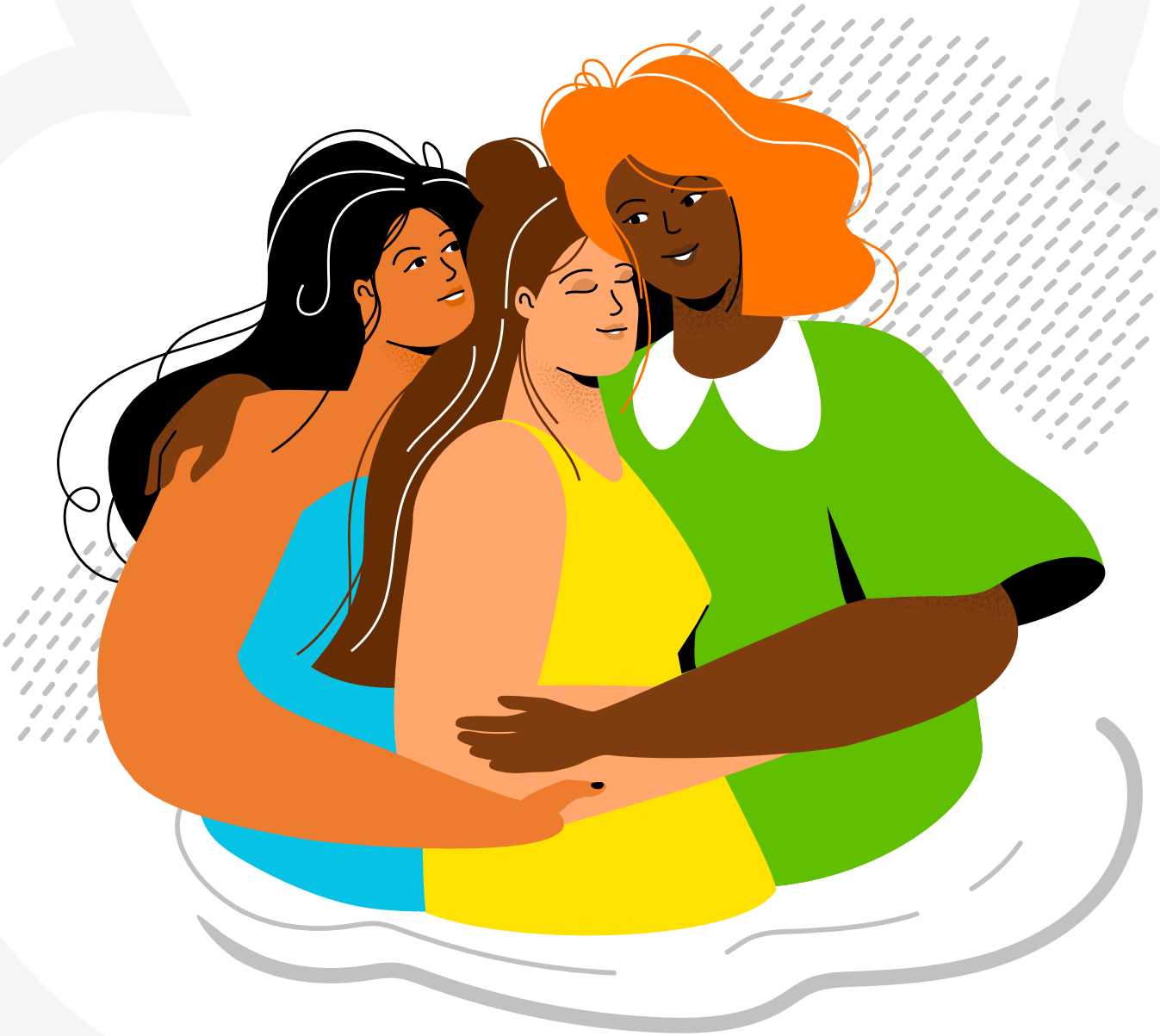
Beyond Surviving

Examining Inequities
in Access to Gender-Based
Violence Support Services
for Racialized Women



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gender AND THE economy

BEYOND SURVIVING:
EXAMINING INEQUITIES IN ACCESS TO GENDER-BASED VIOLENCE SUPPORT SERVICES FOR RACIALIZED WOMEN

A joint report from:

Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health

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Table of contents

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www.gendereconomy.org/intersectional-analysis-of-gender-based-violence

Executive summary

Gender-based violence, race, and barriers to support services
Gender-based violence (GBV) remains a global pandemic with destructive effects on the well- being of women and girls. Defined as any act of violence that results in physical, sexual, or emotional harm and suffering, GBV takes many forms, encompassing intimate partner violence (IPV), non-partner violence, and other harmful acts directed at people based on their gender expression, gender identity, or perceived gender. It can include physical abuse, criminal harassment, emotional and psychological abuse, and coercive control. For all those experiencing GBV—but especially for racialized women—leaving abusive relationships can entail significant challenges, among them surmounting barriers that prevent GBV survivors from accessing formal care and support. This report synthesizes research on barriers to accessing support services for racialized women who experience gender-based violence and the outcomes associated with access to support services that reflect the lived experiences of racialized GBV survivors.

In assembling this report, we reviewed 127 peer-reviewed scholarly studies from 2015-2023. These studies represent the perspectives of both racialized survivors of GBV and service providers; most were conducted in high-income countries, and the majority specifically in the United States. Most research on racialized survivors of GBV focuses on partner violence or domestic violence among African American/Black, Latin/e/x, South Asian, and immigrant women from various countries of origin, although a few of the studies were conducted with Indigenous and Arab women.

Key findings about access to support services and their impact

- Common supports reflected in the literature include healthcare, policing, social work, legal or criminal justice assistance, psychosocial help, and support by social networks such as family, friends, and neighbours.
- People experiencing GBV are often motivated to seek formal care and support to protect their children.
- The presence of supportive informal networks and positive prior experiences with formal service providers can motivate help-seeking.
- Survivors frequently experience barriers when accessing support that relate to the acceptability, affordability, and availability of the services they need.
  - Acceptability barriers include cultural acceptance of violence, internalized stigma and shame, racial and gender stereotypes and oppression, and a lack of culturally and linguistically appropriate services.
  - Affordability barriers include the cost to access services, lack of health insurance and the cost of medical care, and lack of financial autonomy.
  - Availability barriers include lack of knowledge of services, transportation concerns, and time constraints.
- Service providers also struggle to provide comprehensive and culturally competent and safe services to women due to funding constraints, inadequate legal structures, and rigid immigration policies.
- When adequately supported, racialized survivors experience improved well-being, improved self-confidence, reduced psychological distress, increased social connectedness, and increased motivation to help others facing violence.
- Inadequate attention to the needs of racialized survivors can risk secondary victimization by service providers and the escalation of violence from abusive partners.

Implications for research, policy, and practice to support the empowerment of survivors
Support services that meet the needs of GBV survivors can break inter-familial and inter-generational cycles of gender-based violence. But, as the evidence in this report shows, existing models and systems of care are not aligned to the needs and lived experiences of racialized women; they are disempowering, rather than enabling. This review highlights policy, practice, and research recommendations to address key barriers that render the networks of support services for GBV survivors out of reach for racialized women. The review identifies opportunities for policy, practice, and research and evaluation to improve access to necessary supports for racialized women:

Policy

- An intersectional and trauma-informed approach to policy development and implementation should establish governance structures that prioritize the integration of a range of support programs with aligned and sustainable funding to support tailored programs that accommodate different survivor trajectories, and that meet the needs of individuals with different lived experiences.

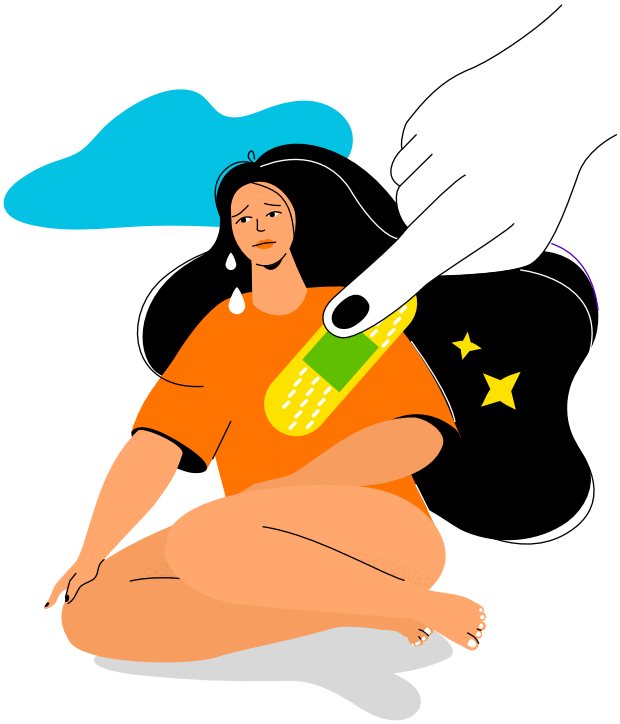
Practice

- Cultural safety and competencies should be embedded in program design, with ongoing training for administrators and staff as well as access to translation and interpretation services for clients available as needed.
- An integrated framework of support should offer survivors easy access to a range of services from housing supports to medical care and job training without financial barriers, supporting empowerment and financial independence.

Research and evaluation

- A strengths-based approach to research will distil meaningful health, psychosocial, education, and economic outcomes from the perspectives of survivors.
- A better understanding of the gaps, successes, and opportunities in existing services will enable providers to improve the framework of support available to racialized women in different settings and set the stage for learning between different jurisdictions.

Race is a determinant of access to support for gender-based violence survivors



Gender-based violence (GBV) remains a global pandemic with significant economic and social consequences for women. Defined as any act of violence that results in physical, sexual, or emotional harm and suffering, GBV takes many forms, including intimate partner violence (IPV), non-partner violence, and other harmful acts directed at people based on their gender expression, gender identity, or perceived gender[1] (see Appendix for definitions of all key terms). GBV can include physical, sexual, emotional, and psychological abuse, and coercive control. The prevalence of GBV remains unacceptably high in all settings, and its harmful effects on the well-being of women and girls has escalated to a global concern, with the United Nation's Sustainable Development Goal #5 targeted explicitly at preventing GBV against women and girls. Women in marginalized communities and minority groups are especially vulnerable to GBV,[2] and racialized women are three-times as likely to experience abuse as non-racialized women.[3]

For survivors of GBV, access to affordable, acceptable care and support is critical. Survivors must be able to reach and obtain support services when they are exposed to or at risk of GBV.[4] But those services also need to be acceptable to survivors and appropriate to their needs. This is especially important for racialized individuals who have historically been subject to inequities within health and social systems. When appropriately targeted, support services provide key opportunities to break the inter-familial and inter-generational cycles of GBV,[5] improving health outcomes and supporting key non-health outcomes such as boosting survivors' confidence and capabilities and facilitating (re)integration into social and economic activities[6] and thus, contributing to the restoration of individual capabilities.

The risks and impacts of GBV for women worsened during the COVID-19 pandemic. Economic instability, financial strain, and quarantine requirements exacerbated the conditions that place women at risk of violence and made critical support services harder to access.[7] Some studies suggest that historically marginalized women were disproportionately impacted.[8] The post-COVID-19 recovery agenda presents an opportunity to "build back better"[9] for the women and children impacted by GBV. But a nuanced understanding of the experiences of racialized GBV survivors is needed to strengthen policy and program support frameworks to better address the needs of diverse survivors and maximize the potential outcomes of GBV support services.[10]

This report reflects our analysis of 127 peer-reviewed studies from 2015 to 2023. These studies examined racialized women's access and use of GBV support services globally from the perspectives of both GBV survivors and providers of support services. While historical inequities make racialized women more vulnerable to violence, they are often excluded from or made invisible in policymaking and interventions for violence prevention.[11] Focusing on their experiences is a way to correct this imbalance. Indeed, intersectionality theory argues for a nuanced understanding of individuals' unique and differing realities to counter a "one size fits all" approach to addressing GBV. Understanding the intersecting social variables (e.g., gender, race, religion, immigration status, and socio-economic status) that shape survivors' experiences of GBV stands to strengthen supports for those who continue to be underserved by existing systems and services.[12]

The overarching questions guiding this review were: What are the experiences of racialized GBV survivors as they navigate, access, and use support services? What are the meaningful health and non-health (e.g., economic) outcomes associated with access to support services that reflect the lived experiences of racialized survivors? The box below describes our methodology in more detail.

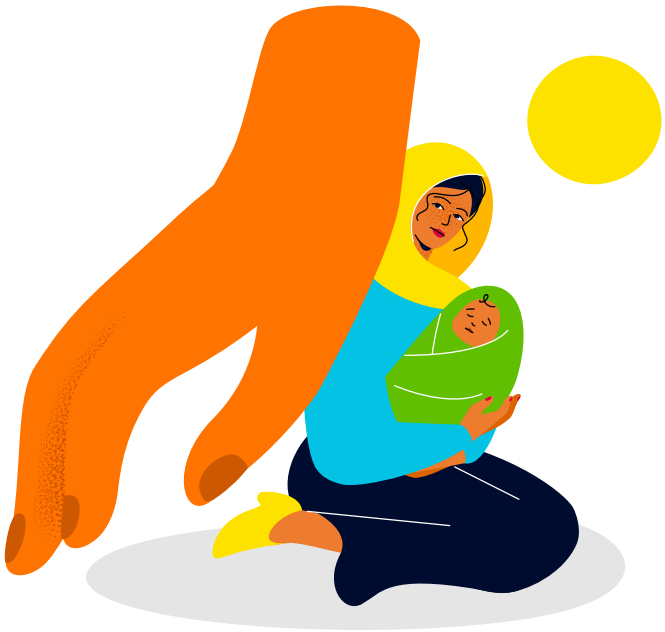
Methodology and sample

To identify relevant studies to analyze, we searched for those covering three overarching concepts: (1) gender-based violence, (2) racialized populations, and (3) access barriers. We included studies published after 2015 to align with the year that the United Nations' Sustainable Development Goals (goal #5 on gender equality specifically) were adopted by all member states. Articles that were not peer-reviewed were excluded. While we recognize that many adults and children experience GBV, to keep our focus on racialized women-identifying and transgender/nonbinary people, we did not include articles that focused on cisgender men, non-racialized GBV survivors, and children (individuals below the age of 15) specifically. This search resulted in 127 peer-reviewed studies conducted from January 2015 to June 2023 which reported on both survivor and provider perspectives about service navigation, access, and use of services. While we aimed to include studies on racialized trans and nonbinary people, there were few results. Throughout the report, we reflect on any information available from the literature on trans and nonbinary survivors.

The studies included in the review predominantly used qualitative methods, and most were conducted in high-income countries, primarily in the United States, but also in Canada, the UK, Switzerland, Malaysia, and China. Nearly all of the studies examined intimate partner violence, with few focusing on non-partner sexual violence. Studies reporting solely on survivor perspectives were predominantly conducted using qualitative methods and looked at the services accessed or sought for GBV, including healthcare, police, social work, legal or criminal justice, psychosocial support, and social networks such as family, friends, and neighbours. Studies that looked at provider perspectives studied healthcare providers, police officers, legal service providers, community shelter staff, and social workers to report their perspectives on servicing IPV and non-partner violence survivors.

The sample studies were diverse in the racial and gender identities they reported. Since most were conducted in the US, in this review, African American women will refer to women of Black African descent born in the US, while Black women will refer to Black women of African descent born outside the US. Thirty-four articles reported on the experiences of immigrant and migrant groups, including refugees and asylum seekers. Seven articles reported on transgender women specifically or included transwomen in their sample.

From these studies we identified information about barriers and enablers to accessing services according to the three domains of the McIntyre Access Framework: affordability, acceptability, and availability.[13] We chose this framework because it considers how multiple causes of inaccessibility intersect. It centres and allows us to map the paths survivors take in seeking help by focusing on barriers faced at different levels of a supportive care system.



Perspectives of racialized women and service providers

What motivates help-seeking?

Many of the studies we reviewed highlighted the importance of both formal and informal supports in supporting decision-making to leave an abusive relationship, especially when children were in the household. These studies spoke to the ways in which survivors relied on formal and informal supports to protect their children.

Desire to protect children

Women often prioritize protecting their children, and their desire to do so is a key motivator to seek formal support services. Studies highlight women's desire to protect their child(ren) and prevent further victimization as a critical factor in motivating people to access care and support.[14] Although many studies reported the risk of losing guardianship of children as a barrier to accessing support services,[15] others showed that children were also a motivating factor.[16] This is true even when leaving an abusive relationship would contradict societal and religious norms. Findings from a study conducted in the United States with Chinese women showed the women prioritized their children's well-being and defied cultural norms by leaving their abusive partners and seeking formal care.[17] Service providers also reported that, in their experience, women seek formal support because of the effects violence has on their children, such as a decline in their academic performance and the deterioration of their physical and mental health.[18]

Informal support

Before survivors seek formal support, they typically speak with a trusted person within their social network who recognizes the violence and expresses concern for their safety.[19] These informal networks can support the survivor in overcoming barriers to accessing formal services by providing information on available resources and financial and material support. Women reported that friends helped them contact law enforcement and provided temporary shelter.[20] Likewise, studies with Arab and African American women[21] described the importance of support from spiritual and church communities.[22] In studies with Latin/e/x women in the US, participants described a determining moment that led them to leave their abuser and seek help from informal or formal support channels—such as realizing that the abuser would not change or that their children could be harmed.[23]

While informal support networks can play a significant role in encouraging women to seek support services, evidence suggests that they can also have the opposite effect, hindering and delaying access to care. Close contacts may discourage women from disclosing violence to outsiders, urge them to stay in an abusive relationship, and/or encourage them to accept abusive behaviours on cultural or other grounds.[24] For example, mothers and siblings of survivors can play a significant role in either facilitating access to care by creating a safe environment or delaying access by judging and shaming the survivor.[25] Similarly, service providers identified informal networks, particularly the family, as deterrents to formal help-seeking.[26] For instance, in a study conducted in the US, an elderly Korean woman was pressured by her family into withdrawing a protection order against her abusive partner.[27]

Positive prior experiences

There is mixed evidence on the role that service providers can play in assisting women in accessing and benefiting from the support needed to leave abusive relationships.[28] For example, in studies of Latin/e/x women in the United States, participants reported that service providers in healthcare, law enforcement, and psychiatric settings could offer empathetic support, helping women feel more comfortable sharing their experiences of violence.[29] Black, Latin/e/x, and East Asian women from three Canadian cities reported that positive experiences with the criminal justice system encouraged them to both continue using services and tell other survivors about resources for support.[30]

A study conducted with psychosocial service providers in Canada revealed that individualized care can enable the delivery of culturally competent support.[31] Providers in this study offered linguistically appropriate services, longer sessions, and the ability to reschedule appointments to find interpreters and professionals.[32] They also used tools such as Google Translate or Babel Fish to ensure that women could get the help they needed even in the absence of interpreters.[33]

What hinders help-seeking?

People experiencing gender-based violence often face barriers to accessing the supports they need. These barriers come in multiple forms, including the availability, acceptability, and affordability of services to address their needs.

Availability

Availability barriers are related to the extent to which support services are known and readily available, offer quality care, and have the resources and capacity to meet survivors' needs.[34] They can be categorized as:

- Knowledge of available services
- Location of services
- Time constraints
- Bureaucratic processes and strict eligibility criteria.

Knowledge of available services

A common theme across all the studies and participant populations we encountered is the need to improve the awareness of available support services.[35] The isolation of GBV is compounded by social and cultural norms that can enable ongoing victimization and mistrust of social and healthcare institutions. There is evidence that among racialized populations, women remain underserved in part because the support options available and eligibility criteria are unknown to them.[36] [37] In one study, South Asian women in the United States were found to have limited knowledge of their legal rights, constraining their use of police and criminal justice system services.[38] In another study, refugee women in the US reported limited knowledge of the services they were eligible for.[39] These challenges were compounded by language and many of the other barriers listed below. For instance, a lack of language proficiency made it challenging for South Asian women in the US to learn about their legal rights and available support services.[40]

Location of services

Access to transportation is often a deciding factor for survivors considering accessing services. Long travel distances in particular are a barrier to gaining support.[41] For example, migrant Black Muslim women in one US study reported they did not have

a driver's license; they described lacking access to reliable transportation and being dependent on others (e.g., children, perpetrators) when they needed to get somewhere.[42] In contrast, Latin/e/x women in a separate US study reported that the proximity to services influenced the likelihood of seeking support.[43]

Time constraints

Further impeding women's disclosure of violence are waitlists and time-limited encounters with providers. For instance, in a study conducted in the US with African American and Latin/e/x women, a survivor reported that a 911 operator told her she should wait for a police officer in the jurisdiction where she was assaulted; after waiting more than five hours, she gave up.[44]

Women accessing healthcare services in the UK reported finding an appropriate time to disclose as a barrier, highlighting insufficient time to discuss experiences of violence during short, time-limited doctor appointments. This potentially explains, in part, how organizational and financial barriers act as a compounding factor for racialized women who face multiple intersecting factors preventing the timely disclosure of violence.

Service providers, particularly within healthcare, law enforcement, and criminal justice settings, also reported time constraints as barriers to providing culturally sensitive services for women.[45] Although longer clinic visits are needed to screen for violence effectively, heavy workloads do not always allow healthcare providers to provide these opportunities.[46] Consistent with women's concerns about their abusive partners accompanying them when seeking services, healthcare service providers reported concerns about their own safety. Several studies highlighted risks for providers who intervene as this can anger the abuser and cause them to become aggressive.[47]

Furthermore, in the US, judges noted that there was insufficient time to speak with immigrant women to explain the court processes, and they believed that in most cases, women remained confused and overwhelmed with the court procedures and paperwork.[48] According to criminal justice service providers, this may result in women presenting inadmissible evidence, which can make an intervention difficult.[49]

Bureaucratic processes and strict eligibility criteria

Several studies conducted with African American women highlighted the numerous bureaucratic steps involved in seeking support services, revealing disparities in access to services. There is a pattern of disenfranchisement among Black women, who experience delayed responses when they apply for housing programs or legal representation.[50] Women's lack of knowledge of available services has also been linked to structural racism: one study highlighted that, in the US jurisdiction it examined, support services were predominantly located in wealthy, white communities.[51]

Having an undocumented immigration status can add another layer of complexity to the barriers GBV survivors experience. Restrictive and inflexible policies—and the constant risk of deportation—can make the challenge of navigating and accessing services appear insurmountable to undocumented immigrants, preventing them from seeking formal care and support. Disclosing partner violence and completing required paperwork to formalize a complaint may have undesirable legal consequences for undocumented survivors, who may fear that they, their abusive partners, or their children will be deported.[52]

Service providers also highlighted the lack of legal structures to address the complex needs of undocumented racialized women who suffer from GBV as a significant barrier to providing services to migrant women with tenuous immigration status. Women with precarious status tend to be more reluctant to come forward and seek services, especially when service providers request immigration documentation and there is any risk of deportation.[53] In a Canadian study, service providers described concerns about providing shelter to immigrant women without documentation, which they mistakenly perceived as breaking the law.[54] Further, evidence in Malaysia suggests that mandatory reporting laws and regulations have made it difficult for healthcare providers to assist victims who refuse treatment due to fear of law enforcement and deportation.[55] To receive comprehensive care from GBV-associated health services or utilize government shelters in Malaysia, survivors are required to first report violent incidents to law enforcement, deterring undocumented migrants from seeking assistance. These studies highlight that system-level gaps make formal support inaccessible for immigrant and refugee women across settings.

Beyond these gaps, specific immigration policies were also identified by service providers as limiting access to available services.[56] Strict immigration policies regulating residency status for immigrant women in most countries make it difficult to provide comprehensive care and support to undocumented migrant women. In some instances, undocumented migrant women were afraid to come forward and seek assistance because of these policies. For those who managed to come forward, completing their treatment or care plan often entailed changes in residence or employment that would require them to return to their countries of origin—leading them to abandon care.[57] For example, a social worker working with migrant women in China described how immigration policies did not support victims of sexual assault. In this context, healthcare services and support for sexual assault victims often required individuals to engage with the service over an extended period that surpassed the legal term that immigrant women were afforded before being required to return to their countries of origin. In this context, they often had to forgo care and support to avoid the consequences of overstaying a work permit.[58]

Acceptability

Acceptability barriers are the attitudes and expectations that prevent survivors from interacting with service providers.[59] They can arise from the relationships and interactions between GBV survivors and services and providers and from women's preferences, attitudes, and beliefs within different settings. Three broad categories of acceptability barriers emerged from the literature:

- Social and cultural perceptions and attitudes
- Racial and gender stereotypes and other forms of systemic oppression
- Lack of appropriate support service settings.

Social and cultural perceptions and attitudes
Barriers arising from social and cultural perceptions and attitudes include cultural acceptance of violence (i.e., normalization of violence, which discourages disclosure of abuse outside the family)[60] and internalized stigma, shame, and mistrust (i.e., women's expectations of discrimination, rejection, disgrace, and disapproval after disclosing violence to formal support services).[61]

Studies with South Asian, Arab, and Latin/e/x women, along with immigrants, especially African immigrants, suggested that cultural acceptance of violence is an important barrier to gaining support.[62] For example, machismo (gender norms for demonstrating masculinity), marianismo (norms encouraging women's self-sacrifice), and familism (cultural value encouraging the prioritization of the family unit) made both US-born and immigrant Latin/e/x women reluctant to disclose violence and seek assistance outside their family unit. Specifically, women hoped their non-disclosure would prevent chisme (gossiping) and the shame it would bring to their family and community.[63] The cultural values of protecting community ideals and prioritizing the family's reputation are often reported by survivors and providers as critical barriers to disclosing experiences of GBV, seeking formal support, and gaining adequate services. Survivors also reported internalized stigma and shame coming from their GBV experiences as a barrier to disclosing abuse and seeking care.[64]

Stereotypes, discrimination, and other forms of systemic oppression
Service providers' racial, ethnic, and gender biases can also exacerbate survivors' mistrust of the system.[65] Racial stereotypes are commonly experienced by African American, Black, South and East Asian, Latin/e/x, and African immigrant survivors, especially those with tenuous migration status.[66] One study conducted with African American women highlighted stereotypes associated with Black bodies as a factor that limited their access to care. For example, Black women's accounts of violence were often dismissed because they were perceived to be resilient and physically capable of defending themselves against a violent partner.[67] Other racialized groups in other settings recounted similar experiences. For example, a study conducted in Australia with Muslim women revealed that some service providers expressed racist stereotypes and assumptions about Muslim men being inherently violent and Muslim women innately passive and submissive. Such stereotypes perpetuated by service providers caused mistrust among survivors and resulted in reluctance to disclose experiences of violence.[68]

Racialized women also consider themselves invisible in GBV-related policies as they have historically been excluded from the policy development process; consequently, their perspectives and unique needs remain unaddressed. A study conducted with African American women in higher education confirmed this idea of invisibility.[69] Women described often feeling excluded in conversations around sexual violence intervention policies, with most sexual assault prevention initiatives focusing on "the missing white woman syndrome"—a prioritization of white women's stories and experiences in media coverage of GBV—and ignoring the highly prevalent experiences GBV among African American women.

Anticipated safety consequences of disclosure were also reported as barriers across all racial groups and common among immigrant women, particularly undocumented immigrants.[70] The abusive partners of undocumented migrant women often threatened to report the latter for deportation.[71] Black women also reported fearing their abusive partners would receive harsher punishment and even violence from authorities because research has shown that Black men in the US are more likely to receive harsher sentencing for IPV than white men.[72] Additionally, Black women fear that authorities will place their children in protective custody, which also occurs at a higher rate for them than for white women in the US.[73] Thus,

although the need to protect children from violence may motivate some women to seek support services, others may feel obligated to protect their family, including their abusive partner, from the violent systems of oppression in which intuitions that provide formal support are often implicated, and avoid seeking help.

In addition, when seeking help from the law enforcement and criminal justice system, race can shape survivors' experiences. Studies discussed how women of colour often have less legal protection when they experience GBV due to differences in forensic evidence collection and interpretation (e.g., bruises are more visible on white women than Black women). Prosecutors also believe that victims of colour are less likely to cooperate with law enforcement due to mutual distrust.[74] Such exclusionary policies and actions are illustrative of structural and systemic discrimination and racism and sustain fear and mistrust in formal support services by survivors, ultimately discouraging women from seeking formal care and support.

For transwomen, transphobia, particularly in healthcare settings and in interactions with police, remains a key barrier for help-seeking.[75] Many providers assume that transwomen can defend themselves against violence.[76] This perception influences ideas of victimhood and beliefs about who gets to be the victim of violence. Latin/e/x and African American transwomen and gender non-binary people in the US reported being ridiculed, turned away from services, ignored, or even blamed for the abuse when attempting to access services.[77]

Lack of appropriate service settings

The service setting itself can impact accessibility. First, healthcare settings are seen by many survivors as not conducive or supportive of GBV disclosures.[78] One study in the UK reported that women often could not disclose experiences of violence in healthcare settings because their abusive partners remained present or had a personal relationship with the service provider.[79] Second, poor living conditions at shelters in the US (e.g., reported insect and mold infestations and lack of heating in the winter) were identified by African American women as barriers to leaving abusive relationships.[80] Compounding the situation, studies highlighted repercussions that women can face when reporting substandard shelter living conditions, including facing threats to apprehend their children.

Communication issues between women and providers also significantly hinder disclosure, especially among African, Latin/e/x, and Asian immigrant women. One study in the US and Australia showed that when attempting to disclose abuse or when engaging with support services, non-English speaking individuals struggled to communicate their violence-related concerns or needs to English-speaking providers.[81] Interpreters were not readily available to women to provide adequate formal support. English proficiency specifically emerged as a barrier in studies examining the experiences of African immigrants in the US.[82]

A lack of culturally sensitive care was identified as an important barrier to accessing formal support across all racial and ethnic groups.[83] Studies with Latin/e/x, South and East Asian, and immigrant women in the US frequently described encounters

with service providers who did not centre their needs for privacy and confidentiality and engaged in "victim blaming" (i.e. suggesting they had some role or responsibility in the violence they experienced). Women in several studies recounted situations where providers assigned fault and discredited their accounts of violence.

At the intersection of racial and gender-minoritized identities, transwomen can experience transphobic services when accessing healthcare from physicians.[84] A study of transwomen in El Salvador, Trinidad and Tobago, Barbados, and Haiti showed that they had been denied access to healthcare services without medically justified reasons.[85] Experiences of overt discrimination often lead transwomen to leave healthcare centres without treatment.[86] These negative experiences also exacerbate pre-existing mistrust in service systems, leading transwomen to disengage from accessing support services with providers who do not understand their communities' nuanced needs.[87]

One study conducted in Uganda reported that bribery was a deterrent to seeking help within law enforcement and the criminal justice reporting system, with police requiring payment from survivors to investigate the reported issue.[88] Corruption within the network of support in this setting erodes trust in institutions and acts as a barrier to help-seeking, especially since many women cannot to afford to pay the bribe and thus do not receive help from the police.[89]

Overall, the studies' findings about acceptability revealed distinct patterns connecting the unique experiences of different racialized women: racial and gender stereotypes were reported mainly by African American and Black women, including transwomen, while language barriers were mostly reported by Latin/e/x, Asian, Indigenous, and immigrant women, and cultural norms encouraging women to accept violence stood out as barriers among South, East, and Southeast Asian women. Despite these similarities, women's experiences of accessing formal support services are ultimately heterogeneous.

Affordability

Affordability refers to the ability to meet the costs associated with accessing services and the impact of these costs on both the use of those services and other health, social, and economic outcomes for survivors. Three sub-themes emerged in the affordability domain:

- Affordability of support services
- Health insurance status
- Financial autonomy and stability

Affordability of support services

Much of the evidence on the high cost of accessing healthcare services comes from the US context.[90] In studies with African American; East, South, and Southeast Asian; and Latin/e/x women, participants consistently discussed the unaffordability of hospitals and medications as a significant socio-economic barrier to seeking medical attention after an exposure to violence.[91] For instance, one woman reported, "Whether it's going to the emergency room trying to get DNA swab... in an ambulance or cop car. It all costs. Trying to do counselling... it's all money, and if you don't have good insurance or you don't have insurance, then you're like, well, I can't afford it, there's nothing I can do."[92]

In another study, Latin/e/x women with precarious immigration status living in the US described the compounded challenges of navigating payment for healthcare while experiencing language barriers (which often contributed to a lack of awareness about the sources and costs of services, and an inability to communicate financial hardship) and unemployment (which left them with fewer resources to meet the costs of services and, often, without health insurance).[93]

In several studies, the high cost of support of services, rooted in various institutions' inflexible payment policies was a barrier to accessing necessary support, especially in healthcare settings.[94] Southeast Asian immigrant women without stable income in China reported that accessing healthcare services was difficult without a regular income.[95] Similarly, Latin/e/x and African American women in the US reported that a lack of sufficient income or unemployment prevented survivors from continuing treatment due to the high costs of healthcare services.[96] Lastly, Rohingya refugee women in Malaysia faced unique challenges, such as difficulty with settling their hospital fees resulting in threats of being arrested and, in some cases, reported to the police by healthcare institutions.[97]

Furthermore, in studies conducted in the US, tenancy requirements for accessing housing contributed to the financial barriers described by African American women.[98] Women in shelters reported having only a limited time to organize alternate accommodation. Housing precarity can make it difficult for women to leave abusive relationships and seek formal care and support. For example, one study conducted in the US with Black mothers found that they often struggled to secure accommodation due to inflexible tenancy policies requiring a strong credit score and an upfront deposit fee.

Service providers attributed high costs and the lack of comprehensive services to inadequate funding and policy prioritization for GBV. For example, studies in Canada, the US, and Switzerland highlighted an urgent need for interpreters when working with migrant women, as interpretation was underfunded by the government and many providers were forced to rely on platforms such as Google Translate.[99]

Studies with healthcare providers also described the impact of underfunding on patient screening, assessment, and treatment. Within the US criminal justice system, limited court funding impacted the availability of staff, such as cultural and court advocates, who play a significant role in explaining the court processes to immigrant women.[100] Due to insufficient funding and resources, certain healthcare providers in private settings in Canada and China raised concerns about financial expenses when managing IPV cases, which normally require lengthy, expensive consultations.[101]

Health insurance status

Lack of health insurance coverage is a significant barrier to accessing support services.[102] For African American, Latin/e/x, and immigrant women in the US, lack of insurance coverage was linked to poverty, making access to medical treatment difficult to attain.[103] Even when services were geographically accessible, low-income, uninsured women found it difficult to access them.

Several studies with migrant and refugee populations across settings illustrated how structural barriers reinforce and exacerbate affordability barriers for GBV survivors. For example, studies in the US with Latin/e/x, Black, and South, East, and Southeast Asian immigrant women demonstrated that documentation and migration status are linked to insurance coverage and, ultimately, access to healthcare for both survivors and their children. Further, in a study conducted in Spain, providers described policy-level barriers that can prohibit and limit access to necessary healthcare. For example, access to healthcare for uninsured women can often require a formal report of the episode of violence and the submission of a residency visa.[104] Similarly, a study with Rohingya refugee women in Malaysia illustrated the challenges of accessing treatment in public hospitals for women who were not eligible for health insurance. In many contexts, policies and regulations for refugee populations and those with precarious immigration status keep support services out of reach, leaving women in these settings at risk for ongoing violence.[105]

Financial autonomy and stability

An abusive partner's surveillance of a woman's financial autonomy can limit her access to support services. Both GBV survivors themselves and service providers report that women who are financially dependent on their partners may fear losing their financial security should they disclose or report their experiences of violence.[106] Concerns about financial autonomy were described in studies with African American women,[107] Latin/e/x women, African immigrant women,[108] and Asian immigrant women.[109] Nigerian migrant women in the UK reported being hesitant to disclose their experiences of violence because they were financially dependent on their abusive partners and feared losing financial security. For these women, reporting the episode of abuse could result in a loss of the household income and new financial obligations for their child(ren) and themselves without a means to support the family.[110]

One study with Black, Latin/e/x, and East Asian women in Canada revealed that financial dependency on abusive partners informed women's decisions to seek support: "Now, I even cannot report to the police because he raped me and had this baby. If I reported him to the police; he could not go to work and would be unable to pay me maintenance. Without his monthly payment, what could I do? My English isn't good enough for me to find a decent job." [111]

Some participants without stable incomes described a "culture of frugality" that influenced whether and how they used IPV-related services. For example, they might prioritize spending money on essential items over taking time off work or paying for transportation to access care. Exposure to IPV was described by some as "a normal occurrence in relationships" that did not warrant seeking, and paying for, formal care and support. For example, in studies with East Asian women in the US, participants described a cultural normalization of IPV, which resulted in women and families not prioritizing spending money on a professional intervention that might secure their safety and address their healthcare needs.[112]

Access barriers for Indigenous populations

Few studies on GBV have focused on Indigenous women. In this review, the Indigenous communities engaged in research included First Nations in Canada, Aboriginal and Torres Strait Islander peoples in Australia, American Indian/Alaska Native people in the United States, and the Maya population in Belize.

Studies with Indigenous communities reported many of the themes highlighted in this report regarding the need for improvements in the availability of gender-based violence resources and information.[113] Specifically, they reported significant gaps in the availability of culturally safe and appropriate resources that consider Indigenous practices and epistemologies of health and healing and include Indigenous staff members.[114] Service providers assisting First Nations women admit they experience uncertainty in addressing cultural safety and partner violence.[115] Indigenous survivors in rural and remote areas, such as the Mayan women in Belize, are less likely to have ready access to adequate GBV resources.[116] Women must overcome travel barriers to gain access to services, which can cause delays in treatment. In a study in the US investigating the impact of rurality on medical assistance delays for American Indian/Alaska Native communities, survivors were more likely to present to services if they were close to their place of residence.[117] Additionally, in smaller communities, providers may be family members and friends, raising privacy and confidentiality concerns.[118] Beyond the cost of transportation and travel barriers, especially among survivors in rural areas, studies also reported inadequate insurance coverage[119] and financial dependency[120] as barriers to accessing formal support for Indigenous women.

The main concern in the studies with Indigenous populations was the ways in which a history of structural violence and discrimination against these populations by state institutions and health systems more generally has ingrained a justifiable mistrust of formal services.[121] One study in the Canadian context showed that racist government policies and practices, both historical and ongoing, have impacted women's experiences of GBV and their help-seeking behaviours.[122] These practices included high surveillance of Indigenous mothers leading to the removal of their children from the home and high incarceration rates in the community. Every survivor in this study described discriminatory experiences when seeking formal resources. American Indian and Alaska Native women in the United States also reported being ignored and not believed by law enforcement and healthcare providers, and consequently being unable to access support.[123] [124] There is a clear and pressing need to establish culturally safe care for Indigenous GBV survivors that acknowledges historical and ongoing harm from colonial systems. Providers must be required to learn and understand the Indigenous cultures they serve and their value systems, and survivors need opportunities to incorporate care options that they find appropriate.[125] In the studies we reviewed, such practices were seen as key in repairing trust in providers and health- and social care institutions that support Indigenous survivors of GBV.

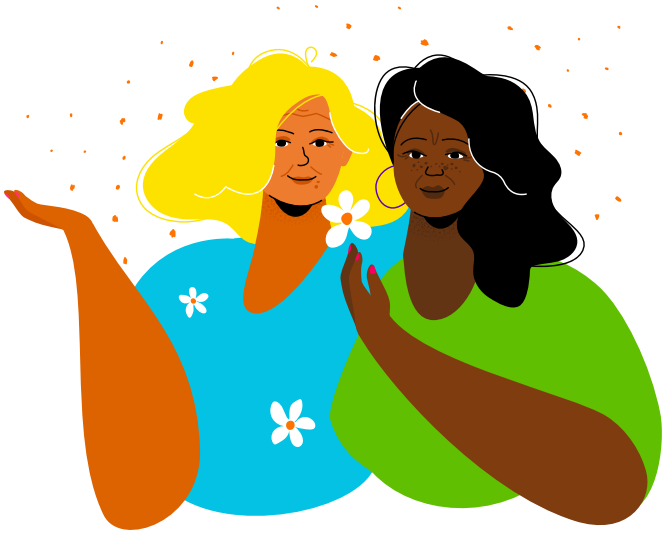
Racialized survivors benefit when met with the right care and support

Despite these many barriers, there is evidence that racialized survivors of GBV benefit when met with the targeted care and support.[126] Service providers recounted how environments that support their clients' agency were an important part of their services, which in turn built women's trust and confidence in formal support.[127] Experiences of gender-based violence can dehumanize and diminish survivors' self-worth, establishing a critical role for service providers to help restore self-confidence, self-esteem, and a sense of self-efficacy (i.e., belief in one's abilities).[128]

The well-being outcomes reported include a significant reduction in chronic stress,[129] increased social connectedness,[130] and increased self-confidence and self-awareness.[131] A study conducted in the US with African American women seeking psychosocial support through mindfulness practices and therapy found that it allowed women to let go of their daily stresses and relax, providing a sense of peace and calmness necessary for them to heal from traumatic experiences.[132] Many survivors can often feel despondent because of depression and chronic stress caused by GBV, and these interventions can support lead to more positive feelings about oneself and support the healing process.

For some women, access to support services not only provides healing and self-confidence, it also helps them re-establish their roles in the community and society. In one study conducted with South Asian women in the US, survivors became empowered to support other survivors and those at risk of violence.[133] Women in the study went on to pursue careers and positions that protect and advocate for other survivors. As described by one participant: "I currently work with survivors myself, I am going to go to school for social work. It made me a more empathetic person; it made me somebody who wants to help others."[134] Pursuing careers in helping professions not only allows survivors to protect and assist other survivors; it also enables them to have stable incomes and maintain their financial independence—a critical factor in improving their quality of life.

Implications for policy, practice, and research



These research findings have implications for future policy, practice, and research that can address the important barriers that racialized women face in accessing the supports they need.

Aligning government policy

Develop intersectional and trauma-informed policy
Using an intersectional lens when developing initiatives and policies for racialized women could create more effective policy. Our synthesis shows how women's unique contexts, including race, immigration status, socio-economic status, gender, sexual orientation, and age, combine and influence their experiences when seeking support services. By not considering intersecting factors, policies may not meet the specific needs of survivors, and it is necessary to develop policies that respond to these needs without revictimizing and penalizing women. For example, it is important to understand how cultures, communities, and intergenerational and interfamilial cycles of violence impact women's help-seeking behaviours.

Further, victimization does not end when a person leaves an abusive relationship or successfully accesses support services. A trauma-informed approach focused on minimizing potential harm and re-traumatization, enhancing safety, and acknowledging the long-term and pervasive nature of GBV is essential to creating effective and comprehensive policies focused on providing continuous and sustainable care and support for survivors.

Close the gaps in immigration policies
Racialized immigrant women face restrictive and inflexible policies that make access to support services difficult. In particular, the threat of deportation and bureaucratic processes that scrutinize their immigration status impede access to care for GBV survivors. Immigration policies could include a particular clause ensuring access to GBV services does not result in deportation for undocumented immigrant women. Moreover, for immigrant women whose immigration status is tied to that of an abusive partner, an expedited process allowing for changes of status based on compassionate grounds could be introduced. Independent immigration status is often a GBV survivor's first step to recovery and healing.[135]

Prioritize funding for GBV prevention and support
A pressing priority for all governments is to invest in the prevention and mitigation of GBV. Coupled with this is an urgent need to invest in community and health supports for survivors. Our synthesis revealed a lack of funding as a barrier to providing adequate and timely services to racialized women. For example, several providers and women experiencing GBV highlighted the need for interpreters within different support institutions, a service gap that could be filled by increasing funding for staff and services to assist non-English speaking survivors with interpreting legal documents. This solution can also be applied to immigration agencies to assist women with understanding the legal policies and laws needed for access to care and to protect women from abuse.

Improving support service practices

Deliver culturally sensitive and appropriate care
Culturally safe care is an enabler of effective support services. Service providers must adopt a culturally sensitive approach that involves understanding survivors' cultural values and giving survivors opportunities to incorporate those values into their care. This approach can build trust between racialized help-seekers and their service providers and foster positive experiences that encourage racialized women to continue seeking support services. Consequently, this approach may improve access to information about available support and increase self-confidence, allowing women to address feelings of shame and isolation and create connections within formal support networks. Care that is culturally safe and compassionate, and especially linguistic support, can improve the communication between service providers and survivors and create support that survivors find acceptable and useful.

Train providers in all sectors on how to screen for GBV and provide referrals

The adoption of trauma-informed practices by all service providers, regardless of setting, is crucial for ensuring there are multiple opportunities to intervene and support women who experience GBV. Our analysis revealed gaps in service provision, such as a reluctance by healthcare providers to screen for GBV, such that many survivors reported never having been screened while in an abusive relationship.[136] Training in violence screening, particularly among different health and care providers (e.g., doctors, community health workers, dentists), police, and criminal justice providers, is key to improving the societal response to GBV. In instances where service providers cannot adequately assist women, they can provide referrals to the appropriate professionals (e.g., social workers) to ensure survivors can access the care they need.[137] This might mean spending more time with women to identify their needs and researching local services. Trauma-informed training is important to increase practitioners' understanding of GBV interventions with racialized populations, refute survivors' misperceptions about formal support services, and decrease women's negative experiences of service provision.

Enable and empower women and their networks

Evidence from both women experiencing GBV and service providers shows that a lack of financial autonomy linked to unemployment and precarious immigration status is a key barrier to seeking help for women. Women need to be empowered by policies and programs that focus on education and training, support employment opportunities, and make work and education more accessible to those who are financially insecure and dependent on their abusive partners.

This review emphasizes the key role of community and family values in supporting the healing and justice journey for racialized women. Women tend to seek assistance from their social and community networks before seeking formal support services. Building and strengthening community partnerships can facilitate survivors' access to local support services and possibly improve referral networks. Local community programs for GBV can also help create an empowering environment where racialized survivors can come together and share their experiences.

Addressing evidence gaps

While this review covered 127 research articles, it also highlighted many gaps in our knowledge about women experiencing GBV and how service providers can address their needs that will need to be filled by future policy and practice. First, most studies in this review were conducted in high-income countries, especially in the US. This may not adequately capture variations across different geographical locations and cultural boundaries. More research in low- and middle-income countries would give us a clearer global picture of the access barriers that women in different economic and cultural contexts face.

Importantly, despite being more likely to experience GBV, transwomen and gender non-binary individuals are under-represented in research studies. This gap indicates the extent to which the needs of racialized transwomen and gender non-binary individuals are overlooked. Their experiences may therefore be misrepresented and lumped with other racialized women's experiences in the existing research on GBV.

Most studies also focus on partner violence, with few looking at non-partner violence. Understanding the experiences of women exposed to and at risk of non-partner violence (e.g., sexual assault in workplaces or public spaces, cyberviolence) will strengthen the network of support and the societal response that is required to address the different forms of violence that remain endemic across all jurisdictions.

Few studies examined the experiences of GBV survivors through a strengths-based lens to distill a comprehensive picture of the range of outcomes and benefits associated with accessing targeted help from formal services. Research that explores the positive outcomes of accessing help from formal and informal support channels could enhance support for and investment in community-focused services for racialized GBV survivors. Likewise, outcome evaluations will also help to identify service gaps and training gaps for service providers.

Most of the studies covered in this review were based on qualitative evidence from interviews. This approach has the advantage of allowing researchers to approach women who experience GBV sensitively. However, when qualitative evidence is paired with quantitative evidence, it is possible to inform and enhance policy and resource allocation decision-making and strengthen the case for investment in expanding effective support services for racialized women. Gathering data with racialized survivors requires attention to culturally sensitive approaches so that people are not re-victimized by the research process and so that the research is developed in ways that are directly beneficial for survivors as opposed to being extractive. This requires the co-development of research with racialized communities, participation of racialized survivors on research teams, and ensuring explicit processes for information and insight to flow back to the communities that provide it. This would allow them to exercise their own agency and benefit from insights, and thus would contribute to data justice and equity for these populations.

Conclusion

This review aimed to understand the current research on barriers to accessing support services faced by racialized women and identify some productive paths forward. Help-seeking behaviours of racialized GBV survivors consist of complex interactions of unique personal, cultural, socio-economic, and institutional factors. There is an urgent need to address the unique barriers racialized women face when experiencing GBV. Comprehensive reforms in policy, practice, and research must focus on increasing all women's agency and improving access to formal care and support for all. Literature on GBV often talks about "survivors," but our analysis suggests that, with the right support services, racialized women can move beyond surviving to regaining safety, agency, and self-determination.

Appendix: Terms and definitions

Gender-based violence

Gender-based violence (GBV) is defined as any act of violence that results in physical, sexual, or emotional harm and suffering. Its forms include intimate partner violence (IPV), non-partner violence, and other harmful acts directed at people based on their gender expression, gender identity, or perceived gender. GBV can include physical abuse, criminal harassment, emotional and psychological abuse, and coercive control. The term is also sometimes used to describe targeted violence against LGBTQI+ populations when referencing violence related to norms of masculinity and femininity and/or gender norms.[138]

Intimate partner violence

We use the Government of Canada's definition of intimate partner violence, which states that intimate partner violence (IPV) refers to multiple forms of harm caused by a current or former intimate partner or spouse. IPV can happen within a marriage, common-law, or dating relationship, regardless of the gender and sexual orientation of the partners and whether or not partners live together or are sexually intimate with one another. It can occur at any time during a relationship and even after it has ended, and may include physical abuse, stalking, sexual violence, emotional and psychological abuse, financial abuse, spiritual abuse, repRoductive coercion, coercive control, and/or cyberviolence.[139]

Racialized

According to the Ontario Human Rights Commission, racialization refers to "the process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life."[140] We define a racialized person as a non-white individual who identifies with a racial or ethnic population.

Barriers

Barriers are defined as obstacles that restrict access to and the use of support services or make it difficult for racialized GBV survivors to access, use, or benefit from health and non-health support services. The need for these services is understood to be self-identified.

Support services

We define support services as the provision of assistance that responds to immediate or longer-term needs, health or non-health (e.g., social, legal, economic), and is deemed beneficial and of necessity by survivors. This can include but is not limited to psychosocial, physical, judicial, economic support, and healthcare services.

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A joint report from:

Institute of Health Policy, Management and Evaluation, Dalla Lana School of Public Health

Institute for Gender and the Economy, Rotman School of Management

University of Toronto

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