Review Manuscript

TRAUMA, VIOLENCE, & ABUSE
1–17

DOI: 10.1177/15248380221137664
journals.sagepub.com/home/tva
SAGE

Seeking Help From Primary Health-Care Providers in High-Income Countries: A Scoping Review of the Experiences of Migrant and Refugee Survivors of Domestic Violence

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Abstract

Migrant and refugee women experiencing domestic violence (DV) may face compounding factors that impact their ability and experiences of seeking help. Health-care providers are in a unique position to identify and assist victims of DV, however, they often lack the confidence and training to do this well. Little is known of the health-care experiences of migrant and refugee women experiencing abuse when they access primary health care (PHC). Using scoping review methodology, we undertook a systematic search of seven databases (Medline, Scopus, ProQuest, CINAHL, Informit Complete, and Google Scholar). We sought peer-reviewed and grey literature, published in English between January 1980 and August 2021 that identified women (18+) who had experienced DV, from low- or middle-income countries (LMICs), seeking help or health care in a primary care setting of a high-income country (HIC). Nine articles met the inclusion criteria. Findings identify sociocultural and sociopolitical barriers for migrant and refugee women seeking help for DV, which are contextualized within the ecological model. Migration-related factors and fear were major barriers for migrant and refugee women, while kindness, empathy and trust in health-care providers, and children's well-being were the strongest motivators for help-seeking and disclosure. This review provides insight into an under-researched and marginalized group of victim-survivors and highlights the need for increased awareness, guidance, and continuing education for health-care providers and health-care systems to provide best practice DV care for migrant and refugee women.

Keywords

domestic violence, violence against women, migrant, refugee, help-seeking, primary care, health care

Introduction

Domestic Violence

Domestic violence (DV) is a human rights and public health issue of epidemic proportions (García-Moreno et al., 2015; Potter et al., 2021; Satyen et al., 2020; World Health Organization [WHO], 2021). Globally, of women between the ages of 15 to 49, 27% have experienced physical and/or sexual violence by an intimate partner at least once in their lifetime (WHO, 2021). The adverse effects on women's physical and mental health are profound, and violence from an intimate partner is the leading cause of homicide death for women globally (Devries et al., 2013). The majority of perpetrators of DV are men and the victims are overwhelmingly female (WHO, 2021). As this demonstrates, DV is a gendered issue and affects women from diverse racial, religious, ethnic, and socioeconomic groups (Afrouz et al., 2020). There are, however, factors that can impact and compound the experience of victim-survivors. The term *intersectionality* was introduced by Kimberlé Crenshaw to highlight the multiple intersecting marginalizations of Black women (Crenshaw, 1989). She later used this framework to highlight the ways in which advocacy and social movements ignored or excluded the additional complexities

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Correction (February 2023): Departments have been added in the affiliations.

of women of color, especially those from immigrant and socially disadvantaged communities (Carbado et al., 2013). Since then, this framework has been used to contextualize multiple intersecting identities and situate these in the broader context of systemic oppression and power imbalance (Cooper, 2015). In the context of victim-survivors, this framework can be used to highlight how intersecting identities, such as indigeneity, disability, socioeconomic status, race, religion, gender, or sexuality, may impact their experiences (Tayton et al., 2014; Vaughan et al., 2015; WHO, 2012). Studies of DV prevalence among migrant and refugee women in high-income countries (HICs) are ambiguous and vary depending on the setting; however, there is strong evidence showing that the impact of resettlement compounds the complexities of abuse (Barrett & St Pierre, 2011; Khelaifat, 2018).

DV and Primary Care

The adverse effects of DV are extensive and include a range of immediate and long-term physical and mental health conditions. This can include chronic pain, sexual and reproductive issues (i.e., sexually transmitted diseases or unwanted pregnancies), anxiety, depression, post-traumatic stress disorder, and suicidal ideation (Tarzia et al., 2020). While research into health-care access and uptake in HICs indicates that women subjected to DV are more likely to seek health care than non-abused women (García-Moreno et al., 2015; WHO, 2013a), there is evidence that women in low-and middle-income cuntried (LMICs) experiencing violence are less likely to access timely and adequate antenatal care (García-Moreno et al., 2015; Metheny & Stephenson, 2017; Musa et al., 2019; WHO, 2013b). Despite this, health-care providers are often the first professionals women come into contact with, thus placing them in a unique position to support victim-survivors (Bhate-Deosthali et al., 2018; Hegarty et al., 2013; Sikder et al., 2021; Taft et al., 2021; Tavrow et al., 2020; Ting & Panchanadeswaran, 2009; WHO, 2013b). However, HCPs can be hesitant to inquire about DV, despite best practice guidelines advocating for the identification and care of victim-survivors in routine health care (Ramsay et al., 2012; Valpied et al., 2017; WHO, 2013b). Further to this, healthcare providers (HCPs) should be aware of the compounding issues of migrant and refugee communities that add to the complexities for victim-survivors, an aspect that is lacking in some DV models of care (Magnussen et al., 2011; Okeke-Ihejirika et al., 2020; Pokharel, Yelland, Hooker, & Taft, 2021).

Primary Care for Migrants and Refugees

Research into racial disparities in health care in HICs has shown associations with socioeconomic disadvantage, trauma and intergenerational trauma, and racial/cultural discrimination, especially for First Nations peoples and African Americans (Betancourt et al., 2003; Vallesi et al., 2018). The WHO describes primary health care (PHC) as a whole-of-society approach to health care that should address determinants of health and provide high-quality, safe, integrated, accessible, and affordable services (WHO, 2019). The general nature, wide use, and accessibility of PHC mean it can be a potential lifeline for women experiencing DV, especially those who are newly arrived in a country and may have limited support networks. If PHC services are not equipped or able to provide tailored and culturally appropriate care, this can compound the adverse effects of violence and compromise the safety and well-being of culturally diverse patients (Pokharel, Yelland, Wilson et al., 2021)

Health-care providers are on the frontline of the COVID-19 pandemic, which has had considerable effects on both health care and DV. Preliminary research into the effects of the COVID-19 pandemic suggests there has been an increase in severity and prevalence of abuse, changes in the dynamics of DV, and significant barriers to seeking help (Boxall & Morgan, 2021; Mlambo-Ngcuka, 2020). Public health measures such as lockdowns, social restrictions, and pandemic-related stressors have left women and children in abusive relationships isolated in homes with their abuser (Khanlou et al., 2020; Mlambo-Ngcuka, 2020; Zero & Geary, 2020). Research into COVID-19 and health disparities has shown that the pandemic has exacerbated health inequalities in high-income, Western countries and disproportionately affected racial and ethnic minority groups (Centers for Disease Control and Prevention, 2022; Chowkwanyun & Reed, 2020; Khanijahani et al., 2021).

Health inequities and the increasingly diverse demographics of HICs highlight the need for health-care systems to incorporate quality, culturally appropriate care. Various forms of cultural awareness training have been integrated to some degree into Western medical education, with the aim of improving the quality of care for culturally diverse groups (Chang et al., 2012; Dogra et al., 2010; Kirmayer, 2012; Thackrah & Thompson, 2013). The term "cultural competence," developed in the 1980s, is often critiqued for being essentialist, viewing culture as fixed, clearly definable, and "other," while also avoiding any questioning of Western social practices or structural inequalities (Blanchet et al., 2015; Jenks, 2011). Terms like "cultural safety" and "cultural humility" are seen by some as more appropriate for addressing the core issues of health inequalities (Chang et al., 2012; Kirmayer, 2012; Laverty et al., 2017; Visintin & Rullo, 2021). Cultural safety acknowledges historical, social, and structural barriers to health care and power imbalance in patient–provider relationships and is often promoted within Indigenous health contexts (Curtis et al., 2019; Gerlach, 2012; Laverty et al., 2017). Cultural humility promotes an ongoing process that strives to recognize power imbalance, whereby practitioners engage in self-reflection and self-critique, learn from, and build respectful relationships with patients (Chang et al., 2012; Hook et al., 2013). In this paper, we use the term "cultural humility." While the integration of cultural humility into health-care training and education has been widely promoted, there are no specific

Table 1. Search Terms.

Concept 1	Concept 2	Concept 3	Concept 4
"Family violence" OR "Domestic violence" or "intimate partner violence" OR "gendered violence" OR "gender-based violence" OR "spous* abuse" OR "battered wom*"	"migrant" OR "refugee" OR "asylum seeker*" OR "immigrant"	"primary care" OR "healthcare" OR "health practi*" OR "doctor" OR "GP" OR "general practi*" OR "physician" OR "nurs*" OR "shared care" OR "midwi*"	"help seeking behavi*" OR "help seek*" OR "safety plan*" OR "danger assessment*" OR "disclos*" OR "screen*"

guidelines in relation to DV (Pokharel, Yelland, Hooker, & Taft, 2021).

This review was conducted within the context of the *Harmony* study, a randomized controlled trial in Victoria, Australia. *Harmony* aims to test the feasibility and effectiveness of a whole-of-clinic system intervention to improve the capacity of primary care clinicians (general practitioners (GPs), nurses, and others) to enquire about DV, provide first-line support, and offer confidential referrals to migrant and refugee women experiencing violence.

This review seeks to scope the literature on the experiences of migrant and refugee survivors of DV when they access PHC and their barriers to help-seeking, in order to inform further research and development of education and other resources for health-care providers working in these settings.

Method

We chose a scoping review methodology to map the global literature on this topic and identify key concepts, gaps in the research, and types and sources of evidence (Arksey & O'Malley, 2005). We deemed this approach appropriate to determine the scope and volume of global literature on this topic, as scoping reviews are often preferred when there is limited research to identify the gaps in a particular area (Pham et al., 2014). This scoping review was guided by the Arksey and O'Malley's (2005) framework, as expanded by Levac et al. (2010). The stages proposed by this framework are as follows: (1) identifying the research question; (2) identifying relevant studies; (3) selection of articles; (4) charting the data; and (5) collating, summarizing, and reporting the results.

Research Question and Study Purpose

The research question is: "What are the experiences of migrant and refugee women subjected to violence when they access primary health care in high-income countries?." This paper aims to examine and summarize the available research into women's experiences and draw out implications for improving health-care policy and practice.

Article Identification and Selection

The primary author (MAL) conducted the search with guidance from an expert librarian. The following medical, health, and social science databases were searched: Medline, Scopus, ProQuest, CINAHL, Informit Complete, and Google Scholar (first 10 pages). Author MAL conducted additional searches of the reference lists of the identified articles. The search combined four concepts adopting keywords and Boolean search strategies (see Table 1 for all search terms used). A grey literature search of websites of known organizations that work in violence against women prevention and response (see Table 2) was completed manually using the search terms, however, none were found fitting the criteria.

Table 2. Grey Literature Searched.

Organization/ Institution	• *Australian Institute of Family Studies* • *Australian National Research Organisation Women's Safety (ANROWS)* • *Centers for Disease Control & Prevention (CDC)* • *Domestic Violence Research Centre* • *Futures Without Violence* • *Harmony Alliance* • *Multicultural Centre for Women's Health* • *OurWatch* • *United Nations Women, Foundation House* • *United Nations Population Fund (UNFPA)* • *VicHealth* • *World Health Organization (WHO)*

The inclusion criteria were (1) women (+18) who have experienced DV, (2) born in a low- or middle-income country, (3) HIC setting, (4) primary health-care setting, (5) written in English, (5) outcomes included women's experience, and (6) published between January 1980 and August 2021. Migrant and refugee women who have intersecting identities (i.e., women with disabilities or women who are not cis-gendered or heterosexual) were not excluded from this review, however, the studies in this search did not identify the inclusion of these groups. No study type was excluded, however as women's experiences within health care was a necessary criterion, this excluded a large number of quantitative studies that did not include in-depth qualitative data. Using the web-based software program, Covidence (www.covidence.org), articles were screened by the primary author, with secondary screening done on all texts divided between each subsequent author. Any conflicts were mediated by author AT.

Charting the Data and Summarizing the Results

The research team developed a data extraction table using Excel (version 2202). The table included: *author & year,*

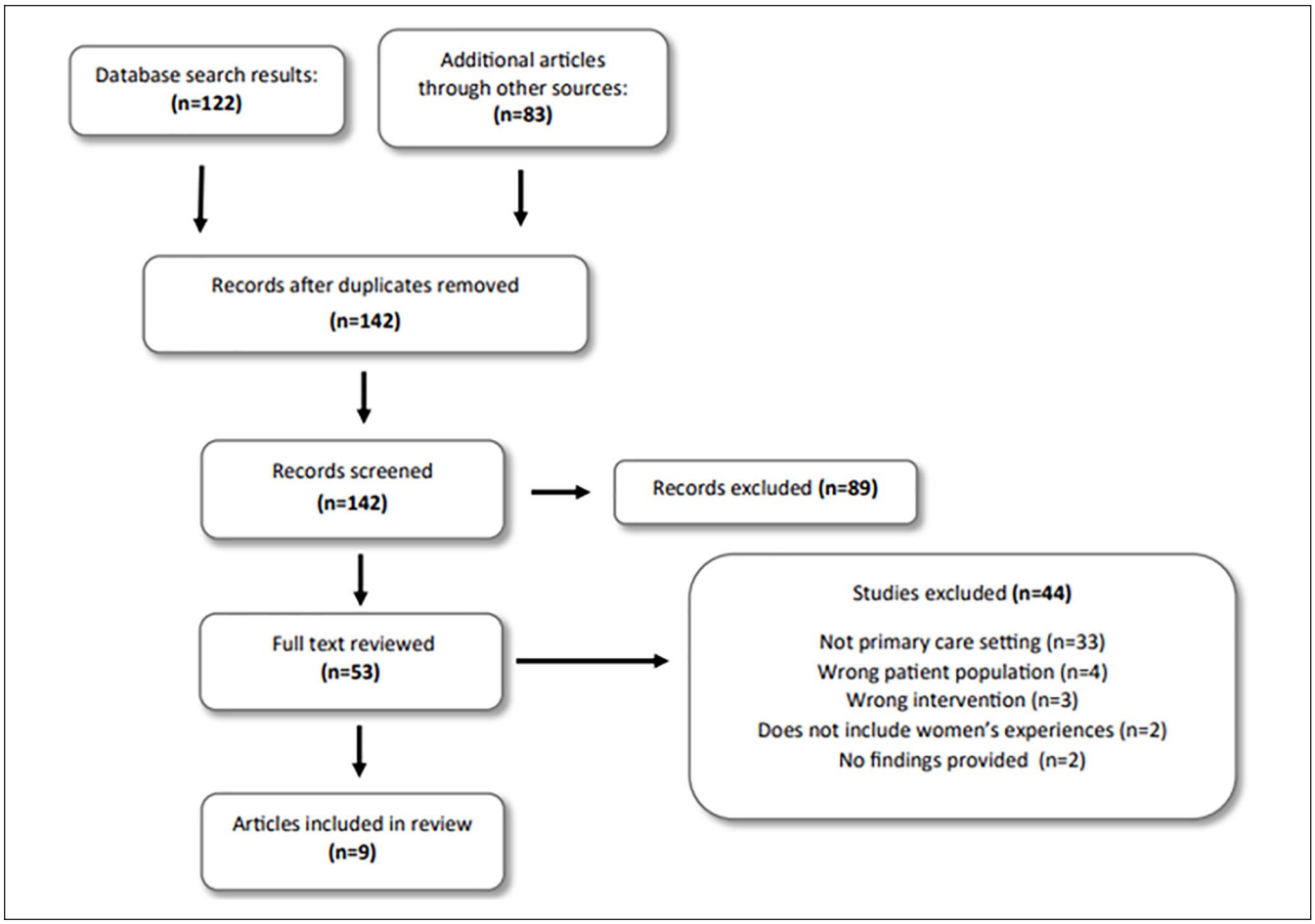

Figure 1. Preferred reporting items for systematic reviews and meta-analyses.

research location, primary care setting, aims, population, study design and method, main findings, and *main barriers and facilitators.* Themes were developed and analyzed inductively through detailed reading of the data to derive key concepts. The data were synthesized into five key themes (1) *fear of repercussions*; (2) *relocation; language, culture, and social isolation*; (3) *HCP perception and interaction*; (4) *trust, empathy, and kindness*; and (5) *turning points*, which were organized into two categories: *barriers* and *facilitators to disclosure.* A CASP appraisal of the studies was done to assess the research and reporting practices (Critical Appraisal Skills Programme [CASP], 2019). The discussion is interpreted within the ecological model (Bronfenbrenner, 1979).

Results

Characteristics of the Studies

The initial search generated 223 articles, and after duplicates were removed, 142 remained. Applying the inclusion criteria, an initial title and abstract screen was undertaken, removing 89 studies, followed by full text screening. After excluding a further 44, 9 articles were included for the final review (see Figure 1).

The studies were published between 2000 and 2021. Six of the nine studies were from the United States and one each from Canada, the United Kingdom, and Norway. Three studies explored Latina women's experiences, two studies focused on South Asian women, and one study focused solely on Asian women. A further study featured a sample of 50% Latina and 50% Asian women, and two studies included participants from various backgrounds. All were qualitative studies; eight were peer-reviewed articles and one was a doctoral thesis. All results are summarized in Table 3.

Following a CASP review, we found that most studies were clear in their objectives, justified their methodology and were designed well. Very few studies, however, addressed the relationship between researcher and participant and any potential power or relationship imbalances, and some lacked sufficient discussion on ethical concerns and participant safety, which are critical elements when conducting research with victim-survivors (WHO, 2016).

Table 3. Summary of Articles Included in Review.

Author and Year	Research Location	Primary Health-Care Setting	Aim (s)	Population	Design and Methods	Findings	Findings (Barriers)	Findings (Facilitators)
Ahmad et al (2009)	Canada	Family physician	Explore the views of South Asian immigrant women with experiences of partner abuse about the meaning of help-seeking and reasons for and against help-seeking	22 South Asian (India, Pakistan, Bangladesh: spoke Hindi) immigrant women	Qualitative study. Three facilitated focus groups with open ended discussion guide Thematic analysis	Main themes: (1) reasons for delay; (2) turning points; and (3) talking to professionals. Women sought help after a long delay, after they had exhausted private coping strategies and things became unbearable	• Social stigma • Gender roles (women's silence, marriage obligation, subordination) • Children's well-being (emotional and economic) • Loss of social support • Knowledge gaps/myths	(Personal) • Ineffective private coping • Abuse severity • Psychosocial consequences (HC Professional) • Trustful • Nonjudgmental • Female • Regularly enquires about abuse • Cultural and availability of services
Bauer et al (2000)	United States	Unspecified	Explore barriers that affect help-seeking and patient–provider communication for abused immigrant women	28 women: 14 Latina (6 Mexico, 3 El Salvador, 2 Guatemala, 3 Colombia) and 14 Asian (5 China, 1 Vietnam, 4 Philippines, 2 Taiwan). Recruited through 4 community organizations	Qualitative study. Four semi-structured focus groups. Analyses unspecified	Main themes: (1) socio-political barriers and (2) sociocultural barriers	Socio-political barriers • Lack of support and social isolation • Social and financial reliance on husbands • Unfamiliarity with the system and country, fear of deportation • Language barriers and racism (from HCPs). Sociocultural barriers • Traditional gender roles • Sanctity of family/marriage > dedication to children • Shame and stigma	None identified
Finfgeld-Connet and Johnson (2013)	United States	Unspecified	Better understand domestic abuse among South Asian women in westernized countries and to make evidence-based inferences related to helping services (systematic review)	Abused South Asian immigrant women living in English-speaking Western Countries	Qualitative systematic review. Iterative approach	Main themes: (1) Culture of paternalism and women's perceptions of abuse; (2) reluctance to take action; (3) process of seeking assistance; (4) availability and suitability of helping services	• Cultural: shame, justification & denial, gender roles, sanctity of marriage, fear of repercussions or ostracization from community • Relocation: Social isolation and adjustment to new country, economic concerns, immigration status, fear of authorities • Systematic; language barriers, perceived racism/judgment by HCPs, lack of awareness of services, fear of losing children	• Escalation of abuse/ exhausted all other avenues • Children's welfare

(continued)

Table 3. (continued)

Author and Year	Research Location	Primary Health-Care Setting	Aim (s)	Population	Design and Methods	Findings	Findings (Barriers)	Findings (Facilitators)
Garnweidner-Holme et al. (2017)	Norway	Antenatal care	To explore pregnant women's experiences with andrecommendations for communication of intimate partner violence (IPV) with midwives in antenatal care	8 women pregnant who had experienced IPV during pregnancy (3 ethnic Norwegian, 1 Iraqi, 1 Turkish, 1 Pakistani, 1 Polish, and 1 Spanish	Qualitative study. Semi-structured interviews. Thematic analysis	Main themes: (1) the mid-wife did not ask about violence; (2) antenatal care was a good arena; (3) lack of facilitators to talk about IPV; and (4) midwives were perceived as powerless	• Perceptions of HCP • Women were not asked about IPV • Language and cultural barriers • Fear of consequences; losing children and not being believed • Lack of or concerns about privacy	• Importance of starting the conversation: explaining IPV and consequences in healthcare (HC) context and providing materials. • Relationship: Trust and kindness; especially due to social isolation
Kelly (2006)	United States	Unspecified	(1) Describe the meanings that battered Latina women give to their health-care experiences, and (2) identify battered Latina women's expectations of health-care providers and health-care systems	17 Latina women recruited from agency for battered women and a legal services program	Qualitative study. Dialogic interviews Phenomenological analysis	Main themes were (1) pervasive fear and despair; (2) interactions with HCPs; and (3) creating safety for disclosure: what women need	• Children's need for family and father • Fear of consequences: deportation/children being taken away • Fear of abuser: Threats on children or deportation • Language barriers, economic concerns, and unfamiliarity with laws and services • HCP relationship: Absence of connection with HCP, lack of safety, empathy, and trust • Parallels in abuser and HCP relationship	• Fear for children; behaving like abuser or leaving them motherless (escalation of abuse) • Wanting to be asked despite fear • Needs: trust of HCPs and awareness of consequences before disclosure
Khelaifat (2018)	United Kingdom	Unspecified	Identify health-care experiences, support pathways and needs of migrant women affected by DV	8 migrant domestic violence and abuse (DVA) survivors recruited from DV agency or "other professionals" (one each from: Côte d'Ivoire, Libya, Sudan, Somalia, Romania, Ukraine, Brazil, India)	Qualitative study. Semi-structured interviews. Thematic analysis	Women silenced through coercive control, fear shame/social stigma (social networks/extended family often promoted the coercive control of silence), fear of deportation (dependence on abuser) and death (of woman and child), and the taboo of mental health and DV (language barriers affected discussion of these). Disclosure experience negatively impacted if HCP offered inadequate response	• Fear of consequences; death, deportation, losing children • Coercive control: Silencing, shame, and social stigma • Language barriers • Inadequate health-care response	• Crisis: escalation or severity of abuse (especially when children involved) • Trust: Positive relationship with HCPs • Impact on children

(continued)

Table 3. (continued)

Author and Year	Research Location	Primary Health-Care Setting	Aim (s)	Population	Design and Methods	Findings	Findings (Barriers)	Findings (Facilitators)
Montalvo-Liendo et al. (2009)	United States	Unspecified	Describe factors that influence disclosure of abuse by women of Mexican descent	26 Mexican women (19 migrant, 7 US born), recruited from two agencies	Qualitative study. Semi-structured interviews Grounded theory	The key themes/findings were (1) kept behind closed doors, (2) lying and denying, (3) compelled decision, (4) unburdening decision, (5) validation, and (6) retraction	• Fear of repercussions (immigration, children) • HCP didn't ask • Staying for children • Financial concerns • Coercive control of isolation • Familismo/protection of partner (denial)	• Escalating violence • Positive relationship with HCP • Desire to "unburden"
Tavrow et al. (2020)	United States	Primary health-care clinics	(1) Assess efficacy of videos in consultation rooms to prompt disclosure and learn more about specific barriers to IPV disclosure for Asian immigrant women, (2) investigate differences in perceptions by ethnicity	60 women (15 Mandarin Chinese, Korean, Thai, and Vietnamese)	Qualitative study. Semi-structured interviews. Content analysis	Results align with other studies that have found Asian immigrants lack awareness about the scope of IPV and many immigrant women quietly enduring IPV because they believe it must be severe physical abuse to warrant seeking help	• Culture: traditional gender roles, shame a stigma • HCP perception: too busy, unprepared/unable to help and lacking empathy • Women unaware they should/could disclose in consult • Lack of awareness of DV • Staying for children • Language barriers	• Importance of trust, empathy, patience, and confidentiality in HCP relationship • Leaving for children • Proactive information regarding consequences of disclosure • Maintaining woman's autonomy, safety, and privacy
Wilson et al. (2014)	United States	Unspecified	(1) Review previous research related to IPV among migrant/seasonal farm worker (MSFW) women and (2) recommend policies that may help to improve the detection, intervention, resources, and available (policy brief)	Migrant/seasonal farmworker women (Latina)	Literature review (policy brief)	(1) Substance abuse by abuser and immigration status of women was a predictor of IPV; (2) HCPs must be culturally sensitive and be aware of feelings of guilt and shame for victims; (3) HCPs struggle with lack of protocol and resources and women are unaware of resources and help available	• Women unaware of resources • Language barriers • Migration status • Financial restraints • Cultural influences	

Note. DV = domestic violence.

Table 4. Critical Findings From Review.

Factors that inhibited disclosure	• **Women feared the repercussions or perceived consequences of disclosure, the most common of which were:** ➢ *Deportation* ➢ *Losing custody of children* ➢ *Financial (if abuser arrested/deported, loses job)* • **Relocation barriers impacted women's abilities and resources to access help, especially concerning:** ➢ *Language* ➢ *Social isolation and support networks* ➢ *Unfamiliarity of new country's social, health and legal systems* • **Negative perceptions and experiences with HCPs, particularly regarding:** ➢ *Racism* ➢ *HCPs seen as powerless and lacking time and empathy* ➢ *Women unaware HCPs can help* • **Cultural/social influences that inhibited disclosure included:** ➢ *Traditional gender roles* ➢ *Collectivism and familism/familismo* ➢ *Shame, stigma, and fear of social ostracization* ➢ *The promotion of silence and use of private coping mechanisms* ➢ *Lack of understanding/knowledge gaps about DV*	**Summary:** Findings are similar to broader studies on women's experiences (shame, social isolation, desire for empathy and connection, etc.) however migrant and refugee women's experiences of help-seeking are severely impacted by migration and relocation factors
Factors that facilitated disclosure	• **Positive experiences and relationships with HCPs were valued and desired very highly, women wanted:** ➢ *Trust, empathy, and connection, someone to listen to them* ➢ *To be validated and believed* ➢ *A safe and private space in which to disclose* • **Women wanted assurances of confidentiality and information about what happens after they disclose (alleviated fear of repercussions)** • **Escalation of violence was a common predictor for disclosure/desire to leave, especially regarding women's fear for the safety and well-being of children**	

Synthesis of Studies

Theme 1: Barriers to Disclosure

The synthesis of these studies highlighted many barriers for migrant and refugee women in primary health-care settings. These included fears of repercussions from disclosure, the impacts of relocation, as well as negative experiences with health-care professionals (Table 4).

Fear of Repercussions

All studies identified a range of common fears, which presented major barriers to disclosure and help-seeking for migrant and refugee women. Eight studies identified financial concerns as a barrier for women; both the fear of being "left on their own" if the relationship ended or if the perpetrator were to lose their job and no longer be able to financially support the family (Ahmad et al., 2009; Bauer et al., 2000; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014).

Fears related to social shame or stigma of both disclosing abuse and potential separation were discussed in eight of the studies. These ranged from concerns about family honor and the fear of being ostracized by their family, and community and social networks promoting silence among victims, thus reaffirming the notion of shame (Ahmad et al., 2009; Bauer et al., 2000; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014).

Eight papers reported women staying in violent relationships for the sake of their children (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020). The motivation behind this ranged from sociocultural (social stigma regarding marriage and family) to sociopolitical (the fear that children will be taken away from them or fears of deportation). The fear of deportation was reported in five of the studies and was especially pertinent for women who were undocumented or on partner visas, with some women also reporting abusers using the threat of deportation and/or child removal as a means of controlling them (Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Kelly, 2006; Khelaifat, 2018; Tavrow et al., 2020).

> They [health-care providers] get you in trouble . . . As soon as a woman is in domestic violence they all assume the kid is in danger . . . so you get scared sometimes and you don't talk. (Kelly, 2006, p. 84)

Relocation: Language, Culture, and Social Isolation

All studies found elements of the impact of culture and relocation on women's experiences. Eight articles identified language as a barrier to care and disclosure in the health setting (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Tavrow et al., 2020; Wilson et al., 2014). Some studies mentioned issues around the use of interpreters, both in terms of the lack of interpreters available in health-care settings and also complexities in the use of interpreters for migrant and refugee women. Some women found that interpreters created a distance between their HCPs and themselves, inhibiting communication and relationship building (Bauer et al., 2000).

> Language is a very important factor. It's very important, not because you don't trust what they don't translate, but because when a third person is used, you lose that contact which is very much a part of us, and it puts more distance between the doctor and the patient. (Bauer et al., 2000, p. 37)

There were concerns about using interpreters from the same cultural community, interpreters not having experience working with victim-survivors, and some women not wanting to disclose in front of a "stranger" (Bauer et al., 2000; Garnweidner-Holme et al., 2017; Khelaifat, 2018). This factor was especially concerning when a family member, or even the abuser, would act as the interpreter for the victim-survivor (Bauer et al., 2000; Khelaifat, 2018). Language barriers ranged from lacking the language skills to adequately understand or explain physical and mental health issues to knowledge or understanding of local laws and awareness of what constitutes DV (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Wilson et al., 2014). Seven studies found social isolation after relocation to be a common issue for women. The lack of, or reduction in, social support networks often meant women kept their abuse secret and came up with private coping mechanisms, such as disbelief and minimization, prayer and modifying their behavior, or adhering to culturally prescribed expectations such as silence and subordination (Ahmad et al., 2009; Bauer et al., 2000; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020).

> Back home if something like this happens, all village people go with sticks to tell the man that it should not happen, but here, we do not have anyone. (Ahmad et al., 2009, p. 617)

> . . . When you live with a person and you are not allowed to have other persons in your live [sic] . . . You have nobody. For some, the midwife is the only person they can meet, and that's why she gets very important. (Garnweidner-Holme et al., 2017, p. 5)

All but one study discussed cultural influences on women's decisions not to disclose abuse (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014). Some identified familism or *familismo* and collectivism, both of which are ideologies which prioritize the family or "in-group" over the individual and as such emphasize duty and loyalty towards family and community (Ahmad et al., 2009; Bauer et al., 2000; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009). Two studies identified these values as imbuing a sense of "hardiness or strength," although women said that these traits could also be exploited by perpetrators as they often silenced women and increased feelings of shame and guilt (Ahmad et al., 2009; Khelaifat, 2018). Six papers highlighted the role of patriarchy and the adherence to traditional gender roles as a major inhibitor to seeking help (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Khelaifat, 2018; Tavrow et al., 2020; Wilson et al., 2014).

HCP Perception and Interaction

Negative interactions with and perceptions of HCPs appeared to reduce women's likelihood of seeking help or disclosing. Some HCPs were perceived as too busy, unempathetic, or limited in their ability to help (Garnweidner-Holme et al., 2017; Tavrow et al., 2020). There were fears from some migrant and refugee women about approaching "mainstream" HCPs (HCPs from the dominant cultural group) including some who were concerned about or had experienced racism and race-based prejudice from HCPs or other authorities (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Kelly, 2006; Khelaifat, 2018). One study found women identifying parallels between HCP and perpetrator relationships, with some women experiencing similar emotional responses in their interactions with HCPs, such as fear, lack of power, and control and feeling invisible (Kelly, 2006). This literature highlights the compounding factors that migrant and refugee women face in seeking help for DV and with primary health-care access.

Theme 2: Disclosure Facilitators

The findings synthesized from these studies showed the importance of connection and trust with their HCP were especially important to migrant and refugee women. We also identified "turning points" in which women were motivated to leave for the well-being of their children, due to the escalation of abuse, or both.

Trust, Empathy, and Kindness

Central to this synthesis was the finding that kindness and care were key to women's experiences of and willingness to

disclose. Seven papers found that a positive relationship with their HCP was a strong impetus for women disclosing or encouraging women to seek help (Ahmad et al., 2009; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020). Trust, empathy, and nonjudgmental and respectful attitudes were highly valued by women.

The theme of trust is interconnected with other factors inhibiting and aiding help-seeking as concerns around confidentiality, safety, and repercussions of disclosure can be reduced or alleviated if a strong foundation of trust and health system supports is established. Listening was identified as a vital skill in HCPs for building a good relationship. Particularly, some mentioned nonverbal cues and behavior, which were especially important for those speaking in a second language who may be relying heavily on body language, mannerisms, and eye contact (Ahmad et al., 2009; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009).

> You need to pick a doctor that listens to you, checks you properly, and has time for you. And when you feel comfortable then you can talk about anything. (Ahmad et al., 2009, p. 618)

Connection with their HCP was highlighted in some studies as especially important for migrant and refugee women, due to the social isolation that came with relocating to a new country (Garnweidner-Holme et al., 2017; Khelaifat, 2018). Misperceptions of the consequences of disclosure and role of HCPs as well as the desire for clear communication were common factors that interplayed with the fears expressed by the women in these studies. Some studies, for example, found that women were unfamiliar with the system and support resources available (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Kelly, 2006; Khelaifat, 2018; Wilson et al., 2014); women were unaware they could talk to HCPs about violence (Ahmad et al., 2009; Khelaifat, 2018; Wilson et al., 2014); and women lacked knowledge or had fear of what might happen if they were to disclose (Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014). Several papers in this review found that women wanted to be, but were not, asked about violence (Ahmad et al., 2009; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009).

Three studies discussed the pathway from informal to formal help-seeking, either by way of encouragement from family and friends or their inability/unwillingness to help (Finfgeld-Connett & Johnson, 2013; Khelaifat, 2018; Montalvo-Liendo et al., 2009). Participants in Ahmad et al.'s study indicated wariness of informal disclosures, expressing concern about "gossip rather than support" (Ahmad et al., 2009). However, much of the discussion around informal help-seeking was shrouded in the complexities of the social isolation that migrant and refugee women face after relocation and community gender roles and expectations (Ahmad et al., 2009; Khelaifat, 2018).

Turning Points

Several studies identified mothering as a central part of women's decisions to seek help or disclose. For some, this was closely connected with the escalation of abuse, due to fears for children's safety and well-being. While many women talked about staying in violent relationships for the sake of their children, six studies found there was a turning point in which women left for the sake of their children (Ahmad et al., 2009; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Tavrow et al., 2020). Women from four studies reported that the escalation of abuse motivated them to seek help (Finfgeld-Connett & Johnson, 2013; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009). Escalation of violence was strongly linked to fears for children as women worried about the safety of their children, feared leaving children motherless, or were concerned about the cycle of abuse continuing in their children. For women in the antenatal setting, midwives providing information about the consequences of DV on unborn children were highlighted as a catalyst for seeking help (Garnweidner-Holme et al., 2017). These studies illustrate the importance of empathy, trust, and kindness from HCPs to enable women to feel safe and valued enough to disclose, as well as the role of mothering in women's decisions to seek help and disclose.

Discussion

To the authors' knowledge, this is the first review to explore and synthesize the primary care experiences of migrant and refugee women experiencing DV in HICs. We propose that the findings can be framed within an ecological model (Bronfenbrenner, 1979), to explain the individual, social, systemic, and political factors that impact migrant and refugee women's ability and willingness to seek help from their HCPs (see Figure 2). This framework contextualizes the complex interplay between an individual and their environment and has been adapted and used widely to understand and address violence against women (Heise, 1998; WHO, 2012). The ecological model allows an examination of contributing factors on sociocultural and sociopolitical levels that move beyond the individual (and individual blame). It could be a useful framework for HCPs to understand the complexities migrant and refugee women face and work with them to increase their safety and well-being (Guruge, 2012).

Microsystem

Bronfenbrenner's microsystem refers to factors in an individual's immediate setting, for example, their home or work

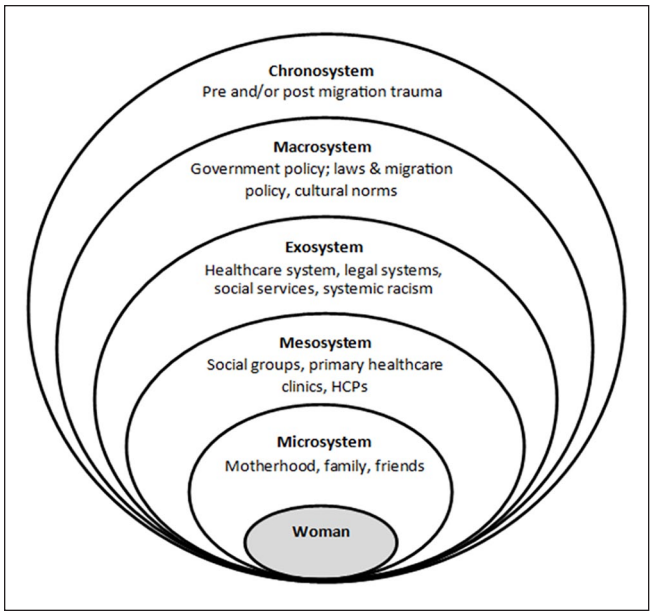

Figure 2. Ecological model of factors influencing health care and help seeking of migrant and refugee women.

(Bronfenbrenner, 1979). This system was very prominent in the context of this review as women's concerns around family were a major finding. Mothering was a strong theme, highlighting the importance of children in women's decision-making; while some revealed they stayed for sake of the children, this research indicates the importance of discussing the safety and well-being of their children with women, as this may be a motivating factor to assist women with their choices and potentially moving through the "stages of change" (Reisenhofer & Taft, 2013). Fear of bringing shame on the family or breaking up the family unit promoted silence among women, as did adherence to traditional gender roles and the belief that DV is a private matter (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014). These findings are consistent with other reviews on broader groups of women's experiences (Feder et al., 2006; Tarzia et al., 2020); however, the interplay between all systems often exacerbate barriers for some marginalized groups (Fiolet et al., 2021; Satyen et al., 2019).

While some studies in this review included employment, education, or income in their demographics, there was little discussion of the direct impact of these intersecting factors on women's access and experiences of health care or help-seeking. Multiple papers discussed the impact of economic insecurity in relation to help-seeking (reliance on abuser), financial stress exacerbating violence, or situations of financial abuse/coercion (Ahmad et al., 2009; Bauer et al., 2000; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Wilson et al., 2014); however, none thoroughly explored the dynamics or potential impact of poverty. One paper noted that individual-level characteristics (i.e., income, education) were rarely discussed by participants compared to sociocultural contexts (Ahmad et al., 2009). Low socioeconomic status is associated with poorer health outcomes, impeding access to health care and can reinforce gaps in income and wealth, creating a "health-poverty trap" (Bor e tal., 2017; Chockshi, 2018; Wagstaff, 2002). This indicates an important element in women's experiences that has been excluded from this area of research.

Mesosystem

The mesosystem represents the interplay between two or more elements in the microsystem. An example would be if a woman attends a mothers' group and the members of this group promote harmful ideas around DV, then this may foster feelings of shame on an individual level. This level is highlighted by numerous papers that discussed the impact of social stigma on reaffirming silence or shame (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014). While the mesosystem often represents the interaction between the woman and her social or work environments, in the context of this review, we will argue that this system can be applied to the primary care setting as well. Primary health care could act as a bridge between women and the broader health-care system. Primary care providers can play a vital role in enhancing social support for women experiencing DV, especially for those who have limited social support networks. Women who have negative perceptions or experiences with HCPs are less likely to access health care or disclose. Conversely, emotional connection and empathy from HCPs were found to be a major facilitator for women in this review. Women described concerns about or experiences of racism, prejudice, judgment, and blame. The comparison of women's relationships with their HCP and their abuser illustrates the potential impact of inappropriate and harmful responses that can re-traumatize victim-survivors. Primary care clinics can be a source of support and a bridge for the woman to the wider systems of care. Positive and culturally safe experiences could be a catalyst for a woman on a microsystemic level (i.e., validation of her experiences) or it could encourage a link to further systemic support for the woman.

Exosystem

The exosystem represents the impact and links within settings in this system that the individual may not have any direct relationship with, but still affects the woman's immediate environment. In the context of this review, this relates to the environments within the broader health care, legal, and other support systems. Language barriers, systemic racism, and unfamiliarity with the host country's health-care system proved to be major barriers for migrant and refugee women.

Services in which women feel alienated, unwelcome, or disempowered have the potential to reinforce silence and foster feelings of denial and guilt. Some papers identified cultural humility and understanding as important elements in building relationships and fostering a safe environment for women (Ahmad et al., 2009; Bauer et al., 2000; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Tavrow et al., 2020; Wilson et al., 2014). Equally a lack of cultural awareness was found to negatively affect women's experience of or willingness to seek help (Bauer et al., 2000; Garnweidner-Holme et al., 2017; Khelaifat, 2018; Wilson et al., 2014). These barriers and experiences highlight the importance of culturally safe, trauma-informed care, which should be incorporated into services at a systemic level. The implementation of systemic changes, like integrating cultural humility training into DV models of care, involves multiple levels of structural and societal commitment. Macrosystemic-level bodies (government) can lead initiatives; however, organizations within the exosystem (health care) must be willing and able to integrate these changes.

Macrosystem

The macrosystem embodies higher level systemic and societal factors such as government policy and cultural norms. Immigration policies and government support for newly arrived refugees and migrants deeply impacted women's experiences and fears around disclosure, especially those on partner visas or undocumented women (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Kelly, 2006; Montalvo-Liendo et al., 2009; Tavrow et al., 2020; Wilson et al., 2014). Women's fears of deportation or the removal of their children highlights the need for HCPs to be aware of the legal and support systems and the real, or perceived, consequences for migrant and refugee women. For refugee and migrant women who may not be eligible for benefits and/or health subsidies, financial insecurity may limit their access to or reduce their perceived need for health care (i.e., they may prioritize children's expenses over their own).

The impact of patriarchal structures and cultural norms was a prominent barrier for women in that they promote silence, denial, and shame and emphasize the importance of family and community over the victim-survivor (Ahmad et al., 2009; Bauer et al., 2000; Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Kelly, 2006; Khelaifat, 2018; Montalvo-Liendo et al., 2009; Tavrow et al., 2020).

Chronosystem

The chronosystem considers the impact of life transitions or major events on a person's development (Bronfenbrenner, 1986) and, in the context of this review, is used in two ways: to highlight the impact of migration and seeking asylum and to consider the impact time and changing environments have on the actions and experiences of perpetrators and victims of DV. Pre- and post-migration trauma or stress has been shown to have adverse effects on individuals, especially for those fleeing conflict or persecution. This may be due to social upheaval, language barriers, visa uncertainty, financial stress, loss of support networks, discrimination, and social isolation (Gutowski et al., 2017; Malm et al., 2020). These themes were all identified in this review and highlight the importance of the elements of the chronosystem to contextualize the numerous intersecting and compounding factors influencing the lives of migrant and refugee communities. This may also include the impact of previous trauma experienced, as noted in two papers (Finfgeld-Connett & Johnson, 2013; Khelaifat, 2018). Changes that occur over time on an individual level (relocation) or on a societal level (attitudes towards women, gender equity practices) can impact the experiences of victim-survivors and were discussed in two papers in this review (Finfgeld-Connett & Johnson, 2013; Wilson et al., 2016). Some research indicates that changing of gendered norms and cultural globalization are linked to an increase in men's violence against women (Fulu & Miedema, 2015; ICRW, 2002). Fulu et al. 2013 argue that to fully understand men's violence against women, historical and societal contexts must be considered to analyze individual actions and that men's perceived disempowerment can exacerbate violence (Fulu et al., 2013). Relocation-induced shifts in men's social and family status or changes in gender roles and relationship dynamics have been found to increase the risk of DV for migrant and refugee women (Bui & Morash, 2008; Finfgeld-Connett & Johnson, 2013; Fisher, 2013; Wilson et al., 2014). Health-care providers should be trained and resourced to be aware of and respond to the multidimensional complexities that come from relocating to a new country and how they impact on women's lives and their experiences of seeking help.

Practice and Research Implications

All HCPs, but especially those in primary care, need foundational DV training (Kalra et al., 2021) and to be mindful of the impact their interactions can have on victim-survivors' experiences of care and decisions to seek help. Negative experiences and relationships with HCPs can intensify women's feelings of shame and silence, just as a positive interaction may encourage women to disclose. Negative perceptions of HCPs indicate a need for proactive information about the role of HCPs, promoting them as a source of support and that they can be trustworthy, helpful, and maintain confidentiality (Table 5).

There is a clear need for bilingual and culturally relevant resources in the health-care setting. This includes employing bilingual/multicultural staff where possible, cultural humility training, and self-reflection by HCPs, offering appropriate interpreters and services as well as providing written/visual

Table 5. Implications From Review.

Implications for policy	This review provides insight into the needs of migrant and refugee victim-survivors that can be incorporated into primary health care at a systemic level, by developing and integrating guidelines and frameworks that primary care clinicians can easily access and use. There is also a clear need for culturally and linguistically relevant resources (including DV-trained interpreters) to be readily available for clinics and primary care clinicians
Implications for practice	HCPs should have foundational DV and cultural competence training. The findings from this review can be used to inform these programs and as a standalone guide to model care for migrant and refugee victim-survivors. The perceptions women held of HCP's attitudes and ability to help (or lack of) indicate the need for proactive information given to women about what HCPs can do for victim-survivors. HCPs should also be applying the components of health equity in their care and addressing social determinants of health for patients
Implications for research	This review adds knowledge to an under-researched area and identified the further gap of migrant and refugee victim survivors with intersecting disadvantages (LGBTQI+, women with disabilities, older women, etc.). While not explicitly searched for, no studies relating to this topic focused on migrant and refugee women, thus highlighting a need for this research to be done. We have also identified a gap in research focusing on the connection of income insecurity and poverty on migrant and refugee victim-survivors' experiences of health care and help seeking

Note. DV = domestic violence.

information like websites or flyers and posters in clinics (Finfgeld-Connett & Johnson, 2013; Garnweidner-Holme et al., 2017; Khelaifat, 2018; Pokharel, Yelland, Wilson, et al., 2021; Wilson et al., 2014). The concept of safe spaces was highlighted in some papers and was closely tied to the need for ensuring privacy and confidentiality in consultations, especially with people who are unsure of their legal rights and the consequences of disclosure. This fear of repercussions from DV disclosure was a major health-care barrier for the women in these studies and highlights the need for clear communication about what happens after disclosure so that women can make informed decisions. For this to be effective, HCPs must understand and be able to communicate the legal obligations and processes, and importantly, be able to link women with appropriate and specific referral services.

This review has highlighted and identified a gap in research regarding migrant and refugee women with intersecting disadvantages and the impact of financial and visa insecurity on women's health care and help-seeking. Despite evidence of the relationship that social determinants of health, like income, have on DV, few studies have explored the role of socioeconomic factors on help-seeking and health care for migrant and refugee victim-survivors (Cunradi et al., 2002). Primary health care has health equity at its core, emphasizing both health promotion and prevention (Pan American Health Organisation, 2005; Rasanathan et al., 2011). Health-care providers have an important role in addressing the social determinants of health for patients in their care, and this review offers insight into the needs of migrant and refugee victim-survivors in the primary care context.

Strengths and Limitations

This review summarizes the research to date on migrant and refugee women's experiences of health care and help-seeking when experiencing DV. A strength of this review is the use of a rigorous and transparent scoping review methodology. A limitation to this review is the lack of specificity regarding the setting in the articles, as very few studies explicitly noted this. Three specified a primary care setting and the rest alluded to the setting, with implications for practice nurses or clinical care or mentioning women's experiences with primary care clinicians. Due to the limited research on this topic, we decided that there needs to be a liberal approach to these criteria. This review explores the experiences of migrant and refugee women in high-income settings; however, these contexts may vary in terms of their health-care systems and policies regarding the treatment of asylum seekers, refugees, and new migrants. While we aimed for a global perspective, we were unable to review any articles published in languages other than English. Further research is needed in the post-COVID-19 context as the pandemic has had a serious impact on migration and social isolation, and the issues facing relocated families in a post-pandemic era may be different.

Conclusion

This review offers a much-needed illumination of migrant and refugee victim-survivors' experiences of health care in primary health-care settings and identifies the sociocultural and sociopolitical barriers to seeking help. Like most women experiencing DV, at an individual level, migrant and refugee survivors experience shame and social isolation. At a relationship level, they desire kindness and empathy from their HCP. However, at an institutional and societal level, the intersecting and compounding elements for migrant and refugee women become more prominent as women face more severe consequences from disclosure due to cultural, political, and migration-related factors. Overall, social isolation and systemic barriers (racism, visa fears) compounded the experiences of migrant and refugee victim-survivors, while relationship and connection with HCPs and children's well-being appear to be the strongest motivators for help-seeking and disclosure. As ongoing global instability

contributes to the increasing displacement of populations, this review suggests the importance of improved understanding, guidance, and system support for HCPs to provide best practice DV care for migrant and refugee women.

Acknowledgments

The authors would like to thank Linda Whitby, Senior Library Research Advisor, for her assistance and advice on the systematic search for this paper.

Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: The first author of this publication is a recipient of an Australian Government Research Training Program (RTP) Scholarship.

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