A Systematic Review of Public Stigmatization Toward Women Victims of Intimate Partner Violence in Low- and Middle-Income Countries

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Abstract

Public stigmatization of women victims of intimate partner violence (IPV) has begun to be studied because of its negative impact on recovery from violence. This systematic review aimed to analyze such stigmatization in low and middle-income countries (LAMIC) by identifying social norms and perceptions linked to public stigmatizing responses, such responses, negative consequences of those responses on victims, and other factors associated with public stigma. Following PRISMA guidelines, five databases were searched using "stigma" and multiple synonyms of IPV as keywords. Selected articles were empirical, written in English, published in peer-reviewed journals, and reported findings on public stigma toward women victims of IPV that had occurred in LAMIC. Nineteen articles met the inclusion criteria. Patriarchal gender roles, normalization of IPV and the consideration of violence as a private matter were the most prevalent social norms among the studies. These led to blaming, isolating and discriminating against the victim, making her feel ashamed, considering her less valuable than before suffering IPV, and dismissing or denying the abuse. Many negative consequences were identified. Anticipated public stigma, associated with not disclosing the abuse and not seeking help, was the most popular. Public stigmatization was stronger when other public stigmas intersected and in the case of disadvantaged social circumstances. Consequences were diminished by protective factors such as informal support and gender-based violence support services. This review provides a global vision for future research in each specific sociocultural context and is a first step in the design of anti-stigma programs in LAMIC.

Keywords: public stigma; intimate partner violence; domestic violence; low and middle-income countries

Based on World Health Organization's definition [WHO] (2022), intimate partner violence (IPV) against women perpetrated by a man is the most common type of violence against women and continues to be a serious global problem. As a result, the United Nations 2030 Agenda for Sustainable Development Goals (SDGs) included the elimination of IPV against women (United Nations, 2022). This violence includes physical aggressions, controlling behaviors, sexual coercion, and/or psychological abuse by men who are their (ex)partners. It has serious short and long-term repercussions for the physical, psychological, and reproductive health of women, which for some is fatal (WHO, 2022). Because of this, in the present study we focus on IPV towards women by men who are their (ex)partners when we discuss IPV.

According to WHO (2022) global prevalence estimates in 2018, 27% of women aged 15 to 49 years who have been in an intimate relationship claimed to have experienced physical and/or sexual IPV at least once in their lifetime. Regarding recent experiences of IPV, 13% of women age 15-49 who have been in an intimate relationship suffered physical and/or sexual IPV in the past year. Currently, there is a scarcity of data on violence experienced by women 50 years or older. Since in this study we focus on IPV occurring in low and middle-income countries (LAMIC), it is worth noting that in these countries the lifetime prevalence of IPV is higher than in high-income countries and that these differences are even greater when we compare IPV in the last 12 months. WHO (2022) believes that this could be because in LAMIC there is less access to economic resources, social services, and divorce and family laws that make it easier to leave abusive relationships.

It has been shown that the process of recovery and liberation from violence is determined by interconnected individual (e.g., age of children), interpersonal (e.g., severity of IPV), and sociocultural factors (e.g., legislative and economic context of the country; Barrios et al., 2020; Flasch et al., 2017; WHO, 2022). Among these factors, recent literature in the

field of IPV (e.g., Kennedy & Prock, 2018; Murray et al., 2018) highlights the importance of public stigma towards IPV victims, since it is a barrier to recovery from violence. Public stigma towards IPV victims was the focus of this study and will be further described below.

Public Stigma toward Victims of Intimate Partner Violence

Stigma has been defined in sociology as a process that emerges in social interactions in which a series of negative stereotypes are associated with a label, leading to prejudice and discrimination toward the people to whom that label is assigned (Goffman, 1963; Link & Phelan, 2001). Public stigma refers to stereotypes, prejudices, and discriminatory actions commonly endorsed by the general public (e.g., friends, family, employers; Pescosólido & Martin, 2015).

Regarding existing theories that explain the public stigma associated with suffering IPV, Overstreet and Quinn (2013) were the first to point out in their studies in the USA that the label of "victim" carried a social image of passivity, weakness, and guilt for the abuse that leads to reactions such as discrimination and isolation of victims by third parties. This social image is anticipated (anticipated stigma; Goffman, 1963) and internalized (internalized/self-stigma) by the victims, which leads to inadequate coping strategies and psychological problems (Overstreet & Quinn, 2013). Further, seven possible manifestations of public stigma associated with IPV victim status have been proposed (Link & Phelan, 2011; Murray et al., 2018): blame, discrimination, loss of status, isolation, shame, dismissed/denied, and blatant unprofessionalism. These reactions are related, according to Murray et al. (2016) to certain social beliefs and perceptions about women, IPV, and victims. Consistent with stigma theories (Pescosolido & Martin, 2015), Barnett et al. (2016) concluded from an investigation they conducted in Kenya that victim labeling, stereotyping, and devaluation emerged first, followed by victim discrimination. Public stigma acted as a social control mechanism to maintain social norms and the resolution of marital conflicts.

Some authors have researched the association of public stigma towards IPV women victims with several variables. For example, this stigma is sometimes exerted by people close to the victim (e.g., family, friends) and professionals who are assumed to be a fundamental source of support (Kennedy & Prock, 2018; Murray et al., 2016), posing a clear obstacle for the disclosure of abuse and help seeking (Murray et al., 2016). Regarding geographic factors, difficulties may be greater in rural areas where isolation and certain social perceptions (e.g., gender roles, women's functions in the family) are even more present (Wright et al., 2021). In addition, Kennedy and Prock (2018) conducted a systematic review that included information on IPV public stigma and focused on samples of IPV women victims. They found a relationship between this stigma and clinical variables (PTSD, psychological distress, and reduced quality of life).

Furthermore, we conducted a systematic review on public stigma toward women victims of IPV in high-income countries (Murvartian et al., under review) where we identified a series of social norms (e.g., gender roles) that were linked to the stigmatizing responses from the general public toward victims of Murray et al.'s (2018) model. These responses in turn were associated with negative consequences for victims (e.g., not disclosing the abuse, the need to constantly prove they were doing things right, etc.), in part because public stigma was internalized and anticipated by them, something that has already been mentioned in the literature (Kennedy & Prock, 2018; Murray et al., 2018; Overstreet & Quinn, 2013). We also identified other factors associated with public stigma, of which the intersection of the public stigma of being a victim of IPV with the public stigma associated with other socially disadvantaged identities (e.g., being diagnosed with HIV) is noteworthy. As such, Murray et al. (2016) emphasize that each experience of public stigma is unique and other added stigmas need to be taken into account, since they amplify the obstacles that IPV public stigma entails, such as the difficulties for help-seeking.

The Current Systematic Review

In this review we aimed to study the public stigma that takes place in LAMIC for several reasons. First, most research generally assumes as the normative center of humanity the populations of Western, educated, industrialized, rich, and democratic countries, especially the United States (Heinrich, 2020), and these countries receive more scientific attention than others (Kahalon et al., 2022; Medin et al., 2017). This represents a clear bias, since it limits the generalizability of results and the understanding of experiences and behaviors of individuals in relation to their sociocultural contexts (Kahalon et al., 2022). Second, public stigma is dependent on the context in which it emerges (Goffman, 1963), which is supported by data. For example, Tran et al. (2016) analyzed the prevalence of physical IPV acceptance attitudes among 39 LAMIC and found significant variations between countries, and a higher prevalence in people with disadvantaged circumstances (e.g., rural areas, poverty, low level of formal education). They explained that patriarchal hegemony was present in many LAMIC and that this influenced education, legislation, and the criminal justice system in a way that facilitated those attitudes. The incidence of IPV in the past 12 months is also higher in LAMIC (WHO, 2022) and previous research indicates trends in predictors and risk factors of IPV for women living in these countries (Coll et al., 2021). Furthermore, the victim's autonomy and financial status influence public stigma and help-seeking (McDougal et al., 2019), which may differ between high-income countries and LAMIC. Third, this follows the conventional classifications of other global IPV studies where the results are divided into high-income or LAMIC (WHO, 2022) and ensures manageable sample sizes.

To the best of our knowledge, there are currently no reviews on public stigma toward women victims of intimate partner violence in LAMIC. However, a systematic review on the experiences of racial and ethnic minority IPV survivors in the US highlighted the weight of

certain social norms in their countries of origin: gender roles, the normalization of violence and the consideration of IPV as a private matter (Ragavan et al., 2020). These and other social norms were identified in Murvartian et al.'s review (under review) in high-income countries. We consider that the social norms associated with public stigmatizing responses toward IPV victims, such responses, associated consequences of these responses for victims, and other factors related to IPV public stigma from Murvartian et al.'s (under review) study might vary in LAMIC, and that understanding how this stigma works in these contexts is the first step in designing sensitive interventions to prevent and combat stigma. Nevertheless, we also must consider that there will be multiple differences between LAMIC due to cultural diversity and varying laws related to IPV, as well as different socioeconomic levels of the population within and between countries. All these aspects, on their own, could produce substantial variation related to public stigma. Therefore, we will make these differences visible throughout this review to the extent possible.

Taking all of this into consideration, we aimed to analyze public stigma toward women victims of IPV in LAMIC. This main objective, based on the previous findings of Murvartian et al. (under review)'s study, was specified in the following research questions:

RQ1. What are the social norms and perceptions associated with public stigmatizing responses toward IPV victims?

RQ2. What are the public stigmatizing responses (by family, neighbors, etc.) toward IPV victims?

RQ3. What are the consequences of those responses for IPV victims?

RQ4. What other factors are associated with public stigma towards IPV victims?

Methods

Search Strategy

This review was conducted following the guidelines of the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (Moher et al., 2015). Five electronic databases (Web of Science, Scopus, PsychINFO, PUBMED, and the Cochrane Database of Systematic Reviews) were searched for peer-reviewed journal articles published between January 2010 and October 2022. Titles, abstracts and keywords were searched for the following terms: (stigma* AND ("partner abus*" OR "partner aggress*" OR "intimate partner violen*" OR "intimate violen*" OR "intimate terrorism*" OR "domestic violen*" OR "domestic abus*" OR "domestic violen* offen*" OR "violen* relation" OR "violen* between parent*" OR "violen* between partner*" OR "partner violen*" OR "spous* abus*" OR "battere*" OR "violen*against wom*n" OR "marital violen*" OR "marital abus*" OR "husband* abus*" OR "dating violen*" OR "family violen*" OR "situational violen*" OR "abus* relation*" OR rape OR "sexual violen*" OR "sexual agress*" OR "sexual abus*" OR gender NEAR/3 violen*). Because sexual violence is referred to in the context of an intimate relationship, terms related to sexual violence were included.

Inclusion and Exclusion Criteria

Empirical studies written in English and published in peer-reviewed journals were included. They were eligible if reporting components of public stigma mentioned in the research questions toward women victims of IPV perpetrated by a man who was her (ex)partner, and only when the violence and public stigma had occurred in LAMIC. Therefore, participants could be living in low, middle or high-income countries as long as the stigma and violence had taken place in LAMIC. It is worth clarifying that the samples of the studies included in our review were composed of professionals, community samples (i.e., general population), victims, among other sources, as long as societal stigma toward victims

was examined in some way (e.g., professionals giving their opinion on the stigma they had observed from others, victims narrating the stigma they suffered from others, etc.).

Studies were excluded when they were not empirical, not written in English, and not published in peer-reviewed journals. They were also excluded if they did not report findings on the components of public stigma mentioned in the research questions toward women victims of IPV perpetrated by a man who was her (ex)partner. For example, if it was an intervention against stigma, if stigma was only mentioned in the introduction section, if stigma was associated to other types of violence (e.g., sexual violence that was not perpetrated by an intimate partner or ex-partner), or if the results did not refer to public stigma, but to other types, such as internalized stigma by the victims (e.g.,, victims' feelings of guilt). Studies were also excluded when violence and public stigma occurred in high-income countries.

After eliminating duplicates, the titles and abstracts were independently screened according to the above criteria by ML (principal investigator), who reviewed 100% of the results, and the third author, SJ, who reviewed a randomly assigned subset comprising 30% of the total, exceeding the recommended minimum of 20% (Ojeda and Del-Rey, 2021). Disagreements were discussed with a third reviewer (MJ), and consensus was reached. Then, ML and MJ independently analyzed the full texts of the remaining articles, and disagreements were discussed with SJ until a consensus was reached.

Data Extraction and Methodological Quality Assessment

Both researchers, ML and MJ, were simultaneously engaged in extracting data in an Excel document. Data collected included author(s) and year of publication, aim(s) of the study, sample(s) characteristics, methodology used in the study of public stigma, role of IPV public stigma in the study (“central role” when stigma was part of the aim(s) of the study, or “secondary role”, when it did not), methodological quality rating, and findings on social

norms and perceptions associated with public stigmatizing responses toward IPV victims, such responses, consequences of those responses for victims, and other factors associated with public stigma toward IPV victims.

Methodological quality assessment of the studies selected was performed by MJ and reviewed by ML using the Mixed-Methods Appraisal Tool (MMAT) version 2018 (Hong et al., 2018). The MMAT has been designed for the appraisal of quantitative, qualitative, and mixed methods studies through two initial screening questions and five criteria that must be met. Quality was not evaluated to exclude articles, but to report possible limitations of the studies included, therefore, detailed information on the criteria that were met and not will be given in the Results section, as recommended by the authors of the MMAT.

Data Analysis and Data Reduction

Relevant excerpts from the articles were selected to answer all research questions. The analysis was carried out following a template analysis procedure, a method that allows us to focus on key areas relevant to the study and build on existing theory (Brooks et al., 2015). First, we established an initial coding template based on the findings from Murvartian et al. (under review)'s systematic review with samples with high-income countries, which respectively corresponds to our four research questions. Their results were useful as a starting point, as they reflected the integration of a large corpus of research on IPV stigma.

As explained before, Murvartian et al. (under review)'s model included several "Social norms and perceptions" related to "Public stigmatizing responses." These responses were associated with "Consequences of stigma on victims." Finally, "Other factors associated with public stigma" were identified that could influence social norms, stigmatizing responses, and consequences. All these themes included several subthemes, which can be seen in Figure 1. Murray et al. (2018)'s "blatant unprofessionalism" subtheme was not included in the

stigmatizing responses theme because Murvartian et al. (under review) suggested its deletion, as it referred to any of the other six reactions from professionals.

[Figure 1 here]

This initial coding template was used first in data extraction and was subsequently modified when necessary. If new information could not fit in the coding scheme, new themes or sub-themes were created, modified, or merged. Others were eliminated if they were not reflected in the studies included in this review. After such modifications, previously revised articles were reviewed again to apply the newly identified codes. This iterative process lasted the whole analysis, until no new information relevant to our objectives could be extracted from the articles. This analysis procedure allowed us to create a final coding scheme that could be readily comparable to that of relevant previous research. During this process, themes and subthemes were individually and independently extracted by ML and MJ. Differences and modifications were discussed until consensus was reached, with the collaboration of SJ. The final coding scheme is explained in detail in the next section.

Findings

The results, according to our objectives, are shown below.

Study Selection

The database searches resulted in 1400 non-duplicate records screened. Figure 2 presents the PRISMA selection process flowchart. Finally, 19 articles met the criteria and were included in this systematic review. Backward reference search was conducted, but no new studies were found.

[Figure 2 here]

Study Characteristics

A detailed description of the characteristics of the selected studies is presented in Appendix A and only the main points are discussed in this section. First, according to the six

world regions established by the WHO (2022), there were nine studies that reported public stigma findings in the African Region; five in the Eastern Mediterranean Region; two in the South-East Asia Region; two in the Western Pacific Region; and one in the European Region. No data on public stigma in the Region of the Americas was found, so from now on, we will specify the results for the rest of the regions except for this one.

Regarding the samples of the selected articles, several studies (n=8) composed exclusively of IPV victims were identified. There were other selected studies in our sample (n=4) that were composed exclusively of community samples (men and women, n=3; women, n=1) and one that, in addition to a community sample (men and women), included community leaders and professionals who provided some type of support or care to victims (e.g., health care providers, police officers, etc.). There was also one study whose sample was composed of only professionals. The samples of the remaining five articles included victims of IPV and other types of samples: non-victim women (n=1); men and women who were not victims of IPV and community leaders (n=1); non-victim women, community leaders and professionals (n=1); and family members and close friends of victims (n=2).

The sociodemographic characteristics of the participants varied in many of the studies or were rarely specified. Regarding age, this was often diverse (n=12), sometimes not specified (n=4) and once homogeneous (20-25 years). Regarding ethnicity/nationality, this was diverse in seven studies (diversity was not specified in one), in 11 articles this information was not given, and it was homogeneous in only one study (Yezidi population only). The economic status was also diverse in 6 studies (in two it was not specified how), in 11 this information was not given, and was homogeneous in one of them (low to modest income). The educational level was diverse in eight studies, in 11 this information was not provided, and was homogeneous in one of them (second to fourth year of university studies). Among the studies that included IPV victims (n=12), two of them included only past victims,

and three, present victims. There were four that specified that part of the sample had suffered IPV in the past, and the rest had suffered violence at the time of the study (only two specified the percentage of past and present victims). Four did not provide this type of information. The marital status of women victims was diverse in each study and was sometimes not specified (n=5).

One of the studies was quantitative and the remainder qualitative. Interviews (n = 15), mostly in-depth, and focus groups (n = 9) were the most popular techniques. Participant observation and survey appeared only once. The MMAT tool found that four of the selected studies had certain methodological weaknesses, however, all of them reached acceptable or high-quality standards. The aspects that showed lower quality were diverse. In the quantitative study, two different samples obtained using different sampling techniques (randomized and convenience sampling), were merged. In addition, different measures on key study variables (public stigma, public stigma challenges, etc.) were each merged in the end as a ‘yes or no' answer for the analysis. These limitations made interpretations of results unclear. In three of the qualitative studies there was insufficient or no explanation about how data was analyzed, and in one of these there were also very few quotes to properly illustrate results.

The role of public stigma in the studies was normally secondary (n=16) and there were only three articles where this stigma had a central role as part of the aims of the study. The latter focused on 1) the association between IPV disclosure and public stigma, and challenges to this stigma (Maticka-Tyndale et al., 2020), 2) public stigma functioning as a mechanism of social control (Barnett et al., 2016) and 3) public shame associated with IPV (Shuman et al., 2016). The aims of the studies varied, including the analysis of barriers to help seeking, the effectiveness of the existing resources for IPV victims, the social costs of violence, and societal perceptions of IPV, among others.

Synthesis of Results

Figure 3 summarizes in pictorial format a model of public stigmatization toward women victims of IPV in LAMIC that we constructed following a template analysis. The final themes and subthemes that resulted from the analysis are represented inside the boxes in Figure 3. These themes and sub-themes are described in the following sections. To help contextualize our results, the countries of the studies where the samples were taken are included along with the citations. Due to space limitations, the exhaustive list of articles that contributed to each category is detailed in Appendices B and C. Thus, only a selection of citations from diverse WHO regions are presented below as examples.

[Figure 3 here]

Social norms and perceptions.

First, gender roles, the normalization of IPV, considering IPV as a private matter, and believing all victims who file a complaint will reconcile with the abuser, constituted the social norms and perceptions identified that were associated with the stigmatizing responses by society. They were found across the five WHO world regions, however, the normalization of violence was not mentioned in any of the two South-East Asia Region studies and thinking that all victims who file a complaint will return to their abusers, was only identified in the European Region article.

Gender roles and the normalization of IPV were closely related. On one hand, women and men were socialized in deeply-rooted patriarchal gender roles (n=11) that attributed the responsibility for procreation, family care, loyalty in marriage, and maintenance of family order to women (Byrskog et al., 2014, Somalia; Furr, 2014, India; Muuo et al., 2020, Kenya; Thurston et al., 2016, China; among others), and financial support, and authority to men, legitimizing control and infidelity toward their wives (Maticka-Tyndale et al., 2020, Kenya; McClearly Sills et al., 2018, Tanzania). Furthermore, wives were expected to resist having

sexual relations, and husbands to ignore this resistance, having the right to have sex without consent (McClearly Sills et al., 2018, Tanzania; Ogunwale & Oshiname, 2017, Nigeria). Failure to comply with gender roles not only was associated with stigmatizing responses from society toward the victims, but also with a higher risk of IPV (Morse et al., 2012, Jordan; Shuman et al., 2016, Coast of Ivory).

On the other hand, the aforementioned gender roles were associated with the normalization of IPV (n=9), as it was considered a valid method of punishing women who did not comply with such roles (Alvarado et al., 2019, Pakistan; Barnett et al., 2016, Kenya; Childress et al., 2022, Kyrgyzstan; Superable, 2017, Philippines; among others). Added to the above was the consideration of IPV as a private matter of the couple (n=14), which could at most be shared with the family, but never with the justice or law system (Muuo et al., 2020, Kenya; Snell-Rood, 2015, India; Strang et al., 2020, Iraq; Thurston et al., 2016, China; among others). In addition, prejudice was detected among the police that all victims who filed a complaint would eventually return to their abuser (Childress et al., 2022, Kyrgyzstan).

Public stigmatizing responses.

The stigmatizing responses explained below were present across the five WHO world regions, except for discrimination and loss of status responses, which were not mentioned in the South East Asia and European Regions. Furthermore, public stigma from professionals was present across all regions, except South East Asia.

Blame.

The most common public stigmatizing response identified (n=14), also exerted from the victim's family and professionals, was holding women responsible for IPV when they disclosed abuse and looked for help (Barnett et al., 2016, Kenya; Childress et al., 2022, Kyrgyzstan; Mannell et al., 2018, Afghanistan; Thurston et al., 2016, China; among others). Women were blamed for the violence either for provoking it - if they did not fulfill the

assigned gender role, such as being obedient wife and faithful to the husband (Alvarado et al., 2018, Ghana; Furr, 2014, India; Muuo et al., 2020, Kenya; Thurston et al., 2016, China), for choosing the wrong husband (Alvarado et al., 2018, Ghana; Thurston et al., 2016, China), or because something was wrong with their character (Alvarado et al., 2019, Pakistan; Snell-Rood, 2015, India). In keeping with the psychological characteristics of women, if they appeared too strong or too weak, they could be blamed (Thurston et al., 2016, China).

Isolation.

Another frequent response (n=11) from friends, family, and the community that victims experienced was isolation (Byrskog et al., 2014, Somalia; Shuman et al., 2016, Coast of Ivory; Snell-Rood, 2015, India; Thurston et al., 2016, China; among others). Women in these studies were not invited to social events because people feared that their daughters would follow their steps (Alvarado et al., 2019, Pakistan). As for family relationships, they were also isolated by their families. For example, they were rejected (Morse et al., 2012, Jordan), no longer helped (Childress et al., 2022, Kyrgyzstan), and excluded from family events (Furr, 2014, India).

Shame.

It was also very common to make the victim feel ashamed if she disclosed the abuse (n=11) (Alvarado et al., 2018, Ghana; Mannell et al., 2018, Afghanistan; Snell-Rood, 2015, India; Thurston et al., 2016, China; among others). This occurred with the general public as well as family members to victims (Childress et al., 2022). In this sense, it was frequently reported that disclosures could bring shame, not only to the victim, but also to the family (McClearly-Sills et al., 2016, Tanzania; Strang et al., 2020, Iraq; Superable, 2017, Philippines), so by making the victim feel ashamed, families tried to avoid stigma by association.

Dismissed/denied.

Looking the other way, helping the abuser, and downplaying or denying the abuse were also frequent responses from others after disclosure (n=11). On the one hand, they community minimized the problem (Apatinga & Tenkorang, 2022, Ghana; Childress et al., 2022, Kyrgyzstan; Thurston et al., 2016, China). Sometimes, people told women that IPV was normal and pressured them to sort things out at home, not leave the abuser, and/or not to press charges (Apatinga & Tenkorang, 2022, Ghana; Childress et al., 2022, Kyrgyzstan; McClearly Sills et al., 2016, Tanzania). Sometimes, the person to whom the woman disclosed the abuse refused to help (Snell-Rood, 2015, India) or returned her to the abuser (Strang et al., 2020, Iraq). Professionals in health, law enforcement, legal, and other sectors also did not provide support to victims (Thurston et al., 2016, China). Several studies indicated that the police were not helpful (Alvarado et al., 2019, Pakistan; Morse et al., 2012, Jordan; Shuman et al., 2016, Coast of Ivory); or that law enforcement and legal professionals did not believe disclosures (Barnett et al., 2016, Kenya). Some studies even reported that professionals supported the abuser or let the abuser go free after being bribed by him (Apatinga & Tenkorang, 2022, Ghana; Childress et al., 2022, Kyrgyzstan; Shuman et al., 2016, Coast of Ivory; Thurston et al., 2016, China). One article highlighted the abandonment of the case by the victims' families in exchange for money (Childress et al., 2022, Kyrgyzstan). In another article, elders did not listen because they refused to talk about problems of marriage (Apatinga & Tenkorang, 2022, Ghana). In line with the above, there were people who suggested to victims not to disclose the abuse because they were aware of the public stigma surrounding IPV (Ogunwale & Oshiname, 2017, Nigeria).

Loss of status.

Another commonly mentioned stigmatizing response (n=9) was that women were considered less valuable than they were before IPV disclosure, losing the respect of others

(Morse et al., 2012, Jordan; Shuman et al., 2016, Coast of Ivory; Strang et al., 2020, Iraq). They were considered unwise for having chosen that husband or for their behavior being contrary to what was expected according to gender roles (Alvarado et al., 2018, Ghana), bad wives (Barnett et al., 2016, Kenya; Superable, 2017, Philippines), untrustworthy, with less remarriage prospects (Alvarado et al., 2019, Pakistan), of no integrity (Thurston et al., 2016, China), and sinners (Barnett et al., 2016, Kenya). Also, after disclosure, women leaders in the community were perceived as incapable and forced to leave their leadership positions (Alvarado et al., 2018, Ghana; Mannell et al., 2018, Afghanistan).

Discrimination.

Among the studies (n=6) women were treated differently, in a negative way, after the abuse was disclosed. Victims were humiliated and insulted (Shuman et al., 2016, Coast of Ivory), lost custody of children and their house because they were considered the husband's property (Alvarado et al., 2019, Pakistan; Barnett et al., 2016, Kenya; Morse et al., 2012, Jordan) or could even be imprisoned (Mannell et al., 2018, Afghanistan), threatened and battered by their own family, the husband's family, or the person to whom they disclosed the violence (Morse et al., 2012, Jordan; Thurston et al., 2016, China) or killed (Mannell et al., 2018, Afghanistan), sometimes constituting honor killings (Alvaradao et al., 2019, Pakistan; Morse et al., 2012, Jordan). Discrimination also occurred by police officers, who sexually harassed, threatened (Alvarado et al., 2019, Pakistan; Shuman et al., 2016, Coast of Ivory), and raped victims, as well as charged them a fee (Shuman et al., 2016, Coast of Ivory).

Consequences of public stigmatizing responses for the victims.

Several consequences of public stigmatizing responses for the victims were identified. First, anticipating public stigmatizing responses by victims was present in all WHO regions. This anticipation prevented women from seeking help -this consequence was present in all WHO regions-, and from not disclosing the abuse -which was present in all but the European

regions-, and it made women choose not to work -which was present in the Eastern Mediterranean region-. Other consequences were not breaking up the abusive relationship -which was found in the African, the Eastern Mediterranean, and the Western Pacific Region articles-, and having difficulties in employment -which appeared in all but the European Region article-. The rest of the consequences were avoidance coping strategies and depression, the need to relocate or abandon their school, the development of internalized stigma, the escalation of violence and dropping the case once it reached the court, which were each explicitly mentioned in just one or two regions.

One of the consequences was that women anticipated stigmatizing responses from others (n=15), therefore, in order to avoid the cultural stigma exerted by the community, women commonly chose not to disclose the abuse (n=15; Apatinga & Tenkorang, 2022, Ghana; Childress et al., 2022, Kyrgyzstan; Strang et al. 2020, Iraq; Snell-Rood, 2015, India; Thurston et al, 2016, China; among others), and not to seek help (n=15; Alvarado et al., 2018, Ghana; Mannell et al., 2018, Afghanistan; Snell-Rood, 2015, India; Superable, 2017, Philippines; among others). They often avoided telling friends, neighbors (Snell-Rod, 2015, India; Superable, 2017, Philippines) or even their family (Alvarado et al., 2019, Pakistan). Women also avoided public and institutional services. This prevented them access to health, legal or gender-based violence support services (Muuo et al., 2020, Kenya; Ogunwale & Oshiname, 2017, Nigeria; Thurston et al., 2016, China), which led to even greater vulnerability. Another consequence of anticipated stigma was what victims would decide not to work to avoid societal judgement and blame (Alvarado et al., 2019, Pakistan).

Public stigma also kept women in the abusive relationships, preventing breakup (n = 6); Alvarado et al., 2019, Pakistan; Thurston et al., 2016, China), even when violence was extreme (Apatinga & Tenkorang, 2022, Ghana). In addition to the loss of economic and material resources that resulted from divorce in these situations, public stigma would leave

them without any other kind of resource. This put victims and their children in a difficult situation (Superable, 2017, Philippines; Morse et al., 2012, Jordan).

In some of the articles reviewed, difficulties in employment (n=3) were also mentioned. Women were denied employment (Furr et al., 2014, India), and potentially lost employment (Maticka-Tyndale et al., 2020, Kenya; Thurston et al., 2016, China). Public stigma was also mentioned as it related to depression, as well as avoidance coping strategies (n=3; Alvarado et al., 2018, Ghana; Superable, 2017, Phillipines; Thurston et al., 2016, China). Women had to relocate (n=2; Alvarado et al., 2019, Pakistan; Maticka-Tyndale et al., 2020, Kenya) or abandon school (n=1; Alvarado et al., 2019, Pakistan) due to the stigma exerted by neighbors and peers.

Some articles also explicitly linked public stigma to the development of internalized stigma (n=2), in the form of internalized blame, shame, and isolation (Apatinga & Tenkorang, 2022, Ghana; Childress et al., 2022, Kyrgyztan). In addition, one article mentioned the escalation of violence as a consequence. Violence increased after police officers notified the batterer that a complaint had been filed, to assist him in getting it dismissed (Shuman et al., 2016, Coast of Ivory). Lastly, an article explained that, if a case reached the court, women were usually forced to "accept payment for agreeing to drop the case" to avoid public stigma (Childress et al., 2022, p.187, Kyrgyztan).

Other factors associated with public stigma toward IPV victims.

Different factors related to social norms and perceptions, public stigmatizing responses, and consequences were discussed. The existence of other intersecting stigmas that made the effects of IPV public stigma worse were mentioned in articles from all WHO regions but the article from the European Region. Furthermore, certain disadvantaged social circumstances were identified that made stigmatizing responses and their consequences worse for victims, which were described in some articles from the African, and Eastern

Mediterranean Regions. Finally, several protective factors were explicitly explored in different articles from all WHO regions but the European, which helped victims cope with their situation.

Intersecting stigmas.

Some studies described how the public stigma associated with IPV intersected with other socially stigmatized characteristics -divorce, and facial disfigurement- which reinforced social norms, public stigmatizing responses, and consequences described before.

The public stigma of divorce was prominently brought up in several articles (n=7) because it made it more difficult for victims to abandon their abusive relationship (Snell-Rood, 2015, India). According to Superable (2017, Philippines), divorced women were perceived as incapable of fulfilling their roles in maintaining the family. They faced reduced remarriage prospects (Alvarado et al., 2019, Pakistan; McClearly-Sills et al., 2016, Tanzania, Thurston et al., 2016, China), or even exclusion from future marriages (Strang et al., 2020, Iraq). They could also be watched (Morse et al., 2012, Jordan), treated differently, or they could be a victim of further violence by others (Morse et al., 2012, Jordan; Thurston et al., 2016, China). After divorcing, their family would also reject them (Morse et al., 2012, Jordan).

In certain cases, IPV left visible marks on women that were associated with further stigmatization. Furr (2014, India) described the public stigma that Indian women faced after suffering facial disfigurement from a fire attack by their husbands. According to this research, these women were rejected, isolated, and marginalized by their families and others due to facial disfigurement public stigma. They received continuous hostile and humiliating verbal abuse from others, and were publicly avoided on buses, streets, and shops. They were also blamed for the problems in their neighborhood, and considered unfit mothers, and of low value.

Disadvantages social circumstances.

Some articles explained how being poor or living in rural areas impacted public stigmatizing responses and their consequences on victims. Alvarado et al. (2019, Pakistan) mentioned that threats and harassment from police were more likely to occur after reporting their case if the victim belonged to a poor family. Similarly, displaced women faced more difficulties in disclosing IPV than settled women, as divorce and public stigma were an 'impossible price to pay' due to their precarious life conditions (Strang et al., 2020, Iraq). Finally, the scarcity of services in rural communities (i.e., only one market or school) could result in the victim losing access to services due to public stigma, leading to worse isolation (Alvarado et al., 2018, Ghana).

Protective factors.

Several factors that reduced the consequences of public stigma for victims were described, which we refer to as protective factors (n=10). Some articles describe instances of informal support from their family (Snell-Rod, 2015, India; Strang et al., 2020, Iraq; Thurston et al., 2016, China), neighbors (Snell-Rod, 2015, India), or other women (Strang et al., 2020, Iraq). They could provide emotional or instrumental support and were preferable to formal help. When matters could not be resolved in the family, religious and/or community leaders were considered a mediation resource in certain countries (Morse et al., 2012, Jordan; Strang et al., 2020; Iraq).

Although formal resources were usually scarce, mistrusted, and stigmatized, some articles explored their usage by victims. These articles described the benefits to victims of GBV support services, which could provide material resources, emotional support, key information, or housing (Mannell et al. 2018, Afghanistan; Maticka-Tyndale et al., 2020, Kenya; Muuo et al., 2020, Kenya). Additionally, Barnett et al. (2016, Kenya)'s participants claimed that hospitals and the health care systems worked against stigmatization, providing

them advice and effective support. However, due to fear of public disclosure, that help was rarely accepted.

Other protective factors identified in the articles were victims' awareness of support services, and self-perceived severity of IPV, as they promoted help seeking (Muuo et al., 2020, Kenya). Women's participation in household responsibilities and financial decision making, as well as involvement in business was also seen as protective (Byskog et al., 2014, Somalia), and was associated with disclosure (Mactika-Tyndale et al., 2020, Kenya). Having a future orientation (Byskog et al., 2014, Somalia), developing a sense of empowerment, and learning how to deal with public stigma (Furr et al., 2014, India) were also considered beneficial. Lastly, in some articles, religion and spiritual beliefs were considered a source of strength (Byrskog et al. 2014, Somalia; Morse et al., 2012, Jordan). In these articles, IPV was portrayed by women as abnormal and forbidden in Islam, developing a certain resistance discourse through religion.

Discussion

Public Stigmatization in Low- and Middle-Income Countries

The aim of this review was to identify and analyze four components involved in the process of public stigmatization of women victims of IPV in LAMIC. These components were: Social norms and perceptions associated with public stigmatizing responses toward IPV victims, such public stigmatizing responses, consequences of those responses for victims, and other factors that could reinforce or weaken the former components. The most significant findings are summarized in Table 1.

[Table 1 here]

First, we observed that the literature on public stigma in LAMIC is still scarce, and this stigma was usually not the focus of the study. Next, we discuss the aspects that we have considered most relevant regarding the public stigma components mentioned before.

Considering social norms and perceptions that were associated with public stigmatizing responses toward victims, the weight of patriarchal gender roles, the consideration of IPV as a private matter, and the normalization of violence were noteworthy, which has already been noted by recent literature (Ragavan et al., 2020; Tran et al. 2016).

The deeply rooted gender patriarchal roles could be considered at the core of public stigmatization and worked to maintain social order (Barnett et al., 2016). For instance, although we found that financial involvement and autonomy in women was associated with higher disclosure (Mactika-Tyndale et al., 2020), women's financial autonomy was also considered a threat to masculinity in certain countries and was associated with a higher risk of IPV and public stigmatization (Horn et al., 2014; McDouglas et al., 2019).

The perception of violence as a private matter of the partner or family was predominant. In this regard, it is interesting how public stigma toward victims was largely extended toward their families (Strang et al., 2020, Iraq) referred to as stigma by association. The family lost social status (Snell-Rood, 2015, India; Strang et al., 2020, Iraq; Superable, 2017, Philippines), was blamed (Alvarado et al., 2019; Pakistan), and shamed (McClearly-Sills et al., 2016, Tanzania; Superable, 2017, Philippines), which could increase social and financial problems (Strang et al., 2020). The severity of this stems from the fact that women could be expected to anticipate, not only the consequences of disclosing the abuse for themselves (Overstreet & Quinn, 2013), but also for their families, contributing to their silence. Likewise, those who decided to disclose abuse sometimes lost the support of their family, leaving them helpless (e.g., Snell-Rood, 2015).

IPV was normalized and justified in most countries. However, the types of violence and the degree to which it was legitimized varied from country to country, which is consistent with Tran et al.'s (2016) findings. In Tanzania, for example, sexual IPV was accepted as a mechanism for men to discipline their wives, and only certain very extreme forms of violence

were considered reportable (McCleary-Sills et al., 2016). This was the case, for example, with gun violence, or anal rape, in this case because sexual practice per se was considered taboo in their context. However, most of the selected articles focused on physical, sexual, or instrumental violence, and barely mentioned emotional or psychological violence, except in a few studies (Shuman et al., 2016; Thurston et al., 2016). There is a possibility that public stigma toward psychological IPV is even higher due to its "invisible" nature and normalization, so disclosure is not warranted. Therefore, studying the public stigma associated with psychological IPV could be a challenge for researchers, especially in LAMIC, as participants may not even recognize it as such.

In addition, and consistent with authors such as Tran et al. (2016), legislation in several countries could form a breeding ground for the normalization and legitimization of IPV from a structural level (structural stigma). In this regard, IPV laws varied from country to country. In some countries, legislation did not criminalize IPV except in cases of very extreme violence (McClearly Sills et al., 2018, Tanzania; Thurston et al., 2016, China) or the laws themselves provided for spousal obligations that legitimized the husband's use of IPV as a control mechanism (Barnett et al., 2016, Kenya). Furthermore, the law sometimes favored the husband in cases of divorce, for example, by granting him custody of the children (Morse et al., 2012, Jordan). Although the existence of laws against IPV and family measures in divorce would imply less structural normalization of violence and, with it, IPV prevalence (WHO, 2022), for these to be effective, efforts to decrease public stigma are necessary. In this sense, Kodikara (2018) found that victims preferred to ask for food assistance instead of relying on existing legislation related to IPV, to avoid public stigma. Interestingly, none of the study participants mentioned this relationship between structural stigma and public stigma.

As explained, the above-mentioned social norms were associated with public stigmatizing responses. The findings reaffirm the robustness of Murray et al.'s (2018) proposal, as all six responses were very present in the papers included in this review and no new ones emerged that could not be included in previous findings. Victim blaming predominated, with respect to which McClearly-Sills et al. (2016) stated the need to strive for perpetrators to be the focus of IPV accountability, and not women victims. In addition, special attention should be paid to the discrimination associated with being a victim of IPV, which, although not as frequent, included some of the most severe actions, such as honor killings (e.g., Alvaradao et al., 2019). It is also worth noting that the six types of stigmatizing responses were also exercised by professionals after the disclosure of IPV, especially by authorities (e.g., Childress et al., 2022), and even by those providing specialized services to victims of gender-based violence (Njuki et al., 2012). These facts alert us to the importance of intervening to prevent and combat stigma in the population, including service providers.

Continuing with our model, very negative consequences associated with public stigmatizing responses on victims were found. Anticipating public stigma, which was related to not disclosing the violence and/or not asking for help (e.g., Snell-Rood, 2015), something that has been alerted by recent literature (Murray et al., 2016), was by far the most popular among the studies and led victims to a greater situation of helplessness. The victims' silence would not only pose a barrier to accessing informal and formal support but would also diminish the beneficial effect of social support received by the victim by those unaware of the abusive situation. In this sense, Weisz et al. (2016) found that when the people offering support to the socially stigmatized person are aware of the stigmatized attribute -in this case, that they are victims of IPV- the beneficial effects of such support on health are greater.

Interestingly, Thurston et al. (2016) claimed their participants talked prominently about face saving and not disclosing IPV, while also telling stories of seeking help trying to

resist IPV. This apparent contradiction of survivors could be understood as a way to indirectly navigate the social norm of no disclosure in their communities, trying to avoid public stigma by not positioning themselves as someone who asks for help. This makes us wonder how often women share their experiences with others, even though, as we have seen, their efforts did not result in receiving support, but public stigma. More research is needed in this regard.

To conclude our model, other factors associated with public stigmatiza were mentioned. In line with previous studies (Murray et al., 2016), we highlight the importance of intersecting stigmas (e.g., associated with divorce; Superable, 2017), as they pose an added difficulty for disclosure and help-seeking. Additionally, disadvantaged social circumstances were related to higher vulnerability to public stigma. An example that is increasingly pointed out by the literature (Tran et al., 2016) is living in rural areas, not only because the isolation to avoid public stigma is greater, since the possibilities of mobility without being recognized are reduced (Alvarado et al., 2018), but also because geographic isolation makes it more difficult to access support services (Wright et al., 2021), which are very important in the absence of informal support (Ragusa, 2013). On the other hand, protective factors against public stigma were highlighted, among which informal social support stood out before support from authorities, which were highly mistrusted (Snell-Rood, 2015). The importance of social support has already been noted in previous studies of ethnic and racial diversity (Ragavan et al., 2020), and has been highlighted by IPV survivors themselves (Flasch et al., 2017). Some studies have found that social support predicts a higher probability of seeking formal help, and better health of victims, even more in the case of informal support (Liang et al., 2005). It is increasingly clear that it is important in cultures where there is a low prevalence of disclosure and help seeking to train the population to be supportive. However, cultural differences must be considered, since, for example, in India women tend to prioritize

the family as a source of support, rejecting help from close neighbors because this would jeopardize family stability (Snell-Rood, 2015). In this sense, intervention proposals such as that of Rai et al. (2022) have emerged. Through virtual scenarios in which the community population must act in the face of different types of violence, they aim to promote effective support responses in cases of IPV in South Asian victims living in the USA. Another protective factor which is worth highlighting was the existence of specialized services for victims (Muuo et al., 2020).

Differences on Public Stigmatization between High-Income and Low- and Middle-Income Countries

Finally, the construction process of our category system allowed us to easily compare public stigma between high-income countries and LAMIC. This is because, through the template analysis, we started from an initial template based on Murvartian et al.'s study (under review) with high-income countries, which was extensively modified through the coding of articles from LAMIC (see Figures 1 and 3). Therefore, we can point out some interesting differences and similarities between the two that we consider essential for the design of training programs and interventions to combat stigma.

First, regarding social norms and perceptions, the normalization of violence, the consideration of violence as a private matter, and gender roles were rarely mentioned in high-income country studies, while in LAMIC they were very prevalent. On the contrary, the belief that there is a victim profile, that leaving the abusive relationship is easy, and that victims who suffer IPV will suffer it again once they enter another relationship, which were detected in high-income countries (Murvartian et al., under review), were not in this study. In a context where IPV is normalized, and disclosure and breaking up are barely contemplated, it is understandable that these beliefs would not exist.

Regarding public stigmatizing responses, all those proposed by Murray et al. (2018) appeared in both high and LAMIC, with the difference that shame was more frequent in the latter. The consideration of IPV as a private matter and the weight of gender roles could explain this difference. Likewise, the way in which public stigmatizing responses were manifested was more severe in LAMIC since, for example, they include the police letting the abuser go free after being bribed, explicit isolation, and verbal harassment to victims, or committing honor killings. The consequences of public stigmatizing responses on victims were similar, however, abandoning school, relocating, and agreeing to drop the charges emerged in this study. Again, given the social norms in LAMIC, it is understandable that the extra effort of the victims to prove that they do things right (e.g., not going back to the offender after the breakup) to be taken seriously (Murvartian et al., under review) did not appear among the consequences of the selected articles. Regarding other factors associated with public stigma, we could not establish relevant differences due to the low prevalence of the subthemes. We can point out that the public stigma that is the subject of this study with other associated public stigmas such as divorce or facial disfigurement were characteristic in several countries in this sample. In articles from high-income countries this intersection was referred to characteristics stigmatized today more or less universally in low, middle and high-income countries, such as having mental health problems.

Although we have found, as we have seen above, particular characteristics in the different LAMIC, the final maintenance of the four a priori themes and the public stigmatizing responses of Murray et al. (2018) in the final coding scheme point to the strength of the general model constructed across countries. In the next sections, we outline limitations, and implications related to practice, policy, and research.

Limitations

Several limitations of our systematic review are dependent on the existing articles on IPV stigma in LAMIC in the literature. Although we tried to contextualize our results in terms of the countries the studies were from, there is a high diversity of cultures, social groups, and ethnicities within and between LAMIC that would certainly impact results. In this sense, there were no studies on public stigma in most LAMIC, which were not represented. In fact, no articles were found from the Region of the Americas. This dearth of research could be related to publication bias, as LAMIC articles generally receive less attention than studies from high-income countries (Kahalon et al., 2022). In addition, among the studies selected in this review, public stigma was usually not the focus of the study. The articles studied broad aspects of IPV, among which public stigma played a role. This led to more superficial data collection, analysis, results, and discussion related to stigma. Also, little attention was given in the reviewed articles to cultural differences, and the diversity of intersectional factors (i.e., age, socioeconomic background, ethnicity, etc) within their samples, which should be better explored in further research. Therefore, although we found many similarities in the social norms, public stigmatizing responses, and consequences of these responses on victims in the reviewed studies, generalization should be made with caution.

On the other hand, a potential limitation of this study is that only the term 'stigma' was used to search for relevant studies. While this decision was deliberate, based on the need to focus on the most specific and relevant literature in the research field of stigma, we acknowledge that this may have excluded some important studies that address related concepts (e.g., "attitudes") but did not mention public stigma explicitly. However, given the dearth of research on public stigma in LAMIC, the present review can serve as a starting

point for the systematic, and focused study of public stigma in all its components in these contexts.

Finally, a possible language bias might be considered a limitation, since we only searched for articles written in English. There may be other articles written in the language of origin of the various LAMIC that could be interesting to our subject. Also, potential relevant literature other than articles, such as books, conference abstracts or theses, were not analyzed.

Implications for Practice, Policy, and Research

Considering the results of this review, we stress the need for increased dialogue on IPV, and for public campaigns to fight public stigma directed at the general population to be funded, highlighting the importance of social support for victims. Moreover, investment is needed in training professional helpers to be aware of their own stigma, and to learn alternative practices that address the unique needs of IPV victims. Professionals should also develop a plan for safety and coverage of victims' basic needs that facilitates disclosure and recovery, and to mobilize the victim's trust networks to achieve and maintain support in the short term. In addition, funding for this unique support and protection should be ensured.

Regarding research advances, the findings of this paper extend previous relevant data related to public stigma in LAMIC, such as the prevalence of physical IPV acceptance attitudes in LAMIC analyzed by Tran et al. (2016). Also, it extends the findings on public stigma from the systematic reviews by Kennedy and Prock (2018) -which restricted their search to studies conducted in the United States- and Murvartian et al. (under review) -which focused on public stigma in high-income countries. For the future, we recommend studies on public stigma in IPV be conducted in all LAMIC, with a specific focus on public stigma. Furthermore, differences between countries, cultures, and social characteristics (e.g., socioeconomic status) on public stigmatization should be explored in depth, as well as the experiences of disclosure of violence (e.g., whether victims tried or not, whether they

succeeded or not, how many times they tried to leave), and public stigma associated with psychological IPV. In addition, culturally-sensitive evidence-based interventions to combat stigmatization should be developed. A summary of all these implications for practice, policy, and research can be seen in Table 2.

[Table 2 here]

Conclusions

From the results in this review, it can be concluded that living in a context of public stigmatization leaves victims completely isolated. This is because, in addition to the isolation caused by stigma, there is a lack of resources to leave the violence and rebuild their lives autonomously, laws and social norms do not favor divorce and access to support resources, or, when resources exist, they are not properly applied by professionals.

Despite the multiple cultural, economic, and other differences between and within LAMIC, we could identify many similarities in public stigma that warrant an in-depth systematic review such as this. We believe this review provides a comprehensive overview that can serve as a compass for further research on the nature of stigma for each specific sociocultural context. Likewise, the findings constitute a first step in the design of prevention and anti-stigma programs and highlight their necessity. To the best of our knowledge, there is only one intervention aimed at combating stigma in LAMIC (Le Roux et al., 2020, Democratic Republic of Congo), which focused on faith community members.

As revealed by our systematic review, addressing social norms regarding IPV in the community, local and/or religious leaders, service providers, and authorities, as well as providing IPV support services free of stigma, creating IPV laws, and awareness of services in the population are essential.

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Figure 1

Initial coding template, developed in Murvartian et al. (under review)

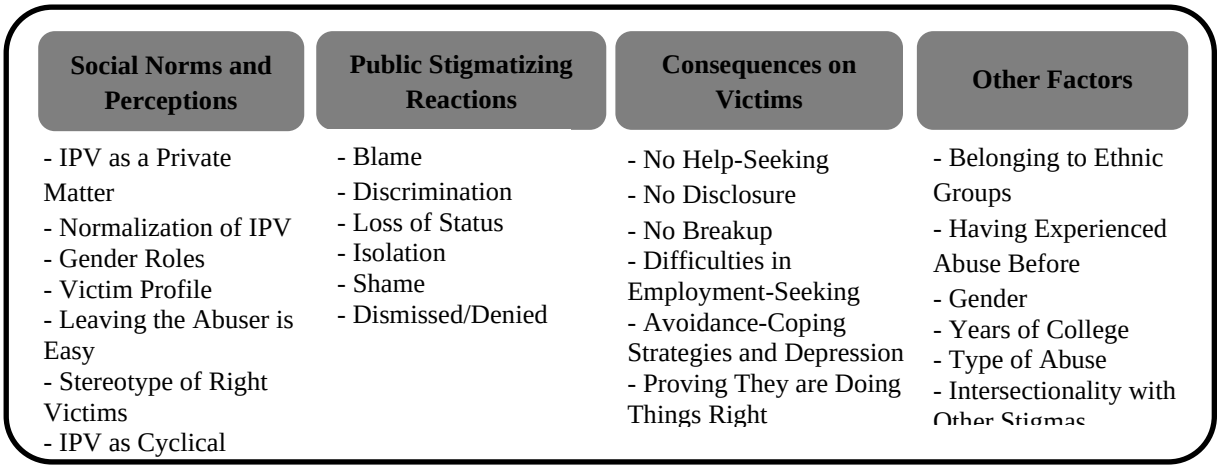

Figure 2

PRISMA flowchart for the inclusion process

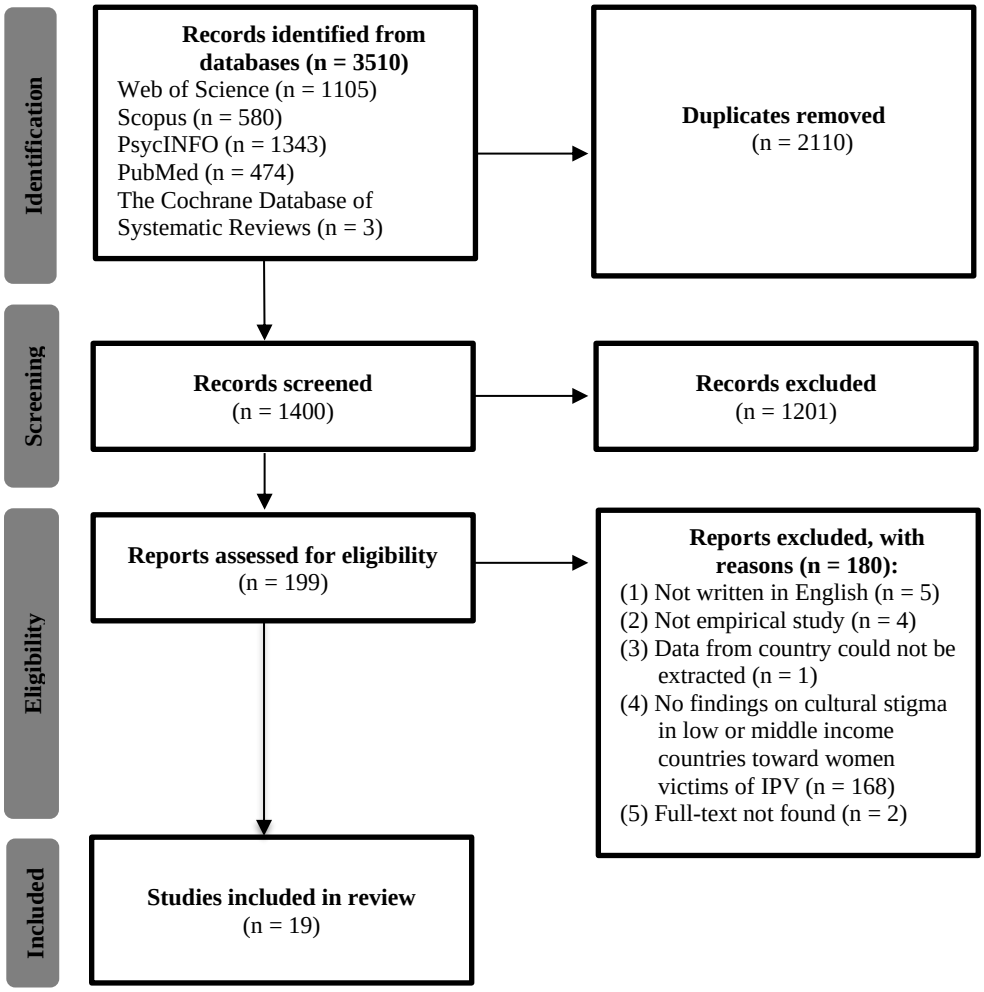

Figure 3

Model of public stigmatization towards women victims of IPV in low and middle-income countries

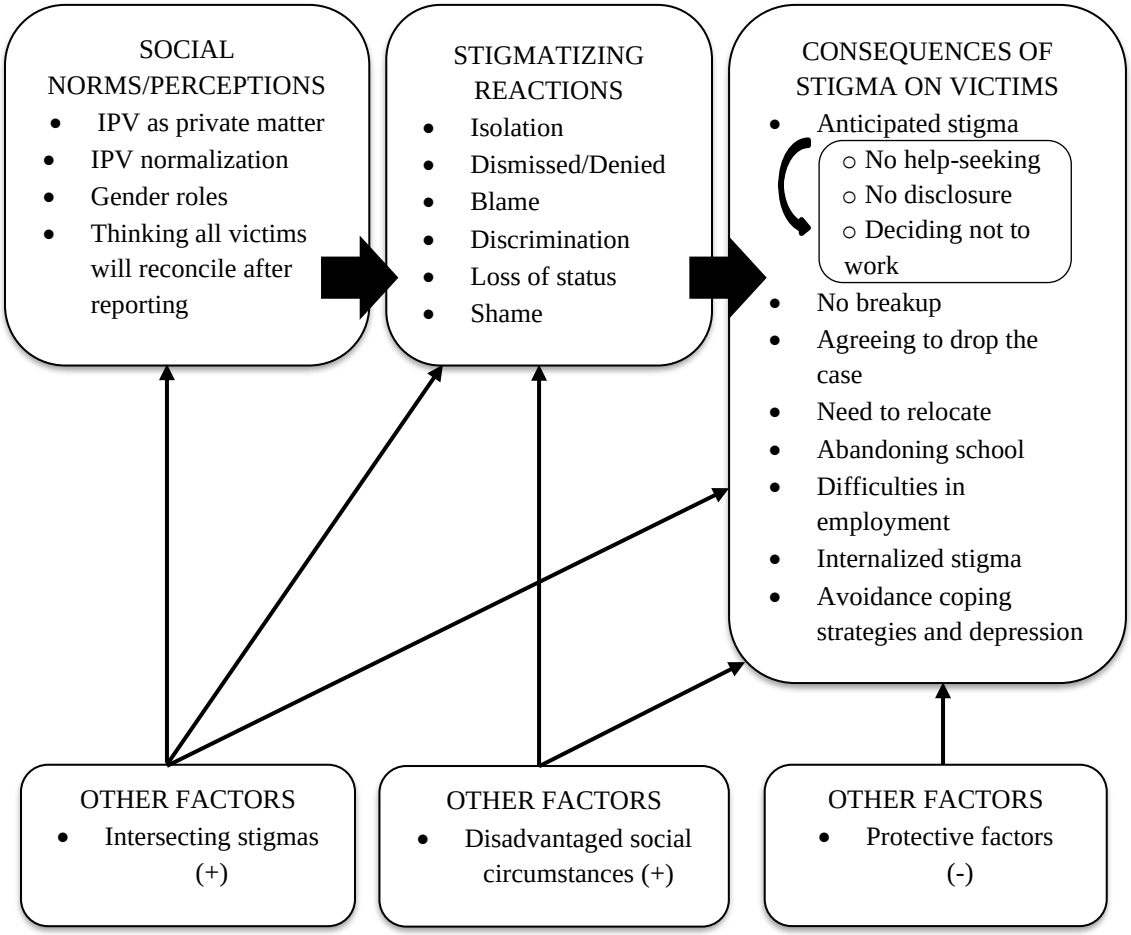

Table 1

Summary of main findings

• Gender roles that dictate women's functions in the family, normalization of IPV and consideration of this violence as a private matter were the most prevalent social norms and perceptions associated with public stigmatizing responses mentioned. • All public stigmatizing responses proposed by Murray et al. (2018)-Blame, Isolation, Shame, Dismissed/Denied, Loss of status and Discrimination (the least prevalent)-appeared frequently. • Many negative consequences of public stigmatizing responses on victims were identified. Anticipated public stigma, associated with not disclosing the abuse and not seeking help, was the most popular among the studies. • Public stigmatization was stronger when other public stigmas intersected (e.g., public stigma associated with divorce) and in the case of disadvantaged social circumstances (e.g., displaced women). Negative consequences on victims could be diminished by protective factors such as informal support and gender-based violence support services.

Table 2

Implications of the Review for Practice, Policy, and Research

Practice	Policy	Research
• There should be dialogue about IPV. • Professional helpers should become aware of their own public stigma and learn alternative ways to address the unique needs of IPV victims. • Professionals should develop a plan for safety and coverage of basic needs of the victims. • Professionals should mobilize the victim's existing trust networks.	• Funding should be invested in public campaigns to combat public stigma. • Increase funding to provide unique support and protection to victims. • Develop funding for the training of professional helpers in awareness of IPV public stigma and in learning best practices.	• Public stigma studies should be conducted in all LAMIC. • Studies that specifically focus on public stigma should be carried out. • Disclosure experiences should be explored in depth. • Public stigma associated with psychological IPV should be explored. • Differences across countries, cultures, and social characteristics on public stigmatization should be deeply analyzed. • Culturally-sensitive evidence-based interventions to combat stigma should be developed.

Appendix A

Characteristics of the selected studies and methodological quality

Author (year)	Sample (country were IPV and stigma occurred and WHO region, sample description and N, Sampling)	Descriptive sample data (age, marital status, ethnicity, job status and level of formal education)	Aims of the study	Methodology used in the study of stigma (Data type, measurement, and analysis)	IPV Stigma Role	MMAT
Apatinga & Tenkorang (2022)	- Ghana (African region) - Women who had experienced sexual intimate partner violence, were at least 18 years old, and were legitimately married or had been cohabitating for a minimum of one year (N=15) - Convenience sampling through snowballing	- Mean age: 42.82; Range: 25-65. - Almost all married or cohabiting. - Krobo, 93.3%; Ewe, 6.7%. - Most were petty traders, a few subsistence farmers, and one teacher. - No formal education, 53.3%; Completed primary, 13.3%; Some secondary, 26.7%; 6.7% Completed tertiary education.	To analyze the barriers to reporting sexual violence among married or cohabiting women.	- Qualitative - In-depth interviews - Thematic analysis	SR	5/5
Muuo et al. (2020)	- Kenya (African region) - Women reporting a new incident/case at a GBV service center in the Dadaab refugee complex. Mostly Somali origin (N=34) - Purposive sampling from a previous study	- Under 21, 8.8%; 21-30, 52.9%; 31-40, 29.4%; Over 40, 8.8%. - No current partner (widowed, divorced, separated or missing), 61.8%; Married, 32.3%; Never married, 5.9%. - No ethnicity information. - No job information. - No formal education, 55.9%; Some or completed primary, 29.4%; Some or completed secondary 14.7%.	To understand the characteristics of violence against women, describe the GBV survivors that seek support services and explore the barriers and facilitators to accessing care in the Dadaab refugee camps.	- Qualitative - In-depth interviews - Thematic analysis	SR	5/5
Maticka-Tyndale et al. (2020)	- Kenya (African region) - Women living in urban slums who had experienced IPV in the last 6 months (N=131). They were from NGO-sponsored support groups for IPV survivors (n=77) and from randomly selected households (n=54) - Convenience and randomized sampling.	- Mean age 28.5; Range 18-55. - All married or in a married-like relationship (51.1% live with husband) - Kikuyu, 46.6%; Kamba, 15.3%; Luhya, 12.2%; Luo, 9.2%; Other, 16,7%. - Employed, 76.3%; Unemployed 23.7%. - No formal education, 26.7%; Some primary, 28.2%; Primary 15.3%; More than primary, 29.8%.	To examine the association between disclosure and IPV stigma and assess the role of challenges to stigma, particularly by active bystanders in the slum neighborhood.	- Quantitative - Survey - Logistic regressions	CR	3/5
Alvarado et al. (2018)	- Ghana (African region) - Women survivors of IPV, non-partner sexual violence and without experience of violence (n=30), same-sex focus groups of men and women (n= 4; 6-10 participants each) and formal and informal community leaders (n=10) - Purposive sampling	- No age information. - No marital status information. - No ethnicity information. - No job information. - No formal education information.	To explore the impact of VAWG on a survivor's health, and the resulting social and economic costs on the survivor, their families and their communities.	- Qualitative - In-depth interviews, focus groups, key-informant interviews - Unspecified coding of data	SR	3/5

Ogunwale & Oshiname (2017)	- Nigeria (African region) - Women survivors to date rape from the University of Ibadan (N=8) - Convenience sampling, selected from previous study	- Age range 20-25. - No marital status information. - No ethnicity information. - No job information. - Second year to four year of university studies.	To explore the physical and psycho-social experiences of Date Rape female survivors at the University of Ibadan	- Qualitative - In-depth interviews - Thematic analysis	SR	5/5
Barnett et al. (2016)	- Kenya (African region) - Focus groups of survivors of IPV who received GBV support from a Trócaire partner organization (n=6, 5-7 participants each, 40 women in total), close family or friends (n=11) and key informants, including paralegals, lawyers, chiefs, counselors and female police officer (n=8) - Convenience sampling	Women survivors data: - Age range 19-61. - Separated, 57.5%; Married, 25%; Single, 12.5%; Divorced, 5%. - Diverse ethnic groups (unspecified). - Kiosk seller, 52.5%; Occasional casual laborers, 20%; Community worker, 10%; Clothes washer, 5%; Teacher, 2.5%; Nurse, 2.5%; Unemployed, 7.5%. - From partial primary school to completed college level. No information regarding close friends, family or key informants.	To show how GBV stigma operates as a form of social control to maintain the valued moral order of male dominance, procreation, and survival.	- Qualitative - Focus groups, In-depth interviews. - Thematic analysis	CR	5/5
Shuman et al. (2016)	- Coast of Ivory (African region) - Men (n=45) and women (n=46) community members in the Adobo, Adjame, and Treichville neighborhoods, of whom some were internally displaced people due to crisis and political violence (n=39) (N=91) - Convenience sampling	- Over 18 years old. - Partnered, 95.7%; Unpartnered, 4.3%. - Diverse ethnic groups (not specified). - Women data: Employed, 76.1%; Unemployed, 17.4%; Students, 6.5% (sample with low socioeconomic status). No information regarding men. - No formal education information.	To examine the frequency of IPV against women in urban Core d'Ivoire and explore how men and women perceive its impact on health, everyday activities and feelings of shame.	- Qualitative - Focus groups - Grounded theory approach	CR	5/5
McCleary-Sills et al. (2016)	- Tanzania (African region) - Key informants (public and private health care providers, Ward Reconciliation Council members, police gender desk officers, civil society representatives, ward/local leaders and representatives of relevant national ministries) (n= 104) and same-sex and age focus groups of men and women (n=12, 48 women, 48 men) from Dar es Salaam, Iringa, and Mbeya. No active recruitment of IPV survivors nor perpetrators. - Convinience sampling through snowballing.	No information regarding key informants. Focus groups participants data: - Group age ranges: 18-24 and over 25 - No marital status information. - No ethnicity information. - No job information. - No formal education information.	To understand community perceptions of VAW and related patterns of and socio-cultural barriers that limit women's agency in help-seeking after experiencing IPV	- Qualitative - Key-informant interviews, participatory focus groups - Field-based analysis workshops	SR	5/5

Njuki et al. (2012)	- Kenya (African region) - Health managers and service providers, voucher management agency managers and government administration officers at the district level (n=97). Focus groups (n=27, 6-8 participants each) with female voucher users and non-users, voucher distributors and opinion leaders such as local village elders, chiefs and community health. No active recruitment of survivors. - Convenience sampling	- No age information. - No marital status information. - No ethnicity information. - No job information. - No formal education information.	To explore the extent to which the Kenya output-based aid gender-based violence recovery services are viewed as effective, as well as any perceived barriers to the use of GBVR services.	- Qualitative - In-depth interviews, focus groups - Thematic analysis	SR	5/5
Strang et al. (2020)	- Iraq (Eastern Mediterranean Region) - Men and women displaced by ISIS occupation (n=27) and from a neighboring settlement (n=24) (N=51) - Convenience sample through snowballing	- No age information. - No marital status information. - Yezidi population. - No job status information. - No formal education information.	To identify available resources for meeting basic needs, dispute resolution and VAW, as well as to identify connectedness to and trust in such resources, with a focus on IPV against women.	- Qualitative - Interviews - Thematic analysis	SR	5/5
Alvarado et al. (2019)	- Pakistan (Eastern Mediterranean Region) - Women survivors of IPV, non-partner sexual violence and without experience of violence (n=24), same-sex focus groups of men and women (n= 8; 6-10 participants each) and experts from non-governmental organizations (NGOs), the judiciary system and commissions related to VAWG (n=8) - Purposive sampling	- Age range 18-60. - No marital status information. - No ethnicity information. - No job information. - No formal education information.	To explore the social costs of VAWG – the social, economic and health-related impacts on the women and girls who experience it, as well as their relatives and communities.	- Qualitative - In-depth interviews, focus groups, key-informant interviews. - Unspecified coding of data	SR	4/5
Mannell et al. (2018)	- Afghanistan (Eastern Mediterranean Region) - Women in safe houses who had experienced violence from their husbands or other male authority figures (N= 20) - Purposive sampling	- No age information. - Separated (in safe houses). - Diverse ethnic groups (unspecified). - No job information. - Most participants were illiterate.	To analyze what is the potential for storytelling to support women's mental health through challenging societal narratives of gender and violence	- Qualitative - Semi-structured in-depth interviews - Thematic analysis	SR	5/5
Byrskog et al. (2014)	- Somalia? (Eastern Mediterranean Region) - Somali born refugee women of fertile age living in Sweden (N=17) - Purposive sampling	- 18-24, 35.2%; 25-34, 47.1%; 35-45, 17.6%. - Married, 76.4% (whereof 76,9% were involuntarily separated); Cohabiting, 11.8; Single, 11.8%. - No ethnicity information. - Parental leave, 41.1%; Language studies, 35.3%; Employed, 17.6%; Preparation program, 5.9%. - No studies or Quran-school, 29.4%; Primary school, 35.3%; Middle/secondary school; 5.9%; High school, 23.5%; University, 5.9%.	To explore experiences and perceptions on war, violence, and reproductive health before migration among Somali born women in Sweden.	- Qualitative - Semi-structured interviews - Thematic analysis	SR	5/5

Morse et al. (2012)	- Jordan (Eastern Mediterranean Region) - Focus groups of women who had ever been married (N=12, 6 participants each, 70 women in total). Four groups were formed with women that had reported family violence exposure - Convenience sampling	- Mean age: 37.8. Group average age range 29.8-45.9. - Married, 47.1%; Widowed, 28.6%; Divorced, 24.3%. - No ethnicity information. - No job information (unspecified diverse socioeconomic backgrounds). - Average group years of education range 3.5-18.	To inform about Jordanian women's experiences and beliefs regarding family violence	- Qualitative - Focus groups - Thematic analysis	SR	5/5
Snell-Rood (2015)	- India (South-East Asia Region) - Women and their households living in one Delhi slum community (N=10) - Convenience sampling through snowballing.	- Mean age: 35: Range 23-60. - No marital status information. - Diverse ethnic groups (unspecified). - No job information (Mean household income 5900 rupees/month; range 3000 Rs-10,000 Rs). - No formal education information.	To explore from whom and how low-income women experiencing domestic violence in urban India seek informal support.	- Qualitative - Participant observation and semi-structured interviews - Longitudinal cross-case comparison	SR	5/5
Furr (2014)	- India (South-East Asia Region) - Focus groups of women with visible facial disfigurement due to fire assault by their husbands (N=2, 10-11 participants each, 21 women in total) - Purposive sampling	- Age range 19-51. - All married (90,5% living with or near husband). - No ethnicity information. - Some employed (servants or street-side vendors, unspecified %) (all lower caste origins, low to modest income families). - No formal education information.	To study the life of women survivors of domestic assaults with fire in India	- Qualitative - Focus groups - Analysis not specified	SR	4/5
Superable (2017)	- Philippines (Western Pacific Region) - Women living with their legal of common-law husbands that had experienced at least three times of physical battering by them and had at least one child (N=6) - Purposive sampling through snowballing	- Age range 24-35. - All married. - No ethnicity information. - Unemployed depending on husbands' income, 66.6%; Connected to government service, 16.6%; Teacher, 16.6%. - No information (lower than college), 83.4%; College, 16.6%.	To explore how battered women viewed their experiences as victims	- Qualitative - Interviews - Heidegger's hermeneutic phenomenology	SR	5/5
Thurston et al. (2016)	- China (Western Pacific Region) - Women who had been abused and had either left the abusive relationship or had no experience of an acute episode of abuse for at least 12 months (N=13) - Convenience sampling, through snowballing	- Age range: early twenties-mid forties. - Divorced, 53.8%; Cohabiting, 46,2%. - No ethnicity information. - Full-time working, 61.5%; Part-time working, 23.1%; Unemployed, 7.7%; Housewife, 7.7%. - Junior high, 15.4%; High school, 15.4%; College diploma, 15.4%; Post-secondary, 46.2%; Missing; 7.7%.	To understand the intersections of gender and other social institutions in constructing GBV from the perspectives of GBV victims in Guangzhou, China	- Qualitative - Semi-structured in-depth interviews - Thematic analysis	SR	5/5
Childress et al. (2022)	- Kyrgyz Republic (European Region) - Focus groups (n=63) and in-depth interviews (n=20) with women (n=65) and men (n=18) who had worked with IPV victims in their current positions (domestic violence or legal advocates, psychologists, healthcare providers, educators, and law enforcement officials) (N=83) - Theoretical sampling	- Over 18 years old - No marital status information - Russian, 6%; Kyrgyz, 94% - All employed (at least 1 year in their current job) - No formal education information	To understand the structural and legal barriers that prevent survivors of DV from seeking help in Kyrgyzstan from the perspectives of professionals working directly with survivors (law enforcement, judicial system, social, health, and educational professionals)	- Qualitative - Semi-structured in-depth interviews and focus groups - Grounded theory approach	SR	5/5

Appendix B

Presence of social norms and perceptions associated with public stigmatizing responses and public stigmatizing responses

	Social norms and perceptions				Public stigmatizing responses					
Author (year)	IPV as a private matter	IPV normalization	Gender roles	Thinking all victims will reconcile after reporting	Isolation	Blame	Discrimination	Shame	Loss of Status	Dismissed/ Denied
Apatinga & Tenkorang (2022)	X	X	X							X
Muuo et al. (2020)	X		X		X	X				
Maticka-Tyndale et al. (2020)			X		X					
Alvarado et al. (2018)	X	X				X		X	X	
Ogunwale & Oshiname (2017)			X		X					X
Barnett et al. (2016)	X	X			X	X	X		X	X
Shuman et al. (2016)			X		X	X	X	X	X	X
McCleary-Sills et al. (2016)	X	X	X			X		X		X
Njuki et al. (2012)	X									
Strang et al. (2020)	X					X		X	X	X
Alvarado et al. (2019)	X	X			X	X	X		X	X
Mannell et al. (2018)						X	X	X	X	

Byrskog et al. (2014)	X		X		X	X		X		
Morse et al. (2012)	X	X	X		X	X	X	X	X	X
Snell-Rood (2015)	X				X	X		X		X
Furr (2014)			X		X	X				
Superable (2017)	X	X	X					X	X	
Thurston et al. (2016)	X	X	X		X	X	X	X	X	X
Childress et al. (2022)	X	X		X	X	X		X		X

Appendix C

Presence of consequences of public stigmatizing responses and other factors associated with public stigma

Author (year)	Consequences of public stigmatizing responses for victims											Other factors		
	Anticipated stigma			No break-up	Dropping the case	Relocation	School abandonment	Difficulties in employment	Avoidance coping strategies and depression	Internalized stigma	Escalation of violence	Intersecting stigmas	Disadvantaged social circumstances	Protective factors
	No help-seeking	No disclosure	Deciding not to work											
Apatinga & Tenkorang (2022)														
Muuo et al. (2020)	X	X												X
Maticka-Tyndale et al. (2020)						X		X						X
Alvarado et al. (2018)	X	X		X					X			X	X	
Ogunwale & Oshiname (2017)	X	X												
Barnett et al. (2016)	X	X		X										X
Shuman et al. (2016)	X										X			
McCleary-Sills et al. (2016)	X	X										X		
Njuki et al. (2012)	X	X												
Strang et al. (2020)	X	X										X	X	X
Alvarado et al. (2019)	X	X	X	X		X	X	X				X	X	
Mannell et al. (2018)		X												X

Byrskog et al. (2014)		X												X
Morse et al. (2012)	X	X		X										X
Snell-Rood (2015)	X	X											X	X
Furr (2014)								X					X	X
Superable (2017)	X	X		X					X				X	
Thurston et al. (2016)	X	X		X				X	X				X	X
Childress et al. (2022)					X		X				X			