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Women's experiences of gender-based violence supports through an intersectional lens: a global scoping review

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ABSTRACT

Objective To apply an intersectional lens to explore how the interconnected social identities of women across global settings impact access experiences for gender-based violence (GBV) supports.

Design A scoping review.

Data sources We systematically searched seven databases to identify studies published in English from the database inception to January 2023.

Inclusion criteria We included peer-reviewed studies with a primary objective of examining the access experiences of populations who self-identify as women (aged 15 years or older) who have experienced GBV, have intersecting identities (ie, racialisation, poverty, etc) that can further contribute to marginalisation and utilised or sought support services.

Methods Two reviewers independently completed title/abstract, full-text screening and data charting. Integrating intersectionality theory and the McIntyre access framework, we analysed support service access and utilisation across social identities, axes of marginalisation and geographic contexts.

Results 210 papers (195 distinct studies) met the inclusion criteria. Most studies (60%) were published since 2015 and used qualitative methods (63%). Findings reflected intersectional differences in women's experiences of accessing GBV services across contexts and lived experiences. Common findings indicate that seeking GBV support was motivated and enabled by informal supports and positive prior experiences in accessing services. However, findings highlight that structural and systemic constraints in existing support systems (in all study settings) impact access to necessary support services and their alignment with women's needs. Few studies examined health and non-health outcomes associated with unhindered access to care.

Conclusions Women's experiences with GBV support systems in different geopolitical contexts highlight barriers across axes of racialisation, poverty, multidimensional violence and other systemic factors, which are often eclipsed in generic one-size-fits-all models of support. This research can inform transformational policy development and tailored interventions to improve outcomes for all women who experience GBV and thus advance gender equality and equity goals.

WHAT IS ALREADY KNOWN ON THIS TOPIC

⇒ Gender-based violence (GBV) differentially affects women according to intersectional identities.
⇒ Support services (eg, healthcare, social, legal services) and informal networks are crucial for enabling prevention, healing and justice for all women.
⇒ Access and utilisation experiences of women with diverse identities who are impacted by GBV are not well understood.

WHAT THIS STUDY ADDS

⇒ An intersectional analysis of the access experiences of women in global contexts shows that they encounter distinct and varied barriers to accessing GBV support networks due to personal, systemic and structural factors, which impact the acceptability, availability and affordability of services.

HOW THIS STUDY MIGHT AFFECT RESEARCH, PRACTICE OR POLICY

⇒ Intersectional analysis is essential in policy and practice design to address the multifaceted challenges women face in accessing formal GBV services, emphasising the importance of culturally relevant and inclusive interventions.

INTRODUCTION

Gender-based violence (GBV) is a public health concern that impacts the health and well-being of women. Globally, one in three women has experienced GBV in her lifetime,[1] disproportionately impacting racialised and other marginalised women.[2–4] Experiences of GBV lead to poor health, economic and social outcomes, exacerbating gender inequalities.[1 3 5] GBV is a violation of human rights and is explicitly included in the United Nations Sustainable Development Goals, with SDG Target 5.2 calling for the elimination of all forms of violence against girls and women in public and private spheres.

GBV is rooted in structural gender inequalities, patriarchy and power imbalances. Our analysis focuses on women, inclusive of cisgender, transgender and gender-diverse individuals assigned female at birth. Gender is a 'multidimensional construct that encompasses gender identity and expression as well as social and cultural expectations about status, characteristics and behaviour as they are associated with certain sex traits', and 'vary(ing) throughout historical and cultural contexts'[6] making gender a central axis that contributes to violence across contexts. Furthermore, societal and cultural norms frequently reinforce gender inequalities and justify violence.[7] Gender is also interconnected with systemic and institutional racism, and classism, rooted in colonisation, and continues to 'other' certain groups across societal systems, extending beyond geographical and political lines.[8]

Given the high prevalence of GBV globally, ensuring effective access to and utilisation of available support remains a pressing concern across geopolitical contexts.[9] While informal support networks are often a critical first point of support of women who experience violence, formal support services, such as healthcare, police and legal services, where available, are also crucial. The ability to access both informal and formal support is key to achieving justice and healing for women[10] and is vital to achieving the SDGs. Culturally situated systemic oppressions can intersect with women's social identities (eg, racialisation, migration status) to heighten their vulnerability to GBV while also creating barriers to accessing support services and seeking help.[11] For example, institutional biases limit access to culturally competent services, create language barriers and engender mistrust of authorities.[12] Racialised women may disproportionately face economic vulnerabilities, resulting in reliance on abusive partners for financial stability[13] and further complicating women's ability to seek help and leave abusive relationships.[14] In many cultural contexts, patriarchal norms intersect with racial hierarchies, resulting in a shared normalisation of violence against racialised women and societal reluctance to intervene.[15] In many countries, cultural taboos against discussing violence and familial pressure to maintain harmony can deter individuals from seeking formal assistance.[16] Moreover, legal frameworks in some countries inadequately address GBV or lack enforcement mechanisms, leaving women without recourse.[17]

Efforts to combat GBV will be more effective if they attend to complex factors, such as race, gender, class and sexuality, among other identities, that intersect to create unique experiences of oppression for women.[5 17–19] The objective of this study is to apply an intersectional lens to explore how the interconnected social identities of women across global settings impact access experiences for GBV supports.

METHODS

We conducted a scoping review of international research published through January 2023 to examine the experiences of women in accessing GBV supports. Our review was guided by Arksey and O'Malley's[20] five-step approach. In step 5, we incorporated community consultation and followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) reporting guidelines for scoping reviews.[21] The protocol for this review was registered on FigShare, an open science platform.[22] Intersectionality theory[18] and the McIntyre access framework[23] guided the search strategy and analysis. This review is part of a larger research project governed by a scientific advisory committee that includes those with lived experiences of GBV and experts in GBV advocacy, along with expertise in healthcare, support of racialised populations and qualitative and quantitative methodologies.

Frameworks

Intersectionality theory

Intersectionality theory guided the conceptualisation of the study and data analysis to capture diverse experiences of GBV across multiple dimensions of identity and inequality.[18 24 25] Intersectionality theory recognises that women are not a homogenous group and their experiences of abuse and exploitation are shaped by potentially converging oppressions and inequalities.[5 18] As such, intersectionality also serves as a tool to dismantle these systems of oppression and privilege.[26]

This review centres on the experiences of women in diverse global contexts, recognising the heterogeneity of women's experiences and the pervasive impact of systemic oppressions linked to social identities. Grounded in intersectionality theory, we examine race as a socially constructed axis of identity that intersects with other dimensions to shape women's vulnerability to GBV and their marginalisation within institutions and support systems. We use the term racialised women as a descriptive concept that situates women and their experiences in context[27] to refer to the 'process by which societies construct races as real, different and unequal in ways that matter to economic, political and social life'.[28] We include women in a global context, recognising that racial inequalities are diverse, not confined to a given society or population, and shifting over time. Transnational racialisation enables and explains the othering of individuals within populations with seemingly homogenous racial groupings and is a relevant construct in intersectional research conducted in the Global South, where race can intersect with ethnicity, religion, poverty, class and other dimensions in complex and diverse ways.[29] Transnational racialisation recognises the circulation of racial ideologies and stereotypes across and within national borders, impacting individuals and communities in various geographical locations.[29]

Racial logics differ across national contexts, shaping both racial identities and the dynamics of inequality. Migrant women from marginalised racial backgrounds may encounter systemic barriers due to stereotypes portraying them as submissive and weak, leading to

exploitation, abuse and objectification.[30] Research in Uganda highlights how the intersection of migration and race can marginalise and exclude some migrants from formal GBV support systems.[31] Likewise, racial biases are inbuilt in social, legal and health systems and processes, stemming from colonial legacies[32] and can interact with individual biases of providers, regardless of their race, to shape the access experiences of consumers, including within countries where racial dimensions might not be immediately evident on the surface. In a study set in the Democratic Republic of the Congo (DRC) during the Civil War, survivors were further marginalised through the racial and ethnic conflict,[33] and in a study in South Africa, legacies of colonialism embedded white hierarchy and apartheid norms of power within the training and work contexts of a predominantly black nursing workforce, impacting work and survivorship experiences.[34]

McIntyre access framework

The McIntyre access framework is used in the health systems and policy literature to analyse access to, and utilisation of, healthcare services and provides the basis for conceptualising and categorising the barriers that women, across axes of different identities, face as they seek support. We use the framework's three policy-relevant domains to examine access issues: availability of care (ie, the supply of services at the right place and time to meet women's needs), the affordability of care (ie, the fit between costs of using services and women's ability to pay) and the acceptability of care (ie, the fit between providers' and patients' attitudes towards and expectations of each other).[23]

Development of review

The research team collaboratively defined the research question with input from individuals with lived experiences and GBV service providers through the study's scientific advisory committee. Three key concepts anchored our research question and informed the development of the search strategy: GBV, women and access to support. We adopted the United Nations definition of GBV, where GBV is defined as any act of violence that 'results in, or is likely to result in, physical, sexual or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life'.[35] This review focuses on all forms of GBV—including both partner and non-partner violence—in a global context to understand access to GBV support services and networks across a diversity of lived experiences and contexts. Our search explicitly extracted data about racial identities that can increase the risk and vulnerability for oppression and sought to identify studies that examined race as an axis of identity of women with GBV experiences. We also included Indigenous women in our review because GBV disproportionately impacts them through historic and ongoing racial and gendered discrimination, and we report on these results separately.

Table 1 Inclusion criteria using the SPIDER research tool

Sample (S)	Populations who identify as women (including cisgender and transgender women), with racial identity defined*, are above 15 years† of age, and self-reported experiences of GBV. Providers of support for the above-mentioned populations.
Phenomenon of Interest (PI)	Utilisation of support services
Design (D)	Any research design (eg, qualitative, quantitative and mixed methods)
Evaluation (E)	Experiences navigating and using support services
Research Type (R)	Peer-reviewed studies that are based on primary research and published in full-text format

*This review aimed to draw attention to existing research that has historically overrepresented white women.[160] As such, we included studies with non-white populations. If racial identity information was not indicated for the survivor population, the study was excluded.
†The minimum age is set as 15 because existing guidance on GBV suggests women between the ages of 15 and 49 are particularly vulnerable to experiencing physical and/or sexual violence by their intimate partner.[9]
GBV, gender-based violence.

GBV supports respond to immediate or longer term health or non-health needs and may be beneficial to women who experience GBV. This definition captures both formal support programmes (eg, provided through legal, health, social programming) as well as informal supports provided by family and social networks, recognising that women often draw on both forms of support and that access to informal supports can mediate and impact how women access formal supports. Our search criteria included criteria such as 'help-seeking behaviour' as well as 'health services accessibility', to capture both formal services and informal networks (see online supplemental appendix A). We were interested in exploring the intersectional experiences of women accessing GBV support regardless of their country or context, so we did not impose geographical or language limits in the search strategy. The review includes studies conducted with women who experienced GBV and with providers of GBV services.

Identifying relevant studies

In consultation with a health sciences librarian, we used the Sample, Phenomenon of Interest, Design, Evaluation, Research type (SPIDER) research tool to define the inclusion criteria for the study[36] (table 1). The search was developed and run in Medline (see online supplemental appendix A) and then adapted for Embase, Web of Science, Scopus, EconLit, CINAHL and PsycInfo. We selected these databases due to their comprehensive and robust inclusion of a broad range of disciplines.

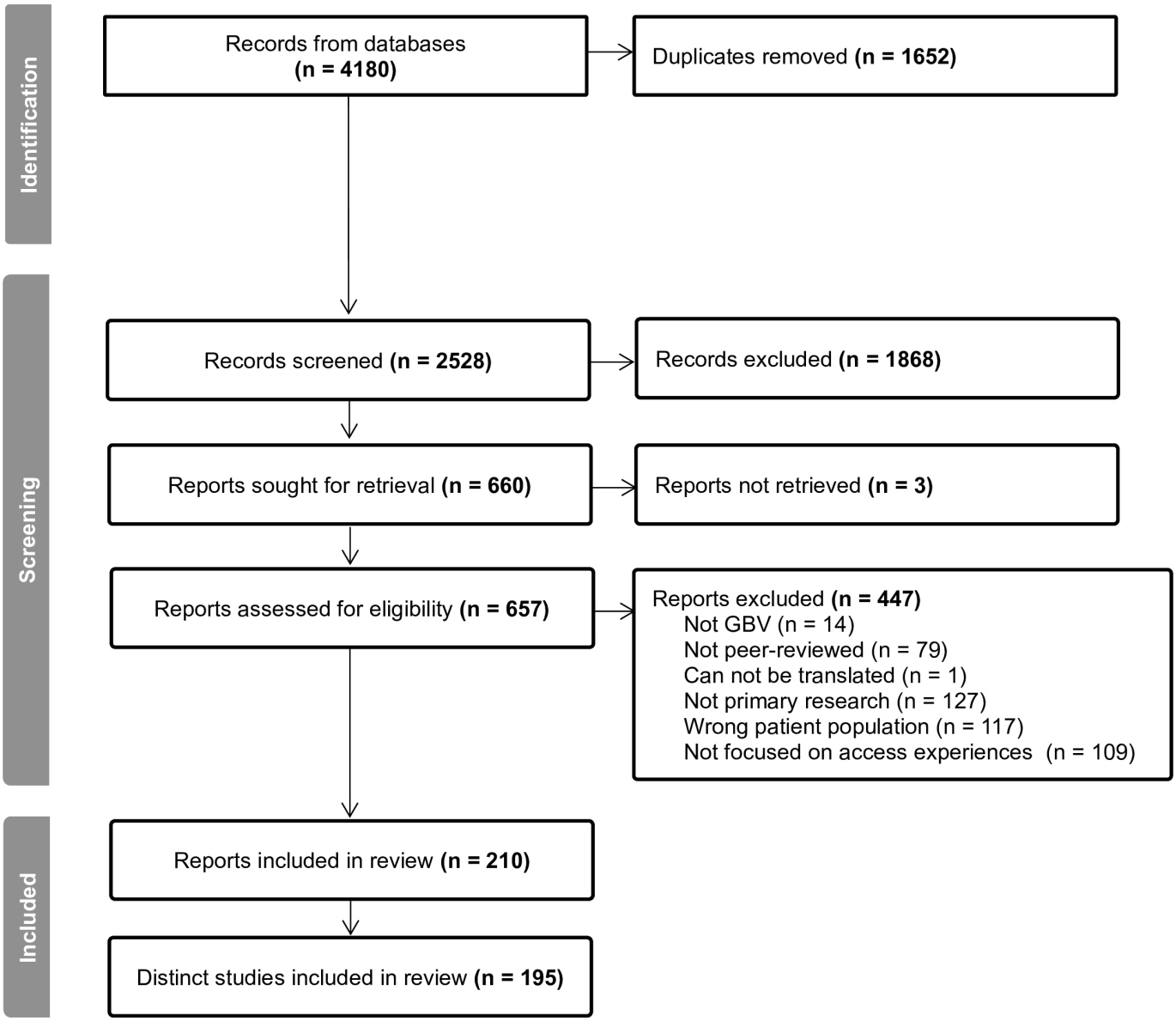

Figure 1 PRISMA flow diagram of the study selection process. PRISMA, Preferred Reporting Items for Systematic Reviews and Meta-Analyses.

Selection of eligible studies

Four authors (CC, IAC, PN, DT) worked in dyads to independently screen and assess articles for study inclusion using the Covidence platform (https://www.covidence.org/). The authors met to discuss and resolve disagreements in consultation with co-authors. Consistent with the guidance on conducting scoping reviews, the methodological quality or risk of bias of the included studies was not appraised.[37]

Charting the data

We developed and pilot-tested a data charting form on Covidence (see online supplemental appendix B). Full data charting was completed by two authors and a third author checked for completeness and accuracy. We charted the following data: author's name, publication year, country where the research was conducted, research aim, methods, populations, results, conclusions, future research and research implications.

Collating, summarising and reporting results

We synthesised the review findings using a qualitative narrative approach.[38] We analysed studies that focused on the perspectives of women who experienced GBV and service providers' perspectives separately. We examined the barriers and motivators to accessing GBV support. Barriers and motivators were examined according to the three domains of the McIntyre access framework, focusing on convergent and divergent help-seeking experiences.[23] We sought to explore how multiple social identities across geographic contexts intersect to influence women's help-seeking behaviours. We analysed details on race, ethnicity, gender identity, immigration status, socioeconomics and setting as reported in the studies. In

Figure 2 Regions represented in the review. For a full description of the studies included, see the sample characteristic table in the online supplemental appendix C.

examining providers' perspectives, we compared them with the findings from studies with women to understand the extent to which providers' perspectives reflect an understanding of the lived experiences of women. We presented the findings from this review on multiple occasions to the scientific advisory board who provided feedback on the methodology, analysis and findings.

RESULTS

A total of 210 papers from 195 distinct studies published between 1988 and 2023 (some studies produced more than one paper based on the data collected) were included in the study (figure 1). The characteristics of all included studies are in online supplemental appendix C. Most studies were conducted in the Global North (84%), mainly in the USA (66%), and the remaining studies were conducted in countries that can be categorised as the Global South (16%), broadly outlined in the economic classifications by the UN Trade and Development[39] (see figure 2). Seventy-six per cent of studies focused on women's lived experiences and 24% of studies described providers' perspectives on access motivators and barriers faced by women. Most studies used qualitative methodologies (63%) and focused on intimate partner violence (IPV) (93%), which is a subset of GBV. The populations represented in the studies include African American women (of African descent born in the USA), black women (who do not identify as African American), Latina/e/x and South Asian populations. Several studies focused exclusively on migrant women (41%) (table 2). Indigenous participants were included in 19 studies.

Access experiences: women and providers' perspectives

This section reports on the themes from studies with women and providers separately. Most studies addressed barriers to accessing support services and networks while fewer studies described motivators that facilitated access experiences. The main findings are summarised in table 3. Notably, the greater emphasis on formal supports in our analysis reflects the predominant focus of the studies surfaced through our search. The analyses of informal supports mainly highlighted their role as barriers or motivators for disclosing violence and seeking formal support (as indicated in the first row of table 3).

Availability

Availability refers to the extent to which appropriate providers and services are supplied at the right place and at the right time to meet women's needs.[23] Studies revealed that availability of support was impacted by awareness of services and service features, including eligibility (perceived or actual) and informal support networks, which helped women navigate and facilitate access.

Informal supports

Informal networks are often the first point of support, and in some cases the only source of support that women seek. Across studies, family and friends played a vital role as informal supports, both by fulfilling emotional and material needs and by facilitating women's exit from abusive relationships.[40–43] A study examining help-seeking among Vietnamese immigrant women in the USA reported that they received support from or within their social networks first, including from siblings (especially sisters) and friends (36)—and sometimes this was their only support. Informal supports assisted with addressing medical needs, providing temporary housing and navigating services (eg, legal support, help connecting women with victims' support agencies and assisting with permanent residency).[41] Similarly, in a study with Mexican immigrant women in the USA, parents and

Table 2 Demographics of the study sample

Demographic category*	N (%)
Perspectives	
Women with lived experience (LE) of GBV	139(66)
Providers	40(19)
LE and providers	31(15)
Type of violence	
Intimate partner violence/domestic violence	196(93)
Non-partner sexual violence/sexual violence	35(17)
Other	3 (1)
Support services	
Healthcare services	149(71)
Law enforcement	104(50)
Legal services	85(40)
Community advocacy	57(27)
Shelters/social work	75(36)
Informal networks (family/friends/religious institutions)	105(50)
Other (immigration, substance abuse, education, child services)	9 (4)
Populations	
African American	53(25)
Black	27(13)
Hispanic/Latina/e/x	70(33)
South Asian	29(14)
Southeast Asian	18(9)
Indigenous peoples	19(9)
Immigrant/migrant/refugee	87(41)
2SLGBTQ+	11(5)

*Each category is not mutually exclusive. The percentages of individual categories will not sum to 100%.
GBV, gender-based violence; 2SLGBTQ+, Two spirit, lesbian,gay, bisexual, transgender,queer, intersex and other identities.

siblings (particularly mothers and sisters) were critical in maintaining longer term support for women leaving violent partners.[44] However, studies described informal support in the form of social and familial networks as limited and complicated. Friends and family are often unable to offer specialised care and support. The availability of assistance can be limited (eg, by time, resources) and impacted by an interplay of women's immigration status, economic conditions and sociocultural dynamics, particularly patriarchy and familialism. Expectations and judgements around maintaining the family unit, and thus a dismissal of the violence, or alternatively, pressure to leave the violent relationship can foster an internalisation of shame and stigma that can hinder or motivate women to access, and continue accessing, informal and formal supports.

Knowledge of services

Limited information on eligibility criteria for government aid also influenced the help-seeking decisions of immigrant women without legal status in the USA. Insufficient knowledge about free legal services, shelters and counselling discouraged immigrant women from seeking help, while women who acquired knowledge of the available services gained self-confidence and a sense of their rights.[45]

Service features

Time-limited encounters with providers hindered help seeking.[46–49] Studies described long waitlists and short appointment lengths with healthcare providers as barriers to disclosing violence as there was insufficient time to deal with more than one issue, establish trust and have confidence that support and follow-up could be offered following a disclosure.[46 50] Time pressures were exacerbated when support services did not provide interpreters.

The proximity of support services influenced both the likelihood that women would report experiences of GBV and their use of these services.[31 45 48 51] A study conducted in Chicago (USA) found fewer GBV organisations in areas where African American and Latina/e/x communities predominately live than in other areas of the city.[52] Another study in the USA found that Latina/e/x women were more likely to report incidents occurring near a police station or their home.[51]

Limited access to transportation further exacerbated help-seeking experiences. Services that were a short distance away, especially not requiring public transportation, enabled access.[40] Paying for transportation—also an affordability issue—was raised in studies with African immigrant women in the USA and Rohingya refugees in Malaysia.[45 53] Additionally, a study conducted in Uganda with South Sudanese refugees found that financial and time costs of travelling long distances, often from refugee encampments, to facilities that offered support services reduced the likelihood that women would access necessary medical care and police services.[31]

Service providers' perspectives on the impact of the availability of services for women

Service providers also discussed informal networks, such as women's natal families, as key contributors to women's decisions to exit abusive relationships and seek formal assistance.[54–56] For instance, in a study examining the perspectives of volunteer counsellors working with Korean immigrant women in the USA, informal networks were reported to be crucial in filling the gap for women with limited access to formal support services.[54]

Several studies reinforced the constraints in healthcare encounters that limit opportunities to address the complexity of issues raised by women when reporting GBV. Healthcare providers in Guyana described time constraints, which limited their ability to comprehensively assess all issues while

Table 3 Overview of barriers and motivators for accessing GBV-related support from the perspectives of women and providers

Access domain	Themes	Barriers	Motivators
Availability	Informal supports	Limited time availability of supporters Socio-cultural dynamics and expectations	Social networks providing emotional and material needs Assistance with accessing information and services Awareness of services features
	Knowledge of services	Misinformation about eligibility criteria Abuser's strategy to isolate and control women	N/A
	Service features	Breadth of support services Long waitlists Short duration of formal consultations making it hard to bring up GBV issues Proximity to services impact timely utilisation of support resources	N/A
Affordability	Costs of services	Cost of treatment/medication Necessity of bribery payments Navigating payment plans	N/A
	Eligibility for, and breadth of health insurance coverage	Lack of insurance coverage, including due to immigration status	Access to health insurance
	Financial autonomy	Immigration status Financial dependence on perpetrator Structural factors inhibiting economic independence	Securing employment which provides financial resources
Acceptability	Normalisation of GBV and internalisation of shame and stigma	Cultural beliefs on help-seeking Internalisation of shame and stigma	N/A
	Systemic racism and discrimination	Previous negative experiences, including experience of racism Fear of retaliation by abuser Losing their children Deportation	Positive prior experiences with service professionals creating safe, respectful and welcoming environments
	Culturally and linguistically competent services	Communication difficulties and few translation options	Provision of translation services

GBV, gender-based violence.

maintaining confidentiality, ensuring full documentation in patients' charts and communicating with other relevant providers.[47] Physicians in Hong Kong also reported concerns for their own safety as women are often accompanied to appointments by their abusers, who can pose threats to providers.[57] Service providers in Malaysia and Canada stated that legal reporting requirements around known or suspected cases of illegal immigration can create difficulties for healthcare providers in treating undocumented immigrant women.[58 59]

Service providers raised concerns about the lack of legal structures to address the distinct needs of immigrant women.[60–62] For example, social workers working with Indonesian, Filipino, Pakistani and Vietnamese women in China reported that Chinese immigration policies could hinder women's access to services due to inflexible regulations regarding expired visas that limited their eligibility for support.[63]

In the study from the DRC, providers highlighted the extreme scarcity of critical equipment and supplies such as emergency contraception for women who have experienced sexual assault, which limited the postexposure care that could be provided.[33] Intersectionality plays a role in this context, highlighting how race, ethnicity and gender compounded women's vulnerabilities to GBV during the Civil War in this country and systemic inequalities and gendered issues amplified barriers to adequate care and resources for already marginalised women. Transnational racialisation also potentially shapes survivors' access to healthcare in settings impacted by conflict and humanitarian crises by linking global power hierarchies and local ethnic conflicts. The systemic scarcity of critical postexposure services like emergency contraception in this setting is characteristic of a devaluation of lives in this context and

is further compounded by local discrimination on ethnic and racial grounds.

Affordability

Affordability refers to the balance between the cost of services and women's ability to pay for them,[23] which is influenced by the complex interplay of race, poverty and immigration status. Affordability is shaped by the cost of services, eligibility for and breadth of health insurance coverage and women's financial autonomy.

Cost of services

High costs, particularly of emergency care visits, hospital stays and physician appointments, were a major barrier to accessing formal support services, especially for women with precarious immigration status who lacked health insurance coverage.[31 49 61 64–67] Several studies conducted in the USA with African American, Latina/e/x, South Asian and East Asian women reported the lack of affordability of healthcare services and medications as significant barriers to accessing medical care to address immediate and longer term health consequences of GBV.[64 68–70] In a study with Rohingya women in Malaysia, women who could not settle their hospital bills faced threats of arrest, which hindered the ongoing use of critical services.[71] The high cost of medical care was also identified as a barrier in a study conducted in Uganda with Sudanese refugees, despite the removal of user fees for primary and some urgent care.[31] This study highlighted the added burden of bribery payments that were required to access law enforcement services in Uganda,[31] an issue that can be relevant in many other contexts as well.

Eligibility for and breadth of health insurance coverage

Studies showed that insufficient health insurance coverage persists as a barrier to accessing healthcare services in many countries, even those with universal health coverage arrangements. Lack of health insurance can cause extreme financial hardship that marginalises individuals within health systems by providing inadequate financial risk protection following a violent attack.[64 68 70 72 73] The reasons for the lack of insurance differed by context: in Canada, the UK and Australia (countries with universal health coverage), immigrant women's undocumented status was the prevailing factor. In the USA, it was both the inability to pay for insurance and women's tenuous immigration status that created difficulties in attaining medical treatment, even when the services were geographically accessible.[70 72–75] Furthermore, for refugee women in Jordan, Uganda and Malaysia, limited access to refugee cards (especially the United Nations High Commissioner for Refugees cards) to cover health costs was a barrier to accessing healthcare services.[31 71 76] The literature from the Global South does not discuss health insurance as a barrier to access, however, this does not imply that it is not an issue, given the inadequate coverage of services in that region.

Financial autonomy

Financial autonomy refers to an individual's ability to control their financial resources and decisions without being dependent on others for financial support.[23] Without it, women, especially those with tenuous immigration status, may not be able to exit a violent situation or access care.[64 69 71 74 77–80] Latina/e/x women in a study in the USA were reluctant to disclose experiences of abuse because of the perceived risk of losing a source of household income and concerns about assuming unaffordable financial responsibilities for childrearing.[75] In studies with African immigrant women in Australia and the USA, women discussed linkages between financial autonomy and cultural practices, such as the payment of a 'bride price' (ie, goods or money given to the bride's family by the groom), which often left women with financial obligations that could not be repaid if they left the abuser.[45 81] Similarly, a study conducted in rural and urban districts in Tanzania, where violence is widely accepted and closely linked to norms of masculinity, revealed that structural factors such as patrilineal inheritance patterns and poverty could contribute to women's economic dependency, as women fear the disclosure of violence will result in abandonment, divorce and a loss of financial support.[82] In this context, gendered power dynamics, cultural norms and poverty intersect and amplify women's economic dependency and associated vulnerability to violence. Additionally, the lack of affordable childcare limited opportunities for securing employment and (re) establishing financial autonomy.[45 75 81]

Service providers' perspectives on the affordability of support services

Providers in various settings also highlighted inadequate funding and policy prioritisation of GBV as barriers to ensuring appropriate access to support services for all women (eg, in Canada, the USA, Switzerland, Malaysia, China)[57 58 71 83–85] and a key limitation for dismantling some of the pervasive structural barriers that can increase the risk of, and sustain poverty for, women who experience GBV. Criminal justice service providers expressed concerns about insufficient funding and resources, which impacted the availability of court and cultural advocates and interpreters to assist women during the judicial process.[86] Studies with providers also showed that funding constraints affected their ability to effectively address complex issues within short consultations, compromising the overall quality of care they could offer women.[57 58]

Acceptability

The acceptability of care—the alignment between the expectations and preferences of women and the delivery care by informal and formal supports—impacts the ability of women to receive and benefit from required care and support.[23] Studies highlighted the normalisation of GBV, systemic racism and discrimination, and inadequate cultural and linguistical competence and

proficiency as factors that impacted the acceptability of support services.

Normalisation of GBV and internalisation of shame and stigma

The normalisation and internalisation of shame and stigma related to GBV were dominant themes raised in many studies.[34 87–98] Among US-born and immigrant Latina/e/x women, gender norms discouraging the disclosure of violence inhibited formal help-seeking for fear of disgracing one's natal family and community.[99–102] Similarly, cultural norms that normalise abusive behaviours, mostly reinforced by informal networks such as the family, dissuaded Latina/e/x, South and East Asian and African immigrant women in the USA, Canada, Australia and the UK from seeking formal support services, including acute medical care following a violent incident.[40 43 45 54 55 65 73 88 93 103 104] Consequently, some studies showed that women rely on social networks, such as family and friends, rather than formal support services led by trained professionals and service providers.[93 94 105 106] For instance, South Asian immigrant women in Canada did not seek support because of family perceptions of IPV as a private matter and the reluctance of family networks to interfere in marital matters, particularly in cases of arranged marriages.[103]

Systemic racism and discrimination

Several studies highlighted that women's prior experiences with support services affected their willingness to seek support subsequently.[45 99 100 107–109] Studies conducted with African American, South and East Asian, Latina/e/x and immigrant women[62 76 79 110–112] consistently described experiences of racial biases and discrimination while seeking care. One study reported that anti-black racism by providers and in health systems in the USA, which often depicted black women as resilient and physically capable of defending themselves from violence, framed women as less deserving of care.[62]

Furthermore, within the legal, justice and child protection systems, race was reported to play a significant role in the outcomes of legal cases. A study conducted in the USA[46] revealed that training for forensic evidence collection and analysis tended to prioritise white bodies and, therefore, did not prepare providers to accurately assess black women's injuries (eg, bruises may be less visible on black women). Black women in the USA, including both African Americans and those of Caribbean descent, underutilised core services like protection orders due to past negative encounters with law enforcement, which led women to believe these services were not accessible or that the risks of accessing support outweighed the benefits.[113]

Across studies specific to immigrant women, especially those with precarious immigration status, fear of deportation as a potential outcome of seeking formal support resulted in delaying or avoiding disclosures of GBV.[41 65 80 95 100 101 114] Although in some studies,[41 101 105 115 116] women described concerns for the welfare of their children as a factor that influenced help-seeking (to protect the health and safety of children and minimise the risks of exposure to IPV), women also hesitated to seek support because of concerns about child removal by social services and its associated outcomes for their children.[50 62 100 117–119] In one study conducted with African immigrants in the USA women reported that their abusive partners would weaponise the risk of child removal by social services, making it difficult to report the abuse.[45] Furthermore, studies conducted with African American women described legitimate fears about how the criminal justice system would treat black men/partners who often face more severe treatment and sentencing by the legal system compared with white perpetrators.[100 101 119]

The intersection of race and gender identities including lesbian, gay, bisexual, transgender, queer and other identities (LGBTQ+) often compounds barriers to accessing resources. In the few studies conducted with Latina/e/x and African American trans women, transphobia and homophobia were reported as leading to mistrust and limited engagement with healthcare and the police. Latina/e/x and African American trans women and lesbians who experienced GBV in the USA reported facing intersecting forms of discrimination when accessing services, such as being ridiculed, turned away, blamed by law enforcement and denied access to healthcare services, compounding the challenges they encounter. Similar issues were discussed in studies from El Salvador, Trinidad and Tobago, Barbados, and Haiti, where women often share the same racial background as service providers. However, shared racial identity did not shield them from discrimination rooted in classism, colourism and systemic biases against marginalised gender and sexual identities. In these contexts, internalised racism, along with societal hierarchies, can manifest in dismissive or discriminatory treatment, further alienating survivors from essential services and reinforcing cycles of violence and exclusion.[112 120 121]

However, some studies described how positive prior experiences with service providers motivated women to continue utilising the services.[45 115 116 122 123] For example, in a study from the USA, Latina/e/x women described healthcare and psychiatric services that offered empathetic and respectful support as an enabler of their help-seeking behaviours by creating safe and welcoming spaces to disclose experiences of violence.[116 124 125] In a study exploring women's experiences with police and criminal justice service providers in Canada, women described positive experiences as those that did not result in them feeling judged, ridiculed or fearful of repercussions for themselves or their children.[122]

Culturally and linguistically competent services

Studies conducted with Latina/e/x, East and South Asian, and immigrant women in Jordan and the USA reinforced how cultural and linguistic competency throughout healthcare, social and legal systems across

settings impacts access to services.[68 76 79 122 126–128] Limited access to interpretation services was described in studies conducted in the USA, Australia, China and the UK, where women faced difficulties communicating violence-related concerns, often exacerbated by the limited time available for healthcare encounters.[73 84 110 122 129] Additionally, concerns about privacy, confidentiality and victim blaming were reported in most studies with African American, Black, South and East Asian, immigrant, and trans women, deterring women from asking for help or continuing to use services.[100 109 121 130]

Service providers' perspectives

Service providers shared similar views to women who had experienced GBV, describing the importance of prioritising supportive environments to understand and address the diverse needs of their clients, enhance client engagement and empower women's agency.[34 57 124 131–133] They identified strategies to enable quality care for racialised women: providing longer sessions with healthcare providers, referring women to specialised providers and ensuring translation services are available.[57 131–133]

Barriers faced by indigenous women

Few studies (n=19) were conducted with Indigenous women or specifically reported on provider perspectives relevant to the needs of Indigenous women. The included studies were conducted with diverse Indigenous communities, for example, First Nations in Canada,[134 135] Aboriginal and Torres Strait Islander peoples in Australia,[136–138] and American Indian/Alaska Native people (as described by the study authors) in the US.[139–142]

The studies described how the experiences of Indigenous women are deeply rooted in systems and structures of persistent racism and discrimination against Indigenous peoples, which have increased their marginalisation and vulnerability in health, legal and social systems[126 129] and consequently fostered legitimate distrust of providers and support services in these systems.[121] A study conducted in Canada reported that racism in government policies and practices that is deeply ingrained in a history of violence and discrimination and is linked to the removal of Indigenous children from their mothers and high incarceration rates, impacted decision-making about whether to use GBV support services.[135]

The studies with Indigenous women highlighted inadequate cultural safety in formal support services[135] and, for rural-residing Indigenous women, the challenges of navigating health, legal and social systems that were physically located at far distances from women's homes and from their informal support networks.[139 143] Furthermore, American Indian and Alaska Native women in the USA described experiences of neglect, discounting and disbelief of their accounts of violence by law enforcement and healthcare providers.[140 143]

Impact of accessing support services

Only a few studies (n=23) provide data and insights into the impacts that stem from accessing support services. Studies demonstrated that when services were client-centred, culturally safe and context-specific, women experienced decreased stress, increased self-confidence and increased self-awareness.[31 40 122 144 145] Women reported that access to social support services can motivate and support the acquisition of new skills.[40 94 144] Positive interactions with empathetic and respectful providers instilled trust and supported women to continue using services and to recommend them to other women.[94]

A subset (n=9) of studies also described negative outcomes. Many cisgender and trans women experience secondary emotional, physical and sexual victimisation, which women described as making them feel as if they had been subjected to abuse again.[52 109 110 121 146 147]

DISCUSSION

This scoping review of women's experiences with GBV supports revealed enduring barriers linked to the availability, affordability and acceptability of support systems. The experience of these barriers is shaped by intersecting dimensions of the lived experiences of women, such as race, poverty and social and geographic location. Because these are often overlooked in the development of GBV support models, they can fail to address structural inequities. Barriers include limited service availability (eg, long waitlists, time limited consultations) and financial barriers (eg, high costs, lack of insurance), family dynamics and systemic issues including race-based stigma and discrimination. These barriers emphasise the need for tailored, inclusive interventions that address structural inequities to ensure effective GBV support is accessible to all women across global geographies.[148] Where available, the review highlights factors that can motivate and facilitate access to services.[149] This review also highlights the dearth of research investigating how unhindered access to different models of GBV support services could impact and improve health and non-health outcomes for women.

Many of the barriers reported in this review are rooted in racism and lasting colonial oppression that manifest in a misalignment of service delivery models to women's needs. Like other scoping reviews on access to GBV support services for women, there were few references to motivators for seeking support.[17 150 151] The primary motivators reported included personal-level interactions, positive prior experiences with service providers, the need to safeguard children and support from informal/family support networks—although informal networks can also undermine access to necessary support services due to the cultural normalisation of violence. Several studies highlight how cultural norms prioritising family privacy can perpetuate GBV by discouraging women from accessing support from their informal networks.[152–154] Disclosing victimisation often risks victim-blaming,

silencing women and deterring their help-seeking.[17] This underscores the need for culturally sensitive approaches that reduce stigma and empower women to seek formal support safely and directly.

Problematically, most of the studies were conducted in the Global North, revealing a notable gap in understanding the GBV access experiences of women in Global South contexts. Racism is a global issue, but its manifestations vary by context, shaped by each society's history, culture and power structures.[29] It often intersects with other forms of discrimination, such as sexism, transphobia and classism, creating compounded challenges. This was reinforced by several articles that illustrated how migrant women of colour may face unique forms of racism and gender discrimination distinct from those experienced by native-born populations in studies conducted in both the Global North and the Global South.[31 58 71 79]

Distinct from other scoping reviews of women's access to GBV services,[17 150 151 155] our review demonstrates how women's experiences are profoundly impacted by intersecting factors including race, ethnocultural backgrounds, poverty and migration. For example, studies with African American and black women, including black transgender women, highlight how pervasive racism and misogyny within services can embed notions of the 'strong black woman' schema that limit the extent to which black women are believed, treated and supported when reporting GBV. Studies with Latina/e/x, Asian and immigrant women reinforce how language barriers continue to marginalise and exclude women from networks of support services. In addition, cultural normalisation and stigmatisation of violence, which manifests differently across cultures and contexts, underscore the critical need for nuanced, culturally competent policies and practices, which are underdeveloped in most settings. Moreover, the complex relationships between migration and mobility, which further enhance vulnerabilities for GBV, were highlighted in studies that discussed challenges with eligibility for formal supports, including healthcare, and the links with these challenges to racism and xenophobia, which serve to further exclude women.[41 46 76] While limited, studies conducted in the Global South highlighted how factors such as corruption and bribery within law enforcement services and structural factors such as patrilineal inheritance and poverty continue to impede women's access to critical services.[31 156–158] While these factors were discussed in research conducted in the Global South, they transcend geopolitical boundaries, particularly in the context of increasing global migration patterns.[159] The heterogeneity of women's experiences calls for services and providers to be responsive to differing expectations, cultural norms and experiences of violence for the communities they service to foster more inclusive and effective GBV supports.

This review shines a specific light on the myriad challenges faced by immigrant and migrant women in accessing and navigating GBV support services. Migration affects the availability, affordability and acceptability of GBV services in host countries. The concept of 'othering' within racial groups can create hierarchies favouring dominant groups, thereby making access to services challenging for marginalised groups.[29] For instance, in the broader context of migration in the Global South, within-group othering leading to intersecting forms of discrimination and oppression can impact how immigrant women are accounted for in health and social services. Additionally, undocumented status, deportation concerns and inflexible resettlement policies shape eligibility for accessing services, potentially leaving migrant women vulnerable to GBV and without recourse, thereby affecting their access to care. Similar to prior research on violence and migration,[17 151 155] most studies included in the review focused on immigrant women in high-income countries with provisions and policies for universal health coverage. Yet, this review highlights that migrant women face eligibility gaps even within frameworks of universal coverage and social protection, which inadvertently weakens the networks of support in these settings. Therefore, policymakers and service providers must account for this complex interplay between migration, vulnerability to GBV and access to GBV support services by recognising and mitigating the structural barriers faced by migrant populations within and across contexts.

Implications for policy and practice

Achieving SDG 5 for gender equality will require targeted interventions and policies that enhance access to GBV services for all women. It entails recognising that women from various backgrounds, including those marginalised due to factors such as racism and processes of racialisation, poverty and immigration status, continue to face unique and sustained challenges in accessing and navigating existing networks of GBV support services. By incorporating the diverse lived realities of women into the design and implementation of GBV interventions and policies, policymakers and service providers can ensure that support services are responsive to the specific needs and contexts of different populations. This will not only enhance the effectiveness of interventions but also promote inclusivity and equity in addressing GBV and thus advance progress towards the SDGs.

Studies consistently emphasised the lack of funding for GBV prevention and treatment, which limited the ability to provide culturally responsive services. Investing in interventions such as interpreter services, hiring staff from diverse cultural backgrounds and implementing cultural competency training programmes can enhance the accessibility and effectiveness of GBV support services and facilitate access to a wide range of health, social and legal services beyond those specifically focused on GBV. Training programmes are also essential for improving the quality of GBV support services, particularly in critical areas such as screening, assessment and communication with women to promote a women-centred approach to care and enhance the safety and well-being of all women exposed to GBV.

Limitations and priorities for future research

Despite our systematic search for peer-reviewed literature in seven electronic databases, we may have missed some articles that met our inclusion criteria but were not indexed in the databases we searched. Likewise, it is possible that studies examined intersectional factors that impact access experiences in populations of women where race was not explicitly defined. Although our review did not have language limitations, the search was developed using English search terms. As a result, we may have missed relevant studies indexed in other languages.

Our review demonstrates a need to build a stronger evidence based on the unique experiences of women with diverse lived experiences in different geographical, cultural and economic contexts. The findings from this review offer only a limited glimpse into the experiences of Indigenous women, women residing in the Global South, transwomen and gender non-binary individuals—groups that are significantly under-represented in the literature on access to GBV services, despite facing disproportionate vulnerabilities and risks of violence. The emphasis in existing research on challenges identified in Global North contexts likely stems from the dominance of funding for GBV research originating from institutions in these regions. Consequently, access barriers and solutions can be framed through a biased Global North lens, which may fail to capture the diverse cultural, economic and systemic realities faced by populations who are marginalised in other parts of the world. While we approached this review with a lens to the potential impacts of transnational racialisation on the experiences of women in diverse geographical contexts, the under-representation of studies from the Global South highlights this as an area that also requires further funding and research. Addressing this research gap requires reorienting research priorities and funding to ensure inclusive, culturally relevant studies that reflect the diverse realities and risks of GBV. Support for Global South-led GBV research and organisations is needed to ensure that proposed interventions to address the conditions that increase risks of violence and improve access experiences are locally relevant and equitable.

Furthermore, qualitative methods dominate identified articles (63%). While this allows for a nuanced and rich exploration of intersectional differences in women's experiences, further quantitative analyses would supplement this understanding by distilling the relationships, pathways and outcomes of better-targeted care that reflects intersectional experiences of women in diverse geographic contexts and examines trends in access to support services over time.

This synthesis also revealed a dearth of research investigating how unhindered access to GBV support services might improve health and non-health outcomes for women. Furthermore, there are opportunities for future research on understanding the barriers faced by women exposed to non-partner violence (eg, workplace violence), reflected in only 17% of the studies in this review.

CONCLUSION

This scoping review highlights the complex, intersectional challenges women face in accessing GBV supports. It underscores how intersecting vulnerabilities—rooted in structural inequities, sociocultural norms and economic disadvantage—shape women's experiences. Through exploration of these dynamics, the review contributes to a deeper understanding of access barriers and provides critical insights for tailoring more effective GBV interventions.

To address the challenges discussed in this review, policymakers and service providers must prioritise the availability, affordability and acceptability of GBV services as well as assure support for informal networks through an inclusive lens that is attentive to the intersectional identities and realities of service users. This includes ensuring that services are physically accessible, culturally sensitive and financially attainable for all women, regardless of their circumstances. By adopting intersectional and equity-driven approaches, services can provide supportive environments where women not only receive the care that they need but are empowered to rebuild their lives free from violence; essential of the achievement of SDG 5 focused on gender equality. Such efforts are crucial for advancing prevention strategies and fostering resilience for individuals and communities. This review highlights the need for sustained commitment to dismantling systemic barriers and building inclusive support systems that enable all women to live with dignity, security and equality.

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