COVID-19 and domestic violence through an intersectional lens: Safety, security, rights

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Support for impacted communities: This report examines domestic violence and abuse during the pandemic in British Columbia. We recognize this information will be deeply disturbing for many people in our province to hear. This issue, while critical to examine, is extremely challenging, especially for people who have experienced or witnessed instances of domestic violence and abuse. British Columbians who experience distress at reading this report or who need immediate help can access a list of crisis lines and emergency mental health supports we have compiled on our website at: bchumanrights.ca/support

Contents

Introduction

COVID-19 emerged as a global pandemic in the early months of 2020, which impacted the safety, security and well-being of survivors of domestic violence (DV)[4] as a result of social and public health-based restrictions (e.g., shelter-in-place orders). On average, more than 10 million women in North America experience DV every year; for these women, home is not a safe place. Yet, within the COVID-19 context, as of March 29, 2020, an estimated 90 percent of Canadians (i.e., 34.2 million individuals) sought to shelter in place, as it was believed that they were safer at home due to a reduced exposure to, and transmission of, COVID-19 (Dunatchik et al., 2020; Schellenberg & Fonberg, 2020).

In this report, these issues are analyzed in more detail through an intersectional lens, including an examination of the impacts of DV during the COVID-19 pandemic on women who experience increased barriers to safety and security as a result of inequality, discrimination and injustice, including immigrant and refugee women (IRW); Indigenous women; women in rural, remote, and northern communities; women experiencing senior abuse; and women living with disabilities. This report also details lessons learned, promising practices, and relevant recommendations made by British Columbian, Canadian and, in some cases, international public and private institutions to support British Columbia's Office of the Human Rights Commissioner's *Inquiry into Hate in the COVID-19 Pandemic* and their subsequent development of recommendations for policy and practice.

[4] DV refers to any form abuse/violence between two or more people who are either currently within or who have previously been in an intimate relationship that results in physical, emotional, psychological and/or sexual harm (Mojahed et al., 2021). While acts of DV are typically understood as any action that causes visible and/or physical harm to an individual's well-being, such as violence, it also includes enactments of power and control including, but not limited to, geographic and social isolation from friends, family and institutional systems of support (e.g., health care, women's shelters) (Mojahed et al., 2021).

Methods

The goal of this systematic literature review was to synthesize research related to the impacts of DV during the COVID-19 pandemic through an intersectional lens, with an emphasis on Canadian and British Columbian contexts. This literature review consisted of three key phases: 1) the development of the literature search framework, including identification of key search terms and parameters; 2) the literature search itself; and 3) literature analysis and write-up. This systematic literature review has an intentional scope that limited the search to documents spanning 2020 through 2022 and were written in English. Discretion was used to include key or foundational works that were published prior to 2020 (i.e., prior to the beginning of the COVID-19 pandemic) and provided important context. A wide range of academic and grey literature[5] sources were included, such as peer-reviewed journal articles, reports, government documents and legislation.

The researchers began by developing lists of search terms relevant to the identified focus of this research. Each search term combination was run through official databases (e.g., ProQuest, Simon Fraser University library, Capilano University library) and other search engines (e.g., Google) to capture relevant academic and grey literature. This search resulted in the identification of over 100 potentially relevant sources, which were reviewed and ranked based on relevance to the research foci (i.e., 1 for most relevant, 2 for potentially relevant and 3 for non-relevant). The sources ranked 1/most relevant were selected for inclusion, read, analyzed and integrated into this report (see references list for full list of sources).

[5] Grey literature refers to sources that are not published within traditional academic databases and indexes or by institutions and organizations whose primary purpose is not commercial publication. For example, reports by government or frontline organizations (Rothstein & Hopewell, 2009).

DV in the COVID-19 context

Sheltering in place can mitigate the spread of communicable diseases; however, isolation within the home, as well as increased social and economic instability resulting from the pandemic, can amplify barriers to safety and risk of DV (Connor et al., 2020; Fraser, 2020; North, 2020; Palermo & Peterman, 2011; Peterman et al., 2020; Pirtle & Wright, 2021; Sorenson et al., 2021; WHO, 2020a; Yasmin, 2016). As of 2020, there were 162 countries that had established shelter-in-place orders, in which approximately 2.73 billion women were encouraged to shelter within the confines of their homes, thereby intensifying barriers to social, legal and economic support for survivors of DV (Froimson et al., 2020; Krishnadas & Taha, 2020; WHO, 2020b). Additionally, within the context of the COVID-19 pandemic, men overwhelmingly reported a loss of a sense of power and control, which, in conjunction with other stressors (e.g., economic instability, social isolation), can cause an increase in the risk and severity of DV perpetration (Peterman et al., 2020; Øverlien, 2020; WHO, 2020a).

The government's enactment of physical and social restrictions to counteract the spread of COVID-19, while necessary, hindered survivors' access to systems of support. For example, due to regulations that imposed a minimum 2-metre distance between people, many women's shelters had to reduce their capacity or close altogether (Connor et al., 2020; Townsend, 2020; WHO, 2020a). While remote services, like DV hotlines, still remained, survivors experienced barriers to accessing them due to issues such as the lack of privacy at home when living with an abusive partner (Froimson et al., 2020). Additionally, to uphold social distancing, a majority of Canadian courts (approximately 91%) transitioned to an online format (e.g., Zoom) and further prioritized cases requiring immediate attention (e.g., bail, urgent family matters). However, the classification of cases as "urgent" or considered to be emergencies varied by the level of the court system, with the federal and provincial governments setting independent mandates for their respective courts (Puddister & Small, 2020). This resulted in a multitude of methods for prioritizing cases, even within the same province. Regardless of the severity of the violence, survivors were not guaranteed immediate or prompt access to these services. Further, when survivors were provided access to online forms of court proceedings, these women faced barriers to full participation, such as a lack of understanding on how these procedures would operate and a lack of privacy if the individual still resided with their abuser (McKeever et al., 2020; Puddister & Small, 2020).

Incidences of DV have increased during the pandemic, and the COVID-19 context has contributed to an escalation in severity and lethality of such violence in existing abusive relationships (Calleja-Agius & Calleja, 2021; Makaroun et al., 2020). Social distancing and shelter-in-place mandates fostered conditions of isolation and placed limitations on accessing essential health and community-based services; these shifts have been accompanied by other markers of high-risk and potentially lethal violence (e.g., increases in the purchase of firearms and other forms of lethal weapons) (Bergman et al., 2021; Calleja-Agius & Calleja, 2021; Dartnall et al., 2020; Makaroun et al., 2020).

Pre-existing gender-based and systemic inequalities are one of the root causes of gender-based violence experienced by women in Canada, including DV (e.g., income disparity, un- and under-employment, disproportionate household and caregiving responsibilities) (Johnson & Colpitts, 2013). The pandemic has dramatically increased these inequalities and barriers. In Canada, 2.8 million women lost their jobs (i.e., laid off, fired), needed to resign (e.g., due to caretaking responsibilities) or were working fewer than half of their pre-pandemic hours during the first year of the pandemic alone (Scott, 2021). This resulted in higher rates of un(der)employment and poverty among women in Canada, which places them at greater risk of experiencing DV (Johnson & Colpitts, 2013). Through an increase in women's un- and under-employment, reduction in their social supports and economic resources and an increase in familial stress resulting from the pandemic, women were at greater risk of violence, including high-risk and lethal forms of DV (Froimson et al., 2020).

Reports since the onset of shelter-in-place orders and other social restrictions illustrate the increasing frequency and severity of DV. Pre-pandemic it was estimated that one in five women experienced DV. As a result of the COVID-19 pandemic and subsequent health and safety measures that were implemented to reduce the spread of this communicable disease, there has been an estimated 20 to 50 percent increase in the rates of DV perpetration against women within the United States (Patel, 2020). Canada experienced an increase of 20 to 30 percent, with the provinces of Alberta and Ontario witnessing an increase of 30 to 50 percent and 22 percent respectively, which is often interconnected with experiences of oppression and systemic vulnerability (Bradley et al., 2020; Bright et al., 2020; Patel, 2020).

Using an intersectional lens

Women in general, and survivors of DV more specifically, are negatively affected by the pandemic at disproportionate rates. The social, economic, legal and health-based inequalities and barriers that are interconnected with rising rates of DV during the pandemic cannot be understood as universally applicable. Historically, it has been demonstrated that as a result of global pandemics, social and economic systems are vulnerable to forms of destabilization that can perpetuate the precarity of an individual's well-being. However, social, and subsequently individual, barriers and risks are framed and constructed by those within power (e.g., white middle-to-upper class men) who have the ability to unilaterally determine who is vulnerable and under what circumstances vulnerability occurs (Herring, 2013; Sharma & Das, 2021). An understanding of vulnerability as defined by those in positions of power and privilege ignores the everyday and systemic risks that marginalized individuals experience. As such, it is imperative to analyze socio-economic disruptions and forms of systemic vulnerability and risk through a framework that utilizes a multitude of individual and socially based identities. An intersectional lens allows for a radical rethinking of the impacts of COVID-19, as a range of interconnected factors impact survivors' experiences with risk and barriers to safety and security while living through the pandemic (Hankivsky & Kapilashrami, 2020; Sharma & Das, 2021). The application of such a framework allows for an understanding of how the experiences of women and survivors are influenced by their multiple intersecting marginalized social identities. Through this lens, the systematic subversion that women experience, specifically those who hold a

multitude of marginalized social identities, can be understood as a compounding system of oppression that creates and perpetuates systemic and social barriers to safety, security and access to resources (Crenshaw, 1989; Pirtle & Wright, 2021).

Immigrant and refugee women (hereafter IRW), Indigenous women and women of colour, as well as women who are older, gender diverse and living in poverty, among others, experience unique risks interconnected with DV. The barriers to safety these women experience were amplified as a result of pandemic-related inequalities and stressors. For example, racialized, immigrant and refugee, and impoverished women experienced the greatest loss of economic resources. Their jobs/roles were less likely to transfer to an online and remote environment, they were more likely to be forced to resign as a result of family obligations or were laid off, and they faced many systemic barriers that hindered their access to means of social support (e.g., women's shelters, financial aid) (Dunatchik et al., 2020; Zamarro et al., 2021). The imposition of strict regulations meant to control and mitigate the spread of COVID-19 has created an "additional public health crisis […] a pandemic within a pandemic," which disproportionately affects women who face multiple intersecting oppressions and inequalities (Pirtle & Wright, 2021, p. 171).

Economic impacts

The onset of the COVID-19 pandemic in the spring of 2020 caused a widespread shuttering of the economy, as companies either moved to an online environment or were forced to temporarily close as lockdown and shelter-in-place orders were implemented. While most have experienced an economic disruption, women's continuity of employment was disproportionately affected (Dunatchik et al., 2021; Fuller & Qian, 2021; Qian & Fuller, 2020). Systemically, women earn less than men, occupy precarious labour positions at higher rates (e.g., temporary, part-time and/or seasonal work) and are more likely to be employed within the informal economy.[6] In combination with gendered and intersectional positionality, women are less likely to have access to forms of social and economic support, which was intensified by the economic recession brought on by the pandemic (Burki, 2020).

The implementation of lockdown orders in March 2020 and working from home allowed many to maintain their jobs. Yet, remote work is a classed and gendered alternative for those who occupy sectors of the economy in which their employment is not dependent upon physical forms of labour (Dunatchik et al., 2021). On average, women are more likely to occupy positions within the service sector of the economy in which remote work was not feasible. As such, in the spring of 2020, women were less likely to have their employment transition to an online format. Nevertheless, regardless of economic participation, women were disproportionately expected to shoulder the burden of familial care, such as childcare, at-home education, cleaning and laundry (Shafer et al., 2020; Statistics Canada, 2021). While unemployed fathers were likely to take on a greater division of domestic work in the pandemic context, this participation was greatly reduced when mothers were also un(der)employed or concurrently working remotely (Shafer et al., 2020).

[6] The term *informal economy* refers to activities and jobs that are not regulated or protected by the government.

Despite the flexibility afforded through remote work, the division of labour within North American households remained gendered. As services shut down, women's domestic labour drastically increased as a result of the closure of schools and childcare facilities, requiring them to either reduce their hours in the workforce or withdraw altogether (Dunatchik et al., 2021; Mooi-Reci, 2021; Shafer et al., 2020). Women with higher educational attainment were initially shielded from this gendered economic recession; the continuation of employment for women with children was nevertheless drastically affected by both the pandemic and subsequent gendered and familial responsibilities. With a loss of childcare facilities and closure of schools, women were expected to take over full-time childcare and educational responsibilities at disproportionate rates, regardless of employment obligations (Brochu et al., 2020; Dunatchik et al., 2021; Lemieux et al., 2020; Mooi-Reci, 2021).

Women's un(der)employment and higher rates of poverty have limited their access to economic resources, which hinders their autonomy and, in instances of violence, increases their barriers to safety (Dunatchik et al., 2021; Fuller & Qian, 2021). Unemployed women have historically reported an inability or lack of willingness to leave abusive relationships, which is largely due to an economic dependency and/or concerns about the safety and well-being of their children. While a lack of employment does not ubiquitously increase the risk of DV, it can perpetuate the social and economic obstacles that hinder women's access to safety, freedom from violence and/or alternatives to abusive relationships. The pandemic and subsequent restrictions, as well as related social and economic impacts, have impeded women's independence while fostering conditions that increase the risk and severity of DV they experience.

Shelter-in-place orders

The pandemic altered the way society interacts and functions by necessitating the imposition of social regulations, such as lockdowns. One common regulation was shelter-in-place/stay-at-home orders, which were implemented by 142 countries in 2020. During this time, an estimated 3 billion people throughout the globe were encouraged and, in some cases, legislated to stay at home (Agüero, 2021; Hale et al., 2020; Krishnadas & Taha, 2020). Shelter-in-place orders were introduced under the pretence that families were safer at home, where the spread of COVID-19 could be mitigated through limiting individual and group contact. Within this context, the home was assumed to be the safest place.

While necessary to minimize the spread of COVID-19, shelter-in-place/stay-at-home orders were enacted at the increased risk of an economic recession, loss of individual employment and income, educational deprivation and exacerbated mental health concerns (e.g., anxiety, depression), which negatively impacted women's safety and security (Agüero, 2021; Krishnadas & Taha, 2020; Pirtle & Wright, 2021). Survivors and anti-violence advocates expressed concerns related to the array of harms that can result from the removal of conventional and social forms of support, as well as mandated isolation (Connor et al., 2020; Pirtle & Wright, 2021). By way of illustration, Amy FitzGerald, the executive director of the BC Society of Transition Houses, explained that the social isolation mandated through COVID-19 lockdown orders "created a very difficult situation for [survivors of DV] to reach out for support services in a safe way" (Steacy & Burr, 2021, para 4).

Measures introduced to prevent the spread of disease failed to take into account how they systematically endangered women due to the increased risks posed through social isolation within the home (Agüero, 2021; Bradbury-Jones & Isham, 2020; Durevall & Lindskog, 2015; van Gelder et al., 2020; Peterman et al., 2020; Roesch et al., 2020; UNFPA, 2020). Government agencies around the globe were, and are still, grappling with the paradox of safety in which they are asking their citizens to stay at home while giving little attention to the systemic harms being inflicted upon women and children living with DV (Øverlien, 2020). The Canadian Minister for Women and Gender Equality acknowledged this increased risk and emphasized the need for consultations with provincial and territorial governments along with frontline organizations in an effort to provide relief funds and bolster forms of support (for example, see Limited Access to Resources section, p. 17) (Patel, 2020).

Shelter-in-place orders can socially and physically separate survivors from means of support while simultaneously isolating them with their perpetrators and limiting their opportunities to seek help and/or leave the relationship (Agüero, 2021; Connor et al., Brown et al., 2020; WHO, 2020a; 2020b). Further, women who had not experienced DV prior to the onset of COVID-19 were at a higher risk of experiencing physical and emotional violence as a result of increased risk factors for violence experienced by the perpetrator, such as daily stress, mental health concerns and socio-economic strain brought on and/or exacerbated by the pandemic (Froimson et al., 2020; Harville et al., 2011).

Through shelter-in-place orders, the everyday activities of women within abusive relationships were systematically monitored by their abusive partners; this concurrently limited moments of freedom traditionally found outside of the shared household in which women could seek support and safety (North, 2020; see also Stark, 2007). Women in abusive relationships may have had their phone calls, text messages, emails and/or other form of correspondence monitored, censored or restricted, which survivors reported as a tactic of control that has increased while sheltering in place (Henry et al., 2021; North, 2020; WHO 2020b; see also Stark, 2007). Further, these governmental regulations and fear of COVID-19 could have been used by perpetrators to isolate survivors from forms of social supports and services (North, 2020; WHO, 2020a). Abusive partners may have used the risk of contracting COVID-19 as a tactic to limit a survivor's access to traditional points of system contact, such as healthcare services and women's shelters, family, friends and other forms of social support, thereby garnering further power and control in the relationship (WHO, 2020b). These barriers to safety were even more pronounced in relationships involving high-risk violence and/or coercive control.

Limited access to resources

Through past historical epidemics, pandemics, widespread public health crises, and natural disasters, it has been demonstrated that essential daily health services are diverted to emergency measures in order to combat and reduce the spread of communicable diseases, as well as alleviate widespread physical harm and structural damage (WHO, 2020a). However, the disruption in service provision was predominantly gender biased, as funding for and access to sexual, reproductive and women's support services (e.g., women's shelters) was interrupted at higher rates than other types of services (Ghoshal, 2020; WHO, 2020a).

While the shift in the distribution of resources of care from health services and safety supports to measures that mitigate a pandemic was considered necessary, the detrimental effects of the removal of support services offered to survivors can have equally devastating consequences as the pandemic itself (Vora et al., 2020). For instance, women's shelters and transition homes provide temporary accommodations for survivors while also fostering connections to, and relationships with, other social supports. Organizations within B.C., and in many locations across Canada, are often staffed by volunteers and are dependent upon financial support from government organizations, charities and private donors (for example, see Tri-City Transitions) (Bergman et al., 2021; Quinlan & Singh, 2020). With a severe reduction in available resources (e.g., personal, financial), some shelters were forced to close during the pandemic. While numerous Canadian shelters remained open, they were often forced to reduce their capacity and adapt or cease their provision of services to non-resident women and/or those not in immediate danger to comply with global, national and provincial health mandates (Bergman et al., 2021; Quinlan & Singh, 2020; Steacy & Burr, 2021).

Beyond shelters and transitional housing, other supports and services offered to survivors (e.g., legal advocates) were either closed or shifted to online modes of service delivery (North, 2020). While the technology that promoted remote forms of communication was generally beneficial to many people during the pandemic, survivors could be placed at greater risk as their privacy and safety inherent within structured in-person court environments was compromised through a shift to online service provision. Further, the use of remote legal services and counselling is dependent upon survivors having access to and some proficiency for using technological means of communication and the internet, as well as the ability to engage with such services and supports without fear of being monitored by their abuser (North, 2020; see also Stark, 2007).

Shelters that remained open or resumed services during the pandemic were forced to implement protocols to promote physical distancing while creating quarantine guidelines and procedures for any women who contracted COVID-19 and required housing. Physical distancing and isolation protocols can hinder the spread of a communicable disease; although these protocols can serve as an impediment for shelters that operate as a communal environment, as their space and facilities have limited capacity (Quinlan & Singh, 2020). The implementation of physical distancing mandates created a shortage of beds. Shelters also experienced an increase in the need for accommodations for women and children seeking safety during the pandemic, but they were unable to provide a greater amount of shelter and support services. While limited shelter space is not a phenomenon limited to global pandemics, it was compounded by a rise in women and families experiencing violence in their homes due to lockdown mandates and stay-at-home orders (Quinlan & Singh, 2020).

Anti-violence advocates and service workers have expressed that increased limitations on mobility in shelters and transitional housing due to COVID-19 protections could have deterred some women from seeking assistance. Martin Girard, a spokesperson for women's shelters in Quebec, stated "in her relationship, she wasn't free and now she comes into our shelter and she's not free either. So, we aren't really helping her" (as quoted in Quinlan & Singh, 2020, p. 579). The social pandemic-related restrictions imposed upon women in shelters and transitional

housing could have exacerbated and perpetuated their feelings of entrapment. Shelters and transitional housing services were caught between regional/provincial and federal health regulations and their own mandate to provide continual supportive services that do not disempower survivors of DV (Quinlan & Singh, 2020).

Numerous shelter workers and anti-violence advocates have argued that the integrity of shelters' ability to deliver unfettered support services was more important than physical and social distancing (Quinlan & Singh, 2020). For example, in response to the increased demand for shelters and services during the global pandemic, survivors' rights groups in Germany have urged governments to utilize hotels as temporary housing for women and children (Ghoshal, 2020; Quinlan & Singh, 2020). While the use of hotel rooms could have allowed shelters to increase their capacity while upholding social distancing and isolation mandates, many advocates and support services have voiced concern that the use of unsecure housing options may create additional security risks for those already the most at risk (Quinlan & Singh, 2020).

While shelters and transitional housing services sought to balance the pressure to uphold health measures and the increase in demand for supports and services, limited access to personal protective equipment (PPE) (e.g., gloves and masks) placed shelter workers and volunteers at risk. While the media continually focused on the limited availability of PPE materials within healthcare settings, what was absent from public discourse was the lack of adequate COVID-19 resources available to shelters, transitional housing and other anti-violence support services. Further, especially at the outset of the pandemic, limited financial resources meant that many shelters and anti-violence services have had to go without protective equipment and have relied largely on the community for donations (Quinlan & Singh, 2020).

The constraints implemented to reduce the spread of COVID-19 have created financial instability for many shelters and anti-violence support services. Within Canada, for instance, many shelters rely on governmental grants, private donations and fundraising in order to provide services and safety to women and children leaving violence (Bergman et al., 2021). With pandemic-induced economic insecurity, donations and grants became sparse and institutionally imposed health regulations of social and physical distancing hindered shelters' ability to fundraise (Bergman et al., 2021; North, 2020). Such financial insecurity was exacerbated by increased costs brought on by the pandemic, such as the need to purchase PPE and pay for hotels and other forms of boarding to address the increased demand for safety and shelter for survivors. Anti-violence advocates and shelter workers began appealing to private organizations, as well as federal and provincial governments, for ongoing emergency funding (Bergman et al., 2021; Quinlan & Singh, 2020).

In May 2020, the government of Canada announced a one-time emergency relief fund of up to $30 million for shelters throughout Canada. This emergency fund was critical in guaranteeing that shelters were able to follow public health guidelines while continuing to provide care, support and safety for survivors of DV (Quinlan & Singh, 2020). While shelters within Canada were provided with a temporary increase in funding, many found this to be inadequate financial relief given the overall increase in the need for shelters, beds and support services during the pandemic (Quinlan & Singh, 2020). Despite the immense challenges brought on by an urgent

need for financial aid, PPE and a greater number of beds to meet the needs of the increased number of women and children seeking safety, a majority of shelters and anti-violence services have continued to operate during the pandemic. While such services worked to sustain themselves and continue to provide care and support, it has been illustrated that shelters and related services operated as obscured and unnoticed entities hidden from both government policy and mainstream attention (Bergman et al., 2021; Quinlan & Singh, 2020).

Immigrant and refugee women

IRW experience multiple intersecting oppressions (e.g., gender, race, immigration status), which increases the barriers to safety they face and limits their access to institutional and social supports (Adams & Campbell, 2012; Glass et al., 2011; Moynihan et al., 2008). The safety of IRW survivors may be compromised through their limited access to supports and services, their precarious legal position, language barriers within systems and supports, bias and discrimination (e.g., racism) and interconnections among these and other forms of oppression. Further, IRW, specifically those who arrived by extra-legal means or have precarious status within the country, occupy a distinctive social role in which they can experience amplified barriers resulting from issues, such as fear of deportation, obstructing their access to services and supports (Cleaveland & Waslin, 2021; Liversage, 2021). Through the imposition of social, economic, legal and physical barriers to safety, the pandemic-related conditions intersect with gender, racial and legal oppression which can further exacerbate the precarious safety, security and well-being of IRW (Crenshaw, 2020; Pirtle & Wright, 2021).

Economic impacts on IRW

DV within immigrant families and communities is not a result of culture and is, instead, a function of socioeconomic inequality, marginalization, and related barriers to safety and support. Immigrant families are systematically deprived of socio-economic resources and opportunities to fully engage in the labour market as a result of issues such as unrecognized credentials in the host country (i.e., deskilling), racism and discrimination in hiring processes and barriers to obtaining work permits. For example, due to a lack of recognition of credentials, immigrants generally, and IRW more specifically, are restricted to positions that are lower than their educational level and labour market experience (Adams & Campbell, 2012; Bhuyan et al., 2015; Glass et al., 2011; Menjivar & Salcido, 2002).

On average, immigrants, with both long- and short-term status within Canada, may occupy precarious labour positions and experience forms of deskilling. This is most apparent for immigrants who enter Canada through the temporary foreign worker program (TFWP) and the live-in caregiver program as it categorizes and labels these individuals as a form of surplus and expendable labour. Accordingly, immigrant women are likely to experience downward social mobility as a result of immigration and the compounding effects of the scarcity of employment opportunities brought on by the pandemic and their imposed precarious labour opportunities as a result of systemic deskilling (Bhuyan et al., 2015; Henry et al., 2021; Menjivar & Salcido, 2002; Sokoloff, 2008; Vaughan et al., 2016). To illustrate, Latinx IRW whose primary income came from domestic work experienced heightened income insecurity during the pandemic, as domestic workers were among the first to be laid off, along with maids and housekeepers, as the Canadian economy transitioned to the home environment. Of note, an estimated half a million immigrants within Canada were ineligible for provincial and national emergency financial assistance (i.e., Canadian Emergency Response Benefit) as a result of an inability to demonstrate a consistent

employment history[7] and/or a social insurance number and, in instances of precarious status, health care and insurance (Cleaveland & Waslin, 2021; Barber, 2013; Pirtle & Wright, 2021; Shields & Abu Alrod, 2020; Strauss & McGrath, 2017).

While it has been demonstrated that an immigrant woman's loss of employment can diminish their power within relationships as a result of a loss of economic resources required for autonomy, the implications of an immigrant man's loss of employment are inconclusive (Henke & Hsu, 2022). It has been shown that as a reaction to a loss of employment, men who perpetrate DV will sense a loss of power and control within the relationships. As a result, these men may either attempt to reify this power through increased acts of violence or mitigate the dissolution of the relationship through a reduction in violence. This is further compounded by a myriad of factors that determine the level of each partner's perceived power, such as a woman's current level of independent economic resources, employment and who is primarily responsible for childcare (Henke & Hsu, 2022). IRW, especially those in sponsorship arrangements, are financially dependent upon their partners and partners' families. Amplified through higher rates of un(der)employment resulting from the pandemic, IRW are increasingly dependent upon their partners for financial support (Evan, 2020); this financial dependence further compounds existing barriers IRW experience when trying to leave violent relationships (Evans, 2020).

Access to services for IRW during the pandemic

Women who occupy intersectional identities, such as IRW and Indigenous women, often experience cultural and linguistic barriers when accessing services and supports; their needs are frequently disregarded through funding decisions in which shelters and other anti-violence support services consistently focus on the needs of the dominant society (i.e., English-speaking and white), which hinders the safety and support for other individuals and communities (Henry et al., 2020). Policies and practices such as these can be based in subtly discriminatory ideologies that create and perpetuate an uneven distribution of resources of care (e.g., welfare, education, employment, housing, shelters) and legal assets (e.g., rights, protections, benefits); this maintains structural inequalities and limits their access to safety, security and care (Del Real, 2018; Henry et al., 2020; Segrave 2017; Vaughan et al., 2016).

As a result of shelter-in-place orders, IRW living with violence experienced increased barriers to seeking help and/or leaving violence, because these orders placed greater restraints on IRW survivors and increased the abusive partner's power and control in the relationship (Sabri et al. 2019; van Gleder et al., 2020). IRW in violent relationships may be subjected to greater amounts of controlling and abusive behaviours, akin to capture and control crimes, through abuse of their precarious positionality (e.g., immigrant status, social isolation, economic dependency) (Cleaveland & Waslin, 2021; Cone, 2020; Landis, 2020; Menjivar & Salcido, 2002). IRW may be reliant upon, or led to believe they are reliant upon, their partners for continued status within the host country (e.g., designated as a dependent class or an undocumented resident) and

[7] To qualify for the Canadian emergency response benefit in 2020, individuals residing within Canada had to demonstrate that they earned a minimum of $5,000 in the previous year (i.e., 2019) and have a social insurance number (& Abu Alrob, 2020).

unaware of their rights. Further, as a result of shelter-in-place orders, IRW faced barriers to points of system contact and social supports outside of their homes, which further entrapped these women in their relationships and hindered their ability to access information on rights or resources that would have countered their abusive partner's narrative (e.g., fostering fear of deportation) (Cleaveland & Waslin, 2021; see also Stark, 2007). Using fear and coercion surrounding an immigrant woman's precarious status, they can be dissuaded from attempting to seek out shelters or other anti-violence services for fear of legal sanctions (Cleaveland & Waslin, 2021).

IRW encountered greater barriers to help-seeking due to the absence of sufficient culturally and linguistically informed supports, both before and during the pandemic. This amplified their risk of experiencing forced social, physical and economic isolation, which further perpetuated the harms inflicted by the perpetration of DV (Ashbourne & Baobaid, 2019; Jiwani, 2006) and was dramatically increased through the enactment of orders that enforce isolation. During the pandemic, shelters saw a general increase in demand for support services; at the same time, they witnessed a decline in requests for assistance from IRW and those with marginalized intersectional identities, such as Indigenous women and women of colour (Bergman et al., 2021). Through sharing their lived experiences, these women have illustrated that the presence of structural barriers, such as the limited accessibility of linguistic and culturally appropriate shelters, has served to hinder their ability and willingness to seek assistance from these institutional resources (Cleaveland & Waslin, 2021; Sokoloff & Dupont, 2005).

Anti-violence services and supports have expressed concern that some women (e.g., those with fewer established social connections, those facing cultural and linguistic barriers and/or those systemically ignored by institutions and governmental agencies) are most at risk of violence. Shelter-in-place orders inequitably affected IRW, as forms of regular everyday social contact are often already limited for newcomer women who are most in need of ongoing forms of social connection and support (Bergman et al., 2021). Accessible and routine social interaction for IRW, such as language courses and community centres, were an initial point of contact which allowed for potential identification of the presence of DV, intervention and help-seeking, especially for individuals who experience greater barriers to accessing social support and shelters.

Challenges to accessing these points of system contact, such as the limitation of in-person interaction with health care providers and language centres, constrained primary and often sole modes of interaction between IRW and larger social structures (Adams & Campbell, 2012; Cleaveland & Waslin, 2021; Ganatra, 2001; Raj & Silverman, 2002). A shelter manager expressed their concern:

> Most services, schools, daycare centres and language training courses for refugee and other persons with minority backgrounds are now closed. Victims of domestic violence from ethnic minority families are often picked up by such institutions. (Bergman et al., 2021, p. 5)

Women without official status (e.g., work permit, residency) might be unwilling or unable to fully access forms of social and economic support due to fear of deportation, and IRW with

status might be equally unwilling or unable to seek assistance due to pre-existing power differentials in their relationship (e.g., power and control tactics, threats of deportation) (Adams & Campbell, 2012; Henry et al., 2021; Liversage, 2021).

IRW living with violence face barriers to information about their rights, how or where to seek assistance and the location and availability of support services, shelters and/or transition housing (Adams & Campbell, 2012; Raj & Silverman, 2002; Moynihan et al., 2008; Shadmi et al., 2020). Immigrant women's dependency on their partners, perceived or actual, creates gender asymmetry in power which can undermine their ability to exert agency (Abraham, 2000; Del Real, 2018; Charsley & Liversage, 2015; Erez et al., 2009; Henry et al., 2021; Liversage, 2013; Segrave 2017; Vaughan et al., 2016). Some immigrant women might be apprehensive in seeking assistance, either through health care providers or social services, for fear of being vulnerable to negative responses and labels (e.g., "illegal") and, ultimately, risk of deportation (Adams & Campbell, 2012; Glass et al., 2011; Moynihan et al., 2008; Raj & Silverman, 2002). As one immigrant woman noted:

> My husband always used to threaten and scare me that he was a [citizen]. He would say that "your visa will be taken," [and] "you just wait till your visa-time is over, then I will show you." Even when I was nine months pregnant, the whole family threatened me that they would take the [residency] card from me. (Liversage, 2021, p. 11)

Regardless of IRW's status, abusive partners exploit the uncertainty and fear of social or legal repercussions of help-seeking (Adams & Campbell, 2012; Gangoli, 2017; Liversage, 2021; Payton, 2015); this was exacerbated by pandemic-related restrictions and closures, which further limited IRW's access to resources and supports.

Even prior to the implementation of pandemic-related restrictions, institutional supports for survivors of violence had inadequate connections with culturally informed supports for immigrants and refugee communities, as well as an absence of sufficient outreach programs and relationships within these communities (Ashbourne & Baobaid, 2019; Raj & Silverman, 2002); these issues created additional barriers for IRW as they did not view these services as culturally or linguistically accessible, even if they were made aware of such supports and services (Ashbourne & Baobaid, 2019). For example, many services may utilize terminology that is not culturally accepted by these women, such as "rape" and "batterer," while ignoring culturally informed care through a focus on Western responses to violence, such as an emphasis on removing a survivor from their home, family and community (Raj & Silverman, 2002; Ting & Panchanadeswaran, 2009).

As a result of the COVID-19 pandemic and the increased need for anti-violence services, government organizations disseminated vital information regarding health, safety and supports for those living with violence. Yet, this information often failed to be provided in an accessible, low barrier and/or culturally informed manner. This information was often framed in a manner focused on outreach in a homogenous way and, when adapted to the needs of other populations such as IRW, it disregarded the primary challenges experienced by diverse groups (e.g., lack of awareness of supports and services) (Bergman et al., 2021; Diaz et al., 2020; MIRA Centre,

2020). This problem existed on a global scale. To illustrate, the Danish National Board of Health translated information on COVID-19 and anti-violence resources into 19 different languages, while making it available solely through websites. These translation processes were slow and utilized non-governmental organizations (NGOs) that had limited resources and experience in translating and interpreting vital information,[8] while further ignoring the challenges faced with respect to availability of, and access to, electronic forms of media for immigrant and refugee populations (Diaz et al., 2020; Raj & Silverman, 2002).

Through the process of migration, IRW lose connection with some of the social and cultural supports that were present in their home countries and experience isolation within the host country (e.g., physical, cultural, social, economic). Such isolation limits IRW survivors' emotional, psychological and social supports, as well as hinders their access to information, services and resources which could provide information on rights and resources within host countries and opportunities for independence (e.g., employment, education) (Adams & Campbell, 2012; Del Real, 2018). COVID-19 further limited IRW survivors' access to social and cultural supports by mandating shifts in service provision by immigration, cultural and community resources that were traditionally relied upon, such as language training centres and immigrant support groups (Sabri et al. 2019; see also Ashbourne & Baobaid, 2019; Raj & Silverman, 2002). Through the loss of pre-established social networks and coercive and controlling tactics by abusive partners (e.g., the removal or monitoring of electronic forms of communication used to maintain social and familial connection over long distances) in combination with pandemic-related regulations, social networks and community-based services that support IRW survivors were often diminished or eradicated altogether (Del Real, 2018; Henry et al., 2021).

Technology was used by many during the pandemic as a means of social connection and support while sheltering in place, and IRW are often reliant upon technological means of communication to connect with family, friends and other means of social support within their home countries and communities. Nevertheless, within the context of abusive relationships, technology can be easily monitored, restricted or controlled (i.e., technology-facilitated abuse) (Douglas et al., 2019; Henry et al., 2021). For instance, several immigrant women in Henry et al.'s (2021) study illustrated how abusive partners would remove contacts on their phones, delete their social media accounts, change their passwords, decline to pay phone or internet bills and/or even destroy their phones. By removing pre-established and trusted systems of social support, and in the absence of established networks of support within the host country, abusive partners can foster increased power and control through isolating these women from counter perspectives, ideologies and narratives while continuing to impose their mono-narrative of fear and coercion (Henry et al., 2021).

[8] IRW experience language barriers and, due to limited access to interpretation, often rely on their partners and/or family members as informal interpreters, which hinders disclosure of violence and help-seeking (Choi et al., 2012; Henry et al., 2021; Liversage, 2021). In instances of DV, a control tactic enacted by partners and in-laws can be to filter the information both delivered and received by IRW and deliberately prevent IRW from accessing language lessons (Abraham, 2000; Erez & Harper, 2018; Liversage, 2021; Raj & Silverman, 2002; Rees & Pease, 2007).

Indigenous women

Even prior to COVID-19, Indigenous communities experienced a greater risk of the spread of communicable and infectious diseases, which is a result of colonization, historical forms of violence and oppression and persistent, ongoing forms of systemic settler colonialism[9] (Burnett et al., 2020; Paradies, 2016). Further, historical and intergenerational trauma, which is the result of colonization and settler colonial violence, distrust of systems, and the harms brought on by colonization and settler colonialism remain (e.g., lack of resources, systemic poverty, negative health mental and physical health impacts, loss of culture, increased rates of violence); there is a lack of culturally informed and Indigenous-led supports and services that meet the needs of Indigenous governments, peoples, communities and cultures across the nation (Allan & Smylie, 2015; Braveman et al., 2011; Heberle et al., 2020; Power et al., 2020).

Highly contagious communicable diseases and pandemics, such as COVID-19, require culturally and trauma-informed care, which is challenging in settler colonial systems and services. Within the continent now referred to as North America specifically, the spread of communicable diseases has traditionally been the result of initial and subsequent forced contact with European settlers, both through inadvertent actions and malicious intent (Churchill, 2004; Moffitt, 2004; Moffitt et al., 2020). Indigenous communities have illustrated how ongoing health-based emergencies (e.g., epidemics and pandemics) exacerbate forms of violence within their communities, specifically, laterally imposed violence and trauma (Moffitt et al., 2020; Power et al., 2020) An Indigenous Elder shared:

> Violence is due to many things […] but in the past first Europeans brought disease to the people. People did not get proper treatment and did not know how to treat each other…people died every day, and the relatives had to bury them together, and this upset the survivors. It made them angry and they took it out on each other. People got very emotional because of all the killings they had in their lifetime, so brutal. It created more anger that turned to violence, and today we can still sense that hate. Three days ago, I had to call the nurse for an elderly woman attacked by her husband. He forcibly spilled hot soup on her. Later I saw the burn. It was red and blistered, so painful. The Community is working towards prevention. It is not helping the whole community. Many people are not practicing our traditional way of life, so not helping, and it is downsizing our strength to weakness. (Moffitt et al., 2020, p. 4)

Colonization and ongoing settler colonialism increased the spread of, and harms caused by, COVID-19 within Indigenous communities, which has demonstrated additional systemic and

[9] Settler colonialism is defined as "an ongoing system of power that perpetuates the genocide and repression of [I]ndigenous peoples and cultures. Essentially hegemonic in scope, settler colonialism normalizes the continuous settler occupation, exploiting lands and resources to which [I]ndigenous peoples have genealogical relationships. Settler colonialism includes interlocking forms of oppression, including racism, white supremacy, heteropatriarchy, and capitalism" (Cox, 2017, para.1).

structural inequalities that continue to affect Indigenous communities and, specifically, Indigenous women (for example, see Moffit et al., 2020).

Historically, during pandemics, Indigenous peoples and communities experience infection rates and symptoms that are more severe than other populations due to the social-political withholding of power and status by the hegemonic[10] culture and society. For instance, during the Spanish Influenza pandemic of 1918 and the H1N1 outbreak in 2009, Indigenous peoples within the settler colonial state of Canada were eight times more likely to die in comparison to non-Indigenous Canadians and three times more likely to be hospitalized (Power et al., 2020). Persistent and enduring settler colonialism promotes the rampant spread of communicable diseases through the continual underfunding of Indigenous communities, resources and supports which causes issues such as the necessity of multi-generational cohabitation within small dwellings and a lack of access to basic necessities of life (e.g., clean drinking water) (Curtice & Choo, 2020). Due to the historical and ongoing impacts of settler colonialism, COVID-19 has inequitably affected Indigenous communities' health and well-being.

As a result of pandemic-related factors such as rising socio-economic, emotional and physical strain, as well as shelter-in-place orders and limited access to support systems and services of care, there was an increase of violence perpetrated against Indigenous women within intimate relationships (Argoty-Pantoja et al, 2021; Power et al., 2020). Since the onset of the pandemic, Indigenous women have reported experiencing violence for the first time or exacerbated forms of DV (Power et al., 2020). The mental, emotional, physical and financial impacts of the pandemic, in combination with settler colonial violence, intergenerational trauma and geographic isolation, have compromised the safety of Indigenous women (Arriagada et al., 2020a; Connors, 2020; Moffitt et al., 2020; NWAC, 2020a).

The Native Women's Association of Canada (NWAC) (2020a) found that there was an increase in DV perpetration against Indigenous women during the first three months of the COVID-19 pandemic (e.g., March to May 2020) in which an average 17 percent of Indigenous women within Canada experienced some form of violence (i.e., physical or psychological) perpetrated by an intimate partner, compared to an average of 14 percent pre-pandemic. Numerous Indigenous women reported experiencing an increase in the severity and/or prevalence of DV because of added stress, such as job loss and income insecurity (Connors, 2020; NWAC, 2020a). A shelter worker noted:

> I've seen [Indigenous] women who are already accessing our space for drop-in services of laundry and showers, telling us more about the abuse, and telling us the abuse got worse because of COVID. (Connors, 2020, para 6)

Particularly, Indigenous women have identified increased levels of familial stress and a decreased sense of safety as a result of shelter-in-place orders and confinement within their homes (CFAIA & Palmater, 2020; Connors, 2020).

[10] The ascendency of a cultural category or social identity (e.g., white, middle-to-upper class men) that promotes an apparent legitimized narrative of the dominance and superiority over all other social groups and identities (Gramsci, 1999).

In a sample of Indigenous women in Canada, 41 percent identified that they were extremely concerned about the impact that shelter-in-place orders would have on family stress levels and, as a result, their own safety and well-being (Arriagada et al., 2020a, 2020b). A reported 70 percent of Indigenous women expressed that financial insecurity is a prevailing factor in the perpetration of DV within their relationships and homes.[11] Financial insecurity has been demonstrated to be a predominant factor leading to familial stress, which can instigate acts of violence either directly or indirectly through the use of adverse coping mechanisms (e.g., drugs and alcohol), as well as perpetuate poverty and limit access to resources and supports (e.g., technology, social supports and support for physical, mental and spiritual health) (Alhmidi, 2021; NWAC, 2020a; Powers & Wilson, 2020).

In Canada, Indigenous individuals had a morbidity rate that was eight times higher than non-Indigenous individuals during the initial months of the pandemic (Power et al., 2020). Indigenous peoples have been subjected to ongoing trauma in the form of settler colonialism that systematically disadvantages Indigenous communities, such as the continual disregard for their traditional land and land stewardship, a lack of access to clean drinking water for some Indigenous nations, systemic barriers to accessing higher education and the attempted erasure of their culture and language. These traumas and harms resulting from settler colonialism perpetuate a "cultural determinant of health" in which these communities experience specific health outcomes as a result of the intersection of historical trauma and socio-economic barriers to immediately accessing resources of care that are a result of settler colonialism, such as clean drinking water and hospitals, and ongoing forms of racism (Power et al., 2020, p. 1).

A one-size-fits-all approach to COVID-19, which resulted from response plans that treated Canada as a homogenous society (i.e., the settler colonial state), often failed to take into account the unique vulnerabilities and risks experienced by Indigenous peoples, such as their physical and geographic isolation on rural and remote reserve land (Power et al., 2020, p. 1); it has been illustrated that:

> There has been and continues to be chronic underfunding of Indigenous healthcare needs in Canada. For generations, Indigenous people's health has not been a priority, even though Indigenous communities are effectively governed as though they are wards of the state. The Canadian government is all too familiar with the poor living conditions and lack of healthcare services that plague Indigenous communities, which place them at greater risk during a pandemic. (Hillier et al., 2020, para 1; see also, Carling & Mankani, 2020; Levesque & Theriault, 2020; McBride, 2020).

While the Canadian government has continually illustrated its awareness of these negative health outcomes, there were no preparatory actions taken to negate a potential pandemic or immediate

[11] Upon the implementation of COVID-19 lockdown orders, Indigenous women were the most disadvantaged by the economic recession due to an increase in unemployment rates from 7.3 percent (i.e., December 2019 to February 2020) to 16.6 percent (i.e., March to May 2020) with an average increase of 9.3 percent. In comparison, non-Indigenous women experienced an increase in unemployment rates from 4.9 percent to 11.7 percent, which is an average increase of 6.8 percent, during the same timeframe (Bleakney et al., 2020).

actions taken to support Indigenous communities to mitigate the detrimental effects of COVID-19 (Hillier et al., 2020; McBride, 2020).[12]

The Canadian government waited to provide much needed support until Indigenous leaders overtly expressed the life-threatening circumstances within their communities (Curtice & Choo, 2020; Hillier, 2020; Nonomura et al., 2020). As a result, Indigenous communities were not initially considered in the distribution of essential resources and supports meant to combat both COVID-19 and, consequently, DV, such as PPE, ventilators and culturally informed and accessible anti-violence services and shelters (Curtice & Choo, 2020; Nonomura et al., 2020). While the Canadian government responded to these pleas for help, the relief funding equalled little more than 1 percent of the national relief budget while the Indigenous population accounts for an estimated 4.9 percent of the Canadian population. As a result, many Indigenous communities initiated their own COVID-19 regulations and relief efforts within their local communities, such as mask mandates for anyone over two years of age and travel restrictions within and across their territories (Hillier, 2020).

Of note, in an effort to combat the high risk of COVID-19 transmission and disproportionate impacts of the pandemic in Indigenous communities, B.C. provided Indigenous peoples with high priority vaccine access during the initial stages of the COVID-19 vaccine rollout (First Nations Health Authority, 2021). Even so, within Indigenous communities across Canada, there was, and continues to be, hesitancy and skepticism surrounding the COVID-19 vaccine due to issues such as historical and ongoing distrust of systems, unmet promises by the Canadian government (e.g., failure to "end boil water advisories by March 2021"), and past "problematic public health messaging and actions" amplifying system distrust (p. E382). For instance:

> A disturbing example of this occurred in 2009 when, during an H1N1 outbreak, the federal government sent body bags to four Manitoba First Nations communities instead of shipments of antivirals, hand sanitizer and flu kits. The story spread and contributed to distrust across the country. Although there is no genetic predisposition to or additional risk of more severe outcomes from H1N1 for Indigenous Peoples, they were nonetheless listed as a stand-alone category of people who should receive the H1N1 vaccine among all identified high-risk groups. Zeroing in on Indigeneity alone meant that many were left feeling like guinea pigs. (Mosby & Swidrovich, 2021, p. E382)

As Mosby and Swidrovich (2021) express, "Canada's shameful histories of racially segregated health care and medical experimentation" require going beyond prioritizing vaccines for Indigenous communities and engaging in culturally informed public health messaging and vaccine education (p. E382).

[12] Of note, Hon. Dr. M.E. Turpel-Lafond (Aki-Kew) (2020) recommended "that the B.C. government, First Nations governing bodies and representative organizations, MNBC, the Provincial Health Officer and the Indigenous Health Officer develop a robust Indigenous pandemic response planning structure that addresses jurisdictional issues that have arisen in the context of COVID-19, which upholds the standards of the *UN Declaration*" (p. 63).

Within Canada, many Indigenous women live in communities that are geographically isolated, and only six percent of women's shelters are located within these communities (CFAIA & Palmater, 2020; Nonomura et al., 2020; Power et al., 2020). The services that exist are spread across large geographical distances, and in combination with isolation, limited transportation and financial burdens of travel, these systems of support are largely inaccessible for Indigenous peoples who experience DV (CFAIA & Palmater, 2020; Nonomura et al., 2020; Power et al., 2020). Additionally, Indigenous women and advocates have noted that women's shelters are deprived of Indigenous representation at all levels, especially in leadership roles (Nonomura et al., 2020). This underrepresentation of Indigenous peoples and cultures in systems of support creates and perpetuates distrust within Indigenous communities and fosters beliefs that such services are incapable of providing safe and empathetic care (Nonomura et al., 2020). This inability to easily access culturally appropriate and/or Indigenous-led shelters and anti-violence services limits Indigenous women's opportunities to seek help and safety.

Early in 2020, the NWAC began collecting data on the experiences of Indigenous women during COVID-19. Their work exemplified how the pandemic exacerbated systemic inequalities and DV, which could have functioned as endemic risk factors for severe COVID-19 health-related concerns (CFAIA & Palmater, 2020; Wright, 2020). NWAC's (2020) findings illustrated that within the COVID-19 context:

> 1. Indigenous women are more worried about domestic violence than they are about most COVID-19 issues; 2. Many more Indigenous women are experiencing violence during this pandemic than usual; 3. Indigenous women most vulnerable to violence […] are in the North, under 35, and have been financially impacted by COVID-10; 4. Romantic partners are overwhelmingly seen as the biggest source of violence; 5. The financial impact of COVID-19 is strongly correlated with violence against Indigenous women. (p. 4)

Existing systemic inequalities can perpetuate the harms of COVID-19, while the pandemic likewise exacerbates these systemic inequalities and risks. This led to NWAC's (2020) recommendation for making it a priority to address systemic violence against Indigenous women, girls and two-spirit peoples in response efforts by all levels of government.

MMIWG2S in the COVID-19 context

There has been a normalization of violence against racialized women and, more specifically, Indigenous women within Canada (Kuokkanen, 2015). Indigenous women, girls and two-spirit peoples have experienced, and continue to experience, disproportionate rates of violence and homicide. More than six in ten (63 percent) Indigenous women reported physical or sexual forms of violence, compared to 45 percent of non-Indigenous women, and they are 12 times more likely to be victims of homicide than their non-Indigenous counterparts (Heidinger, 2022). The preservation of settler colonial systems and policies has perpetuated this "depoliticization" of both non-lethal and lethal forms of violence perpetrated against Indigenous women, girls and two-spirit peoples (Kuokkanen, 2015).

The final report into missing and murdered Indigenous women, girls and two-spirit peoples (MMIWG2S), entitled *Reclaiming power and place: The final report of the national inquiry into missing and murdered Indigenous women and girls*, concluded that the government of Canada was guilty of the perpetuation of acts of colonial genocide through the creation of sociocultural mandates and policies that caused the persistent and intentional underfunding of Indigenous communities and resources which subjected Indigenous women, girls and two-spirit peoples to harmful socio-economic conditions (CFAIA & Palmater, 2020; NWAC, 2020b). These (in)actions by the government of Canada facilitated the perpetration of the violent victimization of thousands of Indigenous peoples (e.g., rape, sexual assault, murder) (CFAIA & Palmater, 2020; NWAC, 2020b); nevertheless, institutional pandemic relief efforts largely disregarded the ongoing violence perpetrated against Indigenous women, girls and two-spirit peoples. Specifically, in May 2020, the federal government declared that because of the rampant spread of the COVID-19 pandemic, it would fail to uphold its mandate to address these vital calls for justice for MMIWG2S and Indigenous communities, and further refused to commit to releasing a national action plan at a future date (CFAIA & Palmater, 2020; NIIMMIWG, 2019; NWAC, 2020b; Power et al., 2020).

Of note, in 2021, the Canadian government published a response to the national inquiry in which they outlined their commitment to ending violence against Indigenous girls, women, two-spirit peoples and transgender individuals (for example, see Federal Pathways to Address Missing and Murdered Indigenous Women, Girls, and 2SLGBTQQIA+ People, 2021). The Federal Pathways report detailed the government's willingness to work with Indigenous communities, although concrete actions still need to be taken to address the disproportionate rates of violence. In addition to this focus on violence against Indigenous women, girls, two-spirit peoples and transgender individuals, Indigenous leaders are calling on the Canadian government to address the systemic settler colonial structures that have been imbedded into its systems, policies and practices (e.g., institutional structural racism within Canadian schools, healthcare systems, child welfare policies and the justice system) (Progress Report on the Missing and Murdered Indigenous Women, Girls and 2SLGBTQQIA+ People National Action Plan, 2022). Indigenous organizations such as NWAC and the Ontario Native Women's Association have produced action plans to further address MMIWG2S, which is an epidemic in the settler colonial state of Canada. These action plans focus on decolonial training through social media campaigns that confront stereotypes and stigmas of Indigenous women, girls and two-spirit peoples that can foster and perpetuate both their violent victimizations and societal inaction (e.g., normalization of violence against Indigenous peoples) (McGuire-Cyrett et al., 2020; Nonomura et al., 2020; Wright, 2020). While Indigenous-based action is pivotal, settler colonialism is a system of oppression enshrined within and upheld by governmental practices and, as such, requires the acknowledgement and attentive action of federal agencies in order to be dismantled.

Rural, remote, and northern contexts

Women who live in rural, remote and northern (RRN) communities within Canada can experience ongoing forms of social and physical isolation from both other members of society and social institutions of care which existed prior to the pandemic. This is due to their remote and often seasonally inaccessible geographical location (for example, see Bright et al., 2020; Moffitt et al., 2020). These forms of isolation can perpetuate psychological distress, such as depression, anger and frustration that is often directed towards an intimate partner, which, in combination with other risk factors (e.g., access to firearms, higher rates of poverty, barriers to disclosure and help-seeking related to concerns about confidentiality), put women in these communities at greater risk of DV (Moffitt et al., 2020; Mojahed et al., 2021). While, on average, only 20 percent of the population of Canada resides within RRN communities, between 2010 and 2018 more than one third of nationally reported incidents of DV and DV-related homicide occurred within these communities (Jeffrey et al., 2019; Moffitt et al., 2020). The onset of the COVID-19 pandemic and resulting safety measures such as shelter-in-place orders greatly exacerbated the pre-existing vulnerabilities and risks of DV experienced by women within RRN communities by imposing further challenges for accessing support that can potentially prevent or mitigate the violence (Moffit et al., 2020).

The likelihood of women experiencing DV increases significantly as forms of social support become inaccessible through geographical and physical isolation, which was compounded by the COVID-19 context (e.g., shelter-in-place orders, limitations placed on existing services and supports, under-resourcing of anti-violence services) (for example, see Moffitt et al., 2020). The more rural and remote a community is, the greater the vulnerability experienced by the women and survivors of violence therein (Bright et al., 2020; Mojahed et al., 2021; Peek-Asa et al., 2011). RRN communities, which consist of fewer than 10,000 people, can be dependent on air traffic for essential services such as food, water, power and even access to emergency services (Jeffrey et al., 2019; Moffitt et al., 2020). As a result of social and geographic isolation, the inaccessibility of support services increases the precarity, vulnerability and risk of DV for women within these communities (Bright, 2020; Capaldi et al., 2012; Farris & Fenaughty, 2002; Lanier & Maume, 2009). Further, the absence of easily accessible social and institutional supports that can occur within these communities increases the risk of DV therein, including high-risk and coercive control-based violence (Farris & Fenaughty, 2002; Myhill & Hohl, 2019; Raghavan et al., 2019; Stylianou et al., 2018). Isolation decreases the visibility of such violence and limits opportunities for intervention.

Access to support and anti-violence services in RRN areas is often inconsistent and, in some instances, unfeasible due to geographical isolation and the under-resourcing of services outside of central metropolitan districts (Bright et al., 2020; Stylianou et al., 2018). For example, within Canada, there are 552 shelters for survivors of DV. Of these, 33 percent (182) service RRN communities. Only four percent (22) of these shelters are geographically situated in proximity to communities with fewer than 1,000 inhabitants, and less than one percent (fewer than five) are located in fly-in communities (Maki, 2018; Moffitt et al., 2020; Moreau, 2019). The modest proportion of the Canadian population who reside within RRN communities provides

institutional and governmental justification for the systemic underfunding of vital support services and agencies of care. This rationalization, however, fails to account for the disproportionally staggering rates that DV occurs within RRN communities relative to central metropolitan districts (Jeffrey et al., 2019; Moffitt et al., 2020). Even prior to the COVID-19 pandemic, data on police-reported violence across Canada suggest that women in RRN communities experience DV at a rate 75 percent higher than their urban counterparts (Conroy et al., 2019; Nonomura & Barker, 2021). Of note, these data do not account for challenges related to help-seeking and reporting in RRN or intersectional factors, which suggests the potential for even greater disproportionality in women's experiences with DV in RRN versus urban communities. Geographical isolation, in combination with policies and practices that systemically harm women who experience intersecting oppressions and inequalities, perpetuates barriers to accessing essential support to intervene in and prevent DV.

For women within RRN communities, accessing DV services, such as women's shelters, requires intricate planning to overcome both distance and limited accessibility of public modes of travel (i.e., inter-city buses, lack of infrastructure), which were increasingly problematic to navigate during the COVID-19 pandemic (Moffitt et al., 2020). While the inaccessibility of essential services creates systematic barriers and challenges that perpetuate and exacerbate the vulnerability of women who reside within RRN communities, this precarity is greatly amplified for women who face intersecting oppressions and inequities, such as Indigenous women who reside in RRN communities (Barker et al., 2019; Godlewska et al., 2020; Moffitt et al., 2020).

Women might have been deterred from travelling outside of their community either due to fear of contracting COVID-19 or as a result of mandates that required social isolation and physical quarantining upon entering another community (Bright et al., 2020; Moffitt et al., 2020); this was compounded by reduced capacities and closures of shelters. The geographical isolation of RRN communities also produced additional hindrances to accessing immediate emergency services, such as police, and with the introduction of COVID-19 safety protocols, police response time has greatly increased (e.g., operators engaging in additional assessment of an individual's and their family's health) (Moffit et al., 2020). During an emergency, such as incidents of high-risk DV, these health checks can create additional and potentially detrimental barriers to receiving timely and essential services (Moffitt et al., 2020). While such measures were in accordance with now rescinded public health mandates, they nevertheless perpetuated systemically gendered pandemic response that put DV survivors at risk, especially within RRN communities (Bright et al., 2020; Moffitt et al., 2020).

In the absence of accessible supports and services, social networks have been demonstrated to be pivotal resources in assisting women living with DV (Goodkin et al., 2014; Moffitt et al., 2020). Yet, an assumption that these tight-knit community relations can replace institutional systems disregards the inherent complexity of interpersonal relationships in RRN communities and how such relationships impact survivors' willingness to seek help in these communities (Goodkin et al., 2014; Moffitt et al., 2020). Individuals within RRN communities often have detailed intricate knowledge of the lives of other community members. While this close and intertwined common network can integrate community members, it can nevertheless promote community-based

gossip that stigmatizes survivors while potentially encouraging acts of retribution against them by an abusive partner (Faller et al., 2018; Moffitt et al., 2020; Moffitt & Fikowski, 2017). Due to limited social supports and a frequent lack of anonymity and/or confidentiality, survivors are confronted with an intricacy of social barriers to disclosing and reporting DV, such as the fear of stigmatization and the loss of economic, social and personal resources (Mojahed et al., 2021). As Maryam Monsef, former Minister for Women and Gender Equality, noted:

> In some pockets, and many of the more rural communities […] some frontline organizations are reporting it's eerily quiet. That's because she's likely under surveillance. She can't call for help. She doesn't know to call for help. And that's another change we are seized with right now. (Patel, 2020, paras. 9–10)

Additionally, survivors within these communities might feel pressure to remain silent about the violence they experience, either as a result of external pressure from the community or based upon the anticipated community response.

Functional isolation in RRN communities is increased through the absence of telecommunication infrastructure. This creates a lack of consistent and reliable access to the internet and telephone services, either directly or through diminished availability and reliability (Moffitt et al., 2020). In the absence of ongoing and consistent access to forms of mass communication, such as the internet, individuals who experience DV in RRN communities can be isolated and hindered from accessing online supports and services, through which they could access actual online legal proceedings and anti-violence services and supports (Moffitt et al., 2020).

RRN communities are confronted with geographical and social isolation, as well as policies that have failed to promote accessible and inclusive infrastructures (i.e., year-round accessible roads, local health services, local women's shelters). Further, as a result of pandemic-related restrictions and policies, RRN communities struggled with additional forms of imposed functional isolation resulting from governmental institutions curtailing the delivery and limiting the accessibility of essential services that would otherwise aid survivors of DV (Bright et al., 2020; Lanier & Maume, 2009; van Gelder et al., 2020). Women within RRN communities who, prior to COVID-19, were confronted with geographical hindrances to accessing shelters and anti-violence supports and services resources now experienced a myriad of compounding challenges when attempting to access vital support (e.g., a lack of economic and social resources, un- and under-employment, and social and functional isolation) (Moffitt et al., 2020).

Age

Approximately 45 percent of Canadian seniors (i.e., 65 years of age and older) have reported experiencing forms of abuse. Women seniors experience higher rates of abuse perpetrated by intimate partners, family members, and/or caregivers (Government of Canada, 2021). Such violence includes physical, sexual, psychological, emotional, financial (e.g., economic exploitation) and/or ongoing forms of intentional neglect and negligence on the part of an individual entrusted with their health and safety. Within B.C. specifically and based on both Vancouver Police Department and provincial Royal Canadian Mounted Police (RCMP) data, reports of violent crimes and incidents of abuse experienced by seniors increased dramatically over the last five years, including the first year and a half of the COVID-19 pandemic (i.e., physical abuse by 87 percent, violent crime by 69 percent, financial abuse by 49 percent) (Kotyk & Sajan, 2021; Office of the Seniors Advocate BC, 2021). Additionally, there was a 49 percent increase in instances of "abuse, neglect and self-neglect" experienced by seniors within this five-year timeframe (Office of the Seniors Advocate BC, 2021, p. 3). Abuse perpetrated against older adults (i.e., senior abuse) often goes unrecognized and unreported because of the close, intimate and often unmonitored relations between older individuals and those entrusted with their care (HelpAge, 2020; Makaroun et al., 2020).

Within the COVID-19 context specifically, adults who are 65 years of age and older experienced multifaceted vulnerabilities related to their health and safety through the implementation of socio-political public health measures enacted to protect them during the pandemic (Canadian Nurses Association, 2021; Makaroun et al., 2020). These policies (e.g., shelter-in-place orders, calls for self-isolation and social distancing) exacerbated existing and ongoing forms of abuse and neglect that are prevalent among older populations by further removing these individuals from the public eye and often isolating them with their abusers (i.e., enforced confinement). This is compounded by pandemic-related economic and social uncertainty and an increased burden of care on perpetrators and continues beyond the rescinding of stay-at-home mandates and other public health orders (HelpAge, 2020; Makaroun et al., 2020).

Older adults who previously relied on social contact, such as part-time work, for safety, security and mitigation of risk, lost many of these connections due to remaining in the confinement of their homes and limiting social interaction (HelpAge, 2020). During the COVID-19 pandemic, seniors are at a heightened risk for experiencing loneliness, social isolation and the psychosocial impacts of social exclusion (Canadian Nurses Association, 2021; D'cruz & Banerjee, 2020). Of note, for older adults and seniors, social exclusion, lack of social contact and loneliness were considered to be an endemic even prior to the onset of the pandemic (D'cruz & Benerjee, 2020). This situation has worsened during COVID-19 due to forced (e.g., stay-at-home mandates) and self-imposed (e.g., limiting social contact) isolation among seniors (Briguglio et al., 2020; Dominguez, 2020). Additionally, common challenges that limit help-seeking among seniors experiencing abuse include isolation, feelings of helplessness, reliance and dependency on their abusers and/or limited knowledge of available services (Dominguez, 2020). Such barriers are amplified by a lack of familiarity/comfort with or limited-to-no access to means of communication (e.g., internet, smartphones, Zoom) and technologies that can mitigate isolation and risk and provide access to key services (e.g., e-health), during the COVID-19 pandemic

(Canadian Nurses Association, 2021; Li Ka Shing Knowledge Institute, 2021; Statistics Canada, 2020; Yazdani-Darki et al., 2020).

Isolation and social exclusion are key risk factors for senior abuse and may lead to amplification of existing violence or instigate new abuse within the home, especially for seniors with heightened vulnerabilities (e.g., pre-existing health conditions, disabilities) and those relying on caregivers (Dominguez, 2020; Makaroun et al., 2020; see also Office of the Seniors Advocate BC, 2021). It has been demonstrated that limitations placed on in-person contact can cause strain and tension as well as exacerbate existing mental health concerns for older adults and their caregivers. Simultaneously, such isolation dramatically reduces opportunities for outsiders to identify and intervene in cases of senior abuse (Makaroun et al., 2020). These strains are interconnected with and compounded by other stressors, such as the pandemic-induced economic recession.

While caregivers who engage in senior abuse may be qualified authorities, such as nurses and care-aides, this kind of abuse is more commonly perpetrated by family and/or kinship-based caregivers, such as partners/spouses and children (HelpAge, 2020; Makaroun et al., 2020). As a global advisor on violence and gender equality noted, which demonstrates the precursors to such abuse (i.e., what conditions/context facilitate a perpetrator to enact elder abuse, what conditions/context are present, and which can exacerbate the elder abuse):

> COVID-19 has caused considerable stress for people of all ages, for example due to lost incomes and difficult conditions created by restrictions on movement, physical distancing and isolation measures. This has seriously affected older people […] especially women, who were already socially and economically disadvantaged before the pandemic. (HelpAge, 2020, para. 3)

Even so, COVID-19 and subsequent restrictions and social and economic impacts are unlikely to be the sole contributing factor to elder abuse (Calleja-Agius & Calleja, 2021). Although the first incident of elder abuse might have occurred after the onset of COVID-19, it is probable that underlying risks of such violence already existed and were heightened by pandemic-related conditions and restrictions (e.g., isolation, social exclusion, barriers to accessing social supports, financial difficulties, strain).

The intersection of sexism and ageism (i.e., gendered ageism) amplifies the vulnerabilities experienced by women seniors (D'cruz & Banerjee, 2020). Within the COVID-19 context, gendered ageism put women seniors at risk of increased challenges related to accessing, and discrimination within, healthcare systems and other key social services. This inequity and "double discrimination" unquestioningly existed prior to the pandemic, but "the gender and age divides show signs of widening during the global response to COVID-19" (D'cruz & Banerjee, 2020, p. 3). Nevertheless, seniors' experiences with systemic inequity within social supports and healthcare services should be considered beyond the nexus of age and gender. Other social identities, including race, ethnicity, ability and language, also influenced seniors' access to healthcare and social services, as well as their overall health and well-being, during the COVID-19 pandemic (Ng et al., 2021; Rueda, 2021). Nevertheless, more disaggregated data are needed to determine the full impacts of these challenges and the impacts of these inequities faced by seniors with intersectional social identities (Rueda, 2021).

Ability

Individuals with disabilities, or those labelled as non able-bodied through an ableist social discourse, are at an increased risk of experiencing forms of DV. Prior to the COVID-19 pandemic, individuals with disabilities were 1.5 times more likely to experience abuse than able-bodied individuals (Hughes et al., 2012; Lund, 2020; Mason, 2015). In Canada, an estimated 20 to 25 percent of women live with a form of physical or mental disability, which, in conjunction with social stigmatization and discrimination, heightens their risk of experiencing DV (Alimi & Abbas, 2020; DisAbled Women's Network of Canada, n.d.; see also Lund, 2020; Mason, 2015). Further, it is estimated that 40 percent of Canadian women living with disabilities have experienced forms of violence, abuse and/or neglect and have reported incidents of violence at a rate two times higher than their able-bodied counterparts (Alimi & Abbas, 2020; DisAbled Women's Network of Canada, n.d.).

Within this population, risk of DV can be amplified by factors such as limited access to care, reliance on caregivers, socio-economic challenges, un(der)employment, limited social contact and/or social exclusion (Mason, 2015). Due to interconnected and complex forms of discrimination and inequality, women with disabilities face a myriad of risks that increase the likelihood they will experience DV, such as isolation, barriers to disclosure and help-seeking and forms of neglect (Sharma & Das, 2021). Women with disabilities are "excluded within an exclusion" due to the discrimination, bias and stigma they experience resulting from the intersections among gender, disability and other factors (e.g., race, poverty) (Sharma & Das, 2021, p. 3).

The degree to which an individual is considered able-bodied is interconnected with their experiences of vulnerability and precarity during a global pandemic (Sharma & Das, 2021). Women with disabilities often face persistent forms of bias and discrimination that negatively impacts caregivers', professionals', and society's responses to their autonomy, authority and expertise about their own well-being, which subsequently hinders their ability to self-advocate and seek help (Barrett et al., 2009; Coston, 2019; Hughes et al., 2019; Lund, 2020; Shivji, 2020). The socially imposed and often institutionally upheld vulnerability of women with disabilities (e.g., deskilling, undermining of autonomy, a lack of appropriate social and health policies) is created by ableist ideologies and compounded by pandemic-related social, economic and health-based impacts and restrictions (Sharma & Das, 2021).

Limitations on social and system contact during the pandemic increased the dependence many women with disabilities have on their abusive partners and limited their ability to seek help. These women may have relied on their abusive partners for ongoing essential forms of care during shelter-in-place mandates, which limited opportunities for identification of and intervention in the violence (Lund, 2020; Shivji, 2020). Further, some women with disabilities may need to be dependent upon their partners for necessities of day-to-day life, such as eating, drinking, getting out of bed and getting dressed. Within the context of DV, abusive partners may exploit such dependence through power and control-based tactics (e.g., withholding or destroying walkers and wheelchairs) (Lund, 2020; Shivji, 2020). Through acts of coercion,

abusers have also engaged in fear-based manipulation related to the transmission of COVID-19 and mandated isolation from systems of support to further exert their control over survivors of DV with disabilities who have fewer emotional and physical resources to seek help (Lund, 2020).

During public health emergencies like pandemics, many individuals who require ongoing care and support have become increasingly dependent upon their partners as traditional systems of care are reduced and impediments to safety are added (Lund, 2020; Shivji, 2020). These women may likewise experience barriers to and/or be fearful seeking help, as disclosing and/or reporting abuse puts them at risk of retaliation by their abusers (i.e., neglect, physical and emotional violence) and/or losing their primary source of care (Lund, 2020; Shivji, 2020). As well, suggestions made by public health officials (e.g., having a backup caregiver) are privileges that are not accessible to, or an option for, many disabled women living with abuse (Lund, 2020; Shivji, 2020). As a result, through mandated and prolonged periods of isolation within the home, violence perpetrated against disabled women has increased an estimated 300 percent (Shivji, 2020).

The precarity and vulnerability of survivors of violence with disabilities has yet to be sufficiently integrated into COVID-19 relief policies or meaningfully addressed in social and institutional responses (Alimi & Abbas, 2020; see also Sharma & Das, 2021). This includes but is not limited to a general lack of disaggregated Canadian data on the impacts of COVID-19 and DV experienced by women with disabilities and those with intersectional identities (e.g., Indigenous, IRW and/or incarcerated women living with disabilities), ongoing and unaddressed barriers to healthcare, one-size-fits all poverty relief efforts, and shelters with ongoing accessibility concerns that were exacerbated within the COVID-19 context (Alimi & Abbas, 2020). As illustrated by Alimi and Abbas (2020), “the Government’s emergency relief for Canadians remain[ed] higher than the disability-related benefits many currently receive” (p. 13). Through an ableist patriarchal social discourse that combines stereotypes and prejudices (e.g., sexism, racism) with persistent social stigmatization and discrimination against individuals with disabilities, these women are experiencing a gender-ableist violence that is not sufficiently addressed by social institutions and response efforts (e.g., the frequent absence of response efforts meaningfully addressing the interconnections among disability, gender and other factors) (Sharma & Das, 2021).

COVID-19 and DV in British Columbia

Within B.C., as well as across the country and around the world, the COVID-19 pandemic has amplified stressors experienced by individuals and families, such as dramatically altering previous routines and ways of life, placing restrictions on movement and contact, and drastically increasing isolation of individuals from their communities, families/kinship networks, friends and care providers (e.g., doctors, counsellors, therapists), among others (e.g., substance use, poverty, housing and food insecurity, un- and under-employment) (BC Centre for Disease Control, 2022; BC Society of Transition Houses, 2021; British Columbia's Office of the Human Rights Commissioner, 2020; Flora, 2021; Office of the Seniors Advocate BC, 2021). These stressors and losses have disproportionately impacted women across B.C., and, as previously noted, such conditions have both increased incidences and risk of DV across the province and placed those who face complex barriers to safety "at an even greater risk" during the pandemic (e.g., IRW, Indigenous women and other marginalized groups) (BC Centre for Disease Control, 2022; Grossman, 2020; Grossman & Kitteringham, 2020; Sarmadi, 2020). At the outset of the pandemic, Angela Marie MacDougall, the executive director of Battered Women's Support Services, explained that:

> Self-isolation is becoming mandatory and in general, women in B.C. have the primary responsibility for unpaid housework, emotional labour, and caregiving responsibilities including child and eldercare. Women will inevitably have to take on these increased unpaid responsibilities. Like the front-line service providers in women and women's serving organizations, women are paid less than other sectors, and the women who access our services are more likely to work in the gig economies or part-time employment or other similar job precariousness. Members of our communities have increased vulnerabilities to work interruptions and stoppages due to COVID-19. And it bears repeating that many people who access our services also experience grinding poverty. (MacDougall, 2020, para. 5)

The pandemic has dramatically exacerbated DV, an "existing public health emergency" within B.C. (Mason, 2020, para. 4), and it created a "shadow pandemic" occurring in tandem with COVID-19 world-wide (United Nations Women as cited in Mason, 2020, para. 4). The COVID-19 contexts are so conducive to DV that some have even deemed it to be "an abuser's dream" (Favaro, 2022, para. 1).

Rates of COVID-19 related increases in DV differ slightly from report to report. By way of illustration, Canada's Minister for Women and Gender Equality reported a 20 to 30 percent increase in DV, depending on province and region, although the provincial and regional data have yet to be released (Patel, 2020) and the Ending Violence Association of Canada noted that anti-violence workers have seen an 82 percent increase in both the frequency and severity of violence reported by survivors (Trudell & Whitmore, 2020). Women's Shelters Canada (2020) reported some decreases in calls to crisis lines during the initial phase of lockdown (i.e., March-May, 2020), but a steady increase in calls thereafter. For instance, Canada's Assaulted Women's Helpline "fielded 20,334 calls between Oct. and Dec. 2020, compared to 12,352 over the same

period the previous year" (Thompson, 2021, para. 2). There is some indication that these rates have not declined, as Women at the Centre, which is located in Toronto, Ontario "reported a 9,000% increase in calls for help by the end of 2021" (Favaro, 2022, para. 11). Youth also reported significant increases in cyberbullying and related abuses resulting from shelter-in-place orders and limited in-person social interaction (Culpert, 2021). In Vancouver, B.C. specifically, rates of DV reported to police had been stated to have increased approximately five percent during the early months of the pandemic alone (Steacy, 2020), and what is clear is that rates of violence and abuse, and the need for anti-violence services, have dramatically increased in B.C. throughout the pandemic (British Columbia's Office of the Human Rights Commissioner, 2020; Culbert, 2021; Patel, 2020; Grossman, 2020; Grossman & Kitteringham, 2020; Owen, 2020; Ryan, 2020; Trudell & Whitmore, 2020).

These increases in DV are accompanied by calls to crisis lines that doubled to tripled nation-wide (Owen, 2020). Within B.C. specifically, Battered Women's Support Services reported that DV calls had increased upwards of 300 to 400 percent during the beginning of the pandemic and initial lockdown period (Bains, 2020; Battered Women's Support Services, 2020b; British Columbia's Office of the Human Rights Commissioner, 2020; Women and Gender Equity Canada, 2020). As noted by Battered Women's Support Services (2020):

> Calls have increased 300 percent as the crisis line is now open 24/7 and as COVID-19 exposes more victims to danger and lethality for having to stay at home. Most calls from the crisis line are from victims and survivors, family members, children and youth and co-workers. Forty percent of the callers are calling for the first time.[13] (para. 3)

Other anti-violence supports and services, such as women's legal clinics, saw similar dramatic increases in requests for support, which was colloquially described as a "tsunami" (Steacy, 2020).

Official reports of violence to police have decreased provincially and nationally (Owen, 2020). These decreases were likely related to barriers to reporting violence and leaving abuse during the pandemic (e.g., increased monitoring by abusers, financial strain). Nevertheless, law enforcement officials and anti-violence supports have expressed that despite the decrease in reporting, the violence that is reported has often escalated in frequency and severity, including a recent rise in femicides Canadawide[14] (Miller, 2021; Owen, 2020; Women's Shelters Canada, 2020). Shelter and transition house workers described that, among the women admitted into their care, 16 percent reported "much more severe violence," 36 percent reported "somewhat more" severe violence, and 48 percent reported "about the same" levels and types of violence. Thirty-seven percent (i.e., over one third) indicated changes in the types of violence being reported (Women's Shelters Canada, 2020, pp. 3-4). Notably, many of the shelters and transition houses

[13] Of note, many women reported experiencing violence, both physical and emotional, for the first time after the onset of the COVID-19 pandemic (Froimson et al., 2020; Harville et al., 2011).
[14] The Canadian Femicide Observatory reported that "92 women and girls were killed in the first six months of 2021" which is "14 more killings than over the same period last year and 32 more than in 2019" (as cited in Miller, 2021, para. 4).

that reported no change in the levels and types of violence were generally located in communities with few reported cases of COVID-19 and limited-to-no lockdowns and closures.

Alongside calls to crisis lines, the need for safe housing (e.g., shelters, transition housing) has increased, while shelters and transition houses had COVID-19 safety plans in place which necessitated that they operate at reduced capacity (BC Society of Transition Houses, 2021; Flora, 2021; Women's Shelters Canada, 2020). Specifically, 71 percent of shelters and transition houses were operating at reduced capacity Canadawide, many of which had to operate at a capacity of 50 percent or less (Women's Shelters Canada, 2020). These challenges were coupled with high rates of staff turnover in shelters and transition houses throughout the pandemic, as well as increased staff shortages related to high rates of COVID-19 infection among workers and added responsibilities of working parents (e.g., school closures) (Women's Shelters Canada as cited in Ibrahim, 2022).

BC Society of Transition Houses (2021) provided a 24-hour "snapshot" of the realities of transition houses in the COVID-19 context:

> In just 24 hours […] 844 people were sheltered or supported in-person or remotely through Transition Housing Programs across BC. An additional 77 people were still waiting for services or had to be turned away from these programs. This was largely due to reduced capacity at transition housing programs in order to meet COVID-19 public health mandates, women feeling apprehensive about coming into the program because of COVID-19 protocols in the house, and women feeling concerned about living in a communal setting during COVID-19. (p. 1)

COVID-19 safety protocols at transition housing have resulted in unavoidable unmet needs and compromised the safety of many survivors and individuals seeking safety. These challenges were a result of reduced capacity, a limited number of beds, a shortage in hotels and reductions in programming (e.g., in-person services and supports, childcare options, transportation services) (BC Society of Transition Houses, 2021; Women's Shelters Canada, 2020). There have, nevertheless, been some measures put in place that operate as "short-term solutions" (e.g., off-site units, hotels, motels) (Women's Shelters Canada, 2020, p. 3). Of note, these challenges are reflective of long-term and ongoing underfunding of anti-violence services within Canada generally and B.C. more specifically, including shelters and transition houses, which was further compounded by the challenges and limitations resulting from the pandemic (Ending Violence Association of BC, 2021).

Promising practices and relevant recommendations made in the literature review

Existing research and advocacy-based literature have identified many promising practices and recommendations for improving the safety and security of survivors of DV during the COVID-19 global pandemic. The emerging promising practices provide a range of different tactics that aim to address such violence through policy and practice. These include response and recovery plan frameworks, sector-based responses, and community- and individual-level considerations situated within intersectional feminist, inclusive and low-to-no-barrier frameworks. These approaches are detailed below.

Intersectional feminist COVID-19 response and recovery plan (including DV)

- Emphasize intersectional feminist approaches that understand and meaningfully address the root causes of DV, including key factors such as housing (in)security, (un/der)employment, access to technology, income, childcare, social and economic inequality (Trudell & Whitmore, 2020), and focus on safety and security for survivors who leave violence, as well as those who chose to stay in or are unable to leave their homes/relationships (e.g., individualized safety plans) (Ministry of Justice & BC Housing, 2015).

- Social and economic COVID-19 safety and recovery plans should be situated within an intersectional feminist framework and meaningfully include short- and long-term responses to DV that are inclusive and low-to-no-barrier (Sharma & Das, 2021; Trudell & Whitmore, 2020). This intersectional feminist framework should be used for the planning and development of policies, programs and practices to address DV and implemented on an ongoing basis for oversight and evaluation of such response efforts (CRIAW-ICREF, 2021b).

- Responses to violence need to reflect the realities, lived experiences and risks faced by those who experience unique impacts and heightened risks of DV, including immigrant, newcomer, non-status and refugee women; Indigenous women and two-spirit peoples; racialized women; women with disabilities; gender-diverse people; sex workers; aging populations; and all others oppressed and made vulnerable by intersecting inequalities (Trudell & Whitmore, 2020). To address these risks and vulnerabilities, it is crucial to:

    - Include immigrants, newcomers, individuals without immigration status and refugees in provincial and federal response plans and stimulus packages, regardless of their status (Connor et al., 2020; Rafieifar et al., 2021);

    - Develop and put into place a plan for affordable, accessible and low-barrier short- and long-term housing for survivors of DV (CRIAW-ICREF, 2021a);

    - Create and support mechanisms for holistic, low-to-no-barrier, inclusive, and decolonial community-based care (Begay, 2020), which involves: 1) developing, translating and distributing life-saving information and materials; 2) redistributing financial resources; 3) supporting and promoting cultural practices of well-being

(e.g., smudging and staying grounded); 4) "connect[ing] with traditional medicines and knowledge"; and 5) "build[ing] community" (Begay, 2020, p. 1).

- The COVID-19 pandemic disproportionately impacts marginalized individuals, specifically those who hold intersectional identities such as Indigenous women and two-spirit peoples through amplifying pre-established systemic inequalities within the settler colonial state, such as institutionalized racism, classism and infrastructural inequalities (OCRCC, 2021). Thus, for ongoing COVID-19 related impacts within Indigenous communities and in anticipation of future pandemics and public health crises, there is an urgent need to design and implement an intersectional feminist-based COVID-19 relief plan that can adequately address both direct (e.g., the spread of a communicable disease) and indirect outcomes (i.e., inequitable access to safety) of this global pandemic, as well as key issues such as vaccine hesitancy within Indigenous communities through education about vaccines delivered by Elders and medical professionals who can provide culturally informed care (CFAIA & Palmater, 2020; Mosby & Swidrovich, 2021).
- Implement a sufficiently funded and inclusive national action plan that addresses DV, especially within the context of COVID-19, that is informed by an intersectional feminist Monitoring, Evaluation, and Learning (MEL) process (CRIAW-ICREF, 2021b). The feminist MEL process would aim to: 1) "produce empirical understanding of how and why inequalities exist and are reproduced"; 2) "aim to reduce or eliminate that inequality"; and 3) have a meaningful focus on "women and patriarchy" within an intersectional frame (Wyatt et al., 2021, p. 4).
- Action plans and response efforts to crises will require that stakeholders across sectors, both public and private, and within the community (e.g., sector workers, policymakers, employers) are provided with substantive, up-to-date and ongoing training on the development, implementation and application of an intersectional feminist lens (CRIAW-ICREF, 2021a). This is key to understanding and meaningfully addressing survivors' experiences with intersecting oppressions and is essential to responding to DV in the context of COVID-19, as well as developing new, and addressing existing, discriminatory policies, programs and responses to such increased violence due to self isolation and stay-at-home public orders (CRIAW-ICREF, 2021a).
- Engage in ongoing work to address and put an end to all forms of inequity, injustice and oppression that amplify risk of and vulnerability to gender-based violence both within and beyond the crisis context as well as hinders the safety and security for survivors (CRIAW-ICREF, 2021b).

Stable, secure and sufficient core funding for frontline and anti-violence supports

- Ensure that anti-violence and frontline agencies are categorized and supported as essential workers. In doing so, provide sufficient and stable core funding, and additional funding and resources, to these services and supports (e.g., crisis support, counselling, legal advocacy,

employment and housing assistance) and those that engage in research on violence against women (CRIAW-ICREF, 2021b; Feminist Alliance for Rights, 2021; Ghoussoub, 2020; Ryan, 2020; UNW, 2020). This core funding should account for the complexity, scope and demand for services (p. 3), as well as the unique and diverse needs of the communities that they serve.

Improve service provision and support for frontline/anti-violence workers

- Prioritize care for frontline and anti-violence workers and ensure that the necessary supports are easily accessible (e.g., mental health and psychosocial support, paid time off, physical and mental health leave) (GBV Guidelines, 2020).
- In providing crucial care and support for frontline workers, account for the fact that women are the most common members of this workforce, and during the pandemic, many women had significantly and disproportionately increased childcare and domestic responsibilities including, but not limited to, providing education and support for children during school lockdowns and periods of remote learning (Connor et al., 2020; GBV Guidelines, 2020; Rafieifar et al., 2021).
- Prioritize the needs of, and improve protections for, low-wage and precarious care workers. In particular, it is essential to address the needs of, and oppressions experienced by, Indigenous and racialized women, who are disproportionately represented in these positions, through "increasing wages, unionization and strengthening labour laws" (CRIAW-ICREF, 2021a, p. 4).
- Both within and beyond the COVID-19 context, the safety, security and well-being of seniors needs to be addressed. The development of a seniors' response plan is key in order to adequately address the social exclusion, isolation and limited-to-no access to services faced by seniors during the COVID-19 pandemic, with special consideration for seniors with diverse social identities (e.g., seniors in RRN areas) (Canadian Nurses Association, 2021). Accordingly, the Office of the Seniors Advocate BC (2021) provided five recommendations to develop and implement systems and protocols for:

    1) "[S]tandards of practice, policies and front-line training with appropriate skills, qualification and competencies to ensure a consistent and robust approach to respond to seniors abuse and neglect in B.C." (p. 5);
    2) "[A] province-wide public awareness campaign and training on seniors abuse and neglect to ensure that the public, health professionals and those who work with seniors have the knowledge and skills necessary to recognize abuse and neglect and know where to go to report and seek help" (p. 5);
    3) "[A] central, single point of contact with one phone number to report calls of concern that is managed by professionals trained in adult protection" to assist with centralizing information, documentation, tracking, monitoring and responding to cases of senior abuse" (p. 5);

4) "[C]onsistent data collection, methods and definitions to record case information, track cases and monitor abuse and neglect cases" (p. 5);

5) To "undertake a review of the *Adult Guardianship Act* and regulations to provide clarity and guidance on the specific practice that is required to protect adults" (p. 5).

- Ensure that response efforts consider and meet the needs of women living with disabilities through targeted responses for disabled women and those with intersectional identities who are disproportionately impacted, including: 1) addressing income insecurity; 2) collecting disaggregated data to better understand the impacts of COVID-19 on diverse and marginalized populations; 3) moving away from one-size-fits-all health responses and create an equitable framework for access to healthcare; and 4) removing accessibility-based barriers to anti-violence supports and services (Alimi & Abbas, 2020).
- Additional and ongoing investments in the public health sector is key, including "federal transfers to the provinces need to be increased and tied to universal public health systems" (CRIAW-ICREF, 2021a, p. 4).

Prioritize safety and building capacity

- Reduce the challenges faced by survivors seeking support and leaving violence within the COVID-19 context by:
    - Improving system communication and coordination, especially while "referral pathways are […] in flux" (GBV Guidelines, 2020, p. 3);
    - Keeping up-to-date lists of available services, types of service provision (e.g., remote, in-person) and contact and entry points for survivors;
    - Providing holistic and wraparound care (e.g., health, nutrition and food security, livelihood, housing, protection, education) (GBV Guidelines, 2020);
    - Meaningfully addressing the needs of diverse communities through providing supports tailored to their unique risks and vulnerabilities as well as the specific needs and demands for services (VAW Learning Network, 2021);
    - Giving specific attention to creating safe spaces for survivors leaving violence, building infrastructure (e.g., childcare, healthcare, education) and developing and directing resources to initiatives that promote women's autonomy and financial independence (e.g., housing, educational and vocational training) (GBV Guidelines, 2020).
- Disseminate information in an accessible manner (e.g., language, culture) about gender-based and domestic violence, and create awareness about the available resources, services and supports across sectors (Feminist Alliance for Rights, 2021). This includes but is not limited to developing awareness campaigns that are low barrier and inclusive (UNW, 2020), such as the You Are Not Alone multilingual awareness campaign. This campaign was an outcome of

the Building Supports project co-led by the BC Non-Profit Housing Association, the BC Society of Transition Houses, and the FREDA Centre for Research on Violence Against Women and Children, which focused on understanding and addressing the barriers to housing, both short- and long-term, faced by immigrant and refugee survivors leaving violence (BC Society of Transition Houses, n.d.).

- Assist and fund anti-violence and support services, including shelters and transitional houses, to stop closures and minimize factors that hinder access, as well as build capacity during a time of significantly increased demand (Feminist Alliance for Rights, 2021). It is key to address capacity issues faced by shelters and transition housing by providing additional options for available space and beds, while accounting for specific challenges these services face due to pandemic-related concerns (e.g., COVID-19 exposed or positive survivors who need safe housing, space to quarantine and access to care and testing).
- Address barriers to safety at all levels, including within the judicial system. Survivors need improved access to court proceedings (e.g., teleconference), and judicial protections (e.g., protection orders/peace bonds) should be extended to, or beyond, stay-at-home orders, lockdowns and/or periods of quarantine or limited mobility due to COVID-19 (Feminist Alliance for Rights, 2021). In that regard, there should be safe venues in the community provided for women to use computers for online access to services and supports. As well, the BC Society of Transition Houses has a Safety Check warning on their website to allow immediate exit, and also has a Get Help Now page including the VictimLinkBC number.

Conclusion

The pandemic and, more specifically, the social and physical limitations put in place to slow the spread of COVID-19, created and exacerbated conditions of precarity for survivors of DV. The pandemic has also highlighted the pre-existing and underlying structural and social inequalities that detrimentally affect survivors, such as inequitable access to resources for women from diverse backgrounds and barriers to safety caused by persistent underfunding and under-resourcing of the anti-violence sector (Bergman et al., 2021). While the COVID-19 pandemic brought about barriers to safety and increased risk for women living with DV generally, survivors who experience intersecting oppressions and inequalities often faced compounded and exacerbated vulnerabilities. For example, pandemic-induced isolation was worsened by a lack of supports and services for survivors (North, 2020). For Indigenous, immigrant, refugee, and culturally diverse women in particular, however, ongoing, systemic and pandemic-related challenges faced when accessing resources due to inadequate and, in some instances, non-existent culturally informed and/or linguistically appropriate services greatly impacted the safety of these women (Henry et al., 2021).

Overall, in the promising practices and recommendations arising from the literature review, it is argued that the COVID-19 pandemic and related complex challenges persist (e.g., isolation, economic recession, barriers to safety), and as society begins moving into recovery phases, an intersectional approach and understanding for implementing systems of support and care in mitigating COVID-19 is imperative. It was expressed that individuals and communities do not experience risk of, and vulnerability to, violence homogenously, and individuals' lived experiences must be taken into consideration when structuring relief policies and mandates (CFAIA & Palmater, 2020; Sharma & Das, 2021). In conclusion, from the review, it was expressed that such policies, practices and responses should meaningfully include the voices and perspectives of those most impacted when developing COVID-19 response and anti-violence prevention plans (e.g., immigrant, newcomer and refugee women, Indigenous women, two-spirit peoples and communities, sex workers, aging populations, those with disabilities and disability advocates, anti-violence workers) (CFAIA & Palmater, 2020; Trudell & Whitmore, 2020).

Addendum

After the completion of this paper, on July 5, 2022, the BC Association of Aboriginal Friendship Centres (BCAAFC) and Battered Women's Support Services (BWSS) released a relevant and important new report: The Road to Safety: Indigenous Survivors in BC Speak Out against Intimate Partner Violence during the COVID-19 Pandemic.

The report's conclusion states:

> Through the research process, our team found that persistent barriers arose for Indigenous women and gender diverse people in BC seeking protection from violent circumstances of [intimate partner violence (IPV)] during the COVID-19 pandemic. Concerns about reduced services and service closures, growing waitlists to access services, transportation, childcare issues, quarantine and isolation, racism and discrimination, and the involvement of MCFD and/or law enforcement agencies prevented women from accessing anti-violence support services. When supports were provided, they were often undertaken without cultural safety for Indigenous women in mind, creating additional stress by taking away Indigenous women's agency, power, authority, and self-autonomy. (BCAAFC & BWSS, 2022)

The report also contains the following recommendations on eliminating intimate partner violence:

> There are five themes that emerged from our conversations with Indigenous IPV survivors and both Indigenous and non-Indigenous support workers that are related to eliminating intimate partner violence:
>
> 1) Early intervention.
> 2) Overhaul of anti-violence service provision
> 3) Emergency transportation for Indigenous women and gender diverse people fleeing IPV.
> 4) Empowering women with access to housing and childcare.
> 5) Overhaul of police and justice system responses to IPV and consequences for perpetrators of violence. (BCAAFC & BWSS, 2022)

A sixth theme, Engaging and Supporting Men and Boys, is also covered in the report.

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