Manchester Metropolitan University

An exploration of Black African and African-Caribbean women's representation and their barriers to disclosing domestic abuse and sexual violence to GPs in Manchester

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Background

Service overview

IRIS is an evidence-based domestic violence and abuse (DVA) training, support, and referral programme for General Practices, which aims to improve the identification of patients experiencing domestic violence and abuse and forward referral for specialist support. IRIS is a collaboration between primary care and third sector organisations, and in Manchester is delivered by The Pankhurst Trust incorporating Manchester Women's Aid (PTMWA, MWA), who have over 40 years' experience of delivering domestic abuse services. The IRIS model has been positively evaluated using a cluster randomised controlled trial (Feder et al., 2011), and more recently, using a longitudinal study (Sohal et al., 2020). IRIS is cited as an example of best practice in national and statutory policy guidance by the Department of Health (2017) and Home Office (2022) respectively and is endorsed by the Royal College of General Practitioners (IRISi, 2022).

IRIS is a well-established and well-integrated programme, having been operating in Manchester for over 10 years, with all 85 GP practices trained. Further, the introduction of IRIS has resulted in consistently positive outcomes with regards to increases in referrals to specialist DVA services and improvement in patient health and wellbeing, including positive feedback from patients themselves (Hussain & Bates, 2021).

Research need

Through their ongoing process of service improvement, Greater Manchester Integrated Care Board (GMICB) identified that there were communities the IRIS service may be underserving. Specifically, Manchester IRIS reported that Black African and African-Caribbean women may be underrepresented in their service, with unidentified barriers which may be resulting in lower disclosure of domestic violence and abuse (including sexual violence and abuse). In order to understand how IRIS may improve the engagement of Black African and African-Caribbean women with their service in Manchester, GMICB approached Manchester Metropolitan University (specifically Professor Khatidja Chantler, School of Nursing and Public Health) to carry out a piece of research to elicit the potential barriers and enablers of service engagement for this specific population.

Aims and research questions

The aims of the research are to:

1. Understand the extent to which Black African and African-Caribbean women may be under-represented in the IRIS service-user population of Manchester
2. Gain insight into the barriers that may prevent Black African and African-Caribbean women in Manchester from disclosing DVA (including sexual violence) to GPs
3. Understand any potential or actual barriers to Black African and African-Caribbean women engaging with the IRIS service in Manchester and ways in which these may be addressed.

In order to fulfill these aims, we proposed the following research questions to focus the study:

1. Is there an underrepresentation of Black African and African-Caribbean women in the Manchester IRIS service?
2. What are the barriers preventing Black African and African-Caribbean women in Manchester from disclosing domestic violence and abuse to GPs?
3. What are the barriers preventing Black African and African-Caribbean women in Manchester from engaging with the IRIS service?
4. How might those barriers to access and disclosure identified by Black African and African-Caribbean women in Manchester be addressed?

Methods

A mixed methods design

This research utilised a mixed methods design comprising two components:

1. an initial quantitative analysis of IRIS service data to assess for over/under-representation of Black African and African-Caribbean women against local population demographics (Research Question 1), and

2. online 1-2-1 interviews to obtain in-depth qualitative data relating to Black African and African-Caribbean women's[1] perspectives on accessing DVA services and disclosure of DVA (Research Questions 2, 3 and 4). The interviews utilised vignettes to enable participants to discuss sensitive subjects without the need for personal disclosure.

Secondary data analysis

Two years of demographic data for IRIS service-users was provided by IRIS Manchester in anonymised form in an Excel database, at the individual level, for the reporting years 2020 to 2021 and 2021 to 2022. Service-users were categorised according to whether they were supported within CCG South, North or Central. The data was analysed using a combination of descriptive statistics (frequencies and proportions) and comparative analytical techniques, specifically, the weighted chi square 'goodness of fit' test to assess the sample's similarity to population-level data for Manchester City local authority area, as reported in the 2021 census. Descriptive statistics were performed in Excel, with the comparative analysis performed in the statistical software 'SPSS' (Statistical Package for the Social Sciences).

[1] Hitherto referred to as 'Black women'

Interviews

One-to-one semi-structured interviews were carried out online using Microsoft Teams with nine women living in the Greater Manchester area (see 'Qualitative Findings' section for sample details). Interviews took place between April and November 2023 and lasted between 25 and 90 minutes. Interviewees were recruited via a number of routes, including though organisations such as the Caribbean and African Health Network (CAHN), and through the University's own student body. This resulted in a small, yet diverse sample for analysis.

Interviews were structured according to an interview schedule, organised around two hypothetical vignettes (see Appendix for full schedule). Vignette One described the situation of 'Paulette' a Black British woman of Jamaican descent, experiencing sexual coercion and harassment from a colleague she recently began dating. Vignette Two described the situation of 'Ndidi' a Black African woman migrating from Nigeria with her two children on a Spouse Visa, experiencing domestic abuse from her husband who has dual British and Nigerian citizenship. These vignettes allowed interviewees to discuss sensitive issues relating to domestic abuse, sexual violence and racial discrimination whilst anchoring those discussions on hypothetical situations, thus removing the need for their own personal disclosure. Despite this, a number of interviewees brought their own (and others') experiences of these issues into the interviews, which resulted in rich accounts, particularly in relation to experiences of racism within health services and migrant women's experiences of domestic abuse.

Interviews were audio recorded and auto-transcribed, with data then organised thematically. Codes (themes) were then collated into an analysis table, allowing for the identification of patterns across the sample. These themes and subthemes were then written up descriptively, with quotes used to illustrate, evidence and provide depth. Pseudonyms (chosen by participants themselves) have been used to protect interviewee anonymity. All interviewees were given £20 vouchers as a thank you for their time, as well as being provided with the details of local domestic abuse and sexual violence services, irrespective of disclosure.

Ethics

The research was given ethical approved by the Health and Education Research Ethics and Governance Committee at Manchester Metropolitan University on 15/03/2023 (Ethos Ethics Reference Number 48327) after a rigorous and reflective review process.

Sample

There were two samples in this study (see relevant sections for full details):

1. 1,125 anonymised female service-users with ethnicity data supported through IRIS within the two reporting years 2020/2021 and 2021/2022

2. Nine African and African-Caribbean female interview participants – none of whom had experienced the IRIS service.

Findings: Quantitative analysis

The quantitative findings are presented in two sections. The first will describe the IRIS ethnicity data for the two reporting years 2020 to 2021 and 2021 to 2022, initially overall, and then by GMICB Manchester subarea (South, Central and North). The second section will then compare the ethnicity proportions within the IRIS data for each year (females only) to the proportions identified for the Manchester City local authority within the 2021 census. This second part of the analysis will provide an answer to the research question 'Is there an underrepresentation of Black African and African-Caribbean women in the Manchester IRIS service?'

Section 1: What does IRIS Manchester's client ethnicity profile look like?

Reporting year 2020 – 2021

Within this delivery year IRIS Manchester had 760 service-users recorded in their database. Of these, 586 (77.1%) were recorded as 'Female', and of these, 539 (92.0%) had ethnicity data recorded. This is particularly positive given that race and ethnicity data can often be missing from health service datasets (Drummond, 2023). The following proportions are based upon the data for these 539 service-users.

With respects to the ethnic backgrounds of particular interest to this analysis – those within the overarching category of 'Black, Black British, Black Welsh, Caribbean or African' – these formed 10.0% of those women with ethnicity data for the reporting year. This was comprised of the three subcategories of:

- 'African' (n=37, 6.9%)
- 'Caribbean' (n=12, 2.2%)
- 'Any other Black ethnicity' (n=5, 0.9%).

Other overarching ethnicity categories were, in order of prevalence:

- 'White: English, Welsh, Scottish, Northern Irish or British' (n=252, 46.8%)[2]
- 'Asian, Asian British or Asian Welsh' (n=160, 29.7%)
- 'White minorities' (n=32, 5.9%)
- 'Mixed or Multiple ethnic groups' (n=22, 4.1%)
- 'Other ethnic groups' (n=19, 3.5%).

See Table 1 for full frequencies and proportions

[2] Due to the project focus on the potential under-representation of minoritised communities, the overarching ethnicity category 'White' has been divided into the ethnic majority 'White British' and those who are from White minorities, including Irish, White Europeans, and Gypsy/ Traveller/Roma. These have been grouped and termed 'White minorities'.

Reporting year 2021 – 2022

Within this delivery year IRIS Manchester had 785 service-users recorded in their database. Of these, 601 (76.6%) were recorded as 'Female', and of these (and even more positively), 586 (97.5%) had ethnicity data recorded. The following proportions are based upon the data for these 586 service-users.

With respects to the ethnic backgrounds of particular interest to this analysis – those within the overarching category of 'Black, Black British, Black Welsh, Caribbean or African' – these formed 13.5% of those women with ethnicity data for the reporting year. This was comprised of the three subcategories of:

- 'African' (n=61, 10.4%)
- 'Caribbean' (n=12, 2.0%)
- 'Any other Black ethnicity' (n=6, 1.0%).

Other overarching ethnicity categories were, in order of prevalence:

- 'White: English, Welsh, Scottish, Northern Irish or British' (n=257, 43.9%)
- 'Asian, Asian British or Asian Welsh' (n=159, 27.1%)
- 'Mixed or Multiple ethnic groups' (n=34, 5.8%)
- 'White minorities' (n=30, 5.1%)
- 'Other ethnic groups' (n=27, 4.6%).

See Table 1 for full counts and proportions

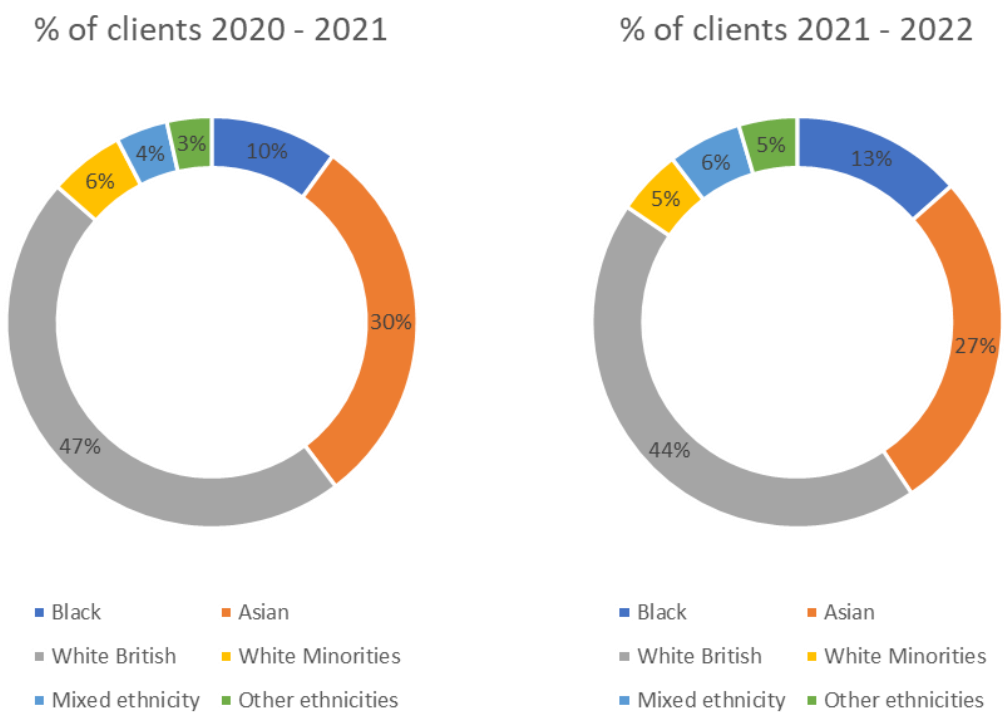
Table 1 Ethnicity breakdown for both reporting years (frequencies and proportions)

Ethnicity category	2020 – 2021 n (%)	2021 – 2022 n (%)
Black, Black British, Black Welsh, Caribbean or African: African	37 (6.9%)	61 (10.4%)
Black, Black British, Black Welsh, Caribbean or African: Caribbean	12 (2.2%)	12 (2.0%)
Black, Black British, Black Welsh, Caribbean or African: Other Black	5 (0.9%)	6 (1.0%)
Asian, Asian British or Asian Welsh: Bangladeshi	10 (1.9%)	17 (2.9%)
Asian, Asian British or Asian Welsh: Chinese	2 (0.4%)	8 (1.4%)
Asian, Asian British or Asian Welsh: Indian	14 (2.6%)	10 (1.7%)
Asian, Asian British or Asian Welsh: Pakistani	123 (22.8%)	114 (19.5%)
Asian, Asian British or Asian Welsh: Other Asian	11 (2.0%)	10 (1.7%)
Mixed or Multiple ethnic groups: White and Asian	4 (0.7%)	6 (1.0%)
Mixed or Multiple ethnic groups: White and Black African	2 (0.4%)	9 (1.5%)
Mixed or Multiple ethnic groups: White and Black Caribbean	12 (2.2%)	16 (2.7%)
Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups	4 (0.7%)	3 (0.5%)
White: English, Welsh, Scottish, Northern Irish or British	252 (46.8%)	257 (43.9%)
White: Irish	6 (1.1%)	1 (0.2%)
White: Gypsy or Irish Traveller or Roma	2 (0.4%)	-
White: Other White	24 (4.5%)	29 (4.9%)
Other ethnic group: Arab	12 (2.2%)	13 (2.2%)
Other ethnic group: Any other ethnic group	7 (1.3%)	14 (2.4%)
All female service-users with ethnicity data	539 (100.0%)	586 (100.0%)

Comparing the two reporting years

The ethnicity profile for IRIS Manchester remained fairly consistent across the two years (see Figure 1 below), although women identifying as being 'Black, Black British, Black Welsh, Caribbean or African' made up an increased proportion of those with ethnicity data – seeing an increase of just over 3%. Those of mixed ethnicity and of 'other ethnicities' saw an increase of 2%, whereas those identifying as White British, or as 'Asian, Asian British or Asian Welsh' decreased by around 3%, with women from White minorities decreasing by 1%.

Figure 1 Ethnicity profile across the reporting years (%)



Comparing North, South and Central

IRIS service-users were categorised according to whether they fell within GMICB Manchester Locality North, South or Central. The ethnicity profiles for each Manchester subarea are reported below, broken down by reporting year.

Reporting year 2020 – 2021

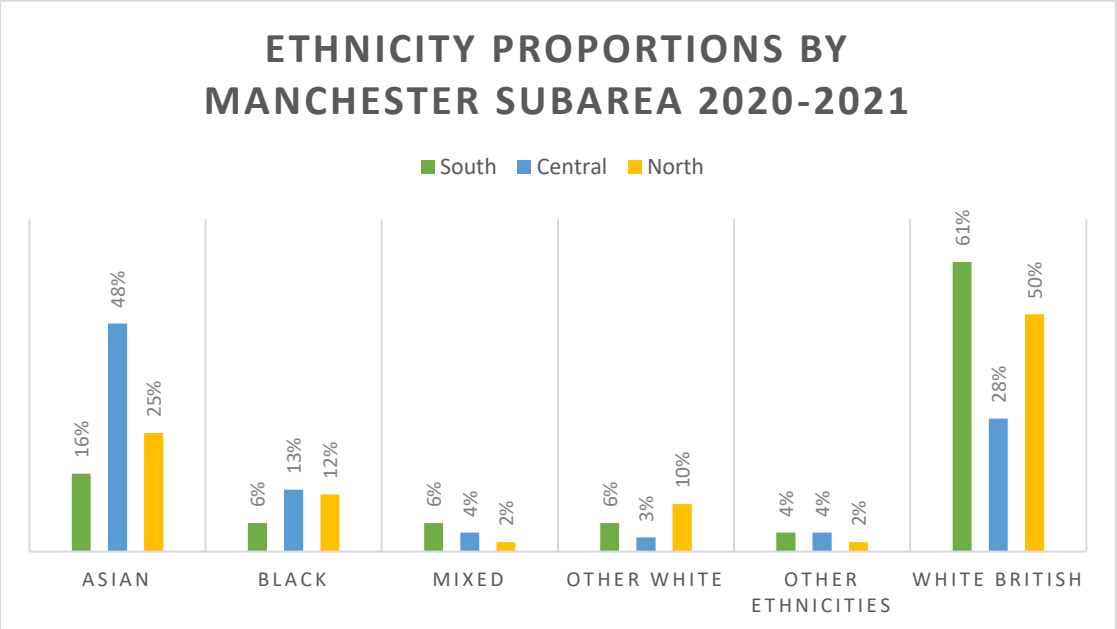
When looking across the Manchester subareas for this reporting year, each has a distinct ethnicity profile, with White British service-users forming the majority of cases in Manchester South (61.4%) and representing the most common ethnicity in Manchester North (50%). However, service-users identifying as 'Asian, Asian British or Asian Welsh' represented the most common ethnicity in Manchester Central (the largest client group) (48.4%). Service-users identifying as 'Black, Black British, Black Welsh, Caribbean or African' were most commonly supported in Manchester Central (12.6%) and Manchester North (11.9%). See Table 2 and Figure 2.

Table 2 Counts and proportions of ethnicity categories by Manchester subarea (2020-2021)

Ethnicity category	Manchester South	Manchester Central	Manchester North
Asian/Asian British	28 (16.4%)	88 (48.4%)	33 (24.6%)
Black/Black British	11 (6.4%)	23 (12.6%)	16 (11.9%)
Mixed Ethnicity	10 (5.8%)	7 (3.8%)	3 (2.2%)
White Minorities	10 (5.8%)	6 (3.3%)	13 (9.7%)
Other Ethnicities	7 (4.1%)	7 (3.8%)	2 (1.5%)
White British	105 (61.4%)	51 (28.0%)	67 (50.0%)
Total*	171 (100.0%)	182 (100.0%)	134 (100.0%)

* Totals include only those females with both ethnicity data and CCG subarea labels.

Figure 2 Ethnicity proportions by Manchester subarea 2020 – 2021



Reporting year 2021 – 2022

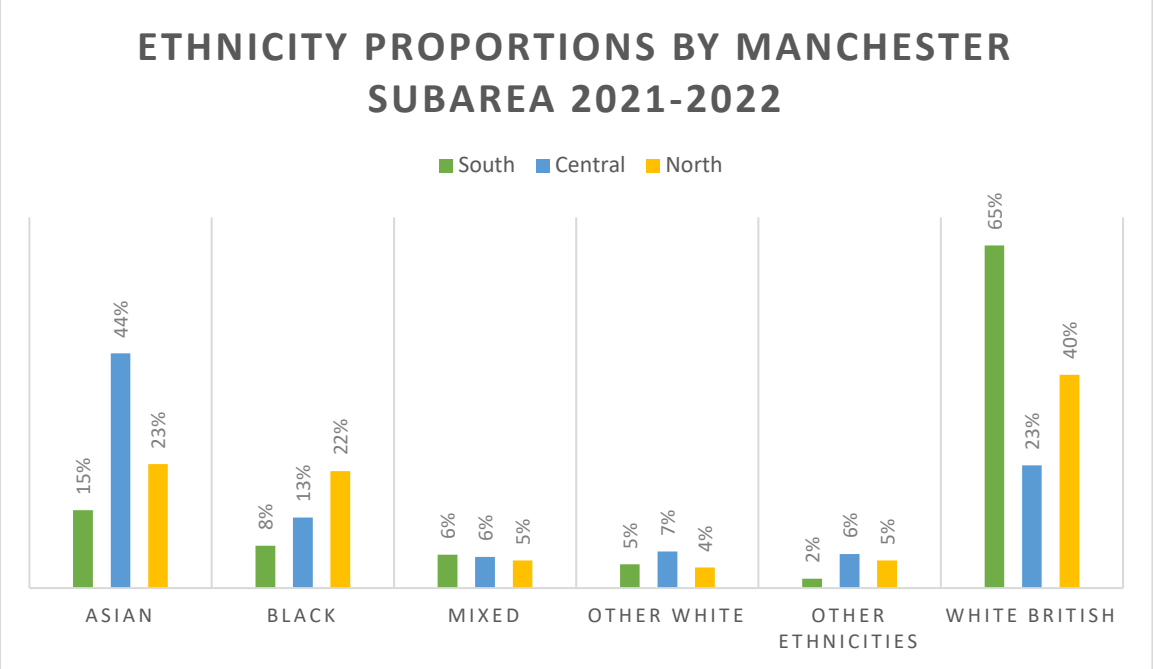
When looking across the Manchester sub-areas for this reporting year, we see similar ethnicity profiles to 2020/2021, with White British service-users again forming the majority of cases in Manchester South (the largest client group) (64.7%) and representing the most common ethnicity category in Manchester North (40.3%). Again, service-users identifying as 'Asian, Asian British or Asian Welsh' represented the most common ethnicity in Manchester Central (44.3%). Service-users identifying as 'Black, Black British, Black Welsh, Caribbean or African' were most commonly supported in Manchester North (22.1%) – a 10% increase on the previous year. See Table 3 and Figure 3.

Table 3 Counts and proportions of ethnicity categories by Manchester subarea (2021-2022)

Ethnicity category	Manchester South	Manchester Central	Manchester North
Asian/Asian British	33 (14.7%)	90 (44.3%)	36 (23.4%)
Black/Black British	18 (8.0%)	27 (13.3%)	34 (22.1%)
Mixed Ethnicity	14 (6.3%)	12 (5.9%)	8 (5.2%)
White Other	10 (4.5%)	14 (6.9%)	6 (3.9%)
Other Ethnicities	4 (1.8%)	13 (6.4%)	8 (5.2%)
White British	145 (64.7%)	47 (23.2%)	62 (40.3%)
Total*	224 (100.0%)	203 (100.0%)	154 (100.0%)

* Totals include only those females with both ethnicity data and Manchester subarea labels.

Figure 3 Ethnicity proportions by Manchester subarea 2021 – 2022



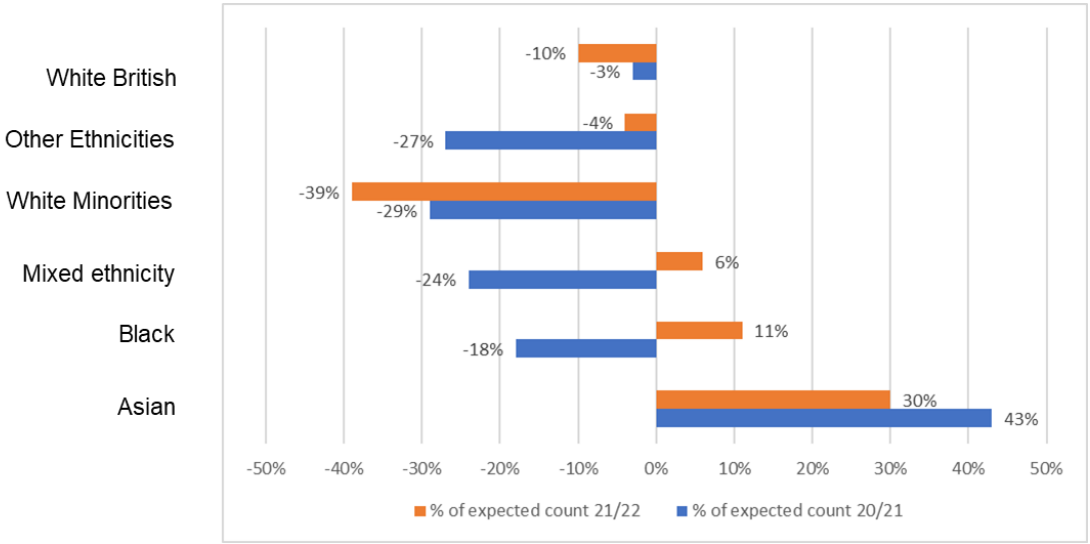
Section 2: Comparison against Manchester City's census data

When comparing the ethnicity profile of female IRIS service-users against the 2021 census data for Manchester City local authority (females only), a goodness of fit test (weighted chi square test)[3] identified the following differences between predicted and actual counts for ethnicity categories.

When looking at the overall ethnicity profile, both years of IRIS data were (statistically) significantly different from Manchester City's census data for 2021 (see Table 4). With respects to the ethnic group of interest for this report, those of 'Black, Black British, Black Welsh, Caribbean or African' heritage were slightly underrepresented in the 2020/2021 data (10% compared to 12.2%). In the 2021/2022 reporting year, however, numbers increased, resulting in overrepresentation within this group (13.5% compared to 12.2%) (see Table 4).

With regards to other ethnic groupings, those from White minorities (e.g. White Europeans, Irish, those from traveller communities) had the highest underrepresentation of any group, with numbers consistently lower than expected over both years (5.9% and 5.1% compared to 8.4%). Those from 'other ethnic' backgrounds were also consistently underrepresented, although this improved in the second year of reporting (3.5% and 4.6% compared to 4.8%). White British service-users also had underrepresentation in the data, although this was relatively minor in both years (46.8% and 43.9% compared to 48.5%). With regards to those from 'Mixed or Multiple ethnic' backgrounds, although underrepresented in the first reporting year, this then improved significantly by the second year of reporting (4.1% and 5.8% compared to 5.4%). Lastly, the ethnic grouping 'Asian, Asian British or Asian Welsh' had the highest overrepresentation of any group, with numbers higher than expected in both years (29.7% and 27.1% compared to 20.7%). See Figure 4 below for under/over-representation across the two reporting years as proportions of the expected figures.

Figure 4 Over- and under-representation for both years (as proportions of expected figures)



[3] A goodness of fit test measures whether your sample data (in this case IRIS ethnicity data) represents or 'fits' the data you would expect to find in the actual population of study (in this case represented by Manchester City's 2021 Census ethnicity data).

Table 4 Predicted and actual counts within overall ethnicity groupings

Ethnicity category	2020 – 2021 IRIS actual[4] n (%)	2020 – 2021 IRIS predicted n (%)	2021 – 2022 IRIS actual[5] n (%)	2021 – 2022 IRIS predicted n (%)	Census 2021 n (%)
Black, Black British, Black Welsh, Caribbean or African	54 (10.0%)	66 (12.2%)	79 (13.5%)	71 (12.2%)	33895 (12.2%)
Asian, Asian British or Asian Welsh	160 (29.7%)	112 (20.7%)	159 (27.1%)	122 (20.7%)	57645 (20.7%)
Mixed or Multiple ethnic groups	22 (4.1%)	29 (5.4%)	34 (5.8%)	32 (5.4%)	15050 (5.4%)
White: English, Welsh, Scottish, Northern Irish or British	252 (46.8%)	261 (48.5%)	257 (43.9%)	284 (48.5%)	134740 (48.5%)
White Minorities	32 (5.9%)	45 (8.4%)	30 (5.1%)	49 (8.4%)	23235 (8.4%)
Other ethnic groups	19 (3.5%)	26 (4.8%)	27 (4.6%)	28 (4.8%)	13320 (4.8%)
All females with ethnicity data	539 (100.0%)	539 (100.0%)	586 (100.0%)	586 (100.0%)	277885 (100.0%)

[4] χ^2 (5, N = 539) = 30.393, p < .001).
[5] χ^2 (5, N = 586) = 22.218, p < .001).

Findings: Qualitative analysis

Sample

Nine women were interviewed from across Greater Manchester. Eight identified as Black African and one as White and Black Caribbean. They ranged in age between 20 and 58 years, with a Mean age of 39. All identified as heterosexual. Three identified as having a disability. All identified as Christian, one specifically as Catholic. None of the women were IRIS service users, meaning this section does not provide any evaluation of the IRIS service itself, but rather provides perspectives on potential barriers to reporting experienced by women from these communities.

Section 1: Barriers to disclosing domestic abuse to GPs

Cultural, community and religious pressures

Cultural backgrounds, societal/community expectations, and religious beliefs were identified by interviewees as being influential in Black women's decisions to report abuse. In particular, the fear of societal judgment and the expectations set by religious and cultural norms were identified as potential barriers to disclosure and included communities viewing domestic abuse and sexual violence (DVA/SV) as "taboo" subjects not to be discussed, of having views which may normalise, minimise, or condone violence towards women and girls, that may subjugate women, reinforce traditional gender roles, and/or blame women for the abuse they were experiencing (for a more global discussion of the prevalence of DVA/SV see Conclusion). Such fear of judgement and shame meant that Black women often *"put up barriers" (Becky)* rather than risking the vulnerability of disclosure.

> *She should [disclose to the GP] but I don't know if she would because domestic violence is a taboo subject. It's not one for… particularly communities like mine to easily just express…(Becky)*
>
> *With our like, background, we're very much like, strong and we don't let things get to us unless it's like at a breaking point… back home and… you know… generally in the Black community, it's like a thing that really happens quite a lot [domestic abuse/sexual violence]. Erm, so it's something that basically they just kind of brush under the table sort of thing and don't talk about it just…get on with it. (Rose)*
>
> *Negative impacts [of disclosure] is how like the community might see her. Erm, because in the community that we come from, the girl is always the one to blame…regardless of what happens. (Becky)*
>
> *Maybe another kind of reason [for victims not disclosing] might be she might think they will put the blame on her too, for accepting the man very fast. (Liz)*

Culturally, she might be...she might be coming out from a very family that's very strict or, you know, just the fact that she had probably….you know, she had sex. That on its own could be like a taboo, like, you shouldn't be having sex out of marriage, for example, things like that. (Dom)

In some places in Nigeria, if you're married, then people are scared to speak out – people in an abusive relationship – because of what people will say. Especially what the church will say. "What will my family say? What will my friends say?". (Eddy)

She would be scared because… she might think people at home might think she's a cause of everything… "Now why should she report her husband in the first place? Somebody that brought her to the UK?". So family members may blame her also. (Liz)

Family was also seen as a potential barrier to disclosure, with one interviewee indicating that for women who had migrated to the UK, *"they [family in country of origin] would think maybe it's better for her to report to a family member than to report to the GP." (Liz)*

Conversely, friends were viewed as a potential source of support and encouragement in disclosing DVA/SV, and particularly important for women who may only have been living in the UK for a short time.

To me, if she's said it to her friends, maybe the friends might encourage her to report to the GP because maybe a few of her friends have been here for a long time. (Liz)

There was a general belief that, although domestic abuse and sexual violence happened across all cultures, it was an issue experienced disproportionately by Black women and girls, and that importantly, Black women's voices were felt to be minimised and silenced by those statutory services which were meant to support them.

Because most young black children, particularly young black girls…are raped everyday and nobody cares. Nobody cares. Nobody cares and it becomes that thing like it's the norm because again, it's taboo in our communities. It's rife. It's absolutely rife in our communities and nobody's talking about it. (Becky)

I'm not saying that other women from other cultural backgrounds don't have the same experience [of DVA]. Obviously they do. But I think sometimes even in that abuse, there's even further abuse because you're Black. (Dom)

Racism and treatment inequity

A number of interviewees described traumatic experiences of racism and discrimination within healthcare contexts and indicated that such experiences were commonplace. Experiences ranged from the presence of racial tropes such as the 'strong Black woman' impacting upon professionals' perception of them as "credible" and "ideal" victims of domestic abuse, to a lack of understanding of Black communities and the physical body. In one case, an interviewee even disclosed sexual abuse as a child by a White GP, an experience which removed her trust in White male doctors (this interviewee was offered support and the opportunity to report the incident). Such discrimination and trauma were highlighted as being significant barriers to

disclosure, with GP practices and healthcare contexts not seen as safe spaces for Black women to be vulnerable.

Trauma

Two interviewees discussed traumatic healthcare experiences which significantly reduced their trust in health professionals and services.

> *All my experience with my kids have been very traumatic within the NHS…extremely traumatic. So even if I was in that situation… the GP would not be the first point of contact to be honest with you personally, because I don't think that will…it's just gonna trigger other things…. To be honest with you, if you speak to ten black women, there will be nine that will tell you all this….There is no Black woman I've spoken to who has not had any traumatic experience within the NHS with childbirth or…with certain situations in terms of medical issues. There is none. I don't know any. (Dom)*

> *I think one of the factors of me not really disclosing to GPs or trust in GPs is because I had quite a…I didn't see it at the time because I was quite young, so I didn't understand, but it did feel uncomfortable and it was like basically I was trying to get a check-up, erm…and it happened to be a male, a White male, who did the check. But it was…so I'll say it was definitely inappropriate… in terms of the check-up that he did. And I knew that it was…I knew it wasn't right because it was like you didn't have to really go that far in terms of the check-up, but… it felt very like, sexualised. So I think…I think it's that thing of sometimes I find that…Black people can be sexualised to certain males and especially at a young age. They feel that you're older than you actually are, cos we look older. Supposedly we look older than our White counter parts and er, they see us more as a woman than a child. (Rose)*

Not feeling heard

The minimising and silencing of Black women's voices was discussed by a number of interviewees and was something which led to mistrust in health services and a reticence to disclose sensitive matters such as domestic abuse or sexual violence to healthcare professionals.

> *Black women, we tend to….from my own experience you have the person when you're talking…it's like no one is listening…especially within the NHS, especially within medical. If I'm going private that's a different story. Like if you are with the NHS sometimes you have the impression whether the nurses you're talking to, the doctor you're talking to… you know, they tend to…lessen the issues that you're having. And not take it very seriously. (Dom)*

> *For them [health professionals] it's like if you're not screaming your lungs out then you're not in pain. But with our cultural background, we've been taught to suppress pain. It's like we've been taught not to…even when you're in pain, you shouldn't be crying, for example. It's just a thing that culturally we've been taught not to do. But if you've been taught not to show pain, how would the other person know that you are in pain? You need to be able to understand and listen to the person, when the person's telling you that "I am in pain", that the person's in pain. (Dom)*

Racial tropes

Racial tropes – specifically, the 'strong Black woman', 'the angry Black woman' – were identified as contributing to treatment inequity within healthcare contexts. Perceptions of interviewees as 'strong' and 'resilient' meant that their concerns were minimised, their treatment deprioritised, and in some cases, they were not seen as 'ideal' or 'legitimate' victims of domestic abuse or sexual violence. The anticipation of such discriminatory practice meant interviewees had minimal faith that if they were to disclose such issues to their GP that they would be believed or taken seriously.

> *I think for the longest time, there's always been a difference [in the health treatment of White and Black women]. There's always been a difference in how they [health practitioners] see us, if you like. And, there shouldn't be. Because women are women, regardless of the colour of their skin. Remember there's always been, the 'facts' that "they're strong, they're resilient, they can deal with things for themselves" you know. "Maybe she did something to him, that's why he did that", and you know, all the excuses of the world coming before the truth is accepted. And you know, the Black woman is seen as a 'tough' and 'able' person to look after themselves, so…to come through violence is something they created, not something that happens to them. And that's the reality. (Becky)*

> *That's exactly what we see all the time. "Oh she's very strong, you're very strong, you're doing really well, you're really really strong" you know. Because we have no choice than to be strong. We have no choice than to be…if not, then…you know you…you'll be on the floor and there will be no one there to pick up the pieces. And that's the one thing that…you know, just the thought of it, just makes you internalise…you know, everything. You don't wanna let things out because you know…what will be the point at the end of the day? You have to be physically strong or mentally strong to go through it. But it shouldn't be that way. (Dom)*

> *But 'the Black woman' that people actually see, the 'Paulettes' of the world that people will see and come across ….probably to some extent being angry and agitated and frustrated – those are masks. Those are pain. Those are expressions of pain, of pain that people don't see. And it is the pain that they don't know how to actually handle it. And they don't know how to deal with it. So what comes out is that…aggressive labelling if you like, of 'the Black woman'. And that's unfortunate, but that's the reality. (Becky)*

Indeed, the expectation of blame, judgement, and of being "interrogated" were significant barriers to disclosing domestic abuse or sexual violence to GPs (or to any statutory service).

> *And most women, most times they feel insecure reporting these things because at the end of the day they do end up being blamed. (Esther)*

> *And also, you know there's also like the racial thing, it's also a problem. You don't want to be perceived as being someone that has loose morals…you know, having a sexual relationship with somebody you're not in a proper relationship with. So you want to be careful about how you are labelled. (Sarah)*

> *But at the same time as well, if she's Black and she's a minority with experience that she may have been having with the past [of racism], she may not want to do that because she might be stigmatised, she might be [worried about people] saying "Ohh she's putting the Black card on*

the table"… And a lot of people, especially Black women feel that way and they don't want to speak out. They won't say anything because…you'd rather not be interrogated. (Dom)

Treatment inequity

Some interviewees felt that the support Black women would be given by agencies, if they did disclose, would be of a lower quality than for White British women – a perspective that could discourage women from disclosing in the first place.

But the follow up and the intensity being pulled I think it will be different. Yes. Like the escalation will be quicker. And erm, whichever department it will be forwarded [on to], will probably be seeing the name of, or seeing the identity of the person, might decide to, well, be quicker if it was a White person. This is just…this is just my opinion… (Esther)

I think erm… a White woman's more likely to get the help and support that they would need as opposed to a Black woman and again… I just think in the UK itself, there's so many people that…have like so much negativity towards people from international… like other countries…I think it's so widespread like it does, it does go across to like, GP's…most industries anyway… people in high positions, the police… (Rebecca)

The moment when someone is kind of conversing with someone that do not speak like you or do not have the same accent as you do… there are moments where they have felt like they've been considered less of a person. (Dom)

Structural and institutional racism

For Dom, racism within the NHS was a significant barrier to implementing meaningful services for Black women, with a lack of visibility of Black doctors and the predominance of Eurocentric medical education, being symptomatic of deep structural and institutional racism.

I can't remember the last time I was in that situation where I felt quite happy to go to the doctors and feel comfortable expressing myself talking and, you know, just being me because I was able to see someone [Black] there. I'm not saying…what I'm saying is that it's beyond just this change. I think it's a lot of things that need to happen. The NHS as well themself needs to be more flexible. They need to be more accepting because even if we say that it's doing changes, there's still a lot of racism within the NHS. There's still a lot of restrictions within the NHS. There still a lot of…less privilege for ethnic minorities. (Dom)

They [Black GPs] are out there, but sometimes you don't see them in your GP, in your surgeries. You don't see them. Where are they? (Dom)

You know, because sometimes the doctor themselves are not, they aren't that educated. I'm not…this is not just to say that doctors aren't doing a good job, but I think there's a lot of things that doctors have been taught…with Caucasian backgrounds. And that's a fact. It's not something I'm saying because…yeah. So they've been taught with Caucasian backgrounds and dealt with…you know, even skin issues, they've been taught with Caucasian skin, not with Black skin… They know what they've been taught. So that's one thing. But how can they know what they haven't been taught? (Dom)

Rapport, trust, and cultural understanding

Interviewees felt that rapport and trust within the GP-patient relationship were central to whether Black women would feel safe in disclosing domestic abuse, and specifically, that GPs would need to have some sort of cultural understanding, or even a shared cultural perspective to develop such rapport and trust.

> *It depends. It depends on what relationship she has with the GP, I think that's very important. And I think that…one thing that I do know for people to disclose, there needs to be an element of understanding of cultural perspective, there needs to be an element of trust, there needs to be an element of creating this environment where she will feel safe to express without any comebacks. And, you know…and so I think that where they will see her as the victim that she is rather than as one that encouraged it*. (Becky)

One interviewee felt that increased representation of the Black community within the GP profession was important – with increased representation meaning a shared cultural understanding, and possibly even a shared native language.

> *I think the vital one is getting people of colour to support people of colour first. I mean to be at the forefront. Because they can relate to their background, their stories, their history. They would be able to insert their self in – that experience is better. I'm not saying White people will not understand, but I think it's easier and it makes you feel more comfortable opening [up] to somebody you feel will understand you…. If possible maybe somebody that you can speak your first language with is… is easier… to express yourself, your emotions, everything to them. (Esther)*

> *Also, if I was to speak to a Black doctor to be honest with you, sometimes it makes me more comfortable…it makes me be more comfortable because sometimes there is a bit of a cultural alignment…understanding… on certain things…which will be probably easier for me as a patient. But sometimes there are things that could not be that obvious to some doctors because of the cultural difference. And it makes things a bit more…You know you don't want to be in a situation where you might end up being judged… (Dom)*

Dom went on to suggest that the way in which Black women respond to domestic abuse and sexual violence – both behaviourally and emotionally – may be different to White British women – something which a GP from a shared background would hopefully understand and take account of. Specifically, it was suggested that social conditioning to respect and obey one's husband might be a cultural factor impacting responses to DVA/SV.

> *It might be a cultural thing whereby she's been… she's been taught not to answer back or not to… do you know… is like certain things that you may understand where she's coming from and you don't wanna judge. That person automatically understands where you're coming from, not in the sense of, "But why don't you react?", "Why didn't you say anything?", "Why didn't you…" do you know what I mean? It's like… because you've been taught not to answer back. You've been taught not to push back. You've been taught not to… and then that's the reason why she's the way she is. Maybe she had to unlearn certain things, but at least she'll be in situation where someone will understand where she's coming from and try and, you know, take a few step backs. That's just an example of certain things that I think. It might be easier to have a Black doctor to speak to. (Dom)*

Any disclosures also need to be accompanied by a clear pathway for support, connecting victims with services and community supports which were appropriate to their cultural backgrounds and specific needs.

> *Disclosure is the key, but the space needs to be safe for that disclosure to happen, and when it does happen, there needs to be a pathway model to help her along the way. (Becky)*

A number of interviewees also highlighted a preference for female GPs in cases of sexual violence or abuse, rooted in past experiences and perceived empathy from female practitioners.

> *I would never go to a male GP because of that experience [of sexual abuse- by a White GP], so it would always be a female, cos that's how I feel comfortable enough to speak to someone that with any situation that I'm going through. Whereas a male I just, I just don't have that trust that they're doing the job that they need to be doing basically. (Rose)*

Closely aligned with trust, was the necessity for assurance and confidentiality in encouraging victims to disclose abuse. The fear that disclosure might lead to further complications, such as worsening domestic situations or legal repercussions, was evident. Interviewees highlighted that concerns about repercussions from the abuser or community stigmatization make it crucial for GPs to provide a secure, private environment.

> *It depends on how the question's being asked and how assurance you're gonna tell that she's gonna be alright… No one is going to [get] hurt anyways…Going to take her kids away from her? That is an assurance. You can't just meet me and tell me… "Are you being abused?". That fear will not let me talk…Give me that assurance. "Listen, I'm here for you. I'm going to take care of you, I'll make sure nothing happens to you". (Eddy)*

> *Yes, there's a risk [of disclosing]. A risk kind of depends, you know, on the…who has access to the information that she's disclosed. And I think that is the only thing that will prevent most women from sharing… (Sarah)*

> *You need to make sure that you know, it's gonna be safe to talk and safe to be able to give that information. (Scarlett)*

Healthcare structures, processes, and access

Aside from barriers to disclosure that were specific to race, ethnicity and culture, were more general barriers relating to the structure and processes within GP surgeries, and issues around accessibility. Barriers related to the practicalities of what to say when booking appointments, the timeliness of available appointments, and having enough time within the appointments themselves to discuss such difficult subjects – all factors which could potentially put women off approaching the GP to have such discussions.

Booking appointments

One interviewee highlighted the challenge inherent in actually being able to book an appointment with a GP to discuss experiences of domestic abuse or sexual violence, with

impracticalities around what to say when speaking to receptionists, and how soon a GP could actually be seen.

> *I'm just picturing how difficult it will be for her to actually express that to the GP because…where would she begin for example? You know, even if you were to book an appointment with the GP…what would you say? For example, that you want to talk about…because… I don't know if you…I'm, I'm sure you probably have been in this situation where you wanna book an appointment and whoever is at the reception will be telling you "Is it an emergency?"... Because she needs to be in an environment which is personally comfortable to be able to talk about it, even just to mention it. Especially if someone's at the reception where you know, you're probably, they're probably around their colleagues… you may not want them to repeat something that you've said or maybe they haven't heard something and trying to make sure they wanna clarify what you said. You know it's gonna… I think the situation is quite difficult to say that… yes, it would be easy to say to talk to a GP about it, but how do we get about it? (Dom)*

Feeling rushed

Also identified as a challenge and potential barrier was the lack of time available within an appointment to feel comfortable enough to disclose experiences of abuse.

> *They don't even have time for people with illnesses, as well as people who are suffering, you know, something outside of an illness sort of thing. (Scarlett)*

> *You can only come up with one issue when you're coming to the doctors and that doesn't help at all because you don't have that platform to express yourself. …because at the moment I'm not sure how many minutes you've got with the doctors, I don't know if it's eight minutes or ten minutes or something like that… so you're literally going to be saying everything you can in ten minutes…and [talking about DVA/SV] that's not gonna be a ten-minute talk. (Dom)*

Inconsistency of GP

Some barriers intersected with previous themes, such as inconsistency of GP being linked to a hampering of trust and rapport – factors identified as central to women's confidence and willingness to disclose domestic abuse or sexual violence.

> *Say [fictional name] is my GP, it doesn't necessarily mean that I see that particular GP all the time, and so it might be that it's somebody new and you know, and it's not easy to just disclose such a… really, really difficult thing. (Becky)*

> *I find that some GPs are quite…like, judgmental or they always have like preconceived ideas. And they might be wondering why she's not like gone to the police, erm, earlier and…you know, she just will have a million thoughts. So, it's… it's whether she feels comfortable enough with the GP, her practice...wherever she's being looked after. Whether she's comfortable staying or disclosing anything to them, and whether she has a regular GP, that she's comfortable with to be able to say that. (Rose)*

Lack of knowledge of GP remit

Interviewees highlighted that a central aspect of accessing services was knowing they existed. None of the interviewees in this sample were aware that domestic abuse and sexual violence services such as IRIS were embedded within GP surgeries or that disclosing to a GP could result in any sort of meaningful support.

I personally was not aware [of services such as IRIS]. I don't think a lot of women know about that. But what I knew was if you have like, physical injuries from a domestic abuse, then you could go to the GP, that would escalate to maybe to the police… or actually, the first point of contact…my first point of contact would be the police actually. So I didn't know you have to contact the GP first and there's a special service, I mean domestic abuse helpline or service available when you contact the GP. (Esther)

It's just whether or not they would go to the doctor first because I think it's just knowing the GP is there with this service, with this knowledge, and with this support. Because to be honest, I wouldn't have thought of going to the GP for something like that. I'd be like, "What's he gonna do?" or "What's she going to do?". You know. And you're thinking, I don't want them to tell me that "Come back in four weeks' time and then we'll talk about it" because you know, I might not have four weeks. It's knowing that it is there and that they can get you on to somebody quickly. (Scarlett)

Unique barriers for migrant women

Interviewees highlighted that Black women who migrate to the UK face even more complex challenges, with specific barriers to disclosure relating to language, lack of social networks, a poor understanding of individual rights, financial and legal precarity, and the lack of social supports for those with no recourse to public funds (NRPF). Such factors – particularly in combination – can create a reluctance to report experiences of abuse due to fear of consequences such as deportation, destitution and fear of child separation.

Whether you're coming from the Caribbean or whether you're coming from Nigeria, we are all refugees in this space. We're all coming through a journey. Whether you come as a child or you come as an adult, we've still come to a land where we have to learn a certain kind of things in a different kind of way. We've come to a land where discrimination is already a base foundation, if you like. (Becky)

Language difficulties

For women migrating to the UK, difficulties around English language comprehension meant increased anxiety around disclosure due to fear of miscommunication – particularly given the sensitivity and emotivity of discussing an issue such as domestic abuse.

Oh, it would be [a barrier]. It would depend if she isn't good…I mean, if she's not a good English speaker, so that will be a big barrier as well. Because I mean…when I just came here [to the UK] 13 years ago, it was hard to even understand what other people were saying. So even when you're speaking, they're like, "Oh, I didn't get it, explain". So this can kind of affect your confidence to, to want to open up to somebody because you might feel, "Oh, God, I might just mess this up.. I might not be able to understand what this person is saying, or they might not be able to understand what I'm saying". So if you, for example, you have somebody that understands your first language, or even if, say, for example, someone coming from Nigeria, [speaking] pigeon English – and most people know how to speak that – you'll feel more freely to relate with these people without any barrier whatsoever. (Esther)

Interpreting English and speaking English is completely two different things. And a lot of times we forget that, you know, we don't….and so again…language will be a barrier in that context,

so it's about making sure that she has got…just because she speaks English it doesn't mean she doesn't need an interpreter. You know, and it is really crucial that people don't overlook that. (Becky)

I don't know how well her English is as well. That might be another factor. Cos she will want to express herself and she's not able to express herself clearly. I find that with people that are, you know, adopt their language… English language and I come across a lot of like… some of my friends that have like, still learning and still adapting to the English language, they really struggle to express themselves, especially when they're upset and angry. It's like they know the word, but they know it in their language. So, to be able to say out in English is completely different. And it's very frustrating for them. So, they take ages to respond, or they take ages to say what they need to say, so it gives it's…there's a lot of thinking room and it could be that that GP is in a rush or you know, they don't have time to listen. So that could be another factor where she's like, "Oh they're not listening to me" you know. So yeah, that's a big, big barrier. (Rose)

But I'm not sure if someone does not have kind of, you know, English as their first language, the background is also not the same. You know…with all that other context that needs to be taken into consideration, how would you allow them to express himself, to make sure they also have access to that facility? (Dom)

Because there are loads of women who do have that [language] barrier for sure and…they don't know what to say, they don't know what to do, how to do it…but the only way for them to get an appointment, is by actually saying what the problem is. (Dom)

Lack of social networks

Lack of social supports was also identified as a potential barrier to disclosure, with a lack of peers and family linked to a reduced opportunity for safe and informal disclosure, for encouragement to seek professional help, and to an increased risk of perpetrator control and coercion.

So you know, they are sort of like there with him [the perpetrator], you know, having to do what he says and hopefully, you know, he will treat them right. And if they don't, well, they don't think they can turn to anybody. If they turn to family, they'll probably just say, "Oh just stick with it" you know, "It'll probably get better". And then they'll probably just listen to that for a bit long until it gets to a point where it's really so bad. (Scarlett)

A lack of social supports – particularly friends, family or colleagues more familiar to the UK – also meant less opportunity for informally gathering information on legal rights and specialist services.

I've come across situations like that many times in this space and erm…it's not an easy one. It's not an easy one because the support network is the same one that is making her feel very vulnerable. And particularly when there's no family network at all and you don't know the system. So, I've got pure examples of this and as much as we would want, [her] to disclose – and [she] will disclose because she has got children as well that need support – but because [she] is new to the country and…cultural barrier is a big issue…[she] will go back [to the perpetrator]. [She] will go back…will go back again…and again…because that is the support

network that she has…unfortunately. She will try to do the right thing. But when you look at the bigger picture she has nothing. (Becky)

Becky went on to suggest that education could help victims who had migrated to the UK to have greater knowledge of their rights and services, although having services which could respond to the cultures and contexts of migrant women was vital.

[Victims] need to be educated. Need to be educated about…not only in terms of the laws of the land, but the support mechanisms that are there to support [them]. And the cultural appropriateness of those support mechanisms is crucial. (Becky)

Community and specialist groups were also seen as vital points of contact for migrant women experiencing domestic abuse, with one interviewee highlighting that GPs should ensure they are aware of, and are connecting victims to, these services.

And also the local community groups that are available to [victims who have migrated] is crucial. Nine out of ten times, you would find that as much as they disclosed to the GP, the system takes over and the system don't connect with those people who they need to connect with to help [migrant victims] along the way. (Becky)

Well, yeah, the community. If they had a community for women, especially in that erm…in that community…that Black and brown community, having that so she feels safe, she feels at home. Erm, having some like-minded people around her, that would definitely help, and you know, also the services, the specialised services, having it in that community as well. If they're fluent in that language too would help as well massively. So, they could explore options for her. They could also like look into what she can access, cos it could be that, yeah, she might not have access to…erm, resources…public funds, but there are other ways that she could go about it without…that being an impact to stop her from getting the support she needs. And I know there are some services out there, but it's just depending on where sort of thing. (Rose)

Financial and legal precarity

Particularly relevant to migrant women were issues around financial and legal precarity, with financial dependency on perpetrators representing a significant barrier to reporting abuse and seeking help. Lack of personal funds can make victims feel trapped, unable to leave abusive situations or seek legal aid.

Oh yeah. Yeah, that is definitely a big barrier. The fact that she has to rely on her husband for financial support and basically everything, and she's young, she's 28. She's just come [to the UK]. (Rose)

I think older ones, older people or people maybe have just come from abroad and you know, they may have just got married and the husband's brought them over. And I think they might feel a bit more sort of erm, resistant to talking, because at first I feel like, you know, they have to feel gratitude towards a man from for bringing them over and looking after them, you know, and erm, he's one that's working, or he's got the money. (Scarlett)

It's one thing just talking to the GP, but it is also another thing actually supporting them once, you know, in that scenario. Because the most important thing will be, where does she go? Where

does she go from there and what does she need to do? Which is financially as well, if her husband wants to say "I can't support you anymore". (Dom)

Given the complexities of migrant women's needs, a number of interviewees highlighted the importance of other services, such as specialist legal support.

First of all, see if she can get access to like an immigration lawyer…who can then help her to explore all the options open to her. (Sarah)

I think the first thing…what the GP probably will be needing to do is refer her to an organisation that could support her…that would be helpful. Second as well, an advice Bureau that will be able to support women in that situation. Just legal advice to see what they need to do. Also help to support her with things for the kids – how will she be able to handle the kids if in that situation if something like this was to happen. (Dom)

NRPF

Having no recourse to public funds (NRPF) was seen as a limiting factor in victims receiving support, and a potential barrier to disclosure. In many cases, interviewees felt that GPs could provide little meaningful support within such a context, with migrant women of colour having very limited options.

It's a massive, massive barrier [to disclosure]. It's just unbelievable. (Becky)

I believe that she's limited in her choices because she does not have access to public funds, so even if the GP were to make some suggestions, I believe all of that [issues] will still be around her…And since she doesn't have to, I'm not sure how helpful, you know, turning to her GP for help will be. (Sarah)

If she's [White] British…I'm not even sure we would be having this conversation…she will be given the house immediately. She'll be given some allowances, her children will be taken care of. Oh, yes, they [service responses] will be very different. Major difference. In fact, they…Police will be involved. Everybody will be at her beck and call. So yes, it will be a world of difference between her and the white British woman. (Sarah)

Indeed, a number of interviewees highlighted how the vignette example felt very relevant, drawing on specific examples relating to family and friends.

No recourse to public funds and everything because when I saw these [vignettes], when I read about this the last time, I immediately remembered... a family friend went through a similar situation. (Esther)

There are so many scenarios, so many people who are in that situation, so many of them that…by the time they speak out, it is too late. (Dom)

Children

A number of interviewees highlighted the added complexity which having children brought to migrant women who are experiencing domestic abuse – specifically as disclosure to GPs could lead to intervention from children's social care and the potential removal of children from the home. This fear represented a distinct barrier to disclosing DVA within any setting, particularly in situations where partners perpetrating abuse had British citizenship and were able to use their increased knowledge and position of power as a mechanism of control.

> *Erm, and nine out of ten times, what I've experienced from my work, is that the authorities don't have the capacity to deal with it. So what happens is, social services come in, frighten her, and then she'll become scrutinised because of the situation of the safeguarding issues with the children. And then the children are taken away and then there's another loss in her life, that then takes a spiral turn. And then what she does is she goes back to him. Because he's the only support network. (Becky)*

> *I think when your children are at stake as well, it puts more pressure on you to, you know, to make sure you do the right thing. So, I think she's just thinking about her children, …the fact that she might have to go back...and leave her children behind. (Rebecca)*

> *You've got the kids to think about as well cos you can't be dragging kids around...you know, they've got to be settled. (Scarlett)*

> *I don't think speaking to GPs is even going to brush the surface of the problem [for migrant women]. I've heard other situations where they've raised their concern, but instead of having to help the mother, they're now actually sending social care, because she's in the situation where the kids are now vulnerable. So they're not even looking at the mother at that point, they're looking at the kids, because obviously the kids will come first. So she becomes even more on edge because she's raised that voice, and now the kids are going to be looked [at]. (Dom)*

Section 2: Addressing barriers to access and disclosure

Alongside interviewees' descriptions of Back women's barriers to disclosing domestic abuse and sexual violence were a number of ideas for how to improve access and make disclosure more likely. These have been grouped into five main themes relating to: Patience, brokerage and cultural understanding; Awareness campaigns and education; Practitioner education; Outreach for Minoritised women; and Specialist 'by and for' services for Minoritised women.

Managing the disclosure process: patience, brokerage, and cultural understanding

Interviewees highlighted that for Black women to feel comfortable disclosing domestic abuse or sexual violence to a GP, there is a need for space and patience to allow the process of disclosure to happen gradually, either within an appointment, or over a number of appointments. Specific to women from Black communities was the need for GPs to have an understanding of those communities, and importantly, the specialist services available which could provide more tailored support.

> *So what you need is a good GP. That's basically the bottom line. You need a good GP who has understanding, patience, and really would look outside the box and not just tick the box and give that person the space they need to actually come to terms with the issues that they have going on for themselves and the tools to deal with it. The tools might not be one that the GP knows, but what certainly I would expect, if my GP is gonna give such advice, what I would expect the GP to know is the issues that affects the communities like ours, and also then understand the pathways that they can take to be able to help them to find their own direction. (Becky)*

> *Start with just talking. Just talking and really….getting to grips with understanding [the victim's] situation, where she is at. And really to then not feel ashamed – I think that's really crucial. And then erm…the second stage could be to then start introducing other members like you know, probably the authorities into the space and then…but it has to be at [the victim's] time rather than at the GP's time. I think it's really crucial that she has to be ready because such disclosure have a ripple effect and it has an impact that is bigger sometimes than where it started from. (Becky)*

> *Yes, if you are asked directly... You know the way the GP is showing genuine interest, you know in asking those questions [about DVA/sexual violence]. (Sarah)*

A number of interviewees highlighted that improved representation of Black communities within GP surgeries was important for improving such cultural understanding, and in feeling confident you were disclosing abuse to someone who really understood your background and cultural context.

> *And I also think representation also matters like going to the GP and seeing somebody you can relate with. I think maybe you feel the person of colour in the position that would help you make you feel more confident and more comfortable to open up. (Esther)*

For a number of interviewees who had described fears around not being believed, ensuring that there was transparency for victims around the support pathways available to them was identified as key, alongside reassurances that their disclosures would be taken seriously.

> *'Good' would look like if they have a clear transparent pathway, that they will really think about what she needs and really believe her in the first place. (Becky)*

Awareness campaigns and education

A number of interviewees discussed the potential positive impact that awareness-raising campaigns and community education could have on both communities' and individuals' understanding of domestic abuse and sexual violence, how to identify harmful and abusive behaviours, how to support women and girls experiencing abuse, and what services are available to provide support. This was identified as particularly important within Black communities where domestic abuse and sexual violence were felt to be highly stigmatised.

> *We need to educate [young people] to be able to identify that when somebody crosses over their space, it's not right and it can never be right, and they need to do something about it. (Becky)*

> *Yeah, yeah, I think firstly it's raising awareness about these services available, making people aware that you have the support (Esther)*

> *Awareness…advocating for women… doing some like…for example creating awareness, maybe printing out flyers, stickers, doing campaign against domestic violence against Black women in Manchester. Also doing some online lectures and things would help a lot to come out to air because there are so many women that are facing domestic violence and they keep it to themself. They refuse to carry it out to the public. (Liz)*

> *Because some women are not aware of where to report domestic violence. They don't really actually know where to start. So creating awareness will really help. (Liz)*

> *So from her perspective, I would think if she had the awareness that if she had reported to the GP she would get the help she needs, she would have done it earlier. (Esther)*

One interviewee highlighted the important role that religious organisations or leaders could have in relation to supporting women within their communities to seek formal sources of support for domestic abuse. This was identified as particularly important within Black African communities, where church was described as "absolute" and "central" (Liz).

> *Like, most people from Black or brown backgrounds that have these strong religious beliefs… I think that can also be, erm, a factor that might delay or even stop them from asking for help. So, I think probably working with these religious organisations, or the churches, the mosques and…raising this awareness and then, telling them when somebody is going through domestic abuse because most people will feel more comfortable to relate with their pastor, or Reverend Father or whatever, to ask for prayers rather than ask for physical help or physical support. So I think making, maybe…educating the religious leaders or whoever the religious body is, so raising awareness that when you're going through domestic violence or sexual violence, you should seek support from your GP or from the police. Or using them as a point of referral. Like, when*

somebody comes to the Pastor, they will pray with them, but also direct them to the GP or the police services that can offer them good support. (Esther)

Awareness activities also extended to the provision of leaflets within GP surgeries, which could provide victims with the information necessary to either disclose elsewhere, or feel comfortable enough to disclose to GPs themselves.

I mean, every time I been seeing a GP, there's always leaflets on loads of different organizations or helplines, so I think yeah, having one there would be a good way for her to access it and I'm sure she would look as well because she'd want to try and look to see what she can find herself without having to ask the GP. (Rebecca)

Practitioner education

One interviewee indicated that one way to address the issue of needing culturally sensitive and responsive GPs was to ensure that both practitioners and their teams were well informed about the issues facing Black women – particularly those migrating to the UK and potentially facing additional challenges such as having no recourse to public funds.

There's two ways a GP can do it. Firstly, you can have…they themselves can educate themselves about the issues that affect Black women…in terms of the community issues that affect them. They themselves can educate themselves and their teams to understand the issues of concern that's related to, like, no recourse to public funds and so forth and so on. And be able to understand what that means, because I don't think that they do. And I think that there needs to be an understanding of that because that affects your whole life in Britain. You know? It impinges on everything. (Becky)

Outreach for Minoritised women

Although only mentioned by one interviewee, the potential for outreach work as a means to support and encourage disclosure of DVA/SV by Black women was highlighted. This was identified as particularly important given the context of mistrust of health services and of feeling unheard by professionals providing and brokering support.

I think they [GPs] should be able to reach out to Black women. They really need to reach out because a lot of them [Black women] are silent. Silent not because they really want to be silent, but because they have no choice…they no choice than to be silent…because there's no point….in actually speaking out. I think there's a lot of women suffering and a lot of them…they can't even say it because there's nowhere for them even to say it. There's nothing really to support them in saying those things. And they feel like, what's the point? (Dom)

Specialist 'by and for' services for Minoritised women

Lastly, there was a recognition by interviewees of the importance of connecting Black women – particularly those migrating to the UK – with services embedded in and

representing the communities they come from – something that would ensure tailored support, a sense of shared cultural understanding and importantly, of feeling heard, understood, and connected.

> *I think yes, I think it [DVA] could be something that would be good for [victims] to disclose, but I also think it's important that any organisation they're gonna be talking to also cater to Black people. I think this is very, very crucial for that to happen, because sometimes they…everything is just designed for Caucasians, or designed for other cultures, but it's not designed for Black cultures. I think that would be the one thing. It would be good for [victims] to talk to any organisation – it's important. But I think if there is a Black organisation that could also be there for her. That could probably be one of the things that I will probably say will be good for [Black victims] to go to. (Dom)*

Conclusion

This research sought to identify whether Black African and African-Caribbean women were underrepresented within the IRIS service within Manchester and the barriers that Black women may face in disclosing domestic abuse or sexual violence to GPs. To answer these questions the research used a mixed methods approach comprising a statistical analysis of IRIS service data, comparing the demographic profile of Manchester IRIS service-users to local population demographics, and semi-structured interviews with Black women from the Greater Manchester area, to explore qualitatively their perspectives on disclosing domestic abuse and sexual violence to GPs and the barriers that may exist that are specific to being a Black woman.

Representation of Black women within the IRIS service

Comparison against Manchester City's population-level (census) data on ethnicity highlighted that although women identifying as being Black African, Caribbean or from 'any other Black background' were slightly underrepresented in IRIS's 2020/2021 service-user data, by 2021/2022 this underrepresentation was no longer present. This is encouraging as it suggests that women from Black communities in Manchester are disclosing domestic abuse and sexual violence to IRIS GPs and through them, accessing the specialist support they need. However, the findings of this analysis should be taken with caution, given that the two years of reported data spanned the Covid-19 pandemic – where reporting of domestic abuse reduced during lockdowns, but then spiked when restrictions were eased (Chantler et al, Domestic Abuse Safeguarding during Covid-19 (DASC) conference presentation, March 2022). Indeed, some of the overrepresentation identified in the second reporting year of this analysis may be reflective of the peculiarities of this time once restrictions were lifted. This is particularly plausible given that the DASC survey also found that stakeholders (nationally) reported an increase in more complex cases, higher numbers of Black and Minoritised victims, and older victims. An analysis of a further year of data could help to investigate whether this is the case[6].

The analysis also identified differences in IRIS's ethnicity profile across the Manchester subareas. However, without population data at the same level to compare against, it is unfortunately not possible to comment on whether these differences represent under- or over-representation of certain communities within these specific areas of Manchester City.

Although women from Black communities do not appear to be underrepresented within the IRIS service in Manchester – something particularly positive given the barriers to disclosure identified by interviewees – their experiences of the service and how it meets their particular needs and circumstances may differ to those from a White majority background. This report therefore recommends that any evaluation of the IRIS service in Manchester utilises an intersectional framework to ensure the needs and service experiences of minoritised communities are properly understood and made visible.

Although the findings of this quantitative analysis suggest that the underrepresentation of Black and other minoritised communities within the IRIS service in Manchester reduced between 2020 and 2022, those from White minorities were consistently underrepresented in

[6] Subsequently, an additional year of data (2022 – 2023) was analysed and again, found no over- or under-representation of Black women, with 12% (63/520) of female IRIS clients identifying as being Black African, Caribbean or 'from any other Black background'.

the data. Further analysis using an additional year of data could help to provide greater insight into which specific communities these may be, in order to focus any future research efforts.

Barriers to Black women disclosing domestic abuse and sexual violence

With respects to the qualitative component of study, interviewees provided rich insight into a range of potential barriers to Black women disclosing experiences of domestic abuse or sexual violence to GPs. These centred around six key themes or issues comprising: fear of community judgement; fear of racism and discrimination in health contexts; a lack of rapport, trust, or cultural understanding; the need for assurances around confidentiality; GP structures, processes and accessibility; and unique barriers for migrant women. It should be noted that whilst the majority of the responses were in relation to the NHS (given this was the focus of the study), it would still be prudent for the learning and recommendations to be considered by wider agencies across Manchester and beyond.

Fear of community judgement reflected interviewees' beliefs and perceptions around the cultural norms and expectations within Black communities. These related to gender roles and patriarchal power structures; the minimisation and normalisation of violence towards women and girls; and domestic abuse and sexual violence as being viewed as "taboo" and "hidden" subjects. Interviewees highlighted that such framing of gender and abuse meant that formal forms of disclosure were discouraged within some Black communities, and in many cases, women were blamed for any abuse they reported experiencing. Such accounts do provide useful insights into some of the additional barriers Black women may face when disclosing domestic abuse within health contexts. However, practitioners must be mindful that although cultural factors do mediate experiences of domestic abuse and help-seeking (Burman, Smailes and Chantler, 2004), research indicates that intimate partner abuse is an enduring *global* problem crossing racial and cultural boundaries, with variations in prevalence pointing more clearly to socioeconomic, rather than racial and ethnocultural factors (Sardinha et al., 2022). This is particularly important given the evidence on the 'culturalisation' and 'racialisation' of violence towards women and girls, with practitioners/services across a range of sectors identified as complicit in the invisibilisation of domestic abuse experienced by Minoritised women due to an uncritical acceptance of 'supposed cultural norms' i.e. erroneous assumptions that such abuse is an aspect of Black or other Minoritised culture (Burman, Smailes and Chantler, 2004; Chantler et al., 2023). Challenging such erroneous beliefs is therefore critical to ensuring equitable access to specialist domestic abuse provision for Minoritised women and girls.

Interviewees' experiences of racism and treatment inequity in healthcare contexts resulted in a general mistrust in health services/professionals, with contexts such as GP surgeries not viewed as 'safe' spaces for disclosure. Indeed, the experience of one particular interviewee recalling her sexual assault and 'adultification' (Bernard, 2020; Davis, 2022) by a White GP during childhood highlights this acutely – an example of how multiple forms of (racist/sexist/ageist) oppression intersect. Accounts of racial tropes such as "the strong Black woman" and "the angry Black woman" meant that interviewees felt strongly that Black women were not viewed as "credible" or "ideal" victims of abuse, but instead as "responsible" and "culpable" – meaning that disclosure of DVA/SV by Black women could bring with it a risk of disbelief, silencing or even blame – findings echoed by a recent Rapid Evidence Review of ethnic inequalities in healthcare by Kapadia and colleagues (2022). For interviewees, such experiences were felt to be rooted deeply in structural and institutional racism within the NHS (and more widely), with poor representation of Black doctors within the GP profession and the predominance of Eurocentric medical training and research tailored to White people (received by all medical professionals irrespective of race/ethnicity) reinforcing and maintaining such

inequity. Although only one piece of a larger puzzle, such findings point to the importance of GP practices (and health services more broadly) embedding Equality, Diversity, and Inclusion (EDI) policy and practice into both training and clinical practice.

Rapport and trust within the GP-patient relationship were identified as key enablers of women feeling secure enough to disclose experiences of domestic abuse or sexual violence. For interviewees however, rapport and trust were strongly mediated by GPs having an understanding of their cultural background – or even of belonging to the same community. Improved representation of Black communities within GP surgeries was therefore identified as an important step towards this. However, research drawing on Minoritised women's perspectives of DVA/SV support has indicated that in some cases, 'preference for professional support from within their communities was offset by a lack of confidence around anonymity and a fear of being recognized and traced' (Burman, Smailes and Chantler, 2004, p. 341). This is particularly relevant given that interviewees in this study indicated the need for assurances around confidentiality and safety. The important issue here is choice; Minoritised women should be given the choice as to whether the GP or other service they are referred to is operating from within, or outside of, their community.

Alongside barriers specific to race, ethnicity and culture were those relating to the structures and processes operating within GP surgeries. Interviewees highlighted that the practicalities of booking appointments – both in terms of having to state explicitly what your issue is to receptionists and in difficulties of receiving a timely appointment – would likely act as barriers to women coming to the GP for support around domestic abuse or sexual violence. Other barriers included not having enough time within appointments to bring up and discuss fully sensitive issues such as abuse, not having good rapport or trust with the GP due to a lack of consistency in which GP patients see, and importantly, a lack of visibility of the IRIS service, meaning women not having any knowledge that disclosing abuse to a GP is possible, or could lead to any sort of meaningful support. However, it is important to note that IRIS is not immediately visible for a reason – the service is not widely advertised so that women are able to make appointments at a GP surgery and receive specialist support without the perpetrator connecting that the GP practice is a place where their victim may be accessing such support. This does, however, create a tension between the need for visibility and the need for victim safety.

Echoing the findings of reports such as '*Safety Before Status'* (DAC, 2021) and '*Women Living in a Hostile Environment*' (EVAW, 2018), interviewees highlighted the additional challenges faced by Black women migrating to the UK, with such challenges seen as both barriers to disclosure and to receiving effective support should they choose to disclose. Additional barriers included those relating to language, a lack of positive and enabling social networks, a poor understanding of individual rights and services, financial dependency on perpetrators, legal precarity relating to immigration status, a lack of welfare supports from having the status of 'no recourse to public funds' (NRPF) and having children who victims fear losing should they disclose to the authorities. Indeed, a number of interviewees had personally supported women experiencing such challenges and highlighted the near impossible situation they found themselves in, and the paucity of options available to them. Practitioners delivering and partnering with IRIS must be cognisant of such barriers and challenges to support for women migrating to the UK and be proactive in seeking specialist services which can offer them tailored support should they choose to disclose.

Addressing the barriers to disclosure Black women may face

Interviewees also provided insight into those factors which could enable Black women to disclose their experiences of domestic abuse or sexual violence to GPs. Although a number have already been discussed, these included: the space and patience to allow the process of disclosure to happen gradually; GPs to have a good understanding of Black communities and culture; improved representation of Black communities within GP surgeries; connecting Black victims to specialist 'by and for' services embedded within their communities (where desired); and lastly, carrying out awareness campaigns and outreach activities within Black communities to give victims knowledge of healthy relationships and available services, and to enable communities to support and encourage victims of abuse.

This research represents an important step by IRIS in improving their understanding of the needs and circumstances of the Minoritised communities they serve, ensuring that their domestic abuse provision is both accessible and equitable for those who may face additional barriers to support. Further, the findings of the analysis of IRIS's service data are encouraging; not only in that they indicate that Black women are accessing the service in proportions similar to the population living in Manchester City, but also that their collection of ethnicity data is both embedded within practice and of good quality and completeness. Such factors provide a firm grounding for robust research which can inform and refine practice cognisant of Black women's individual needs and rights. Nevertheless, the qualitative data illustrates the multiple barriers Black women face in disclosing DVA/SV, meaning IRIS programmes and partners must be aware of these to ensure equitable access.

It is encouraging to note that GPs do receive diversity training and that IRIS training does enable understanding of the additional barriers which Black women face when seeking help for domestic abuse. It is recommended that this research further informs that training. IRIS provide information on legal rights, benefits, housing, and support for women with No Recourse to Public Funds and this is reported on and monitored by commissioners. IRIS also offer choice of local services for victims to link into such as those specialising in FGM support, Asian women's support and Black women's support. However, this is not currently monitored, and it is recommended that promotion of choice is more closely looked at by the service and their commissioners.

Limitations

There are two main research limitations that warrant mention. First, the quantitative analysis was predicated on the assumption that domestic abuse prevalence within Manchester City is similar across all ethnicities. A more accurate analysis of representation would need to involve a comparison of the demographic profile of IRIS service-users against the demographic profile of all women who experience domestic abuse (rather than a comparison to the population demographic more broadly). However, given the hidden nature of domestic abuse, and the difficulties in establishing accurate prevalence rates for it, this was unfortunately beyond the scope of the research.

Second, the qualitative component of the research drew on the accounts of a small number of Black African and African-Caribbean women living in the Greater Manchester area. The small number, alongside the fact that only one interviewee was of African-Caribbean descent, meant that insights into this particular community (and indeed, intersections with other protected

characteristics such as age, sexuality, and disability) was limited. This is relevant given that Black women and 'Black communities' are not a homogenous group, and therefore any research exploring underserved communities should aim to be as representative of those groups as possible. Additionally, the qualitative component only represented the experiences of women who had *not* received IRIS support, experiences which may have been different to those of women accessing the service.

Recommendations

Based on the analysis above, we make the following recommendations:

1. GP surgeries partnering with IRIS to ensure that General Practitioners and other surgery staff have good cultural awareness and understanding of their local Minoritised communities and the role of unconscious bias in consultations with Minoritised patients experiencing domestic or sexual violence.

2. GPs to be made aware of the additional challenges Black women may face in relation to disclosing domestic abuse and sexual violence: particularly the findings of this research in relation to a mistrust of health services due to experiences of racism and discrimination; and the additional challenges faced by migrant women.

3. The DVA Board for Manchester promotes DVA training for professional interpreters.

4. GMICB to review (potentially with IRIS clients themselves) the structures and processes operating within surgeries to ensure processes are enabling of access – particularly to those victims whose first language is not English and in relation to digital access only.

5. Manchester DVA Board to commission/carry out awareness campaigns and outreach activities within Black and other Minoritised communities to give women and men knowledge of healthy relationships and available services, and to enable communities to support and encourage victims of abuse. This should also include work within schools and colleges and religious organisations.

6. GP surgeries partnering with IRIS to ensure they have good knowledge of and partnership relationships with commissioned local specialist 'by and for' organisations, and other VCSE organisations and that Minoritised women are being offered choice of referral on to these organisations to receive culturally sensitive DVA/SV or community support, should they want support from a 'by and for' organisation.

7. IRIS to carry out regular analyses of their demographic data to explore representation in relation to ethnicity, age, sex and gender, sexuality, and disability.

8. GMICB to commission research drawing on multiple years of data to allow for a more extensive, nuanced, and intersectional analysis of its demographic profile, for example investigating the interaction of ethnicity and age, ethnicity and disability, ethnicity, and

sexuality etc. Such intersections could then also be explored qualitatively to gather the lived experiences and perspectives of individuals at those intersections.

9. IRIS to audit evaluations gathered from IRIS service users to specifically review the experiences of Black women who have received the IRIS service, to ensure equity of access and provision.

10. IRIS to disseminate the learning from this report to IRISi and GMICB to share the learning with the Manchester Domestic Abuse Board and the Greater Manchester Domestic Abuse Steering Group.

11. IRIS to develop an action plan to address barriers going forward

Responding to the report

In response to the learning and recommendations made in this report, Manchester IRIS and GMICB are already undertaking research and audit activities which will be detailed in a follow-up report. The report will include:

- Responses to each of the recommendations
- An audit of IRIS evaluation forms for women of Black African and Black Caribbean heritage – including qualitative feedback
- An updated analysis of Manchester IRIS's client ethnicity profile
- An overview of the work of IRIS in relation to women of Black African and Black Caribbean heritage

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Appendix

Interview schedule with vignettes

Vignette 1: Paulette – born in the UK to Jamaican parents

Paulette is a 42-year-old Black British woman born in the UK to parents who migrated from Jamaica in the early 70s. Despite her experiences of both racial and sexual discrimination over the years (in education and the workplace), she has worked her way up to becoming a chartered surveyor in a well-regarded firm. She hopes to make Partner in the firm over the next few years. Last year Paulette started an on-and-off relationship with a man in another department at work. On a night out three weeks ago, she met up with him for drinks and they went back to her house where they had sex. In the morning, he wanted to have sex again, but she did not, but he pressured her into it. Paulette ended the relationship a few days later. Since then, he has started to send her abusive text messages. She has also started to feel nervous and on edge as she is concerned that he will turn up at her home or office uninvited. She is worried the situation will soon start to impact upon her work and her mental health. She has an appointment with her GP soon and is wondering whether she should disclose this to him.

Questions:

- What do you think Paulette *should* do in this situation?
- What do you think Paulette *would* do in this situation?

- Should she report her experiences to the GP?
    - If not, why not?
    - Should she report it to someone else instead?

- What might prevent Paulette from turning to her GP for help?
    - Are any of these barriers specific to her being a Black British woman of Caribbean descent?

- What might encourage Paulette to turn to her GP for help?
    - Would being asked directly but sensitively by a GP encourage her to disclose her experiences?
    - Should professionals such as GPs or nurses be asking people questions about domestic abuse or other experiences of sexual violence?

- If she did seek help from her GP, what support do you think they could or would provide?
    - What support would Paulette like from a GP in this situation? What would 'good' support look like?
    - What would happen if she did disclose her experiences?
    - Would there be any risks in her disclosing?
    - Would the support or response she received be different to a woman who was White British? If yes, in what way?

Vignette 2: Ndidi – moved to the UK from Nigeria on a Spouse Visa

Ndidi is 28 years old. She moved to the UK from Nigeria around 18 months ago with her two children to join her husband (their father) who has dual British and Nigerian citizenship. Although she has a Spouse Visa, she has no recourse to public funds, meaning she has no access to welfare support, or local authority housing. Although initially things were going well in their relationship, over the last six months Ndidi's husband has become more demanding, controlling, and verbally abusive to her. Last week he pushed her up against the wall and shouted in her face, and this was in front of their two young children. Ndidi has told her husband that if the abuse continues, she will be forced to leave him. In response, he threatened that he would ensure she was deported to Nigeria and the children would stay with him in the UK. She would never be allowed to see them again. Ndidi feels she has limited options given she is currently unemployed, is financially dependent on her husband and has no options for alternative housing. She has a few friends but no family she can turn to for support. Ndidi needs to take the children to the family GP for vaccinations soon and is wondering whether she should discuss the situation with them during the appointment.

Questions:

- What do you think Ndidi *should* do in this situation?
- What do you think Ndidi *would* do in this situation?

- Should she report her experiences to the GP?
    - If not, why not?
    - Should she report it to someone else instead?

- What might prevent Ndidi from turning to her GP for help?
    - Are these barriers specific to her being a woman who has no recourse to public funds?
    - Do you think Ndidi's cultural background is important here?

- What might encourage Ndidi to turn to her GP for help?
    - Would being asked directly but sensitively by a GP encourage her to disclose her experiences?
    - Should professionals such as GPs or nurses be asking people questions about domestic abuse or other experiences of sexual violence?

- If she did seek help from her GP, what support do you think they could or would provide?
    - What support would Ndidi like from a GP in this situation? What would 'good' support look like?
    - Would she be entitled to support given her immigration status?
    - What would happen if she did disclose her experiences?
    - Would there be any risks in her disclosing?
    - Would the support or response she received be different to a woman who was White British? If yes, in what way?