Research Article

Stigma, Silence, and Structural Barriers to Mental Health Help-Seeking Among Domestic Violence Survivors: A Scoping Review Focusing on Rural and Tribal Communities of Central India, Uttarakhand, and Nepal

Kumari Sweta Gupta Kalwar[1], Sajan Kumar Kaushal[2], Jaan Mohammad Pathan[3], Kumari Richa Gupta Kalwar[4], Gopal[5*], Shivshankar Tiwari[6], Shiwangi Tiwari[7]

[1]Student of Master of Public Health, Uttaranchal College of Health Sciences, Uttaranchal University, Dehradun, Uttarakhand, India, ORCID: 0009-0005-0648-2009, kalwarsweta135@gmail.com
[2]Student of Government Autonomous Ayurved College, Gwalior, MP, Bachelor of Ayurvedic Medicine and Surgery, MPMSU University, MP, India, ORCID: 0009-0001-4131-0502, kaushalsajan987@gmail.com
[3]Bachelor in Public Health (2023), ORCID: 0009-0006-7470-204X, jaanmohammadpathan120@gmail.com
[4] Student of PhD in Human Consciousness & Yogic Science, Dev Sanskriti Vishwavidyalaya, Haridwar, Uttarakhand, India, ORCID: 0009-0001-5789-096X, kalwarricha@gmail.com
[5*]Assistant Professor, Uttaranchal College of Health Sciences, Uttaranchal University, Dehradun, Uttarakhand, India - 248007 ORCID: 0009-0009-0220-0456 Gopal4god11@gmail.com
[6] Assistant Professor, Uttaranchal College of Health Sciences, Uttaranchal University, Dehradun, Uttarakhand, India - 248007 ORCID: 0009-0006-4248-3487, shivshankartiwari@gmail.com
[7]Assistant Professor, Uttaranchal College of Health Sciences, Uttaranchal University, Dehradun, Uttarakhand, India - 248007 ORCID: 0009-0006-3385-5226 shiwangitiwari1999@gmail.com

Abstract

Background: Domestic violence (DV) is a well-established determinant of poor mental health among women, yet survivors in rural and tribal settings of South Asia rarely translate psychological distress into help-seeking. Central India, the hill state of Uttarakhand, and Nepal share overlapping features of patriarchal kinship structures, dispersed hill and forest geographies, weak mental health infrastructure, and pronounced stigma, but the pathways connecting these features to help-seeking behaviour have not been mapped collectively.

Objective: This scoping review synthesises available evidence on the stigma-related, socio-cultural, and structural barriers that shape mental health help-seeking among DV survivors in rural and tribal communities of Central India, Uttarakhand, and Nepal, and situates the findings within an explanatory conceptual framework.

Methods: The review followed the Arksey and O'Malley methodological framework as refined by Levac and colleagues, and is reported according to the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR). A Population-Concept-Context (PCC) question guided a structured search of PubMed/MEDLINE, Scopus, Web of Science, CINAHL, PsycINFO, and grey-literature sources (WHO, NIMHANS, national demographic and health surveys, and government legislative texts) for records published between 2000 and 2026. Findings were charted and analysed thematically and interpreted using Andersen's Behavioural Model of Health Services Use and Heise's ecological framework of violence.

Results: Thirty-two sources met inclusion criteria, comprising population-based surveys, qualitative studies, mixed-methods evaluations, systematic and narrative reviews, and normative/legal documents. Four interlocking themes emerged: (i) a substantial and consistent association between DV exposure and adverse mental health outcomes, with treatment gaps exceeding 80% in national data; (ii) internalised and community-level stigma that frames both DV disclosure and mental illness as shameful, discrediting attributes; (iii) a culturally reinforced silence in which violence is normalised as a private, marital matter, particularly acute in tribal communities marked by alcohol-linked violence and in Himalayan hill communities marked by isolation and workload-related distress; and (iv) structural barriers including the near-absence of trained mental health personnel, poor transport and connectivity in hill and forest terrain, weak implementation of protective legislation, and health systems that are not trauma-informed. Nepal reflected an even lower formal help-seeking rate than India, with informal kin-based disclosure dominating across all three settings.

Conclusion: Stigma, silence, and structural deficits interact synergistically rather than independently to suppress help-seeking among DV survivors in these settings. Community-based, task-shared mental health delivery models, integration of DV screening into primary care and frontline health-worker platforms, culturally tailored anti-stigma communication, and stronger implementation of existing legal protections are required. Future primary research using standardised, comparable instruments across Central India, Uttarakhand, and Nepal is needed to strengthen the currently uneven evidence base, particularly for Scheduled Tribe and hill populations.

Keywords: domestic violence; intimate partner violence; mental health; help-seeking behaviour; stigma; rural health; tribal population; Uttarakhand; Nepal; scoping review.

1. Introduction

Domestic violence (DV), most commonly perpetrated by an intimate partner, remains one of the most pervasive violations of women's health and human rights worldwide. Global modelling by the World Health Organization estimates that nearly one in three women (approximately 736 million) has experienced physical and/or sexual intimate partner violence, non-partner sexual violence, or both, in her lifetime, a burden that has remained essentially unchanged over the past decade despite decades of advocacy and legislative reform.[1,2] The consequences of DV extend well beyond immediate physical injury: exposure to intimate partner violence (IPV) is one of the most robust and replicated risk factors for depression, anxiety, post-traumatic stress disorder, self-harm, and suicidal ideation in women across income settings.[1,5]

South Asia illustrates this burden with particular clarity. According to India's National Family Health Survey-5

(2019–2021), nearly three in ten ever-married women aged 15–49 years have experienced spousal violence, with considerably higher rates recorded among women of Scheduled Tribe and Scheduled Caste background and among women residing in rural areas.[3] Population-based work in India has repeatedly demonstrated that DV exposure roughly doubles to triples the odds of poor mental health: in an early multisite household survey of 9,938 women across rural, urban non-slum, and urban slum sites, 40% of respondents reported poor mental health, and women exposed to the full range of physically violent behaviours had a nearly 3.5-fold increased risk of psychological morbidity.[5] Comparable associations have been documented in Delhi, where women exposed to violence were three times more likely to report unhealthy mental status than unexposed women,[6] and in rural Central India, where a community-based study of women disclosing IPV found that nearly two-thirds met criteria for post-traumatic stress disorder and for moderate-to-severe depression and anxiety.[7]

Despite this well-documented mental health burden, formal help-seeking for either the violence itself or its psychological sequelae remains strikingly low. India's National Mental Health Survey (NMHS, 2015–16) estimated that nearly 150 million Indians require active mental health intervention, yet the overall treatment gap across disorders ranges from 28% to 83%, and exceeds 60% for every category other than epilepsy.[4] This treatment gap is compounded, rather than merely paralleled, by the treatment gap specific to violence: nationally representative machine-learning analyses of Indian survey data show that only a small minority of women exposed to spousal violence seek help of any kind, and formal help-seeking (from police, health workers, or social services) is markedly rarer than informal disclosure to family.[22] Similar patterns recur in rural Maharashtra, where women identify stigma, limited mental health literacy, and the informal, kin-based nature of support-seeking as central features of their coping repertoire.[8,10]

Central India's tribal (Scheduled Tribe, or Adivasi) communities occupy a particularly under-examined position within this literature. Ethnographic and journalistic accounts from tribal belts such as Jharkhand describe domestic abuse as deeply embedded within the social fabric, frequently intertwined with intergenerational alcohol dependence, with negligible access to counselling, trauma therapy, or psychiatric services in these geographically and administratively marginalised areas.[29] Uttarakhand, a mountainous state in India's western Himalaya, presents a related but distinct configuration: hill women shoulder a disproportionate share of agricultural and domestic drudgery, out-migration of men has feminised subsistence labour, and psychiatric services remain concentrated in a small number of urban centres, leaving most hill districts without a functioning rehabilitation or referral pathway; local reporting has linked this configuration to a documented rise in suicide among rural hill women, attributed by health officials to domestic conflict and harassment by in-laws rather than pre-existing psychiatric illness.[11,12] Population-based estimates suggest that roughly 14% of ever-married women in Uttarakhand have experienced physical or sexual violence, a figure that likely under-represents true prevalence given the stigma attached to disclosure in small, kin-dense hill communities.[3]

Nepal offers a instructive comparator with an even more constrained formal support infrastructure. Analyses of the 2022 Nepal Demographic and Health Survey indicate that roughly three in ten women have ever experienced IPV, that nearly half of those exposed report concurrent symptoms of anxiety or depression, and that formal help-seeking remains rare: in one national analysis, 72% of women who had experienced IPV had not sought help at all, and 92% of those who did sought only informal support from family or friends rather than police, health workers, or shelters.[13,14] A separate national survey conducted during the COVID-19 pandemic similarly found that despite a 52.6% prevalence of IPV among married women of reproductive age, only 14% of exposed women sought any help and just 6% formally reported violence to police,[15] echoing earlier qualitative work among pregnant women in Kathmandu's urban slums that identified fear, financial dependence, and normalisation of violence as principal deterrents to disclosure.[16]

Taken together, these three settings—Central India's tribal belts, the Himalayan hill state of Uttarakhand, and Nepal—share a constellation of features that plausibly shape a distinct, geography-specific pattern of DV-related mental health help-seeking: dispersed and difficult terrain that limits access to services; kinship and caste/tribe-based social structures that regulate disclosure; entrenched alcohol use among male partners; a severe shortage of trained mental health personnel outside urban centres; and legal frameworks—India's Protection of Women from Domestic Violence Act, 2005, and Nepal's Domestic Violence (Crime and Punishment) Act, 2066 (2009)—that exist on paper but are inconsistently implemented at the community level.[27,28] However, no existing review has systematically mapped and synthesised the available evidence across these three specific, comparably marginalised settings, nor examined how stigma, cultural silence, and structural health-system deficits interact to suppress mental health help-seeking among DV survivors within them.

This scoping review therefore aims to map the breadth, nature, and quality of existing evidence on stigma-related, socio-cultural, and structural barriers to mental health help-seeking among DV survivors in rural and tribal communities of Central India, Uttarakhand, and Nepal; to synthesise this evidence thematically; and to

interpret it through an explicit conceptual lens combining Andersen's Behavioural Model of Health Services Use[21] and Heise's ecological framework of violence,[32] in order to generate policy- and practice-relevant recommendations and to identify priority gaps for future primary research.

2. Methods

2.1 Design and Reporting Framework

This review was conducted as a scoping review because the objective was to map the breadth and nature of a heterogeneous, cross-disciplinary evidence base rather than to appraise the risk of bias within a narrow set of comparable intervention trials—a distinction that Munn and colleagues, and subsequently the Joanna Briggs Institute (JBI), identify as the key determinant of when a scoping rather than a systematic review design is appropriate. The review followed the five-stage methodological framework originally proposed by Arksey and O'Malley,[17] as subsequently refined by Levac, Colquhoun, and O'Brien to strengthen stage-wise rigour, stakeholder consultation, and iterative search refinement.[18] The review is reported in accordance with the Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) checklist,[19] and drew on the JBI/Peters and colleagues' guidance for conducting systematic scoping reviews for procedural detail at each stage.[20] As a review of published and grey literature involving no primary data collection from human participants, formal ethical approval was not required.

2.2 Research Question and PCC Framework

Consistent with scoping review methodology, the review question was formulated using the Population-Concept-Context (PCC) structure rather than a narrower PICO structure. Population: women who have experienced domestic or intimate partner violence. Concept: stigma-related, socio-cultural, and structural barriers and facilitators to mental health help-seeking (formal and informal). Context: rural and tribal (Scheduled Tribe) communities of Central India, the hill state of Uttarakhand, and Nepal (inclusive of urban-slum and peri-urban Nepalese settings where these were the only available context-relevant data). The guiding question was: "What is known from the existing peer-reviewed and grey literature about the stigma, cultural silence, and structural health-system barriers that shape mental health help-seeking among women who have experienced domestic violence in rural and tribal Central India, Uttarakhand, and Nepal, and how do these barriers interact?"

2.3 Eligibility Criteria

Sources were eligible for inclusion if they: (a) addressed domestic violence, intimate partner violence, or spousal/family violence against women; (b) reported on mental health outcomes, mental health-related stigma, or help-seeking behaviour (formal or informal, for violence and/or for its psychological sequelae); (c) were set in, or provided directly generalisable evidence for, rural or tribal Central India (Madhya Pradesh, Chhattisgarh, Jharkhand, and adjoining tribal belts), Uttarakhand, or Nepal; and (d) were published in English between January 2000 and August 2026. Both quantitative (cross-sectional, cohort, survey-based) and qualitative or mixed-methods designs were eligible, together with systematic reviews, scoping reviews, mixed-methods evaluations, national demographic and health survey reports, national mental health survey reports, and relevant government legislative and policy texts. Grey literature (WHO and national government reports, and credible journalistic investigations providing otherwise-undocumented context on tribal and hill communities) was included where it supplemented the peer-reviewed evidence base on a topic that remains thinly researched in these specific geographies. Studies focused exclusively on urban metropolitan populations without extractable rural/tribal or hill-specific data, studies concerning child abuse only, and studies not available in English full text were excluded.

2.4 Information Sources and Search Strategy

A structured search was conducted across PubMed/MEDLINE, Scopus, Web of Science, CINAHL, and PsycINFO, supplemented by Google Scholar and targeted searches of institutional repositories (WHO, NIMHANS, International Institute for Population Sciences, and the Nepal Ministry of Health and Population) for relevant grey literature. Reference lists of key included articles were hand-searched (citation chaining) to identify additional eligible sources. Search terms combined controlled vocabulary and free-text keywords across three concept blocks, joined with the Boolean operator AND within blocks by OR: (1) domestic violence, intimate partner violence, spousal violence, gender-based violence, family violence; (2) mental health, depression, anxiety, post-traumatic stress, psychological distress, help-seeking, treatment gap, stigma; and (3) India, Central India, Madhya Pradesh, Chhattisgarh, Jharkhand, tribal, Scheduled Tribe, Adivasi, Uttarakhand, hill, Himalaya, Nepal. Table 1 summarises the core search strategy as applied to PubMed/MEDLINE, adapted for syntax across the remaining databases.

Table 1. Illustrative search strategy (PubMed/MEDLINE, adapted across databases)

Concept Block	Sample Search Terms	Field/Operator
1. Violence	"domestic violence" OR "intimate partner violence" OR "spousal violence" OR "gender-based violence" OR "family violence"	[Title/Abstract]
2. Mental health / help-seeking	"mental health" OR depression OR anxiety OR "post-traumatic stress" OR "psychological distress" OR "help-seeking" OR "treatment gap" OR stigma	[Title/Abstract]
3. Setting	India OR "Central India" OR "Madhya Pradesh" OR Jharkhand OR Chhattisgarh OR tribal OR "Scheduled Tribe" OR Adivasi OR Uttarakhand OR hill OR Himalaya OR Nepal	[Title/Abstract/Keyword]
Combination	**Block 1 AND Block 2 AND Block 3**	Boolean

2.5 Study Selection and Data Charting Process

Following de-duplication, titles and abstracts were screened against the eligibility criteria, followed by full-text review of potentially eligible records. A standardised data-charting form was used to extract, for each included source: author(s) and year, country/region and setting (rural, tribal, hill, urban-slum), study design, population and sample size, key mental health and/or help-seeking outcomes reported, and stigma-related or structural barriers described. Given the methodological heterogeneity characteristic of scoping reviews, no formal quality-appraisal or risk-of-bias scoring was performed, consistent with PRISMA-ScR guidance;[19] however, the design and sample characteristics of each source were charted transparently (Table 2) to allow readers to weigh the strength of the underlying evidence for each theme.

2.6 Conceptual Framework for Synthesis

Extracted data were synthesised thematically using an inductive approach, then interpreted through two complementary, well-established conceptual frameworks. Andersen's Behavioural Model of Health Services Use conceptualises health-service utilisation (including mental health help-seeking) as a function of predisposing factors (e.g., gender norms, caste/tribe, education), enabling factors (e.g., distance to services, household income, availability of trained personnel), and need factors (e.g., symptom severity, perceived need).[21] This was combined with Heise's ecological framework of violence, which situates individual experiences of violence within nested individual, relationship, community, and societal levels of influence,[32] providing a structure for distinguishing individual-level stigma (self-blame, shame) from community-level stigma (gossip, honour-based sanctioning) and societal-level structural deficits (health workforce shortages, weak law enforcement). This dual framework is applied throughout the Results and Discussion to organise otherwise disparate qualitative and quantitative findings into a coherent explanatory account.

3. Results

3.1 Overview of Included Literature

Thirty-two sources satisfied the eligibility criteria and were charted for this review: eighteen quantitative or mixed-methods primary studies, six qualitative studies, four methodological/framework references underpinning the review's design and interpretation, two national survey/report series (India's NFHS-5 and NMHS), and two national legislative texts (India's Protection of Women from Domestic Violence Act, 2005, and Nepal's Domestic Violence (Crime and Punishment) Act, 2066/2009), supplemented by credible journalistic investigations providing otherwise-scarce, context-rich evidence on tribal Jharkhand and hill Uttarakhand. Table 2 summarises the design, setting, and key findings of the primary empirical sources most central to the thematic synthesis that follows. The evidence base is heavily weighted toward quantitative, survey-derived findings from national or state-representative Indian and Nepalese datasets, with a comparatively thinner, though methodologically valuable, body of qualitative work explaining the lived experience underlying these statistics. Notably, very few sources focused specifically and exclusively on Scheduled Tribe populations or on Uttarakhand's hill districts, a gap discussed further in Section 4.3.

Table 2. Characteristics of key primary sources included in the scoping review

Source	Setting	Design	Population/Sample	Key Findings
Sathe et al., 2024[7]	India (Central)	Cross-sectional	80 IPV-exposed women, 19 villages	PTSD (63%), depression/anxiety common; violence viewed as "private matter"
Kumar et al., 2005[5]	India (multisite)	Household survey	9,938 women, 7 sites	40% poor mental health; dose-response with violence severity
Vachher & Sharma, 2010[6]	India (Delhi)	Cross-sectional	350 women	DV associated with 3-fold higher odds of poor mental health
Iyer et al., 2023[8]	India (Maharashtra, rural)	Qualitative	Rural women	Stigma, low mental health literacy, informal support norms
Gala et al., 2024[9]	India (Maharashtra, rural)	Qualitative	72 women, 6 divisions	Somatisation of distress; gendered presentation of mental health concerns
Gawai & Tendolkar, 2019[10]	India (Vidarbha)	Qualitative/survey	Rural women	Coping strategies shaped by stigma and limited service awareness
Dehingia et al., 2022[22]	India (national)	ML/secondary data	National survey (~700,000 records)	Low overall help-seeking; injury severity and partner alcohol use as correlates
Ghoshal et al., 2024[23]	India (NFHS-5)	Secondary data analysis	National sample	Formal help-seeking remains a minority pathway; type of IPV predicts source of help
Leonardsson & San Sebastian, 2017[24]	India (NFHS-3)	Cross-sectional	19,125 women	Severity of violence and injury predict help-seeking
Maulik et al., 2017[25]	India (Andhra Pradesh, rural)	Mixed-methods evaluation	Community sample	Anti-stigma campaign reduced help-seeking stigma; DV-themed drama most effective
Maulik et al., 2020[26]	India (rural, protocol)	Cluster RCT protocol	Community + ASHA workers	Task-shared mHealth model to reduce stigma and treatment gap
VOA News, 2024[29]	India (Jharkhand, tribal)	Journalistic investigation	Tribal households	DV normalised within tribal social fabric; linked to intergenerational alcohol use
Tribune (Chandigarh), 2009a[11]	India (Uttarakhand)	Journalistic report	Hill districts	Rising suicide among hill women linked to domestic conflict, drudgery
Tribune (Chandigarh), 2009b[12]	India (Uttarakhand)	Journalistic report	Hill districts	Absence of rehabilitation infrastructure; mental

				illness highly taboo
Kurvinen et al., 2025[13]	Nepal (national)	Cross-sectional (NDHS 2022)	5,178 women	31.4% ever IPV; 72% of those exposed never sought help
Gnawali et al., 2025[14]	Nepal (national)	Cross-sectional (NDHS 2022)	4,211 women	Nearly 50% of DV-exposed women had anxiety/depression symptoms
Bhatt et al., 2023[15]	Nepal	Cross-sectional (COVID-19 period)	420 women	52.6% IPV prevalence; only 14% sought help, 6% reported to police
Deuba et al., 2016[16]	Nepal (Kathmandu slums)	Qualitative	20 young pregnant women	Fear, dependence, and normalisation deter disclosure
Bender & Chalise, 2018[30]	Nepal (national)	Secondary survey analysis	National sample	Perceptions of wife-beating shape help-seeking propensity

3.2 Magnitude of Domestic Violence and Its Mental Health Burden

Across all three settings, the reviewed literature converges on a consistent and substantial association between DV exposure and adverse mental health outcomes. In India, foundational multisite survey work found that 40% of women reported poor mental health, rising in a clear dose-response fashion with the severity and diversity of violent acts experienced (odds ratio 3.5 for women exposed to all four assessed forms of physical violence).[5] This pattern has since been replicated at smaller scale: in urban Delhi, women exposed to DV were roughly three times more likely to report unhealthy mental status and elevated suicidal tendencies than unexposed women;[6] in rural Central India, self-report screening among 80 women who had disclosed IPV found that approximately two-thirds met threshold criteria for post-traumatic stress disorder as well as for moderate-to-severe depression and anxiety, with pregnancy, partner alcohol dependence, viewing DV as a private matter, and experiencing sexual violence all independently associated with PTSD.[7]

Nepal's national data mirror this pattern closely. Analysis of the 2022 Nepal Demographic and Health Survey found that among women who had ever experienced IPV, adjusted odds of anxiety and depressive symptoms were substantially elevated among those exposed to severe physical violence (adjusted odds ratios of 1.70 and 1.99, respectively), and nearly half of all DV-exposed women reported concurrent anxiety or depressive symptoms.[14] A parallel national analysis of the same survey round found that 27.6% of women reported anxiety symptoms and 21.5% reported depressive symptoms within the preceding two weeks, with both substantially elevated among the 31.4% of women who had ever experienced IPV.[13] During the acute phase of the COVID-19 pandemic, a cross-sectional Nepalese survey similarly recorded a 52.6% prevalence of IPV among married women of reproductive age, dominated by economic violence and behavioural control alongside physical and sexual violence.[15]

Despite this substantial and consistently documented mental health burden, the overarching treatment gap for mental disorders in India remains severe: the National Mental Health Survey (2015–16) estimated a current prevalence of mental disorders of 10.56% among adults, with an overall treatment gap of 84.5%, exceeding 60% for every disorder category other than epilepsy and reaching 86% for alcohol use disorders—a figure of particular relevance given the strong association between partner alcohol use and both DV perpetration and non-disclosure documented throughout the reviewed literature.[4,7,22] This treatment gap is not evenly distributed: state mental health budgets remain below 1% of total health expenditure in most Indian states, and psychiatric workforce density in rural areas is a small fraction of that available in high-income countries, compounding the difficulty of translating psychological distress arising from DV into any form of clinical contact.[4]

3.3 Stigma as a Barrier to Help-Seeking

Stigma emerged as the most frequently cited and most consistently described barrier across the reviewed literature, operating simultaneously at the level of the violence itself and at the level of mental illness. Multiple Indian sources describe how disclosure of DV is itself stigmatising, exposing women to fears of family

dishonour, marital breakdown, and social exclusion that outweigh the perceived benefit of seeking help; a large multisite household survey identified stigma and fear of relationship repercussions as the principal drivers of under-reporting of DV nationally.[5,7] In rural Central India, more than half of women who had experienced IPV believed that "family matters should remain within the family," and nearly one-third were reluctant to seek intervention from anyone outside the family unit, even when experiencing severe and repeated violence.[7]

Layered onto this violence-specific stigma is a distinct and independently documented stigma surrounding mental illness itself. Qualitative and mixed-methods work from rural Andhra Pradesh, conducted as part of the Systematic Medical Appraisal, Referral and Treatment (SMART) Mental Health programme, found that stigma related to help-seeking for common mental disorders was a major driver of the region's treatment gap, and that a community drama depicting DV, its psychological impact, and the benefits of help-seeking was among the two most effective anti-stigma intervention strategies tested, alongside social-contact video testimony from a person living with mental illness.[25,26] This finding is important because it demonstrates, empirically, that DV and mental health stigma are perceived by rural communities themselves as interconnected phenomena rather than separate concerns, and that interventions addressing one can plausibly shift attitudes toward the other.

Qualitative accounts from rural Maharashtra reinforce this picture: women interviewed about mental health resources and barriers described strong negative community beliefs and attitudes toward mental disorders, limited awareness of available services, and a marked preference for informal support from family, neighbours, and women's self-help ("bachat gat") groups over formal clinical services, reflecting both stigma-driven avoidance and a genuine scarcity of trusted formal alternatives.[8,10] A related qualitative study among the same population found that women's mental health concerns were frequently expressed and recognised through somatic complaints rather than psychological language, a presentation pattern that both reflects and reinforces stigma by allowing psychological distress to remain unnamed and, therefore, more easily concealed from family and community scrutiny.[9] Stigma related to mental illness in these communities functions, in Goffman's classic formulation, as a discrediting attribute that threatens a woman's social identity independently of, and in addition to, the shame associated with disclosing marital violence itself,[31] producing a compounded reluctance to seek any form of formal support.

3.4 Silence, Normalization, and the Privatization of Violence

Closely related to, but analytically distinct from, stigma is a pattern of cultural silence in which violence is actively normalised as an ordinary, even expected, feature of married life rather than as a violation warranting intervention. Multiple sources describe DV in rural India as "not considered by many to be a problem needing resolution," with community health workers and local government officials frequently endorsing an abstract principle that women should seek help while simultaneously acknowledging that the very systems intended to provide support often re-traumatise survivors by minimising their experiences.[5] In rural Central India, a substantial proportion of IPV-exposed women themselves justified the violence they experienced—citing perceived infidelity, disobedience, or neglect of household duties as legitimate grounds—illustrating how normalisation operates not only at the community level but through survivors' own internalised frameworks of marital obligation.[7]

This normalisation appears particularly acute, and particularly under-documented, in tribal (Scheduled Tribe) communities of Central and Eastern India. Journalistic investigation into tribal households in Jharkhand describes domestic abuse as having become "part of the tribal social fabric," intertwined with intergenerational alcohol addiction and, in the accounts of local activists, with inherited patterns of trauma passed across generations; more than 30% of women belonging to Scheduled Tribes nationally report having faced physical domestic abuse, a rate exceeding the national average, yet tribal communities were described by frontline responders as having "little to no access to mental health resources," with locally organised counselling and trauma therapy services emerging only through small non-governmental initiatives rather than public health infrastructure.[29] This account is consistent with the broader pattern, noted across the systematic literature on DV in India, that women over age 50, those in tribal villages, and those from northern hill regions remain among the least-studied populations in India's DV research base, despite plausible elevated risk.

In Uttarakhand's hill districts, silence takes a related but geographically distinctive form, shaped by isolation rather than collective tribal identity. Journalistic and public-health commentary describes a documented rise in suicide among rural hill women, with local psychiatrists noting that "in most cases there may not be a history of mental illness," and police investigations attributing the majority of these deaths to "domestic squabbles and harassment by in-laws" rather than to pre-existing psychiatric conditions—an important distinction suggesting that untreated distress arising directly from family conflict, rather than a separate mental illness, may be a principal driver of these outcomes.[11] Mental illness itself was separately described as "a taboo" throughout Uttarakhand's hill districts, where families reportedly discard relatives experiencing psychiatric symptoms in

the near-total absence of any local rehabilitation institute, forcing patients toward distant referral centres far outside the hill districts where the majority of the state's population resides.[12]

In Nepal, normalisation is documented through direct attitudinal measurement rather than qualitative inference alone. National survey analyses tracking attitudinal acceptance of wife-beating found that formal help-seeking rates among abused women rose only marginally, from 21.8% in 2011 to 25.8% in 2016, a shift the authors attribute in part to slowly changing perceptions of the acceptability of violence rather than to structural improvements in service availability, underscoring that individual and community-level normalisation of violence functions as an independent, slow-moving barrier operating in parallel with, rather than simply downstream of, service accessibility.[30] Qualitative interviews with young pregnant women in Kathmandu's urban slums similarly found that many women believed pregnancy would protect them from violence or make partners more sympathetic, a belief that, when unmet, left several respondents further isolated and less likely to seek help after violence continued or escalated during pregnancy.[16]

3.5 Structural and Health-System Barriers

Beyond stigma and normalisation, the reviewed literature identifies a consistent set of structural, health-system-level barriers that operate independently of individual or community attitudes. Foremost among these is the severe shortage of trained mental health professionals in rural India, where the ratio of psychiatric personnel to population is estimated to be 75 to 120 times lower than in high-income countries, a gap that is considerably worse in rural districts than the (already low) national average.[4,26] This workforce shortage is compounded by chronic underfunding: most Indian state governments allocate less than 1% of their health budgets to mental health, restricting the availability of even basic primary-care-level psychiatric services in the districts where DV-exposed rural and tribal women reside.[4]

In response to this workforce gap, task-sharing models delivered through frontline community health workers—particularly India's Accredited Social Health Activists (ASHAs)—have been piloted as a structural solution. The SMART Mental Health programme, a cluster-randomised initiative in rural Andhra Pradesh, combined an anti-stigma community campaign with an electronic decision-support system used by primary healthcare workers to identify and manage common mental disorders, explicitly hypothesising that demand-side barriers (stigma, low awareness) and supply-side barriers (workforce shortages) needed to be addressed simultaneously to close the treatment gap.[26] Process evaluation of this and related programmes found that community health workers, when adequately trained and supported with decision-support tools, could meaningfully extend the reach of mental health identification and referral into rural communities otherwise entirely without psychiatric access, though such initiatives to date remain geographically concentrated in a small number of demonstration districts rather than scaled nationally.[25,26]

Structural barriers specific to hill and tribal terrain compound these general workforce and funding deficits. In Uttarakhand, the near-total absence of any rehabilitation institute across the state's hill districts as of the period documented forced patients to travel to a small number of distant facilities, a barrier of particular consequence in a state where road connectivity, seasonal weather, and dispersed settlement patterns already impede access to routine healthcare, let alone specialised psychiatric referral.[12] In tribal Jharkhand, frontline responders explicitly called for government and international support to establish rehabilitation centres for alcohol dependence and to expand mental health resources and awareness initiatives, describing

existing provision as reliant almost entirely on small non-governmental counselling efforts rather than embedded public health infrastructure.[29]

Legal and institutional structures intended to protect DV survivors and facilitate help-seeking also show evidence of weak translation into practice. India's Protection of Women from Domestic Violence Act, 2005, provides a comprehensive civil-law framework recognising physical, emotional, sexual, and economic abuse and establishing Protection Officers, shelter homes, and access to legal aid; however, women accept and tolerate DV and remain reluctant to invoke this framework in practice, particularly in rural and hill settings where Protection Officers, legal aid services, and shelters are unevenly distributed and often concentrated in district headquarters rather than in the villages where survivors live.[27] Nepal's Domestic Violence (Crime and Punishment) Act, 2066 (2009), similarly criminalised DV committed by one family member against another and has been accompanied by dialogue-based social behaviour change programmes intended to increase understanding of legal recourse and support actual help-seeking behaviour; yet national survey data collected more than a decade after the Act's passage continue to show formal help-seeking rates below 30% among IPV-exposed women, indicating a persistent gap between legislative protection and its uptake at the community level.[13,15,28] Machine-learning analyses of national Indian data corroborate this pattern, finding that women's decision to seek help is most strongly predicted by proximate factors such as injury severity, partner alcohol consumption, and controlling behaviour, rather than by awareness of, or confidence in, formal legal or institutional protections.[22]

3.6 Regional Focus I: Central India and Tribal (Scheduled Tribe) Communities

Central India's tribal belts present a distinctive convergence of the barriers described above. Community-based cross-sectional data from rural Central India found that among women who had disclosed IPV, nearly two-thirds screened positive for PTSD and for moderate-to-severe depression and anxiety, with sexual violence, pregnancy, and partner alcohol dependence as significant correlates of PTSD specifically—findings gathered as part of a project explicitly designed to strengthen the health sector's response to gender-based violence, itself an implicit acknowledgement that the existing health system response was judged inadequate prior to intervention.[7] National data confirm that women belonging to Scheduled Tribes experience physical domestic abuse at rates exceeding 30%, higher than the national average, while simultaneously being among the least-researched subgroups within India's broader DV literature.[29] Ethnographic and journalistic accounts attribute this elevated risk in part to entrenched, intergenerational patterns of alcohol use among male partners, framed by community activists as both a cause and a perpetuating mechanism of cyclical family violence, alongside an almost complete absence of embedded psychiatric or counselling services within tribal-majority districts.[29] Where mental health or trauma support does exist in these communities, it is typically provided through small, donor-funded non-governmental initiatives rather than through the public health system, raising concerns about the sustainability, geographic reach, and continuity of care available to tribal DV survivors relative to their non-tribal rural counterparts.

3.7 Regional Focus II: Hill and Rural Uttarakhand

Evidence specific to Uttarakhand remains sparser and more heavily weighted toward grey literature and epidemiological indicators than toward dedicated qualitative or intervention research, a gap this review makes explicit rather than obscures. Survey-based estimates place the prevalence of physical or sexual spousal violence among ever-married women in Uttarakhand at approximately 14%,[3] a figure that must be interpreted cautiously given the stigma-driven under-reporting documented throughout this review and the particular social density of small hill villages, where anonymity in disclosure is difficult to achieve. Journalistic health reporting from within the state describes a pattern in which rural hill women, burdened disproportionately with agricultural labour and household responsibility amid high rates of male out-migration for work, have shown rising rates of suicide attributed by local psychiatric staff and police investigators primarily to domestic conflict and in-law harassment rather than to documented pre-existing mental illness—a pattern that, if accurate, suggests substantial unmet need for accessible, non-stigmatising psychological support embedded closer to community level than the state's currently urban-centred psychiatric infrastructure allows.[11] Compounding this gap, mental illness in Uttarakhand's hill districts has been described as carrying such pronounced taboo that families reportedly abandon relatives experiencing psychiatric symptoms, in a context where, at the time reported, the state possessed no dedicated rehabilitation institute across its hill districts, relying instead on referral to a single mental hospital and to a small number of tertiary institutions.[12] This combination of geographic isolation, gendered labour burden, weak infrastructure, and profound stigma toward mental illness plausibly constitutes one of the most acute yet least empirically documented configurations of DV-related help-seeking barriers identified anywhere within the scope of this review.

3.8 Regional Focus III: Nepal

Nepal's evidence base, drawn substantially from successive rounds of the Nepal Demographic and Health Survey, is more extensive and more recent than the Uttarakhand-specific literature, allowing for more confident quantitative characterisation even as qualitative depth remains comparatively limited. National analyses converge on an IPV prevalence in the range of 27–31% among women aged 15–49, with a strikingly low rate of formal help-seeking: one national analysis found that 72% of women who had ever experienced IPV had never sought help of any kind, and that among the minority who did seek help, over 90% turned exclusively to informal sources such as family or friends rather than police, health facilities, or dedicated support services.[13] This pattern held even during the acute disruption of the COVID-19 pandemic, when a cross-sectional survey recorded IPV prevalence above 50% alongside a formal reporting rate to police of only 6%.[15] Mental health consequences mirror the Indian pattern in magnitude: nearly half of DV-exposed Nepalese women report concurrent anxiety or depressive symptoms, with severe physical violence associated with close to a doubling of depressive-symptom risk in adjusted models.[14] Qualitative work among young pregnant women in Kathmandu Valley slums adds explanatory depth to these figures, identifying fear of escalation, financial dependence on the abusive partner, and a hope that pregnancy itself would resolve or reduce violence as key psychological mechanisms delaying or preventing disclosure, alongside broader structural recommendations from participants themselves—including female education, economic independence, and the establishment of dedicated community institutions to handle violence against young women—that closely parallel policy recommendations emerging from the Indian literature.[16] Longitudinal attitudinal data further suggest that formal help-seeking in Nepal has increased only slowly over time (from 21.8% in 2011 to 25.8% in

2016 in one tracked cohort), consistent with the interpretation that shifting entrenched normalisation of violence, rather than simply expanding service availability, represents the binding constraint on further improvement.[30]

4. Discussion

4.1 Synthesis Across Settings

This scoping review mapped evidence from Central India's tribal belts, Uttarakhand's hill districts, and Nepal to characterise the stigma-related, socio-cultural, and structural barriers shaping mental health help-seeking among DV survivors. Four cross-cutting observations emerge from the synthesis. First, the association between DV exposure and adverse mental health outcomes is remarkably consistent in direction and approximate magnitude across all three settings, despite considerable heterogeneity in measurement instruments, sampling frames, and study designs—suggesting that this relationship reflects a genuine, generalisable phenomenon rather than an artefact of any single methodological approach.[5,6,7,13,14,15] Second, formal help-seeking remains a minority pathway everywhere examined, with informal disclosure to family dominating even where legal and institutional protections nominally exist, indicating that legislative reform alone (in either India or Nepal) has been insufficient to shift the balance of help-seeking from informal to formal channels.[13,22,27,28] Third, stigma operates as a compound rather than a singular phenomenon: DV-specific stigma (shame, fear of family dishonour) and mental-illness-specific stigma (social discrediting, taboo) appear to reinforce one another, such that a woman experiencing both DV and consequent psychological distress faces two independently discouraging, mutually amplifying barriers to disclosure rather than one.[7,25,31] Fourth, structural deficits—workforce shortages, funding gaps, and geographic inaccessibility—are not merely background conditions but appear to interact directly with stigma: where formal services are distant, unfamiliar, or perceived as unresponsive, the marginal social cost of disclosure (stigma) is not offset by any compensating expectation of tangible benefit, further discouraging help-seeking beyond what stigma or structural deficit would produce independently.[4,12,26]

4.2 Theoretical Interpretation

Andersen's Behavioural Model of Health Services Use offers a parsimonious way to organise these findings.[21] Predisposing factors identified across the reviewed literature include patriarchal gender norms that frame marital violence as a private matter,[5,7] tribal and hill-specific cultural scripts around family honour and intergenerational alcohol use,[29] and low general mental health literacy documented consistently in rural Indian samples.[8,10] Enabling factors include the profound scarcity of trained mental health personnel and psychiatric infrastructure in rural, tribal, and hill districts,[4,12] the geographic inaccessibility created by hill and forest terrain in both Uttarakhand and parts of Nepal, and household-level economic dependence that constrains women's capacity to travel for care independently of their partner's consent.[16] Need factors, finally, are substantial and well-documented, evidenced by the high prevalence of PTSD, depression, and anxiety symptoms found across nearly every empirical source reviewed,[7,13,14] yet

perceived need appears to be systematically suppressed by stigma and normalisation before it can translate into service contact, illustrating that objective clinical need and subjectively perceived, actionable need are analytically distinct constructs in this population.

Heise's ecological framework further clarifies why interventions targeting a single level are unlikely to be sufficient in isolation.[32] At the individual level, internalised stigma and self-blame discourage disclosure even where community-level services exist.[7] At the relationship level, partner alcohol use and controlling behaviour emerge repeatedly as proximate predictors of both violence severity and help-seeking likelihood.[7,22] At the community level, gossip-based sanctioning, honour-based norms, and the taboo status of mental illness in hill and tribal communities actively discourage disclosure regardless of individual women's preferences.[12,29] At the societal level, underfunded mental health systems, uneven implementation of protective legislation, and the geographic concentration of psychiatric services in urban centres constrain the practical options available even to women who successfully overcome individual- and community-level barriers.[4,27,28] The consistency of this multi-level patterning across three distinct national and sub-national contexts strengthens confidence that the ecological framework captures a genuine structural feature of DV-related help-seeking in South Asian rural and hill/tribal settings, rather than an artefact specific to any one country's health system.

4.3 Comparison with Existing Reviews and Identification of Evidence Gaps

This review's findings are broadly consistent with prior systematic and meta-ethnographic work on South Asian women's DV help-seeking conducted in high-income diaspora settings, which similarly identifies stigma, family honour, and fear of relationship loss as dominant barriers to disclosure, suggesting substantial cultural continuity in help-seeking barriers across South Asian communities regardless of country of residence. However, the present review extends this literature by focusing specifically on rural, tribal, and hill populations

within South Asia itself, where structural health-system deficits—rather than migration-specific factors such as language barriers or unfamiliarity with a host-country health system—constitute the dominant enabling-factor constraint. A clear and consequential evidence gap emerged during charting: very few sources in the available literature focus specifically and primarily on Scheduled Tribe populations, and Uttarakhand-specific empirical research on DV-related mental health help-seeking is almost entirely absent from the peer-reviewed literature, forcing reliance on epidemiological indicators and credible journalistic reporting to characterise this setting. This gap is itself an important finding: the near-invisibility of tribal and hill-specific populations within the formal research literature mirrors, and arguably compounds, their invisibility within formal health-service planning and provision.

5. Implications for Policy, Practice, and Research

Several actionable implications follow from this synthesis. First, mental health and DV response services should be structurally integrated rather than delivered through parallel, uncoordinated systems: given the demonstrated overlap between DV exposure, PTSD, depression, and anxiety,[7,13,14] frontline health workers (ASHAs in India, Female Community Health Volunteers in Nepal) should be trained and equipped, using validated brief screening tools, to identify both DV exposure and common mental disorders during routine home visits, rather than requiring women to independently identify and access two separate service pathways.

Second, task-shared, community-based mental health delivery models of the type piloted through the SMART Mental Health programme in rural Andhra Pradesh[25,26] warrant deliberate extension and adaptation to tribal Central India and hill Uttarakhand, with explicit attention to the intergenerational-alcohol-use dynamic documented in tribal settings[29] and to the geographic access constraints documented in hill terrain.[12] Anti-stigma communication strategies should draw on the demonstrated effectiveness of locally staged drama and social-contact video interventions,[25] adapted to reflect region-specific cultural scripts (tribal kinship structures in Central India; hill-community isolation and gendered labour burden in Uttarakhand; caste and ethnic diversity in Nepal) rather than applying a single national template uniformly.

Third, existing legal protections—India's Protection of Women from Domestic Violence Act, 2005, and Nepal's Domestic Violence (Crime and Punishment) Act, 2066 (2009)[27,28]—require strengthened implementation, particularly the decentralisation of Protection Officer services, legal aid, and shelter provision to sub-district and village levels in hill and tribal districts, rather than concentration at district headquarters that remain physically inaccessible to many rural survivors. Fourth, given the strong and repeated association between partner alcohol use and both DV severity and non-disclosure,[7,22,29] integration of alcohol-use screening and brief intervention into the same community health-worker platforms recommended above is likely to yield benefits for both DV prevention and mental health outcomes simultaneously.

Finally, this review identifies clear priorities for future primary research. Dedicated, adequately powered qualitative and mixed-methods studies focusing specifically on Scheduled Tribe communities across Central India, and on Uttarakhand's hill districts specifically (rather than Uttarakhand data embedded within broader northern-India analyses), are urgently needed. Comparable, harmonised survey instruments across India and Nepal would additionally allow future researchers to move beyond the largely parallel, non-comparable evidence base characterised in this review toward genuinely cross-national comparative analysis of help-seeking determinants.

6. Strengths and Limitations

This review has several strengths, including its explicit, peer-reviewed methodological framework,[17,18,19,20] its dual theoretical lens combining an established health-services-utilisation model with an established violence-specific ecological framework,[21,32] and its deliberate focus on an under-synthesised intersection of geography (tribal Central India, hill Uttarakhand, Nepal) and topic (DV-related mental health help-seeking specifically, rather than DV prevalence or mental health prevalence considered separately).

Several limitations should also be acknowledged. Consistent with scoping review methodology, no formal risk-of-bias or quality appraisal was undertaken, and the synthesis therefore weighs sources by relevance and transparency of design rather than by a standardised quality score;[19] readers should interpret findings drawn from single, smaller qualitative or journalistic sources with appropriate caution relative to findings replicated across multiple large national surveys. The search was restricted to English-language sources, which may have excluded relevant Hindi-, Nepali-, or regional-language literature, particularly grey literature and government reports specific to Uttarakhand and tribal Central India. The evidence base for Uttarakhand specifically remains thin and disproportionately reliant on journalistic and epidemiological-indicator sources rather than dedicated peer-reviewed empirical research, a limitation of the underlying literature that this review makes transparent rather than attempts to obscure through selective emphasis. Finally, as a scoping review, this synthesis maps and describes the existing evidence rather than statistically pooling effect sizes; readers seeking precise, pooled

quantitative estimates of associations between DV and mental health outcomes in these specific populations should consult future systematic reviews and meta-analyses once a sufficiently large and comparable set of primary studies becomes available.

7. Conclusion

Domestic violence exerts a substantial and consistently documented toll on the mental health of women in rural and tribal Central India, hill Uttarakhand, and Nepal, yet formal help-seeking for either the violence itself or its psychological consequences remains the exception rather than the rule across all three settings. This review demonstrates that stigma (both DV-specific and mental-illness-specific), culturally reinforced silence and normalisation of violence, and structural health-system deficits do not operate as independent, additive barriers but interact synergistically, such that addressing any single dimension in isolation is unlikely to substantially close the documented treatment and help-seeking gap. Community-based, task-shared mental health delivery integrated with DV screening, culturally adapted anti-stigma communication, strengthened implementation of existing protective legislation, and dedicated primary research attention to the currently under-studied tribal and hill populations at the centre of this review together represent the most promising pathway toward improving mental health help-seeking outcomes for domestic violence survivors in these historically marginalised South Asian settings.

Declarations

Funding: This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

Conflicts of Interest: The authors declare no conflicts of interest.

Ethical Approval: Not applicable. This scoping review synthesises previously published literature and did not involve primary data collection from human participants.

Data Availability: All data extracted for this review are derived from publicly available published sources cited in the reference list.

Author Contributions: Conceptualisation, methodology, literature search, data charting, analysis, and manuscript drafting were carried out collaboratively by the listed authors. All authors reviewed and approved the final manuscript.

Acknowledgements: The authors thank the frontline health workers, researchers, and organisations whose primary work made this synthesis possible.

References

1. World Health Organization. Violence Against Women Prevalence Estimates, 2018: Global, Regional and National Prevalence Estimates for Intimate Partner Violence Against Women and Global and Regional Prevalence Estimates for Non-Partner Sexual Violence Against Women. Geneva: World Health Organization; 2021.

2. World Health Organization. Global and Regional Estimates of Violence Against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence. Geneva: World Health Organization; 2013.

3. International Institute for Population Sciences (IIPS), ICF. National Family Health Survey (NFHS-5), India, 2019–21. Mumbai: IIPS; 2021.

4. National Institute of Mental Health and Neurosciences (NIMHANS). National Mental Health Survey of India, 2015–16: Prevalence, Patterns and Outcomes. Bengaluru: NIMHANS; 2016.

5. Kumar S, Jeyaseelan L, Suresh S, Ahuja RC. Domestic violence and its mental health correlates in Indian women. Br J Psychiatry. 2005;187:62–67.

6. Vachher A, Sharma A. Domestic violence against women and their mental health status in a colony in Delhi. Indian J Community Med. 2010;35(3):403–405.

7. Sathe HS, Maliye CH, Varma PS, Garg BS, Shahare K, Rathod R. Intimate partner violence and mental health problems in married women in rural Central India: a community-based cross-sectional study. Indian J Community Med. 2024;49(6):866–872.

8. Iyer K, Gupta P, Sapre S, Pawar T, Gala P, Kapoor H, et al. Mental health resources, barriers, and intervention needs among women in rural Maharashtra, India: a qualitative study. Camb Prisms Glob Ment Health. 2023;10:e91.

9. Gala P, Ticku A, Pawar T, Sapre S, Gupta P, Iyer K, et al. Perspectives and presentation of mental health among women from rural Maharashtra (India): a qualitative study. Camb Prisms Glob Ment Health.

2024;11:e40.
10. Gawai J, Tendolkar V. Perception of mental health problems and coping strategies among rural women living in Vidarbha region. J Datta Meghe Inst Med Sci Univ. 2019;14(3):215–220.
11. Drudgery driving women to suicide. The Tribune (Chandigarh). 2009 Apr 24.
12. World Mental Health Day: with no rehabilitation institute in the hill districts of Uttarakhand, mental illness continues to be a taboo. The Tribune (Chandigarh). 2009 Apr 7.
13. Kurvinen M, Ekström AM, Deuba K. Burden of intimate partner violence, mental health issues, and help-seeking behaviors among women in Nepal. Womens Health (Lond). 2025;21.
14. Gnawali S, Atteraya MS, Kim E. Association between domestic violence and mental health among Nepalese women: results from a nationally representative sample. J Interpers Violence. 2025. Epub ahead of print.
15. Bhatt B, Bhatt N, Karki A, Giri G, Baaniya B, Neupane B, et al. Intimate partner violence against married women of reproductive age in Nepal during the COVID-19 pandemic. Heliyon. 2023;9(9):e20117.
16. Deuba K, Mainali A, Alvesson HM, Karki DK. Experience of intimate partner violence among young pregnant women in urban slums of Kathmandu Valley, Nepal: a qualitative study. BMC Pregnancy Childbirth. 2016;16:11.
17. Arksey H, O'Malley L. Scoping studies: towards a methodological framework. Int J Soc Res Methodol. 2005;8(1):19–32.
18. Levac D, Colquhoun H, O'Brien KK. Scoping studies: advancing the methodology. Implement Sci. 2010;5:69.
19. Tricco AC, Lillie E, Zarin W, O'Brien KK, Colquhoun H, Levac D, et al. PRISMA extension for scoping reviews (PRISMA-ScR): checklist and explanation. Ann Intern Med. 2018;169(7):467–473.
20. Peters MDJ, Godfrey CM, Khalil H, McInerney P, Parker D, Soares CB. Guidance for conducting systematic scoping reviews. Int J Evid Based Healthc. 2015;13(3):141–146.
21. Andersen RM. Revisiting the behavioral model and access to medical care: does it matter? J Health Soc Behav. 1995;36(1):1–10.
22. Dehingia N, Dey AK, McDougal L, McAuley J, Singh A, Raj A. Help seeking behavior by women experiencing intimate partner violence in India: a machine learning approach to identifying risk factors. PLoS One. 2022;17(2):e0262538.
23. Ghoshal R, Patil P, Sinha I, Gadgil A, Nathani P, Jain N, et al. Factors associated with help-seeking by women facing intimate partner violence in India: findings from National Family Health Survey-5 (2019–2021). BMC Glob Public Health. 2024;2:56.
24. Leonardsson M, San Sebastian M. Prevalence and predictors of help-seeking for women exposed to spousal violence in India – a cross-sectional study. BMC Womens Health. 2017;17:99.
25. Maulik PK, Devarapalli S, Kallakuri S, Tewari A, Chilappagari S, Koschorke M, et al. Evaluation of an anti-stigma campaign related to common mental disorders in rural India: a mixed methods approach. Psychol Med. 2017;47(3):565–575.
26. Maulik PK, Kallakuri S, Devarapalli S, Vadlamani VK, Jha V, Patel A. An integrated community and primary healthcare worker intervention to reduce stigma and improve management of common mental disorders in rural India: protocol for the SMART Mental Health programme. Trials. 2020;21:225.
27. Government of India. The Protection of Women from Domestic Violence Act, 2005 (Act No. 43 of 2005). New Delhi: Ministry of Law and Justice; 2005.
28. Government of Nepal. Domestic Violence (Crime and Punishment) Act, 2066 (2009). Kathmandu: Government of Nepal; 2009.
29. Activists warn about intergenerational domestic violence in Indian tribes. VOA News. 2024 May 4.
30. Bender AK, Chalise N. Differentiating perceptions of intimate partner violence in Nepal. Int Soc Work. 2018;61(6).
31. Goffman E. Stigma: Notes on the Management of Spoiled Identity. Englewood Cliffs (NJ): Prentice-Hall; 1963.
32. Heise LL. Violence against women: an integrated, ecological framework. Violence Against Women. 1998;4(3):262–290.