an adequate response to women's needs.

[a] We analyzed only the data from the interviews with the survivors who were attended by health services.

3.2. Factors promoting welcoming practices

Across most studies, violence survivors emphasized the importance of welcoming practices performed by health care professionals. For this reason, they identified health services as an appropriate and trustworthy point of entry when seeking help.[53] They also highlighted the relevance of support networks throughout the recovery process.

3.2.1. Welcoming practices

Survivors identified welcoming practices as the most relevant factor in the response to violence, as it validates their experiences and enables nonjudgmental listening.[53–55] When provided by a trained multidisciplinary team,[56] with empathy and active listening, welcoming practices strengthen therapeutic alliance.[53–55] Survivors reported feeling calmer and safer when cared for by health care professionals who demonstrated respect and ensured confidentiality.[52–55,57] Another study highlighted the importance of welcoming practices, the attention received, and the professional conduct of health care workers.[54]

Training initiatives involving health teams and violence survivors showed that survivors initially experienced difficulties in reporting their experiences. However, following these training activities, they felt more empowered to speak about their experiences and valued being listened to without judgment.[52–58]

Nevertheless, some studies reported that health professionals focused on survivors' symptoms, limiting care to the prescription of medication.[53] They also noted that professionals often failed to provide adequate guidance[56,58] and neglected the psychosocial dimensions of care.[53,55,57,58]

3.2.2. Health services as the first point of contact

Survivors reported health services as safe and accessible spaces to seek help,[52,53,56] particularly when violence intensified[53,56–58] or when it affected their children.[54,55,57] They valued the technical competence and human sensitivity of multidisciplinary teams, especially in providing guidance on prophylactic care and the side effects of certain medications.[54] They also emphasized the importance of receiving psychological support[55–58] and identified the absence of mental health professionals as a significant gap in welcoming practices.[53,55–58]

Violence survivors also reported a therapeutic alliance improvement after participating in training programs and valued the availability of appropriate spaces that ensured confidentiality when sharing their experiences.[53] Conversely, some studies indicated that survivors sought health services in situations of severe trauma.[55,56,58]

3.2.3. Social support networks

The connection between violence and health requires welcoming practices that include adequate physical environments, staff training, and integration with social support networks.[58] Some survivors evaluated support services negatively, including women-specialized police stations and judicial system agencies. They reported insensitivity, negligence, and victim-blaming attitudes,[55,57] characteristics of institutional violence, which undermine trust in institutions.[57]

Two studies reported that survivors identified staff transfers and health care professionals' work schedules as factors that compromise the continuity and quality of welcoming practices.[53,58] Other barriers to effective welcoming practices included the absence of mental health professionals in some health services and a lack of commitment to referring survivors to other services within the support networks.[58] The absence of protocols for welcoming practices and referral pathways further hindered survivors' access to their rights,[58] including legal abortion in cases of sexual violence

3.3. Factors hindering service delivery

Survivors identified several barriers to effective welcoming practices within health services, including limited staff, insufficient staff training, infrastructure not suited for the provision of care, and restricted knowledge on women's rights.

3.3.1. Inadequate staff and facilities

Some studies reported insufficient staff[53] available to perform welcoming practices, as well as weak or absent technical training for this specific assistance.[52] Long waiting times and physical spaces that compromise survivors' privacy were also highlighted.[52,54] The lack of clear and appropriate explanations by health care professionals[53,54] was identified as a factor that undermines the continuity of welcoming practices.[55,58]

Reduced staff compromised case follow-up and the effectiveness of referral pathways.[52,54,55] The absence of mental health professionals among health service staff was also reported as a significant barrier.[57,58] In addition, unclear communication between support services and poorly defined referral pathways may hinder case resolution.[52,53,56,58] Nevertheless, one study indicated that training staff led to improved capacity among health care professionals to recognize survivors, listen to them without moral judgements, and refer them to appropriate support services.[52,53]

3.3.2. Women's rights

Survivors reported limited knowledge of their own legal rights as well as of the available support networks. This limitation hindered their

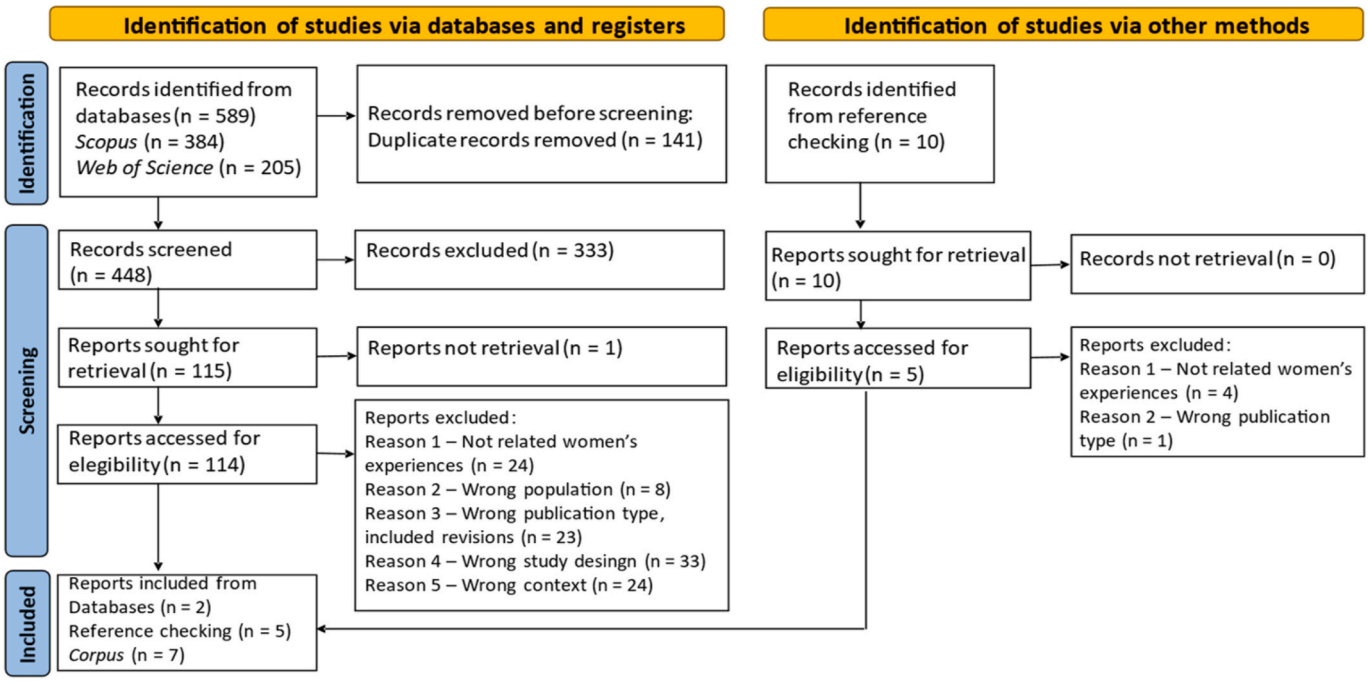

Fig. 1. PRISMA flowchart of the search, selection, and inclusion process of articles.

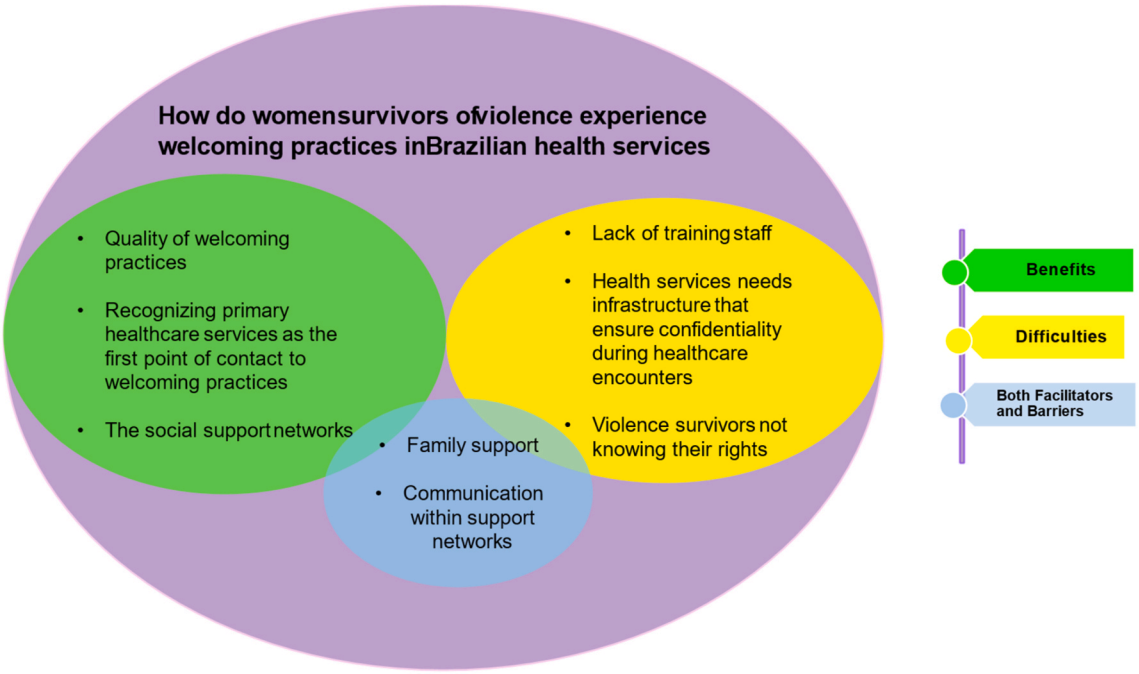

Fig. 2. Organogram of the findings with codes and main themes.

pursuit of care within health services.[52,55–57] In some cases of sexual violence (SV), this lack of information also obstructed their access to legal abortion[52,55].

Several survivors described their referral pathways through health services as lengthy and uncertain.[52,53,55,56] They also reported not knowing what documents were required to access government benefits, such as work leave.[53,55] This lack of information, affecting both survivors and health care professionals, was identified as a factor that may compromise the effectiveness of welcoming practices.[52,53,55] Furthermore, when health care professionals themselves are unaware of women's rights, survivors may be exposed to even more forms of violence.[53,55,56]

3.4. Factors acting as both facilitators and barriers

Several aspects were found to function either as facilitators or as barriers depending on their presence, quality, and context. Family support and intersectoral networks communication were identified both as protective elements and as barriers to accessing welcoming practices within health services.

3.4.1. Family support

Survivors highlighted the influence of family members on their decisions to seek care within health services. Some women reported receiving support and encouragement from relatives,[56–58] while others indicated that family responses were characterized by controlling behaviors and victim-blaming[56,58], which undermined their pursuit of institutional help. In some cases, family members and individuals within survivors' social communities failed to maintain confidentiality regarding their disclosures.[53] Survivors also noted that, in certain situations, they received greater support from friends than from family.[53]

3.4.2. Communication within support networks

In some studies, survivors identified the support network as a facilitating factor in their search for welcoming practices when referral pathways were conducted appropriately, carefully, and with adequate knowledge and responsibility.[53,57] Conversely, they reported compromised effectiveness when referrals were used by health care professionals to shift responsibility or hinder specific interventions.[52,54,57] Survivors also noted that, in some cases, health care professionals referred them to other professionals or services due to a lack of knowledge about how the support network operates.[52,53,57,58]

4. Discussion

Strengthening institutional and community-based care networks, establishing clear referral pathways, and improving timely access to health services are essential steps toward more responsive and equitable welcoming practices for survivors of violence. Training multidisciplinary staff in welcoming practices, confidentiality, and gender-based violence management — including intersectoral networks — is critical to improving survivors' experiences and case outcomes.

This review highlights gaps in scientific literature about VAW, particularly the scarcity of studies prioritizing survivors' narratives. Future research should extend the analysis to other regions of Brazil and to international settings to enhance generalizability. Further investigations centered in survivors' perspectives are needed to formulate public policies, evaluate the quality of welcoming practices, and support ethically grounded and inclusive health systems.

Limitations in staff training, infrastructure, and coordination across services, along with limited knowledge of women's rights among survivors, remain as barriers to effective welcoming practices. Strengthening both institutional and family support networks as well as clarifying welcoming practices pathways are necessary to reduce institutional violence and improve access to health services.

Recognizing survivors as active agents in their recovery is essential for meaningful welcoming practices, empowerment, and the development of equitable and humanized health services.

4.1. Conclusions

This qualitative review highlights the importance of critical reflection on welcoming practices and their implementation, as well as the need for training health staff to understand the multiple dimensions of gender-based violence. A deeper understanding of these issues and of intersectoral networks can improve survivors' experiences regarding welcoming practices, as well as welcoming practices' outcomes.

Strengthening support networks, both institutional and familial, defining clear protocols for welcoming practices and referral pathways, and facilitating survivors' access to health services are factors that can contribute to the development of more responsive, inclusive, and humanized health services. In a national context currently undergoing recovery after a period marked by setbacks in gender and human rights agendas, fostering critical dialogue and social engagement may help protect hard-won rights.

Prioritizing survivors' voices and recognizing them as protagonists of their own stories and co-authors of their recovery processes are essential steps toward effective welcoming practices. Amplifying these voices can promote autonomy and empowerment and contribute to the construction of more inclusive, equitable, and democratic societies.

Ethical approval

Ethical approval was not required for this study because it is based exclusively on previously published studies.

Author contributions

BG-S conceptualized and designed the study. BG-S and LR participated in article screening and data abstraction. BG-S conducted the data analysis, interpreted the results, and drafted the first version of the manuscript. LR and CN provided critical revisions for important intellectual content. All authors have read and approved the last version of the manuscript.

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Declaration of competing interest

The authors declare that they have no conflicts of interest.

Appendix A. Supplementary data

Supplementary data related to this article can be found at https://doi.org/10.1016/j.puhe.2026.106345.

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