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REVIEW

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Social determinant factors and access to health care for women experiencing domestic and family violence: Qualitative synthesis

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Abstract

Aims: The aim of this study was to explore the social determinant factors and access to health care for women with lived experience of domestic and family violence.

Design: Qualitative synthesis.

Data Sources: A search of CINHAL, Embase, Medline and PubMed, was conducted between December 2021 and March 2022.

Review Methods: Primary qualitative studies published in English from 2000 to 2021 were included. Findings were thematically analysed using the Levesque et al. (2013) access to healthcare framework. Study design was assessed using the Critical Appraisal Skills Programme for qualitative research.

Results: Twenty-eight studies were included. Findings related to the Levesque domains of *approachability*, *appropriateness* and *availability* of health services. Social determinants included perceived stigma and fear of discrimination leading to a lack of trust in healthcare professionals and fear of disclosure, which prohibits disclosure. Women reported their limited awareness of available support services, an absence of health professional screening and insufficient response when they disclosed presence of domestic and family violence, which collectively reduced their healthcare access.

Conclusion: Findings advance our understanding of how social determinant factors influence women's ability to access health care. The determinants related to discrimination and stigma, which prohibited the establishment of trust, were the most influential factors on access to care.

Impact: Women experiencing domestic and family violence are hesitant to disclose, and violence continues in secret. Social determinant factors of stigma and trust prohibit women's disclosure and therefore their access to health care. Findings hold implications for nurses' consciousness of these social determinant factors. Raising nurses' awareness to curiously question the presence of domestic and family violence may build trust that leads to disclosure and improves access to health care.

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No Patient or Public Contribution: The authors intend to present the findings to people with lived experience in the next phase of this programme of research.

KEYWORDS
access to care, domestic abuse, domestic violence, family violence, health service, health care, intimate partner violence, qualitative

1 | INTRODUCTION

The incidence of domestic and family violence is as high as one in three women worldwide (World Health Organization, 2021). Most violence is intimate partner violence, and up to 38% of murders of women are domestic violence-related (World Health Organization, 2021). Despite its high prevalence, many women do not disclose that violence is occurring, instead suffering in silence, which sometimes results in fatal injury and/or illness. The social determinants of health are profoundly influential on the incidence of domestic and family violence and women's willingness to disclose. As an example, the COVID-19 pandemic led to a substantial increase in rates of domestic and family violence due to the additional stress placed on everyday living, which amplified the impact of social determinants on access to health care. The mandated social isolation and the recurrent COVID-19 lockdowns impacted on people's income, their job security, working life conditions, social inclusion and sense of discrimination (Smyth et al., 2021; Usher et al., 2021). Together, these placed women at greater risk of intimate partner violence and the social isolation reduced their opportunities to seek help (Boxall et al., 2020). The aim of this qualitative synthesis is to explore the social determinant factors and access to health care from the perspective of women experiencing domestic and family violence.

1.1 | Background

Domestic and family violence (DFV) is a global public health issue of substantial scale (World Health Organization, 2014). In Australia, 2.2 million people have experienced physical or sexual violence from a former or current partner (Australian Institute of Health and Welfare, 2022). Whilst it affects people of all backgrounds, women and children are most impacted, with one in five women and one in 21 men experiencing sexual violence at least once since the age of fifteen in Australia (Australian Institute of Health and Welfare, 2022). Domestic and family violence most commonly occurs in intimate partner relationships and can include physical or sexual abuse, intimidation, coercion and emotional abuse. Up to 3.6 million Australians have experienced emotional abuse from their partner (Australian Institute of Health and Welfare, 2022), at an estimated cost in 2015, of $22 billion (KPMG, 2016). Domestic and family violence have a direct impact on health, often resulting in sexual health diseases, mental and physical health conditions along with increased risk of smoking, alcohol or substance use disorders (World Health Organization, 2013).

Despite their health needs, access to health care is challenging for women experiencing domestic and family violence (Reisenhofer & Seibold, 2013). The controlling behaviours of perpetrators create either a physical barrier to accessing health care or women fear the ramifications of disclosure (Dichter et al., 2020; Joshi et al., 2012; Laughon, 2007; Lichtenstein, 2006; Mackenzie et al., 2019; Narula et al., 2012; Reisenhofer & Seibold, 2013; Stone et al., 2021). The stigma associated with domestic and family violence and the fear of being judged are also barriers to disclosure (Bradbury-Jones et al., 2011; Bradbury-Jones et al., 2015; Dichter et al., 2020; Lichtenstein, 2006; Mackenzie et al., 2019; Mantler et al., 2022; Narula et al., 2012; Olive, 2017; Reeves & Humphreys, 2018; Reisenhofer & Seibold, 2013; Spangaro et al., 2019; Srinivasan et al., 2020; Stone et al., 2021; Taylor, 2020). Collectively, these challenges often mean women do not disclose violence, or they do not seek health care, resulting in misdiagnosis and/or unnecessary treatment for the presenting condition, or receiving no care at all (Joshi et al., 2012).

Improving healthcare access for women experiencing domestic and family violence cannot be addressed within the traditional paradigm of health care. The social determinants of health must be considered and are defined as *'The non-medical factors that influence health outcomes. They are the conditions in which people are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, and political systems'* (Senate Standing Committees on Community Affairs, 2013). Social determinants that directly impact health equity include safe housing, access to transport, discrimination, racism and violence, education, job opportunities and security, income, access to affordable quality health care and early childhood development services (World Health Organization, 2008). Recent evidence suggests that discrimination and stigma could be the most influential of the social determinant factors on women's willingness to disclose and thereby seek access to health and other services (Murray et al., 2018). Findings from the National Community Attitudes towards Violence against Women Survey (Webster et al., 2018) highlighted a limited understanding of domestic and family violence among Australian communities. For example, almost 32% of Australians believe that women who do not leave their abusive partners are partly responsible for the continuation of the violence. A staggering 42% of Australians agreed that it was common for sexual assault accusations to be used as a way of getting back at men. Twenty-one per cent agreed that sometimes a woman can make a man so angry he

hits her without meaning to (Webster et al. 2018). Stigma intersects with other forms of social marginalization including homelessness, racism and sexism, and is a fundamental, yet often hidden, social determinant of health that directly impacts access to health care (Hatzenbuehler et al., 2013; Stangl et al., 2019).

1.2 | Theoretical framework

In conducting this qualitative synthesis, the Levesque et al.'s (2013) access to care framework was used. Levesque et al. (2013) recognized that the mere existence of services does not create access, rather they are influenced by individual and structural factors. The shaded boxes running horizontally through Figure 1 below represent key steps in healthcare access. The lower row represents predisposing, enabling and need factors for *individuals* or consumers, and the upper row represents the *process factors* for systems and healthcare service structures that influence ways that access is or is not realized.

The consumer's access is considered in terms of their ability to perceive, seek, reach, pay and engage with health care. The health system perspective considers the approachability, acceptability, availability and accommodation, affordability and appropriateness of health care (Levesque et al., 2013). The Levesque framework has been applied across various contexts to explore consumer and provider perspectives of access to health care (Cu et al., 2021). Recent Australian examples include access to domestic violence services for women with disabilities (Robinson et al., 2021), access to health care for women experiencing domestic and family violence (Hollingdrake et al., 2022) and a scoping review of access to primary healthcare services for Indigenous peoples (Davy et al., 2016).

2 | THE REVIEW

2.1 | Aims

The aim of this review is to explore social determinant factors and access to health care from the perspective of women experiencing domestic and family violence. The questions guiding this synthesis were:

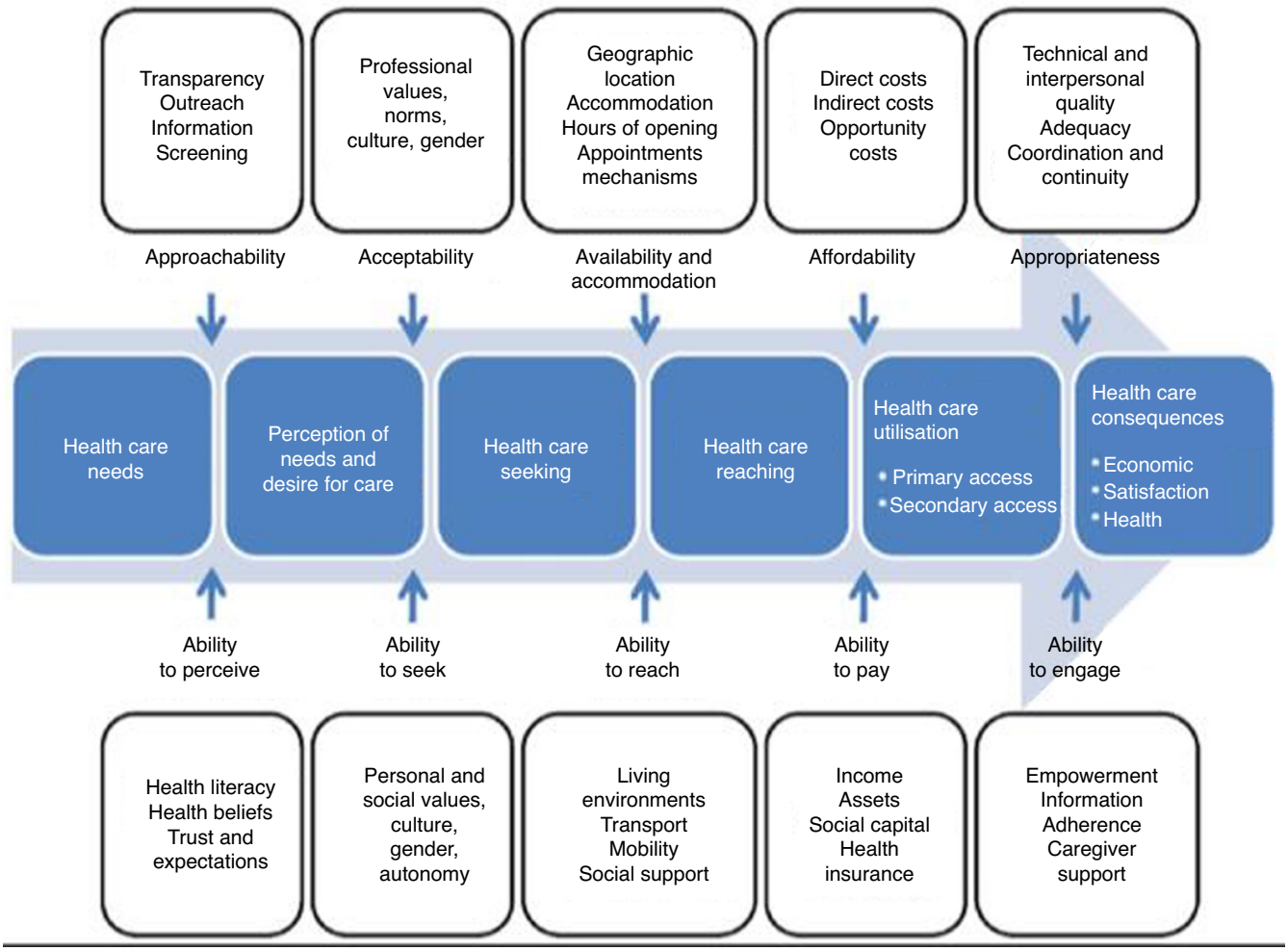

FIGURE 1 Levesque framework

1. Exploration of the social determinant factors that may influence access to health care for women experiencing domestic and family violence.
2. Understanding the ways that social determinant factors intersect with access to health care for women experiencing domestic and family violence.

2.2 | Design

A literature review of qualitative studies was conducted and developed using the Joanne Briggs Institute (JBI) approach (Lockwood et al., 2015). Other types of reviews were considered, and a qualitative synthesis was deemed the most appropriate to apprehend an in-depth understanding of the social determinants, from the perspectives of those with lived experience. The PICoS (Population, phenomena of Interest and Context, Study design) framework by the Centre of Reviews and Dissemination (Tacconelli, 2010) was used to develop the research question and eligibility criteria. The review focused on people experiencing domestic and family violence (population of interest), their access to health care (phenomenon of interest) in any healthcare setting (context). A qualitative synthesis approach chosen.

2.3 | Search methods

A comprehensive search of existing literature was conducted in December 2021 using the following databases, CINHAL, Embase, Medline and PubMed. The search strategy was developed by the authorship team and a research librarian. The search terms were piloted with the research librarian prior to conducting the final search. The final search terms combined Boolean Phrases as follows: (domestic violence OR domestic abuse OR intimate partner violence OR family violence OR partner abuse OR spousal abuse) AND (healthcare OR health care OR health services) AND Australia OR Canada OR USA OR UK OR New Zealand OR Ireland AND Narrative OR Interviews OR focus groups OR Qualitative.

Eligible studies were those published from 2000 to 2021, written in English language focused on people experiencing domestic and family violence, used qualitative methods, and participants were aged over 18 years. Studies undertaken in Australia, New Zealand, Canada, the United States of America (US), the United Kingdom (UK) or Ireland were eligible for inclusion. These six countries were chosen as their healthcare systems, and demographics hold similarities with each other about universal healthcare funding and culture and race.

All search results were exported to Covidence (Veritas Health Innovation Ltd.) for eligibility screening and duplicate records were automatically deleted. A pilot screening of the first 10% of studies was undertaken by the three authors simultaneously. No changes were made to the eligibility criteria, and the remaining studies were screened independently by at least two authors. Where disagreements arose, a third author made the final decision on inclusion. The full-text screening of remaining studies was undertaken as above.

2.4 | Quality appraisal

Included studies were appraised using the Critical Appraisal Skills Programme tool (CASP) designed for health-related qualitative research, endorsed by Cochrane and the World Health Organization (Long et al., 2020). Each study was reviewed independently by at least two authors. There were no disagreements in the appraisal. None of the studies were excluded based on quality.

2.5 | Data abstraction

Two data extraction forms were developed by the research team. The first included the main characteristics of each qualitative study including, author, year of publication, title, methodology, purpose, theoretical framework and findings. The second used the five domains of the Levesque framework: approachability, availability, affordability, appropriateness and acceptability. The qualitative findings of each included study were extracted and analysed using an adaptation of the (Braun & Clarke, 2006) thematic analysis approach to deductively identify and extract themes relating to social determinants and access to health care. The first author read the findings of the papers (familiarization). The key concepts were identified (coding) and discussed with all authors. Patterns (themes) were identified in relation to the five domains of the Levesque et al. (2013) framework, and were reviewed collectively by all authors.

2.6 | Synthesis

Synthesis of the qualitative findings was influenced by the approach of (Popay et al., 2006). Given the qualitative focus of this review, a narrative synthesis of the findings was considered the most appropriate. The social determinant factors that influence access to health care for women experiencing domestic and family violence were extracted through the lens of the Levesque et al. (2013) framework and then synthesized narratively under the heading of each access to care domain. Some of the findings overlapped between the Levesque five domains, and through discussion with all authors, the domain of greatest focus for each theme was agreed on. For example, the concept of 'trust' appeared to be most prominent in the domain of acceptability, yet it also related to the domain of approachability in relation to the high turnover of health care staff and continuity of care provision.

3 | RESULTS

A total of $n = 2252$ studies were imported to Covidence on the 5th of December 2021, and $n = 414$ duplicates were automatically removed by the software. Title and abstract screening resulted in exclusion of $n = 1716$ studies. The remaining $n = 122$ studies were

subjected to full-text review, and further $n = 94$ studies were excluded. In total, there were $n = 28$ studies included in this qualitative synthesis, as shown in Figure 2.

3.1 | Study characteristics

As shown in Table 1, included studies were from the US ($n = 17$), Australia ($n = 6$), the UK ($n = 4$) and one from Canada. All participants were women, and most studies undertook semi-structured interviews ($n = 12$), in-depth interviews ($n = 6$), focus groups ($n = 4$), in-depth and semi-structured ($n = 1$), dialogic interviews ($n = 1$), qualitative descriptive ($n = 1$), focus group and in-depth ($n = 1$), critical incident technique ($n = 1$) and Carspecken's (1996) critical method ($n = 1$). The theoretical frameworks underpinning the studies were varied and included feminist theories ($n = 5$), grounded theory, Anderson's model of healthcare use, Ritchie and Spencer's framework, critical ethnography, Dixon Woods lens of candidacy, epistemic privilege, community-based participatory approach, social identity theory, critical realism and postmodern complexity theory, social–ecological approach, and one study used the Levesque et al. (2013) framework. Most of the qualitative data were analysed thematically ($n = 13$), or through content analysis ($n = 3$), other data were analysed using situational analysis, qualitative comparative analysis, qualitative descriptive analysis, or inductive analysis. There were $n = 609$ participants across all studies, with a range of $n = 5$ to $n = 68$. The age range of participants was 18–74 years.

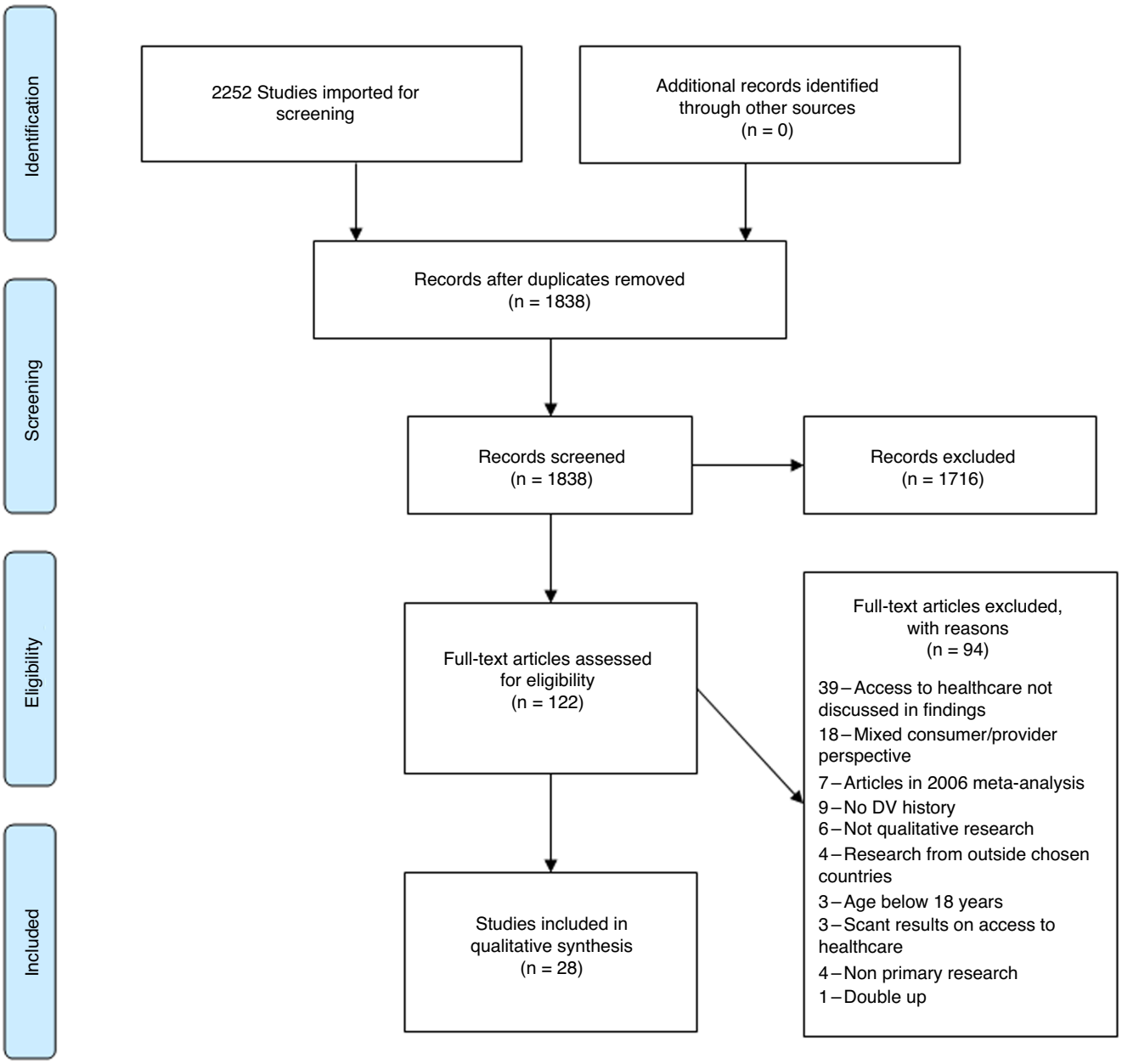

FIGURE 2 PRISMA diagram summarizing article identification and screening process

TABLE 1 Data extraction

Author	Interview method	Purpose	Theoretical framework	Findings
Alhusen et al. (2020) US	Semi-structured	Explore women with disability perspective on their unintended pregnancy experience	None declared	Two-thirds of the women experienced both reproductive coercion and physical violence highlighting the need for screening
Bradbury-Jones et al. (2015) UK	Critical Incident technique	Identify women's use of maternity services, expectations and identify if the service met their needs	Anderson's model of healthcare use	Positive staff who empowered women to have control over their own care were key in women's use and access of maternity healthcare services
Bradbury-Jones et al. (2011) UK	Semi-structured	To explore the primary healthcare experience of women living with domestic and family violence (DFV)	Ritchie and Spencer's (1994) framework	Low self-esteem and fear of stigma acted as barriers for women in discussing abuse. System failures reduced timely communication
Burnette (2015) US	Carspecken's (1996)	To understand indigenous women's experiences with services following violence	Critical Ethnography	A need for social workers to have increased training across services to address violence against Indigenous women
Dichter et al. (2020) US	Semi-structured	Examine middle-aged women's views on screening and disclosure of domestic violence	None declared	Disclosure of abuse was impeded due to feelings of shame or stigma, lack of trust in the provider or fear of safety /privacy
Dichter et al. (2021) US	In-depth, Semi-structured	To understand survivors' experiences with healthcare-connected DFV services	None declared	Healthcare-connected DFV services were crucial but required trauma-sensitive care, trust, privacy and clarity
Dienemann et al. (2005) US	Focus groups	To understand abused women's preferences when they disclose DFV	None declared	Women identified the following: *Treat me with respect*, *Protect me*, *Document*, *Give me control*, *Immediate response*, *Give me options*, *Be there for me*
Joshi et al. (2012) US	Focus groups	To increase knowledge about strangulation survivors	Grounded theory	Strangulation was a re-occurring form of DFV, with fewer than half seeking medical care. Medical responses were varied.
Kelly (2006) US	Dialogic interviews	To improve the understanding of the healthcare experiences of abused Latina women	Feminist framework and concept of marinization	Fear, worry and uncertainty were common themes. Fear of perpetrators were matched with fear of disclosure to healthcare providers
Laughon (2007) US	Qualitative descriptive	Examine how abused African American women, protect themselves	Grounded theory	Women's healthcare decisions were influenced by racism, poverty, violence and mental/physical health
Lichtenstein (2006) US	Focus groups and in-depth	Examine issues of domestic violence and health care for HIV women	Grounded theory	Domestic violence was a barrier effecting women's ability to access medical care for HIV/AIDS

TABLE 1 (Continued)

Author	Interview method	Purpose	Theoretical framework	Findings
Liebschutz et al. (2008) US	In-depth	To examine the risks and benefits of disclosing DFV	Grounded theory	No harmful disclosures identified. Unhelpful disclosures caused distress and isolation from health care. Beneficial disclosure includes respect and appropriate referrals
Mackenzie et al. (2019) US	Semi-structured	Exploring disclosure through 'structural competency' and the role of the General Practitioner (GP)	Dixon Woods lens of candidacy	GP's communicating their view to woman experiencing DFV shaped her future help-seeking. Greater GP awareness required to reduce stigma
Mantler et al. (2022) US	In-depth	To explore rural women healthcare experiences in the context of DFV	Feminist intersectional lens	Rural women lacked a healthcare provider in their area. Health care accessed failed to meet needs
Moe (2007) US	Semi-structured	Examination of the aspects of help-seeking, and social and institutional responses	Epistemic privilege and Standpoint feminist theory	Findings highlighted the socioeconomic, political and control tactics used by abusers and structural factors that impede women from seeking help
Narula et al. (2012) US	Semi-structured	To identify gaps in care for women who have experienced DFV and how their physician cared for them	None declared	Findings included the lack of insight into abuse due to absence of physical violence. Fear of being judged and feelings of fear were barriers to disclosure
Nicolaidis et al. (2010) US	Focus groups	To understand how depression care in African American women is influenced by racism, violence and social context	Community-based participatory approach	A strong theme revolved around a perception of racism in accessing health care, with a deep mistrust of the 'white' health system. Image of 'strong black woman' was also a barrier in accessing care
O'Connor-Terry et al. (2022) US	Semi-structured	To identify the experience of survivors of DFV in reproductive decision-making and healthcare access	None declared	Findings identified a need for confidential services due to fear and coercion from partners
O'Doherty et al. (2016) Australia	In-depth	To explore how DFV affects women's identity	Social identity theory	Findings confirmed the devastating effects violence has on women's identity. The need for health settings to develop flexible individualized interventions
Olive (2017) UK	Semi-structured	To assess women's emotional responses following DFV during ED presentation	Critical realism and postmodern complexity theory	Commonality of acute stress experience in women following DFV in the emergency department, that impacted negatively on consultation. The need for a specialist DFV service as first contact
Reeves and Humphreys (2018) US	Semi-structured	To gain knowledge on the healthcare experiences of women survivors	None declared	The need for a trusting patient-provider relationship, trauma-informed care and the importance of trauma history screening during health assessments

(Continues)

TABLE 1 (Continued)

Author	Interview method	Purpose	Theoretical framework	Findings
Reisenhofer and Seibold (2013) Australia	Semi-structured interviews	To understand the healthcare experiences of Australian women living with DFV	Grounded Theory	The main categories identified were: *Accessing healthcare; Challenges and barriers; Care women need* vs. *care women receive; Discourses of IPV and constructions of self; Acknowledging IPV and moving on*
Robinson et al. (2021) Australia	Focus groups & individual	To explore how DFV services understood and supported access for women with disability	Levesque et al. (2013) access framework. Feminist methodology	Despite women having a complex range of physical, social and mental health issues, consistent findings were identified that align with Levesque et al. (2013) model
Spangaro et al. (2019) Australia	Semi-structured	Investigate DFV interventions for Indigenous women	Social–ecological approach	A mix of impact reported. Positive impact included: Continuity of care, non-judgmental questioning, support and validation
Srinivasan et al. (2020) Australia	Semi-structured	To understand reproductive abuse as a form of violence against women	None declared	Themes identified by women included: *Take my concerns seriously; Reinforce its wrong; Ask about other forms of violence; Address my sexual health autonomy*
Stone et al. (2021) US	In-depth	Identify barriers to substance use treatment for women experiencing DFV in a rural setting	None declared	Barriers in accessing services included: Geographic location, lack of transport, lack of integrated substance use and DFV services, stigma and social isolation
Taylor (2020) Canada	In-depth	Exploring women's help-seeking with attention to power imbalances when presenting for suicidality following DFV	Feminist grounded theory	System entrapment was problematic for women seeking help—feeling controlled without being validated by health professionals. This can further harm. Empathy and a trauma-informed approach is required
Tower et al. (2006) Australia	In-depth	To explore the health issues of women experiencing DFV and identify problem areas of health care	Postmodern and feminist	Health is complex for women experiencing DFV and health issues were found to not be adequately addressed

3.2 | Quality appraisal

All 28 studies were assessed using the CASP quality appraisal tool (Table 2). All 28 studies were considered valuable research. Eight of the 28 studies met all aspects of the quality appraisal criteria. Fourteen studies met 90% of the quality appraisal criteria, the lowest score, for only one study, was 60% of the criteria. The most common reason for not meeting all of the criteria was that studies failed to mention the relationship between the researcher and the participant.

3.3 | Social determinant factors

Applying the Levesque et al. (2013) framework to the qualitative findings highlighted multiple social determinant factors that influenced access to health care for women experiencing domestic and family violence. The social determinant factors that positively and negatively influence access to health care are shown in Table 3, against the relevant Levesque domain. Each domain is discussed individually below.

3.4 | Approachability

Using the Levesque framework, *approachability* means that the people requiring a service know that it exists and how to access it. This includes individuals' ability to perceive their need for care, relating to health literacy, beliefs and knowledge (Levesque et al., 2013). Thirteen studies cited social determinants that negatively influenced the approachability of healthcare services. Eight studies cited women's fear that their children would be removed from them as a barrier (Alhusen et al., 2020; Dichter et al., 2020; Dienemann et al., 2005; Kelly, 2006; Laughon, 2007; Mackenzie et al., 2019; Narula et al., 2012; Spangaro et al., 2019). A participant in a US-based study expressed a fear of child protection service involvement after losing custody of her older daughter to her abusive husband, this resulted in feeling penalized for being abused, and this was her statement:

> '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).

Factors that improved access to health care for women living with disability, included information about options for women, warm and friendly female providers available for care and continuity (Robinson et al., 2021). Findings highlighted women's perception of the importance of being made aware of available services, which strengthened their ability to make informed decisions. Health professionals who demonstrated a supportive attitude facilitated women's awareness and empowered them towards a greater sense of influence and control over their situations (Bradbury-Jones et al., 2015).

3.5 | Acceptability

Acceptability of a service relates to the professional values and culture in an organization. On an individual level, it includes an individual's autonomy, social, cultural and gender beliefs in choosing to seek care (Levesque et al., 2013). Healthcare providers' attitudes were identified as a major barrier to healthcare access across most studies. Participants across 27 studies described fear of judgement, lack of trust and associated stigma in disclosing domestic violence with healthcare providers. Fear and lack of trust were frequently due to poor experiences in the past (Alhusen et al., 2020; Bradbury-Jones et al., 2011; Bradbury-Jones et al., 2015; Dichter et al., 2020; Mackenzie et al., 2019; Mantler et al., 2022; Narula et al., 2012; O'Doherty et al., 2016; Olive, 2017; Reeves & Humphreys, 2018; Reisenhofer & Seibold, 2013; Robinson et al., 2021; Spangaro et al., 2019; Srinivasan et al., 2020; Stone et al., 2021; Taylor, 2020). For marginalized women, (including First Nations women, immigrants and women experiencing homelessness), this sense of distrust in healthcare providers and systems was magnified (Alhusen et al., 2020; Bradbury-Jones et al., 2011; Kelly, 2006; Nicolaidis et al., 2010; Spangaro et al., 2019).

The social stigma attached to domestic violence was also a consideration, including cultural stigma or fear of being labelled a bad parent for staying with the perpetrator (Dichter et al., 2020; Lichtenstein, 2006; Mackenzie et al., 2019; Mantler et al., 2022; Narula et al., 2012; O'Doherty et al., 2016; Olive, 2017; Spangaro et al., 2019; Stone et al., 2021; Taylor, 2020; Tower et al., 2006). A participant in a study on reproductive coercion and unintended pregnancies among women living with disability (Alhusen et al., 2020) described her sense of 'anticipated stigma', indicating that she wasn't comfortable discussing her violent relationship due to *'fears of being judged'*. The same participant described internalized stigma that manifested as a feeling of being too difficult for staff to deal with, stating,

> 'I mean the system is meant to help women like me, but I think the disability piece makes it that it could be a problem for me. Sometimes I wonder if that's why I have never been asked about the abuse. If they don't know, they don't have to do anything, right?' (Alhusen et al., 2020)

Stigma in healthcare environments was further highlighted, where women in violent relationships who were seeking help for suicidal ideation felt further dehumanized by the healthcare system (Taylor, 2020). As one participant stated,

> 'You can go [to the ED] and suffer worse than if you were being abused by your partner because you leave there feeling like you are worthless. Even if you tell them, you were suicidal, it is not taken seriously. They almost refuse to treat you. They refuse to talk to you. You are just worthless … You can come out of [the hospital] feeling three times worse than when you go in with a crisis … because [the HCPs] are too judgmental'.

TABLE 2 CASP quality appraisal

Author	Aim	Methodology	Design	Recruitment	Data collection	Relationship researcher and participant	Ethical considerations	Data analysis rigorous	Clear statement of findings	How valuable is the research
Alhusen et al. (2020) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Bradbury-Jones et al. (2015) UK	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Bradbury-Jones et al. (2011) UK	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Burnette. (2015) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Dichter et al. (2020) US	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Cannot tell	Cannot tell	Yes	Valuable
Dichter et al. (2021) US	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Valuable
Dienemann et al. (2005) US	Yes	Yes	Yes	Yes	Yes	No	Cannot tell	Cannot tell	Yes	Valuable
Joshi et al. (2012) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Kelly (2006) US	Yes	Yes	Yes	Cannot tell	Cannot tell	No	Yes	Cannot tell	Yes	Valuable
Laughon (2007) US	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Cannot tell	Yes	Valuable
Lichtenstein (2006) US	No	Yes	Cannot tell	Yes	Yes	No	Yes	Cannot tell	Yes	Valuable
Liebschutz et al. (2008) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Cannot tell	Yes	Yes	Valuable
Mackenzie et al. (2019) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Mantler et al. (2022) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Moe (2007) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Narula et al. (2012) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Nicolaidis et al. (2010) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
O'Connor-Terry et al. (2022) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
O'Doherty et al. (2016) Australia	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes[a]	Yes	Valuable
Olive (2017) UK	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Reeves and Humphreys (2018) US	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes[a]	Yes	Valuable
Reisenhofer and Seibold (2013) Australia	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes[a]	Yes	Valuable
Robinson et al. (2021) Australia	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable
Spangaro et al. (2019) Australia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

TABLE 2 (Continued)

Author	Aim	Methodology	Design	Recruitment	Data collection	Relationship researcher and participant	Ethical considerations	Data analysis rigorous	Clear statement of findings	How valuable is the research
Srinivasan et al. (2020) Australia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Stone et al. (2021) US	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Taylor (2020) Canada	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Valuable
Tower et al. (2006) Australia	Yes	Yes	Yes	Yes	Yes	Cannot tell	Yes	Yes	Yes	Valuable

[a]Yes, but does not say how many researchers.

This perceived judgement, and disempowerment was theorized in Taylor (2020) as *'system entrapment'*. Women described feelings of humiliation and shaming when help seeking, and this experience was enhanced in emergency department settings. Women presenting in mental health crisis perceived that healthcare professionals labelled them as 'crazy' women, resulting in feelings of invalidation, further entrenching the entrapment that women experience when being controlled by their abuser (Taylor, 2020).

Relationships with healthcare professionals were reported as fundamental to the acceptability of services. Bradbury-Jones et al. (2011) highlighted the difference that a supportive relationship can have, one participant stating,

> 'You could be five minutes in a surgery [a health centre or clinic], but those five minutes are enough to make you walk from the surgery to the car park feeling worse… sad, tears, feeling stupid or whatever, or to come out and to be smiling and feel good and prepared to get on with your day. So, it does make a big difference how they help you'.

Women in the studies reported that a collaborative approach between the person seeking support and the service provider helped them to establish trust and facilitated knowledge and capacity building that increased their sense of autonomy (Chandhok & Anand, 2020).

3.6 | Availability

Availability refers to geographical location, allocated time to address complexity, wait times and hours of the clinic, whilst on an individual level, it includes aspects about their mobility, access to transport, ability to use a phone or computer to make an appointment and social supports (Levesque et al., 2013). Six studies identified the inability to reach healthcare services due to inadequate transport or geographical location (Dichter et al., 2021; Laughon, 2007; Moe, 2007; Robinson et al., 2021; Stone et al., 2021). For example, one participant was accepted to a service but stated,

> 'Because I don't drive, it was about going to their offices and things like that and a lot of the time it might be that they need to come out and do some things at home once the order is in' (Robinson et al., 2021).

Other participants highlighted the struggles of accessing health care in rural areas,

> '…there's no regular public transportation…I would have to get up at 4:00 in the morning, get on a bus…I'd be at the [bus hub] for 3 hours waiting for the next bus to come back' (Stone et al., 2021).

TABLE 3 Social determinant factors and access to health care

Approachability	**Acceptability**
Positive social determinant factors influencing access to care:	Positive social determinant factors influencing access to care:
Cultural safety[24]	GP provided choices to empower women to decide[25,28]
Negative social determinant factors influencing access to care:	*Negative social determinant factors influencing access to care*:
Fear of disclosure, for example losing children, highlighting visa status[1,6,7,9,10,13,16,24]	Fear of being judged by health professionals[2,7,8,13,14,15,16,19,20,21,24,25,26,27]
Sense of disempowerment to make choices about own health/ treatments[2]	Lack of specialist support for disabled women[2]
Health literacy and retainment of verbal information[2]	Disclosure barrier: Shame, stigma, lack of connection, judgement[5,7,9,12,13,14,16,19,20,22,24,26]
Women feel overwhelmed and lack information about services[6,23,27]	Inability to seek health care due to stigma of abuse/shame or denial[11]
Information on human and legal rights and different resources available[7,9]	Racism or mistrust of 'white' healthcare services[10,17]
Non-English speaking women feel more isolated due to fear[9]	Services not respectful of cultural needs[10,17,24]
Inability to perceive need due to nature of abuse/depression/ substance use[10,11,13]	Services not accommodating women with children[10]
Mental health stigma hindered ability to reach out for help[27]	Intergenerational messages normalized DV in the family[10,17,19]
	Women felt labelled, stigmatized and judged reducing access to healthcare[28] dynamics patient-provider/minimizing abuse, health professional's own agenda[19,21,25]
Appropriateness	**Affordability**
Positive social determinant factors influencing access to care:	*Negative social determinant factors influencing access to care*:
Culturally safe programme with women with lived experience[17]	Women's ability to afford referral should be considered[7]
Trauma-informed consultation (women able to stay clothed, be examined with another woman)[21]	Lack of access to medication/treatment due to losing or no medical insurance[10,15,26]
Negative social determinant factors influencing access to care:	Inability to pay for medication[11]
Information of long-term contraception treatment to assist women with reproductive autonomy[1,25]	Lack of free accessible contraception options[18]
Medical terminology/health literacy for women with learning difficulties, lack of empowerment[2,17,23]	Lack of consistency with mental health professionals as relied on free service[21]
Long ED waits difficult for women with children[7]	Limited patient-provider times due to health insurance model[21]
Police and hospitals to collaborate to provide a safe space for women[7]	Poverty a barrier[23]
Factors tied to insurance may preclude confidentiality, for example required partner consent for contraception[18]	**Availability**
Secondary victimization experienced by women when presenting to ED/power dynamics patient-provider/ minimizing abuse, health professional's own agenda[19,21,25]	*Negative social determinant factors influencing access to care*:
	Reliance on perpetrator for transport[1,11,26]
	Lack of transport to access services[6,15,23,26]
	Services difficult to reach by public transport (geographical location)[10,26]
	Lack of working telephone to access services[6,23]
	Lack of privacy away from perpetrator or children to reach services[6]
	Inability to seek health care due to shelter curfew times and shelters not accepting children[14,26]

Note: References: [1]Alhusen et al. (2020); [2]Bradbury-Jones et al. (2015); [5]Dichter et al. (2020); [6]Dichter et al. (2021); [7]Dienemann et al. (2005); [8]Joshi et al. (2012); [9]Kelly (2006); [10]Laughon (2007); [11]Lichtenstein (2006); [12]Liebschutz et al. (2008); [13]Mackenzie et al. (2019); [14]Mantler et al. (2022); [15]Moe (2007); [16]Narula et al. (2012); [17]Nicolaidis et al. (2010); [18]O'Connor-Terry et al. (2022); [19]O'Doherty et al. (2016);[20]Olive (2017); [21]Reeves and Humphreys (2018); [22]Reisenhofer and Seibold (2013); [23]Robinson et al. (2021); [24]Spangaro et al. (2019); [25]Srinivasan et al. (2020); [26]Stone et al. (2021); [27]Taylor (2020); [28]Tower et al. (2006).

Six studies highlighted a lack of flexibility in services as a barrier to health care access, including long wait times or insufficient length of time to discuss domestic and family violence (Dienemann et al., 2005; Mantler et al., 2022; Narula et al., 2012; Nicolaidis et al., 2010; Reeves & Humphreys, 2018; Stone et al., 2021). Participants' ability to reach services was impeded by the inability to access a computer or phone (Dichter et al., 2021; Robinson et al., 2021). Three studies highlighted the ways that perpetrators sabotaged access to health care, including one instance where a perpetrator physically took a participant's car to prevent her from attending healthcare appointments (Lichtenstein, 2006). Another relied on her partner to drive her to the appointment so he had control over whether she attended or not (Alhusen et al., 2020). A participant in Stone et al. (2021) study exploring barriers to substance use treatments for women experiencing domestic and family violence in rural settings stated,

> 'He would take my shoes and all the baby's warm winter gear, so we couldn't leave […]. He would unplug the phone so I couldn't call nobody. The nearest town was, like, 2 miles away…, Me, I could do it easily, but with a newborn baby without a winter coat… I was aware of a lot of places that I could go, [but] I just couldn't. I wasn't able to'.

3.7 | Affordability

Affordability reflects the price of a service and treatment-related expenses against a person's income, insurances and ability to pay (Levesque et al., 2013). The ability to access health care due to affordability of a service was disclosed in eight studies (Dienemann et al., 2005; Laughon, 2007; Lichtenstein, 2006; Moe, 2007;

O'Connor-Terry et al., 2022; Reeves & Humphreys, 2018; Robinson et al., 2021; Stone et al., 2021). Affordability factors included lack of allocated time to address the complexity of domestic violence, lack of low-cost contraception, mental health support or rehabilitation programmes (Australian Institute of Health and Welfare, 2022; Moe, 2007; O'Connor-Terry et al., 2022; Reeves & Humphreys, 2018; Stone et al., 2021). Affordability of medication was a barrier in two studies (Laughon, 2007; Lichtenstein, 2006). In a broad sense, women's poverty limited their options and choices.

3.8 | Appropriateness

Appropriateness refers to the adequacy of service delivery in accordance with the person's needs. This includes individuals' ability to engage with services, the information provided to empower a person and the person's capacity to follow the treatment required (Levesque et al., 2013). Participants across five studies illustrated how controlling partners can appear supportive, but they control the narrative of the consultation or sabotage the treatment altogether (Dienemann et al., 2005; Laughon, 2007; Mackenzie et al., 2019; Reeves & Humphreys, 2018; Reisenhofer & Seibold, 2013). This type of health care sabotage was highlighted in a study on the emergency department experiences of women experiencing domestic violence (Reisenhofer & Seibold, 2013). One participant stated,

> 'I sought health care for severe depression and suicidal thoughts, saying: 'And I did go and see [the doctor] and speak to him a little bit about…how I felt…I'd often… thought how I'd kill myself…but of course X was sitting there'.

The partner's presence prevented disclosure of the violence and the participant was prescribed antidepressants rather than receiving the help she needed. Incidents like these highlighted how health professionals can unintentionally collude with a perpetrator in reinforcing the abused woman as 'mad' to hide the underlying abuse (Mackenzie et al., 2019). Participants recommended staff training to identify controlling behaviour and create opportunities for private consultations, allowing space and time to disclose domestic and family violence and thereby receive appropriate interventions.

Power imbalances play a role in the way that service appropriateness can influence access to care. The exclusion of participants from decision-making processes was a common theme, one woman stated,

> 'I just don't trust the medical field anymore…It's [as if providers say] 'this is what we're offering you. If you don't take it and do it exactly the way, we want you to do it…we don't have anything for you' (Reeves & Humphreys, 2018).

O'Doherty et al.'s (2016) study on fractured identity in the context of domestic and family violence outlined the secondary victimization that women can face when seeking help for injuries. As one participant described: *'I had a burn once and I had some of the gauze melted into the skin and they tried to take it off and when I kept telling them that it hurt, they were like, "no it doesn't" and I'm like, "yes it does"; they were like "no it doesn't." I found that kind of thing was quite regular…So, I kind of felt a little ignored'.*

4 | DISCUSSION

The aim of this qualitative synthesis was to explore what and how social determinant factors influence access to health care for women experiencing domestic and family violence. In focusing on the lived experience accounts from women, this study has revealed first-hand insights into the challenges facing women experiencing domestic and family violence and accessing health care. Included studies identified multiple social determinants, each having some role in access to care, mostly reducing rather than facilitating access. Some of the social determinant factors were perhaps more openly visible than others, for example the impact of income on the accessibility to healthcare services, particularly for those living in regional or rural areas, and the impact of health literacy and the general awareness of services available. Most prevalent were the factors of discrimination and stigma, which are perhaps less visible and yet substantially disabling of women's disclosure of domestic and family violence and their willingness to access healthcare services.

Stigma was reported in many forms, such as internalized stigma, stigma from perpetrators, anticipated stigma and enacted stigma in health care environments (Hatzenbuehler et al., 2013; Murray et al., 2018). Women's internalized stigma, manifested as feelings of shame, guilt and worthlessness, and appeared to be the most powerful of all in reducing women's perceptions of their own health needs and their ability to seek help. The anticipated stigma was particularly powerful in women's decision to disclose and seek health care, prominent here was the women's fear that their children would be removed and a fear of being judged. Enacted stigma was characterized by being dismissed, left out of decision-making processes, not given options for private conversations and, unintentional collusion with perpetrators.

The antidote to stigma's influence on access to health care was perceived as being in the hands of the health professional leading a consultation. Women reported often feeling far worse after disclosing domestic and family violence. The difference was the women's perception of how the health professional engaged with them. In circumstances where the health professional was perceived as friendly and non-judgmental, and was informative, the women felt empowered and facilitated to access the services they needed. This highlights above all, that the perception of trust and non-judgement, the hallmarks of trauma-informed practice, are fundamental to improving access to health care for women experiencing domestic and family violence.

Of most concern is the presence of anticipatory stigma, which paralyses women from even attempting to access health care. A recent focus group with Australian women with lived experience of domestic and family violence highlighted the importance of a woman's

first contact with a healthcare provider and how this shapes their impression of a service and their willingness to disclose domestic and family violence and therefore access the health care they need (Hollingdrake et al., 2022). The underlying sentiment of participants in this focus group was that the'…onus was perceived as being on them to find a way to access what they needed, from a health system that they did not trust and did not always understand'.

Another dominant factor, related to the Levesque domain of *appropriateness*, was the length of time available for a health professional consultation, which was seldom perceived as long enough to enable the women to build trust and to disclose the presence of violence. Perhaps an unintentional consequence of universal health funding, the issue of length of consultations was evident in included studies from the UK, US, Australia and Canada (Bradbury-Jones et al., 2011; Narula et al., 2012; Reeves & Humphreys, 2018; Stone et al., 2021; Taylor, 2020; Tower et al., 2006). What appeared to work well were services that reflected continuity, whereby trust was developed over time by repeatedly engaging with the same health professionals, such as that which occurred in maternity care (Spangaro et al., 2019). In Australia, routine screening for domestic and family violence is not mandatory, although it is strongly encouraged during pregnancy (Australian Government, 2018). A recent qualitative study of health professionals working in an Australian mental health service reported a perceived lack of domestic and family violence training, and a perceived lack of knowledge about domestic violence and the available services to support people when domestic violence is disclosed (Gillespie et al., 2022). Participants reported that screening for domestic and family violence was not something that they 'automatically' considered as part of their care (Gillespie et al., 2022).

Whilst no single professional group can resolve all the impediments to access to care, nurses are often the first contact for women experiencing domestic and family violence and therefore can influence the impact of these social determinant factors at an early phase of care. Current evidence suggests that a key role for nurses is firstly to identify the presence of domestic and family violence (Turner et al., 2017; World Health Organization, 2013). Whilst screening for domestic and family violence is critical (Aljomaie et al., 2022), evidence also suggests that it does not necessarily increase referrals to specialist services, nor does it reduce the incidence of re-exposure to violence (O'Doherty et al., 2015). Our findings resonate with those from other studies indicating that establishing trust between the woman and the health care provider is of most importance (Bradbury-Jones et al., 2014; Jack et al., 2017). With trust, the barriers imposed by stigma can be reduced so that disclosure can occur. With disclosure, opportunities for referral and necessary support can be provided (Bradbury-Jones et al., 2014). A review of the role of home-visiting nurses working with women experiencing domestic and family violence reported that relationship building was of the utmost importance to the nurse's practising in this context (Adams et al., 2022). Our findings further suggest that the pathway to establishing trust is through a non-judgmental approach.

4.1 | Limitations

A limitation of qualitative research is the degree to which the findings are transferable to other circumstances, contexts and settings (Flemming, 2007). A strength of this review is that it included 28 studies, from a variety of settings and contexts. The cumulative synthesis of these study findings may enhance their transferability by collectively overcoming the small sample size, single-site characteristics of most of the included qualitative research designs. Nonetheless, rather than aiming to produce findings that are transferable to every circumstance and context, we sought to appreciate and apprehend an in-depth understanding of the phenomenon of social determinant factors and access to health care for women experiencing domestic and family violence.

A second limitation relates to the application of the Levesque framework. In extracting and synthesizing the study findings, we identified an overlap of several social determinant factors between the five domains of access to health care, and this perhaps reflects the complexity of these factors. Furthermore, we were unable to code the concept of 'perpetrator control' to the five Levesque domains. We are giving consideration as to how to adapt the Levesque framework to ensure that the influence of the behaviours of others on access to care can be included in the context of domestic and family violence.

5 | CONCLUSION

There are multiple social determinant factors that influence equity of access to health care for women experiencing domestic and family violence. Determinants related to discrimination and stigma were most notable, which prohibited the establishment of trust and therefore disclosure and access to appropriate health care. Time limitations and a lack of continuity of health care service delivery further exacerbate this issue. Given the increase in incidence of women experiencing domestic and family violence, there is an urgent need for health care professionals to challenge health care culture that can further marginalize vulnerable populations, working towards a non-judgemental and inclusive health care system.

AUTHOR CONTRIBUTIONS

LP, OH and JC made substantial contributions to conception and design, or acquisition of data, or analysis and interpretation of data; involved in drafting the manuscript or revising it critically for important intellectual content; given final approval of the version to be published. Each author should have participated sufficiently in the work to take public responsibility for appropriate portions of the content; and agreed to be accountable for all aspects of the work in ensuring that questions related to the accuracy or integrity of any part of the work are appropriately investigated and resolved.

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CONFLICT OF INTEREST

The authors declare that they have no conflicts of interest.

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DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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