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Vulnerabilities and Inequities: Challenges Experienced by Professionals Engaged with Migrant and Refugee Survivors of Gender-Based Violence in Canada

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Abstract

Migrant and refugee women are vulnerable to gender-based violence (GBV) at multiple points along the migratory pathway, including after they arrive in Canada. Their vulnerability in Canada is related to legal and policy frameworks to (im)migration, settlement and integration but also to the precarious nature of social services for migrant and refugee survivors of GBV. Drawing upon theorizing on intersectionality, vulnerability and precarity, this article describes findings from a qualitative study involving the reflexive thematic analysis of 43 interviews with professionals engaged with government policy and the provision of public services for migrant and refugee women survivors of GBV in Canada. Our analysis reveals their marginalization within social systems and their involvement in unintentionally reproducing obstacles faced by migrant and refugee women. The findings add to and nuance the small body of research on the experiences of professionals involved in Canadian GBV services for migrant and refugee women. We make contributions to theorizing, highlighting the structural components that impact service provision to migrant and refugee survivors of GBV, and suggest recommendations for policy change.

Keywords: public service providers; migrant and refugee women; gender-based violence; domestic and intimate partner violence; vulnerability; precarity

1. Introduction

Migrant and refugee women (MRW)[1] are vulnerable to gender-based violence (GBV) at various points along the migratory pathway, from their country of origin to their final destination, including the time after their arrival. GBV consists of acts of violence against individuals because of their gender, gender expression, gender identity or perceived gender (Government of Canada 2025). Forms of GBV perpetrated against MRW can include domestic/intimate partner violence (D/IPV), forced marriage, sexual violence, female genital mutilation (Carman and Elash 2018), witnessing destruction of communities and families (Clarke et al. 2024), and violence against LGBTQ+ persons perpetrated in countries of origin (Jordan and Morrissey 2013); physical attacks, sexual harassment, exploitation, trafficking and malnutrition during transit (Borges 2024; Tsegay and Tecleberhan 2025), and D/IPV, immigration-related abuse (Tabibi et al. 2018), and sexual violence in the host country. In the 2018 national Survey of Safety in Public and Private Spaces, immigrant women (25.2%) were less likely to report experiences of GBV (unwanted sexual behaviour, sexual and physical assault) in public spaces, workplaces and online than non-immigrant

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women (41.2%) in Canada (Cotter and Savage 2019, p. 37). Likewise, Canadian immigrant women (30%) were less likely to report experience of D/IPV than non-immigrant women (48%) (Cotter 2021, p. 20). According to the 2019 General Social Survey of Victimization, 22.4% of women in Canada reported experiences of D/IPV to the police, 44.3% used a formal support (counsellor, shelter, crisis line or sexual assault centre), and 72.1% sought informal support from a friend, family member, coworker or religious leader (Conroy 2021, pp. 31–32).[2] After arrival in Canada, some MRW want to talk about their experiences with staff at settlement service agencies or seek help from anti-violence service providers to mitigate the impacts of GBV. Yet many do not, largely due to the social stigma associated with GBV (Tastsoglou and Wilkinson 2023) and the structural barriers to help-seeking (Tastsoglou 2025; Yalcinoz-Ucan et al. 2025). Intersecting structures of gender, race and class create and amplify systemic inequalities which contribute to the marginalization of MRW in Canadian society and hinder their attempts to seek safety (Tastsoglou et al. 2022). Systemic inequalities exacerbate MRW's vulnerabilities and increase their dependency on the individuals and groups who exercise power over them. While our understanding of how intersecting inequalities impact MRW's experiences of GBV and help-seeking efforts is growing, more research on how policy makers and service providers are responding to this information is needed. In this study we explore two questions: (1) How do systemic inequalities impact the organizations and individuals that provide services to MRW who seek help? and (2) How does the structural marginalization of anti-GBV and immigrant settlement services in Canada contribute to the vulnerabilities of MRW survivors of GBV?

This article is based on the analysis of data collected through qualitative interviews with individuals who work in government, settlement, advocacy, and GBV services to create and implement policies and services for MRW in Canada. Most of these government workers and service providers are women, some with their own histories of migration and/or GBV. Our findings show that government personnel, members of NGOs, and front-line service providers encounter systemic marginalization and societal challenges in assisting MRW survivors of GBV. In other words, the institutional vulnerability of immigrant and GBV policy and service provision is associated with the individual vulnerability of MRW survivors of GBV.

Conceptualizing GBV as a social problem involving intersecting structures of inequality that create vulnerability helps us understand why it is difficult for service providers and policy makers to assist MRW survivors of GBV (Tastsoglou and Freedman 2025). While changes in service delivery can assist some individual MRW survivors and changes in policy can provide service providers with more tools for working with them, the larger structures and systems that make MRW vulnerable to GBV and make it difficult for organizations to help them remain in place. Our analysis of the interview data shows how service providers, anti-GBV advocates, and policy makers understand the complexity of intersecting systems in immigration, public health, and social services in Canada, where service provision and advocacy efforts remain dependent on government funding to provide limited support for specific categories of MRW survivors. Professionals in these sectors do not want to jeopardize the support they currently offer to their respective groups by taking on supporting others who do not meet the government's criteria. The precarity of GBV and immigration policy and funding models, coupled with the increasing demand for support services, leaves professionals in these sectors with little time and energy to collaborate in advocating for systemic change.

Theory and Research on Service Provision to MRW Survivors of GBV

According to Fineman's (2020) vulnerability theory, all people experience periods of vulnerability throughout the course of their lives due to the biological fact of physical

embodiment. She argues for an equitable distribution of institutional responsibility for providing essential care for people experiencing situations of vulnerability, emphasizing the important role of state institutions in supporting people through vulnerable times (Fineman 2017). Turner (2006) also theorizes from the standpoint of human vulnerability. For him, human embodied vulnerability to suffering is the basis for universal human rights. This includes the right to safety from and care because of cruel or degrading treatment, such as GBV. To this Turner adds the concept of institutional vulnerability. "Social institutions necessary for our survival are themselves fragile and precarious, and there is a complex interaction between our human frailty, institution building, and political or state power" (Turner 2006, p. 1). According to Turner, there is a dynamic interrelationship between individual human vulnerability and institutional precarity. Social institutions need to be continually scrutinized and reformed when they fail to safeguard human vulnerabilities. Furthermore, Butler (2009) highlights the universal human vulnerability to violence. Butler (2004, 2009) illuminates "ways of distributing vulnerability", or the unequal distribution of ontological/existential "precariousness" because of political decision-making and its transformation into socially constructed "precarity".

We harness these conceptualizations of individual and institutional vulnerability and precarity to analyze the perspectives of professionals who contribute to GBV policy and interventions for MRW survivors. Migration produces situations of vulnerability as people move from known contexts to the unfamiliar. Contemporary migration is a result of global economic, social, and environmental precarity in which people from countries of the global South migrate to the global North, seeking better work, education and living conditions. Vulnerability is context-dependent and dynamic. Thus, we can analyze the role of Canadian governments in the distribution of political, economic, social and cultural precarity for various groups of MRW and the organizations/agencies responsible for providing them support in situations of GBV (Reilly et al. 2023).

In their review of the legal and policy frameworks pertaining to GBV and immigration in Canada, Tastsoglou et al. (2022) identify fault lines that contribute to MRW's vulnerability to situations of GBV. Federal and provincial laws and policies exist to support MRW survivors of GBV, however there is significant variation between provincial/territorial laws and policies, leaving survivors in some regions of the country more vulnerable than others. While governments share responsibilities for caring for the needs of MRW survivors of GBV and their children by providing funding for social services through the National Action Plan to End GBV, funding to sustain core service delivery is described as an "opportunity for action", rather than a commitment (FPT Forum 2022). Since the late 1980s, neoliberal political ideologies about austerity, individual responsibility, and privatization (Reilly et al. 2023) have influenced Canadian social policies, leaving responsibilities for service provision for MRW survivors of GBV to non-state agencies and organizations without adequate funding (Chan 2020).

Research on the diverse experiences of MRW survivors highlights their unique needs as well as the barriers they face when seeking help from service providers. Refugee women are vulnerable to multiple forms of GBV perpetrated by male intimate partners and strangers, government officials, security forces, development workers and civilians as they flee their countries of origin, during periods of displacement, and in the country of asylum. Based on a study of refugee women in Portugal, Borges (2024) asserts that refugee women are particularly vulnerable to structural violence because of the stigma and prejudice they face as members of ethnocultural minority groups. A critical, intersectional ethnographic study of Syrian refugee women's experiences of pre- and post-migration trauma (Al-Hamad et al. 2023), highlighted language barriers, housing challenges, economic insecurity, social isolation, and a lack of trauma-informed and culturally sensitive healthcare services in

Ontario, Canada. In a study of Eritrean refugee women survivors in the UK (Tsegay and Tecleberhan 2025), researchers identified religious and cultural support for patriarchal family structures, post-migration stress, financial dependency on abusive husbands, a lack of education about domestic violence and resources available for seeking help, and language barriers as factors that contributed to their experiences of D/IPV post-settlement. A systematic review of research on the sexual and reproductive health care needs of refugee women who experience GBV identified structural barriers to health care services such as precarious legal status, community norms and lack of trust with service providers (Mathis et al. 2024).

Research with immigrant women in Canada emphasizes their vulnerability in situations of GBV and hesitancy to seek help from service providers are exacerbated by socio-economic inequality (Barata et al. 2005; Fong 2010), racialization and racism (Bannerji 2002), immigrating with young children (Brownridge 2009), unfamiliarity with their legal rights and the public support services for abused women (Wachholz and Miedema 2004), and the loss of family and friendship support networks (Cottrell 2008). Some studies illustrate the ways that culture shapes immigrant women's experiences of GBV and help-seeking. Muruthi et al. (2022) found that the collectivist cultural backgrounds and transnational ties of African immigrant women survivors prevented them from disclosing experiences of GBV. They did not want their families to worry about them, create barriers for family members to migrate to the US, or seem ungrateful for the opportunity to immigrate. Likewise, research with Arab immigrants in the US and Canada (Shalabi et al. 2015) highlights that in situations of violence, families prefer to consult trusted relatives to maintain privacy and family honor. This is difficult to do following migration, coupled with the lack of confidentiality within Arab immigrant groups when abuse is disclosed (Kulwicki et al. 2010). Niroomand et al. (2024) review of research on Iranian immigrant women survivors of D/IPV found that in addition to their precarious immigration status, the stigma of divorce and reluctance to use women's shelters, they tolerated violence because cultural, religious and education factors prevented them from recognizing psychological and financial abuse. According to Chan's (2020) research of immigrant women survivors of D/IPV in British Columbia, Canada, domestic violence and immigrant settlement agencies provide service for immediate, basic needs but cannot afford to implement new strategies, evaluate current practices, train staff or prevent staff turnover due to low wages. Based on research with Yazidi refugees, Battacharyya et al. (2021) argue that Canadian settlement organizations are unable to adequately address the long-term impacts of trauma among immigrant and refugee survivors of sexual and GBV.

There is relatively little research featuring the perspectives and experiences of Canadian professionals engaged in policy and service provision for MRW survivors of GBV and most of what has been done has focused on services for survivors of D/IPV (Giesbrecht et al. 2022). Challenges identified in the existing research with professionals include differing understandings of D/IPV, the complexities of the intersection between D/IPV and immigration policies and processes; lack of trust between service providers and immigrant women (Holtmann and Rickards 2018); difficulties in navigating the criminal justice, immigration and family law systems, securing funding, defining service mandates and making referrals as well as ensuring culturally competent service provision (Chan 2020; Tastsoglou et al. 2014); the lack of safe shelters, services and public transportation in northern communities (Wuerch et al. 2019); difficulties in adequately responding to the needs of newcomer women's children who may have experienced pre-migration trauma along with exposure to D/IPV; failures to address the intersecting needs of newcomer women survivors and their children in the immediate aftermath of violence, and the lack of longer-term supports (Giesbrecht et al. 2022); "strategic thinking" of professionals who

are refugee advocates in their efforts to support GBV survivors in the adjudication process when the latter claim protection in Canada (Tastsoglou and Nourpanah 2019); and finally, the overlooked educational and emotional support needs that service providers specifically dealing with refugees and refugee claimants are faced with (Brigham et al. 2015).

Research on pre-migration trauma is on the rise, emphasizing the need for service providers to attend to MRW's experiences of pre-migration trauma—trauma and violence experienced in their country of origin or in transit can impact how survivors perceive and respond to violence postmigration in Canada (Tabibi et al. 2018). Wathen and Mantler (2022) argue that trauma is the response to a series of overwhelmingly negative events. Complex traumatic experiences occur alongside forms of structural violence and oppression including those rooted in pre-migration experiences. Trauma- and violence-informed care requires understanding trauma as an ongoing, historical and systemic experience that impacts individuals and collectives. Trauma is linked to intersecting systemic inequalities such as racism, poverty, and immigration status (Wathen and Mantler 2022). Best practices for supporting GBV survivors from diverse backgrounds should include service provider training in trauma-informed practices which include understanding intersectionality, women's backgrounds, cultural norms, fostering trust and inclusivity, building community relationships, and sharing culturally responsive education on GBV (Taylor et al. 2024).

2. Materials and Methods

This article draws upon data from the Canadian research program, associated with the international project Violence Against Women Migrants and Refugees: Analyzing Causes and Effective Policy Response. The Canadian research team consists of four faculty at four different universities, postdoctoral fellows and graduate student research assistants. Following approval from the research ethics boards of the four universities, members of the project's Expert Advisory Group provided us with contact information for organizations that created policies for or provided services to MRW survivors of GBV across the country. Professionals were recruited through English and French emails sent to government departments, immigrant settlement agencies, nongovernmental organizations (NGOs), and community-based organizations across the country. Criteria for inclusion was experience working with MRW survivors of GBV or involvement in developing policy and/or programs the support MRW. Semi-structured interviews were conducted with 43 professionals by postdoctoral and graduate student researchers between fall 2019 and summer 2020. Interviews were conducted in English and French in person, but also remotely by phone or with online software and lasted between thirty minutes and two hours. Participants were asked about the focus of their work, their understanding of GBV, the kinds of GBV experienced by the MRW with whom they work, the impediments to providing MRW survivors with support, factors contributing to GBV, trends and challenges to improving the lives of MRW survivors of GBV, biggest threats to their work, and changes needed.

Forty-two of the research participants identified as women and one as a man. These professionals, from here on referred to as key informants (KIs), had been working in their current jobs from three months to thirty years. Fifteen KIs were responsible for services in the immigrant settlement sector. Thirteen KIs worked in the anti-violence sector to support survivors of domestic violence. Six KIs worked in provincial or federal government departments dealing with women's issues, immigration, and policy. Five KIs worked with NGOs focusing on women's issues, anti-violence, and immigration. Two KIs provided legal services to immigrants and refugees and two KIs worked in health care clinics for refugees. While participants were from all regions of the country (Atlantic, Central, Western and Northern), this is a convenience sample and not representative of the population of KIs.

All the interviews were transcribed verbatim by two postdoctoral researchers and information that might identify individual research participants or their organizations was removed from the transcripts. One of the co-authors, while working as a postdoctoral researcher with the project, used QDA Miner software, version 2024.0.5, to conduct the initial analysis of the data. Braun and Clarke's (2006, 2019) reflexive thematic analysis was used as an analytic guide for the study. Reflexive thematic analysis clarifies and builds on Braun and Clarke's (2006) early work. Data analysis for this project was completed using the six recursive phases of reflexive thematic analysis: familiarization with data; coding; generating initial themes; reviewing and developing themes; refining, defining, and naming themes; and writing up (Braun and Clarke 2021).

In the first phase, the co-author read and re-read transcripts to familiarize herself with them and noted initial observations and reactions. Next, she generated initial codes by coding passages across the data set using line-by-line coding. In reflexive thematic analysis, coding is a subjective process that is unstructured and organic (Braun and Clarke 2021). Themes are developed from codes, so the third, fourth, and fifth phases were dedicated to developing, naming, and refining themes based on conceptual similarity. Both analytic and interpretative work is required for reflexive thematic analysis, so generated themes captured both "semantic (explicit or overt) and latent (implicit, underlying; not necessarily unconscious) meanings" (Braun and Clarke 2021, p. 39). At each iteration in these three phases, the co-author checked back to ensure that the theme sufficiently captured the raw data. Six themes and nine subthemes were created in the complete analysis.

The theme used to answer the research questions for this manuscript was Challenges and Vulnerabilities and it included the subthemes: (1) "of work" and (2) "of individuals". The first subtheme "of work" consisted of data related to macro systemic challenges faced by KIs in navigating government and legal systems and policies, micro systemic challenges experienced by KIs at the organizational and personal level working with MRW as well as the biggest threats to their work, which were used in describing KIs' experiences of organizational marginalization within Canadian social systems and the consequences of systemic marginalization for workers in the anti-GBV and settlement sectors. The second subtheme "of individuals" consisted of data related to KIs' perspectives on MRW's vulnerabilities and the impediments to providing GBV support, which were used to describe KI's involvement in reproducing the systemic inequities experienced by MRW survivors of GBV.

3. Results and Discussion

In what follows, we describe three themes: (1) the marginalization of immigrant settlement and anti-GBV sectors in social systems; (2) the marginalization of workers in these sectors as a result; and (3) the reproduction of systemic barriers for MRW survivors of GBV. The relationship of each theme to the research literature is also addressed.

3.1. Marginalization of Immigrant Settlement and Anti-GBV Sectors in Social Systems

Our analysis highlights that the agencies, organizations, and departments within which the KIs work, whether in the anti-GBV or immigration sector, are marginalized by federal and provincial governments in Canada. Almost without exception, front-line service providers, administrators and members of NGOs said that inadequate and/or precarious government funding was the biggest threat to their work in supporting MRW survivors of GBV.

GBV services are marginalized and their status is precarious within Canada's social service sector, despite a report by the Chief Public Health Officer (Taylor 2016) emphasizing that GBV is an important public health issue with direct impacts on Canadian's physical and

mental health and indirect contributions to chronic stress and risky behaviours with their associated health impacts. Canadian women's shelters, second-stage housing, domestic violence outreach services, sexual violence services, and women's advocacy organizations depend exclusively on short-term provincial and federal government grants and their fundraising efforts. They do not receive sustained core funding like Canadian health care or police services.

Furthermore, there is inadequate collaboration between government departments in Canada on the issue of MRW's experiences of GBV, which falls at the intersection of their respective mandates. Funding and policy for services provided to MRW survivors of GBV comes from several government departments. The courts and police are funded by justice departments; shelters and second-stage housing by social assistance/development departments; domestic violence outreach by women and gender equality departments; sexual assault nurse examiners by health departments; child welfare by social welfare departments; and immigrant settlement services by immigration, education, or labour departments. Different departments have different priorities and supporting MRW survivors of GBV and their children is not the top priority for any one of them. Commenting on the need for a more collaborative government approach, a worker in a community-based organization providing translation services for shelters said:

> *This is where I think the policy responses will have to work—when these kinds of intersectionalities exist, several ministries of several services need to come together to deal with it, not one can deal with it alone.*[3] (KI18)

When government departments do not collaborate, the unique needs of MRW survivors of GBV are not adequately addressed.

The government's uncoordinated mandates and insufficient support have implications for public support for MRW of GBV. A KI from a policy agency explained that people generally do not want to talk about the topic of GBV. "[GBV is] a topic that, because it is difficult and because it often traditionally has not been talked about, I think it still, I think it's getting better, but I think it's still easy for people to want to ignore it" (KI14). Even if GBV is mentioned by political and community leaders, it is not prioritized for resource allocation. As one KI suggested, "Politicians and police departments talk about the importance of domestic violence, but I don't really see that the resources are being put in place to support what they're saying" (KI30). Simply put, GBV service providers are "overtaxed and underfunded" (KI31).

In a similar way, public misconceptions about and prejudice against immigrants threaten government funding for settlement services. A KI reflected on these misconceptions:

> *What happens is when immigrants come, they are seen as taking away opportunities... So, what happens is the intention of the, what would you say, the government, of wanting to bring people in and doing it and opening borders, doesn't trickle down to the regular citizen. You know? So, there is always that unhappiness. Why are we bringing [more immigrants]? Without realizing that there is a huge problem when you don't bring [immigrants].* (KI18)

The Canadian federal government recently announced a "pause to population growth in the short term to achieve well-managed, sustainable growth in the long term," (Government of Canada 2024) citing a lack of housing and strains on social services in the country. However, governments in Canada shifted towards a neoliberal policy agenda in the late 1980s, cutting back investments in affordable housing and social welfare programs (Coulter 2009; Silvius 2016). It is more likely that the decision to cut back on immigration quotas was due to public opinion polls showing growing anti-immigrant sentiments among Canadians (Environics Institute 2025). The sector crises that were blamed on immigrants emerged, in

fact, as a result of government policy cuts in the same sectors. This is a telling example of how neo-liberal-inspired economic policies work in tandem with xenophobia and racism. Immigrants were framed as over-consumers of housing and social services instead of as citizens with legitimate needs (Coulter 2009). The marginalization of the immigration and anti-GBV sectors is underscored in this case by policies whose outcomes are attributed to a third party, i.e., immigrants and refugees. At the same time, the federal government's "population pause" announcement was not welcomed by provincial governments (Kilpatrick 2025) who rely on immigrants to meet labor market demands.

Responding to the needs of MRW survivors of GBV is a relatively recent development in the immigrant settlement sector in Canada. Even though many refugees have experienced GBV in war or camps for displaced persons and immigrants arrive in Canada in relationships and part of families, their experiences as survivors of GBV were not originally considered part of the needs to be addressed through settlement services. Funding for settlement staff training and resources to respond appropriately to MRW survivors of GBV was late in coming. Like the GBV sector, funding for GBV-specific services within the immigrant settlement sector is precarious. A KI working in the settlement agency shared:

> *Our biggest threat is that the funders, 'cause we're funded provincially and federally, would put our services to an educational institute, at the regional college, or they may put our funding through an economic development blend, because, you know immigration, regardless of whether you're a government assisted refugee or you're an entrepreneur, it's all economic right*. (KI10)

This KI explained that provincial and federal governments' chief priority for immigration is economic growth. Immigrants contribute to Canada's financial prosperity through their participation in the labor market, in the establishment of companies, in investments, and in maintaining population levels. The provision of settlement services, intended to assist immigrants' success in these areas, is the responsibility of provincial governments. In this participant's experience, the delivery of settlement services has been shifted from non-for-profit settlement organizations to different provincial departments, depending on government priorities, without consideration for the specialized services needed by and developed for MRW survivors. It takes time to build trust between settlement staff and MRW (Holtmann and Rickards 2018; Mathis et al. 2024), and it is in the development of a trusting relationship that survivors of GBV may disclose their experiences to settlement service providers. Settlement service providers, in turn, need time to build capacity for responding appropriately to MRW survivors' needs (Cameron et al. 2025; Taylor et al. 2024). When funding and responsibility for settlement services is transferred from a not-for-profit settlement agency to an education system (for language and employment training programs, for example) then trust and capacity in the non-for-profit settlement sector to address MRW survivors' experiences of GBV are eliminated from settlement service provision. This is an example of how government economic priorities marginalize services for MRW within the settlement sector. It also suggests a lack of collaboration between the government departments that share responsibility for delivering immigrant settlement services.

A settlement worker explained the complexity of the available funding model to provide services for immigrants and refugees:

> *[We] have two levels of funding. One is from the federal and one from the provincial. Now, the federal funding is only appropriate for us to work with the immigrants who have the permanent residence or the refugee who already have the first stage of approval. That's it. The rest goes to the provincial funding. Now, from the international students, from Provincial Nominee Program, from temporary foreign workers, from the refugees, from the Canadian citizenship, it goes to the province. . . However, the provincial funding is, very, very slim, very small*. (KI23)

Government funds for settlement support are allocated based on different categories of entry and immigration status. Yet there are gaps and if an MRW survivor of GBV does not meet the specific criteria for a particular kind of settlement service, she is ineligible for support. This demonstrates a lack of coordination of federal and provincial policies. Table 1 lists the different categories of MRW and the basic benefits they are entitled to from the federal and/or provincial governments for public services.

Table 1. Health, Income, and Settlement Entitlements of MRW.

Legal Categories	Health Care	Income Assistance	Settlement Services
Citizens and Permanent Residents (PRs)	Yes	Yes, when requirements are met	Only PRs
Sponsored Partner (with PR application by spouse in process; or conditional PR for 2 years)	Yes	Can apply if sponsoring relationship breaks down and requirements are met	Yes
Resettled Refugee (Government Assisted Refugee)	Interim Federal Health Plan (IFHP); later, provincial plan	Refugee Assistance Program (RAP), monthly allowance for basic needs and beyond if approved, for one year	Yes
Refugee Claimant	IFHP for essential health care services	No, if claimant's origins are in "safe" countries	Only those approved by federal government
No Legal Status	No access (unless paid by individuals or private insurance	No access	No access
Temporary Foreign Workers (TFW)	Yes, under provincial health care	No. Employer can terminate contract, usually without notice	TFW Support Programs by provincial NGOs
Temporary Resident Permit (TRP)	Only through purchase of a private plan	Yes, upon meeting federal/provincial requirements	No access to federally funded services

A settlement worker shared her frustration with this funding model: "Can you imagine if you needed help and you wanted to go tell somebody: 'Hey, I'm being beaten at home!' but they don't even get in the door?" (KI28) To ensure compliance, the use of government funds must be accounted for through reporting which is time consuming for organizations that are under-staffed. Neoliberal governments require increasingly complex bureaucratic processes to justify and account for spending by not-for-profit organizations. Coupled with inadequate funding, this means that there are not enough staff to draft proposals, write reports for funders, and meet the demands for services. These complex funding and reporting models contribute to the precarity of settlement service organizations (Turner 2006).

The absence of core funding for non-governmental organizations that deliver services to MRW survivors of GBV has resulted in greater pressure on staff, many of whom identify as members of minority groups, to produce evidence of the need for funding through grant applications and reports. KIs described racism as a systemic problem embedded within the whole process of accessing government funding from incorporating a non-profit organization, to who is well-equipped to write the funding applications, to the diversity of people serving on application assessment committees:

> *They [members of racialized groups] might not be as sophisticated in their funding application as maybe a white agency that has been doing it for years. So, they might not have the funds to have a [professional] fundraiser, so their funding application might not be as polished. I think funders have to look at that and perhaps be a bit more kind. If you don't have a fundraiser, it is really hard to do a really snazzy application . . . Who is reviewing the applications? What do those people look like?* (KI20)

This KI suggested that the funding processes need to be more equitable. Systemic racism manifests in the application and adjudication procedures for federal and provincial funding, rendering funding processes inequitable for community-based service organizations led and staffed by members of racialized minority groups.

Broader systemic problems, like the lack of affordable housing in Canada, thwart the efforts of KI's organizations to help MRW survivors of GBV improve their circumstances.

> *Once they leave and they stay in those 30-day transition houses and if they're lucky, the two years second stage housing. [Then] they have no place to go—there are no houses. . . The children will say, "We were comfortable. We were eating twice a day. Why are we living like this?". . . The disillusionment at the level of the courts and things is so bad. . . The system that starts with "Violence is wrong, it is a criminal act," doesn't support that anywhere else afterwards. There is a way but no way. . . We are saying "Hey look! Abuse is wrong!" [but] underneath that the small print is "if you can, just continue staying where you are." That is the small print there.* (KI18)

Decades ago, federal and provincial governments reduced investment of public funds for affordable housing in favor of market-based solutions (Coulter 2009; Silvius 2016), abrogating responsibility for supporting vulnerable groups experiencing housing insecurity (Fineman 2017). According to KIs, the criminalization of GBV by the Canadian government has not been accompanied by systemic government support for the basic needs of survivors and their children (migrant and non-migrant alike), like housing. Women's shelters and community-based second-stage housing organizations assumed responsibility for housing diverse survivors of GBV without sufficient resources (Maki 2019; Silvius 2016). This makes the work of the KIs' organizations enormously challenging because they can only provide MRW survivors of GBV with short-term periods of respite from violence and abuse.

3.2. Marginalization of Workers in the Immigrant Settlement and Anti-GBV Sectors

A consequence of unreliable and inadequate government funding for organizations providing support to MRW survivors is low wages for workers in the anti-GBV and settlement sectors. A worker in a policy agency shared, "Okay. So maybe you already know the workers who are in this field are usually underpaid" (KI16). Low wages are coupled with a high demand for services, resulting in a stressful working environment. Several KIs spoke about burnout:

> *Burn out is very rampant in the service providing community. This is hard work. It is not well rewarded. The need is so great. You know like everywhere you could go you would find huge wait lists and yeah, I think that is like a big threat to this whole sector. People are burnt out and not doing their best work and don't have the energy to think about improvement or innovation when we are just trying to handle the demand that is in front of us.* (KI19)

> *You know there's always some challenge but with some setback right, the setback being is that it's an underfunded position. You know a lot of these settlement agencies, and currently where I work right now, there's a huge turnover rate. You know there are people that are leaving the position because the workload is so demanding, but the compensation for it just isn't there.* (KI11)

Dealing with turnover and finding replacement workers given these working conditions is not easy, as explained by a KI working in a women's shelter:

> *Presently in [my city] finding people to work is a challenge in general and there doesn't seem to be a lot of uh, there's a shortage in the workforce in general, in all fields. Ours is not an exception, so we're having trouble finding people. Our team has been relatively stable, you know in all the time that I've been at the shelter, I've worked with a very specific team, an amazing group of women and in the past five or six years we've had more turnover than we've ever known.* (KI42)

A KI providing counselling to perpetrators and survivors of D/IPV explained challenges with staffing where he works:

> *For many, many years, there was three of us and we weren't all full time. . . we always had a huge waiting list which was ridiculous. . . we couldn't keep a waiting list that was endless so that people would wait forever so then I would have to cut off, even filling the waiting list at some point. Then we got DV [domestic violence] court which has allowed us to hire a couple more counsellors which has been helpful but it's still, you know. I was so excited when we got two more. I thought it was gonna make a big difference, but we're jammed again so and I feel like a broken record, what I'm saying is that we just don't have enough staff to do the work that we can do and so domestic violence is not recognized as something that needs to be resourced. Even the Department of Justice doesn't think that we should be resourced. They created the domestic violence court and gave all the money to the courts and gave out pittance to us.* (KI30)

Specialized domestic violence courts were established in Canada in the 1990s in order "to provide a more coordinated, collaborative response to domestic violence, characterized by better informed and more consistent decision-making and the provision of victim support and offender treatment services" (Koshan 2018, p. 517). While the establishment of a specialized court led to additional funding to employ more counsellors in this KI's organization, the demand for services continued to grow beyond the capacity of staff. Some have argued that this is a result of limited funds being split between victim and offender services (Koshan 2018). Notably, the KI commented that the government department responsible for operating the specialized court does not adequately support counselling as a form of offender treatment or victim support, indicating a lack of understanding of evidence-based responses to the crime of D/IPV (Nason-Clark and Fisher-Townsend 2015) and marginalizing the work of the counsellors in this agency.

A KI from a policy agency spoke to how the underfunding of organizations supporting MRW survivors of GBV ultimately contributed to inefficiencies:

> *I don't know if everybody would agree with me on this,. . . and I don't say that lightly because it's not that there's a lack of will, of different organizations and agencies to work together, but I think the needs are so great in this space and I think often the agencies that are delivering a lot of the services are so focused on the priority of serving the needs of the of the individuals that require their services. . . So potentially you have the same organizations that are all stretched, all you know off the corner of their desk. . . and its good and its helping their communities but then if we were able to kind of. . .be more effective at that collective work then maybe that could take away some of those pressures so that you had one great video or resource or guide on prevention and resources that are available that is then just kind of shared or adapted instead of kind of reinventing the wheel.* (KI14)

An example of how funding disparities between community organizations impact collaboration was provided by a KI working in a not-for-profit organization supporting refugees:

> *We'll see government funded organizations who are asking us to send [interpreters] and our budget's under $200,000 a year, asking us to send our volunteers that are very precious to us (. . .) My response is usually "I don't wanna prevent the client from being able to access this vital service that you're providing that they need but I would like to have a conversation. For this time, yes, we'll try and accommodate that but there needs to be a conversation about how your organization is going to address this internally. These aren't people that are salaried that we're sending to you. These are volunteers that we work hard to train." (. . .) It's not something that's a resource that can be easily shared because then they start volunteering for another organization, they might not have time for us.* (KI38)

In this example, inadequate funding for community-based service organizations meant some MRW survivors did not have access to interpretation services so they can communicate about complex, traumatic experiences of GBV in their mother tongue. The scarcity of funding and the competition for scarce funding between organizations that provide services to MRW survivors of GBV discouraged collaboration among workers.

Finally, ethical conflicts appeared in the everyday work of service providers. The providers were plagued by anxiety, being poorly prepared on how to handle them. A KI working in primary health clinic for refugees spoke about the necessity of "decentering [the] Western, Canadian/North American knowledge base in terms of the design of services and support available in the community" (KI19). The Western knowledge base perpetuates a racist and patriarchal system in the not-for-profit sector.

> *We [in the immigrant settlement sector] have the same trend that all non-profits have, which is that if the organization is really big and has a really big budget, it has a better chance of having a white male at the head of it. . . [on the other hand] our membership is very diverse, ethnically diverse, and it skews female.* (KI26)

Patriarchal social support systems in Canada, designed by governments, funded through competitive application processes, and delivered by government and nongovernmental organizations, continue to privilege white male power (Dawson 2025). Tastsoglou et al. (2022) argue that GBV is a social product of these material and discursive structural inequalities of gender, class, age, race and other social divisions. This has detrimental impacts throughout the GBV and settlement service sectors, marginalizing not-for-profit organizations led and staffed by ethnically diverse women serving MRW survivors of GBV.

A domestic violence service provider spoke about MRW survivors' connections to their communities and the ethical dilemma GBV's marginalization within intersecting systems poses for her:

> *The clients don't want to leave because it's more than just leaving their partner. The potential to leave their place of worship, their community, their friends, is a very real threat. Because if [the community and friends] are taking the perpetrator's side, which oftentimes the guy's charming, he might be a community leader, you know? He's not smacking his wife in public, so then people are saying that she must be disobedient or isn't doing what she needs to do and it's very victim-blamey. . . Who am I to say it's gonna be better if you leave, because you're not just leaving your husband, you're leaving your entire life. Is it truly better for this woman to go live by herself in subsidized housing taking English classes all alone and never being with her community? Is that better? There are times where I question that maybe it's not and then it's kind of that ethical dilemma of I don't know what the best support is.* (KI32)

This KI was aware of the existence and importance of informal support from minority cultural communities for MRW survivors of GBV as well as the isolation that can result when they disclosed domestic violence and seek help outside their support networks

(Kulwicki et al. 2010; Muruthi et al. 2022; Shalabi et al. 2015). Ashbourne and Baobaid (2019, p. 318) question the "goodness-of-fit" between public GBV services and the needs of minority cultural groups. They argue that collaborative approaches between public service providers and cultural groups can better address the unique vulnerabilities of MRW women who experience GBV. As noted in the above quote, education is needed in minority cultural communities to hold perpetrators of violence accountable and to support, rather than blame, victims (Niroomand et al. 2024).

3.3. The Reproduction of Systemic Barriers for MRW Survivors of GBV

The work of KIs is embedded in Canadian economic, political, and social systems which reproduce structural inequalities and vulnerabilities based on the intersection of MRW survivors' gender, class, ethnicity/race, immigrant status, and geographic location/context (Al-Hamad et al. 2023; Fong 2010; Mathis et al. 2024; Segrave et al. 2023; Tastsoglou and Freedman 2025). In addition to the evidence that their work is marginalized within these systems, there is evidence from the interview data that some aspects of their work reproduce systemic vulnerabilities for migrant survivors of GBV.

Best practices in responding to the unique needs of MRW survivors suggest meaningful collaboration between public service providers in the settlement and anti-GBV sectors (CISSA et al. 2021). Yet, making referrals is difficult when some service providers discriminate against MRW survivors of GBV:

> *A worker at a particular shelter who is anti-refugee and it's possible—these things come up and I'm hyper-aware of that in terms of whom I'm referring to the shelter. If it's someone without status, we're definitely not gonna refer to that particular shelter because we discovered some attitude that wouldn't be safe for certain clients . . . [staff members] might be xenophobic*. (KI38)

Anti-immigrant and anti-refugee sentiments in Canadian public discourse (Environics Institute 2025) and systemic racism in the mechanisms of public service provision (Abji et al. 2019) influence the attitudes and competencies of public service providers. In this way, systemic barriers percolate to the provision of services.

An immigrant settlement worker commented that in her rural region "there's not a great deal of cross-cultural competency within the supports that are available" (KI10). Cultural competency among public service providers is defined as an "active engagement in a lifelong process" of working with clients from diverse cultural, racial, ethnic and religious backgrounds (Tervalon and Murray-García 1998). More recently, the concepts of cultural humility and cultural safety have appeared in the literature on health care service provision (Foronda et al. 2015). Some argue that cultural competency training for white, heteronormative, English-speaking service providers about the cultures of racialized groups "contributes to the reproduction of racial and ethnic stereotypes and racism" (Lekas et al. 2020, p. 2). Cultural humility involves self-reflexivity and willingness to learn from MRW about their experiences and the cultural contexts of their lives. Without cultural humility and safety, racist stereotypes of MRW can be perpetuated by service providers (Taylor et al. 2024).

Even those who understand and strive for cultural humility, struggle to respond to the unique needs of MRW survivors. This is often the case with religious MRW because education on and understanding of religion as a component of culture is largely absent from the Canadian higher education systems in which professionals are trained. Religion as a way of knowing and source of moral guidance has been supplanted by science and secularism (Van Arragon 2026). A shelter worker shared an example of the challenge working with religious migrant survivors:

> *For many [MRW survivors] religion plays a huge factor. So, women really feel, they feel very constrained and that's something that's difficult for me personally when somebody says to me, "It's in God's hands." And our goal when we're working with them is to see that it's in her hands, that she has some power over the situation. So of course, not being somebody of faith myself, how to respect that belief and recognize the importance that it has in her life and not minimize it at all because it's part of her framework in how she makes decisions. But also incorporate in her, accompanying her in getting a sense that she has some power over the situation, that she has the right to make decisions over her own life.* (KI42)

This KI recognized that religion is an important aspect of a survivor's framework for decision-making, however it is a double-edged sword because religious beliefs and practices can both increase survivors' vulnerability to violence and provide resources for change (Nason-Clark et al. 2018; Shalabi et al. 2015).

After commenting on the lack of culturally competent services for MRW survivors living in rural regions, another KI from the settlement sector said, "I don't think many mainstream service providers know about a refugee's journey and how long it took a refugee to settle in Canada." She continued with an example,

> *We had an experience with one of the shelters in a rural area where like for them the victim was like an alien coming from a spaceship. They would judge her for that parenting because she's feeding her children milk with sugar because for her, milk and sugar is actually a nutritious meal that she couldn't get a hold of in a [refugee] camp. So, for giving them just milk with sugar for breakfast, they were criticizing her for that.* (KI13)

This quote illustrates refugee women's ongoing vulnerability to structural violence (Borges 2024) when shelter workers do not take the time to understand their experiences of pre-migration trauma (Wathen and Mantler 2022; Taylor et al. 2024).

A KI who worked in the settlement sector before getting a position in government provided a perspective on how sometimes collaboration between service providers in a community is not trauma-informed:

> *We get a lot of backlash too from the victim and a lot of it is, well "This is revictimizing me right, because I've had to now retell my story again to you guys." You know? It was hard enough to report to police. Right, and maybe this is the first time that she or he has ever reported to police right. "And now I'm having to retell my story again".* (KI11)

Experiencing or witnessing violence can result in trauma, which can be disruptive physically, cognitively and emotionally (Li 2016). Having to repeatedly speak about experiences of GBV can trigger a survivor's trauma-response (Tabibi et al. 2018). The aim of trauma-informed practice is safety for MRW seeking help by limiting the potential for them experiencing harm in interactions with service providers (Wathen and Mantler 2022, p. 234). Coordinated collaborative community responses to disclosures of GBV by MRW can prevent retraumatization.

In addition to the evidence of barriers to collaboration between those who assist MRW survivors of GBV, it is apparent that some collaborative practices are not trauma-informed. Yet understanding what trauma-informed care is and practicing it are two different things. A KI from a shelter shared her frustrations:

> *I have very experienced staff but it's challenging to get them moving from theory to practice. So, there is not a person on my staff that couldn't well-articulate for you what trauma-informed care is. There's about 10 percent of my staff that function from a trauma-informed place. There's about 90 percent of my staff that think they practice from a trauma-informed place, but I can't, I can't get them there. . . It's very challenging*

> *because it's very hard to convince somebody that they're not doing something that they already think that they're doing really well*. (KI 36)

Given that most MRW survivors of GBV will have experienced some form of trauma, the effective implementation of collaborative trauma-informed practice among anti-GBV and settlement service providers is important for the wellbeing of their clients and themselves. However, there are gaps in understanding how trauma-informed care should be implemented (Berring et al. 2024).

KIs voiced that social systems are inadequate in protecting MRW from GBV perpetrators after they arrive in Canada. KI18 gave an example of a Canadian serial abuser who continued victimizing migrant women because there was no place for professionals like her to file their complaints.

> *We have many of these women who come through meeting people, whatever they used to call, the mail order brides or whatever right? We have actually an issue with one person who has abused several women one after another. And this was something we were not even, there was no place to complain, "Look, don't give this guy this power to get more people in because he is abusing every one of them!"* (KI18)

In this case, the KI identified a man who had sponsored several women's applications to immigrate to Canada through the Family Sponsorship program. Under the program, the sponsor is responsible for providing the necessities of life (i.e., food, housing, health care) until the woman becomes a permanent resident, a process which can take several years. Marital or relationship breakdown does not automatically nullify the sponsorship agreement, leaving an immigrant woman in a dependent relationship with an abusive sponsor (IRCC 2023). While service providers can assist immigrant women in applying for an end to a sponsorship agreement, they are unable to access personnel in the immigration system to provide information about male sponsors who they know are serial perpetrators of GBV.

The immigration policy landscape is complex and some GBV service providers do not understand how these complexities compound the vulnerability and safety of MRW survivors. KI38 provided an example:

> *Where and what place or organization is safe can change depending on the people there because even if an organization has a certain policy, there might be a particular staff member who decides to kinda take something in their own hands and, "Oh well this person shouldn't be in Canada because they don't have any papers."*

Other KIs spoke about service providers who understand the precarity of MRW survivors' immigration status and who would not disclose information to border services or police. Yet there are those with heightened awareness that they work in precarious organizations and do not want to break the law and jeopardize future government funding opportunities. This puts them into situations where they must choose between protecting the life of a non-status MRW survivor of GBV or following policies that could lead to her deportation. A KI recalled a case where she had referred a client to another organization where a staff member called the police on the client.

> *[She] called the police on the client when this woman had rescued her child from a vicious partner and fled to Canada and finally thought she was here in safety to have the police called on her by a shelter worker . . . felt really xenophobic . . . huge lack of understanding [from the staff member] . . . so then [the migrant woman has] been really anxious around disclosing information to service providers ever since, so it set a really bad tone for her in terms of developing a rapport of kind of trust with service providers*. (KI38)

The MRW survivor felt betrayed by a shelter worker to whom she had turned for help, making it difficult for other service providers in the community to regain her trust. This ex-

ample illustrates how MRW survivors are vulnerable to structural violence after settlement (Borges 2024).

4. Conclusions

The present study has focused on two research questions: The first question is about the ways in which systemic inequalities impact the organizations and individuals that provide services to MRW survivors of GBV who seek help. The second question is about the ways in which the structural marginalization of anti-GBV and immigrant settlement services in Canada contribute to the vulnerabilities of MRW survivors of GBV. Overall, our findings show that government personnel, members of NGOs, and front-line service providers encounter systemic marginalization and systemic societal challenges in assisting MRW survivors of GBV. Ultimately, the institutional vulnerability of the immigration and anti-GBV policy and service provision is associated with the individual vulnerability of MRW survivors of GBV.

We categorize our findings under three themes: 1. marginalization of immigrant settlement and anti-GBV sectors in social systems; 2. marginalization of workers in the same sectors and 3. reproduction of systemic barriers for MRW survivors of GBV.

1. Marginalization of immigrant settlement and anti-GBV sectors: Our analysis highlights that the agencies, organizations, and departments within which the KIs work, whether in the anti-GBV or immigrant settlement sector, are marginalized by federal and provincial governments in Canada.
    (i). Almost without exception, front-line service providers, administrators and members of NGOs said that inadequate and/or precarious government funding was the biggest threat to their work in supporting MRW survivors of GBV. Canadian women's shelters, second-stage housing, domestic violence outreach services, sexual violence services, and women's advocacy organizations depend exclusively on short-term provincial and federal government grants and their own fundraising efforts. They do not receive sustained core funding like Canadian health care or police services.
    (ii). Furthermore, there is inadequate collaboration between government departments in Canada on the issue of MRW experiences of GBV. Funding and policy for services provided to MRW survivors of GBV comes from several government departments. When government departments do not collaborate, not only are the unique needs of MRW survivors of GBV not adequately addressed but also the governmental departments' uncoordinated mandates have implications for public support for MRW of GBV creating the impression that GBV is a problem of minorities, immigrants and refugees, i.e., fuelling anti-immigration, xenophobic and racist stereotypes.
    (iii). Precarious funding for public services for survivors of GBV can be traced back to Canadian neo-liberal government policies that have aimed since the 1980s at cost reduction through cutting housing and social services. The contemporary affordable housing and public welfare service crises have been conveniently blamed on immigrants and refugees with the result of recent polls showing altering public perceptions of immigrants. This is an example of systemic racism working in tandem with neo-liberalism. What this effective collaboration means for the settlement and anti-violence sector NGOs is chronic underfunding and greater use of bureaucratic processes. Frequent and meticulous reporting eats into the time and resources of staff—often immigrants and minority group members themselves—who instead of providing much-needed services are becoming diverted into report and proposal writing.

2. Marginalization of workers in the settlement and anti GBV sectors: lower wages, unstable working conditions, and high levels of stress are some of the manifestations of such marginalization. Workers in these organizations are experiencing high levels of stress from lack of stability and diminishing resources, while trying to cope with multiple demands on their time. Patriarchal and racialized models of service provision further reduce the ability of service providers in these sectors to provide critically important services related to GBV experiences among MRW. Our findings highlight that professionals who work to create government policy and deliver public services for MRW survivors of GBV experience marginalization and precarity within social systems that are already marginalized. Despite the recognition that GBV is a public social problem in Canada and declared an "epidemic" in some provinces (e.g., Nova Scotia), governments continue to treat it as a short-term problem, possibly afflicting specific migrant populations, with inadequate resources. This hinders collaboration between government departments, and between organizations that provide GBV and settlement services. Institutional precarity also means staff are faced with impossible ethical dilemmas in choosing between the life of one's organization and the life of a survivor who is appealing for help but does not meet the government requirements for service provision.
3. Systemic barriers at the intersection of gender, race/ethnicity, class and immigrant status are unavoidably reproduced in the provision of services to GBV survivors who are MRW. How this happens is illustrated in the case of service providers who need higher levels of training that they cannot access, so as to be able to recognize, understand and address pre- and/or post-migration trauma and deal with post-traumatic stress in the populations they serve, or to design appropriate responses in dealing with complex cultural issues. The lack of inadequate training is ultimately connected with the afore-mentioned neo-liberal cuts in service provision. Evidence of institutional marginalization and precarity leads to some public service providers reproducing/reinforcing barriers to MRW survivors' help-seeking efforts. This includes culturally unsafe and trauma-triggering practices. Overall, it is safe to argue that the Canadian immigration and anti-GBV system magnifies the vulnerability of MRW survivors of GBV.

Based on these findings, we make theoretical and policy contributions. Theoretically, we have shown that systemic challenges and inequities in the "distribution of vulnerability" (Butler 2004) to GBV experienced by MRW are mirrored in the institutional precarity (Turner 2006) experienced by government workers, advocates and service providers in the settlement and anti-GBV sectors. These vulnerabilities are a result of political decisions that maintain neo-liberal capitalist, racist and patriarchal systems (e.g., economic, immigration, legal) privileging white, native-born, middle and upper social class male power. Instead of the state taking responsibility and caring for families during a time of vulnerability through the immigration process (Fineman 2020), as it claims to do by funding settlement and GBV services, the state is increasing the vulnerability of women and families by creating a hierarchical system of entitlements depending on a MRW's legal status and placing constraints on service providers' ability to respond while creating impossible ethical dilemmas for them.

On the policy level, our analysis of the systemic marginalization of policy and services for MRW survivors of GBV underlines the importance of recognizing the challenges that GBV represents for society at large. The characterization of GBV as a problem of immigrant and refugee minority groups fuels an "us/them" binary between Canadians and immigrants and refugees (Korteweg 2012, p. 139), diverting attention from GBV as a national and global (Tastsoglou and Freedman 2025) social problem. Addressing the vulnerability of all

Canadians to GBV will involve multiple systemic changes. This includes equitable access to affordable and safe housing (Segrave et al. 2023) and taking a public health and safety approach by establishing stable core funding for GBV social support services. A promising initiative is the "Gender-Based Violence Settlement Strategy" led by the Ontario Council of Agencies Serving Immigrants (CISSA et al. 2021). The Strategy's guiding principles are anti-racist, anti-oppressive, culturally safe, gender-based, intersectional and trauma- and violence-informed. One of its strategic priorities is to "enhance client-centred services that recognize the intersectional needs and experiences of newcomers, immigrants and refugees" (CISSA et al. 2021, p. 8). This includes the development of training resources for service providers. It is our hope that the implementation of the recent National Action Plan to End Gender-Based Violence (FPT Forum 2022), will also provide the impetus needed for systemic changes in Canada.

Finally this paper would be incomplete without identifying its limitations. First, the MRW's own voices are absent in detailing their experiences of the systemic obstacles in accessing and making use of the services provided to them in the settlement and anti-GBV sectors from their own perspectives. Meaningful as these findings through the policy makers and service providers' perspectives are, the MRW voices would provide an important triangulation and validation of our findings. This analysis has already been partially done as far as accessing health services (Tastsoglou 2025) and the obstacles that the MRW of this research project encounter there. It remains for us to expand the analysis to other types of services to be able to fully assess the reliability of this paper's findings. Second, most of the KI's addressed their work with MRW survivors of D/IPV and not other forms of GBV. D/IPV has been the primary focus of GBV research and service provision in Canada for decades. Further research is needed to identify barriers and needs of MRW survivors of different types of GBV such as sexual exploitation.

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Notes

[1] Migrant and refugee women is the phrase we use to denote the range of different legal/social statuses of immigrants and refugees in Canada. Individuals can apply to immigrate as permanent residents through federal work-based programs, regional work-based programs, and family sponsorship programs. Individuals can enter the country with temporary work and study

permits and, if eligible, apply for permanent residency after arrival. Individuals outside of the country can be referred to move to Canada by the UN Refugee Agency, a designated referral organization or a private sponsor. Individuals can make a claim for refugee protection at any port of entry or from within Canada (IRCC 2026).

[2] Analysis of help-seeking by women victims of D/IPV by immigrant status were not included in this report.

[3] Quotations have been "cleaned" for non-lexical sounds and repetition

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