MARCO Brief Report

Adapting the violence against women systems response to the COVID-19 pandemic

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MAP Centre for Urban Health Solutions
UNITY HEALTH TORONTO
UNIVERSITY OF TORONTO

About the MARCO Study

The MARCO project is evaluating how local efforts responding to the COVID-19 pandemic serve people experiencing marginalization, and how these interventions can be improved. Changes in society to control the pandemic have affected everyone, but they place a particularly heavy burden on people who are marginalized.

We evaluated programs that support many communities who may be experiencing marginalization during COVID-19, including people experiencing homelessness, people with developmental disabilities, people who use drugs, and women who are experiencing violence. The MARCO Community Committee and Steering Committee chose the programs. The programs include:

- COVID-19 Isolation and Recovery Sites (CIRS)
- Encampment Outreach
- Substance Use Service (SUS) at the COVID-19 Isolation and Recovery Site
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative (SPPI)
- Violence Against Women (VAW) Services

The MARCO VAW Study was co-led by Alexa Yakubovich and Priya Shastri.

About this Report

This report is a brief summary of one of the MARCO Evaluations. This report highlights the key findings of the study of VAW Services (the MARCO VAW Study). A full length report will be released in December 2021.

The views contained in this report do not necessarily express the views of any MARCO community partner, funding agencies, MAP, St. Michael's Hospital, Unity Health Toronto, the University of Toronto, or any other organization with which MARCO authors or project team members are affiliated.

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Land Acknowledgement

We wish to acknowledge the sacred land on which MAP and Unity Health Toronto operate. It has been a site of human activity for 15,000 years. This land is the territory of the Huron-Wendat and Petun First Nations, the Seneca, and most recently, the Mississaugas of the Credit First Nation. The territory was the subject of the Dish With One Spoon Wampum Belt Covenant, an agreement between the Iroquois Confederacy and Confederacy of the Ojibwe and allied nations to peaceably share and care for the resources around the Great Lakes. Today, the meeting place of Toronto is still the home of many Indigenous people from across Turtle Island and we are grateful to have the opportunity to work in the community, on this territory. We are also mindful of broken covenants and the need to strive to make right with all our relations.

Website: maphealth.ca/marco Email: marco@unityhealth.to

What we did and what we learned

What was evaluated?

The MARCO Violence Against Women (VAW) study aimed to build a shared understanding of challenges and strengths in the response to VAW during the COVID-19 pandemic and develop actionable recommendations. Our team included women with lived experience of gender-based violence, VAW and allied organizational representatives, and applied academic researchers. In addition, we relied on the guiding expertise of an Advisory Group comprised of VAW leadership from the Toronto Region Violence Against Women Coordinating Committee (VAWCC). Using a community-based, transformative research framework, we investigated how VAW services in the Toronto region adapted to the pandemic, the influence of contextual factors like funding, and the experiences of survivors.

To answer these questions, we conducted:

- A mixed-methods survey of 127 VAW frontline and leadership staff in the Toronto Region;
- A focus group with 7 members of the Toronto Region VAWCC;
- 18 interviews with VAW frontline and leadership staff; and
- 10 interviews with VAW survivors accessing services in the Toronto Region during the pandemic (from March 2020).

We aimed to recruit as diverse a sample as possible for staff and survivor interviews. Our considerations for participant recruitment included: service type (e.g., counselling, housing, shelter); organization type (generalist versus specialist); and personal identities and factors, such as ethnic, racial, and sexual identities.

What were the key findings?

Below we provide an initial summary of some of our key findings, pooled across all our data sources, according to each of our three research questions. More in-depth analyses of our results are forthcoming and will be shared in reports, presentations, and papers.

1. How have VAW organizations in the Greater Toronto Area adapted their organizational practices to the COVID-19 pandemic?

During the pandemic, most VAW organizations adapted in-person programming to virtual or telephone formats wherever possible and created entirely new remote programming. Indeed, increased learning and capacity around the use of technology was the greatest opportunity experienced during the pandemic according to both frontline and leadership across VAW service types.

While both residential VAW services (including emergency shelters) and organizations with only non-residential VAW services made changes to their programming, those with residential VAW services tended to report making more dramatic programmatic overhauls. These included, for instance, setting up hotel or motel supports for client quarantines and stays and implementing infection prevention and control protocols for

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essential in-person services. On the other hand, organizations with only non-residential VAW services (including but not limited to counselling, advocacy, and healthcare), more often indicated that their VAW caseloads dramatically increased and they needed to expand their VAW workforce to meet this demand.

2. How have contextual factors (such as resources, coordination within and beyond the VAW sector, and staff wellbeing) influenced these adaptations and service delivery during the pandemic?

The challenges posed by the pandemic greatly impacted the mental health of staff (both frontline and leadership). Frontline and leadership both listed keeping work life separate from home life and increased workloads as the most significant personal challenges they experienced during the COVID-19 pandemic. The majority of VAW staff reported that their work was more distressing during the pandemic and showed significant symptoms of anxiety, depression, and vicarious trauma.

Frontline staff reported flexible working hours and pandemic pay as the most helpful supports received during the pandemic. Organizational cultures of staff teamwork and resourcefulness facilitated staff resilience and their ability to adapt to pandemic-related challenges.

Coordinating intra- and intersectoral work has been a major challenge exacerbated by the COVID-19 pandemic, despite evidence of pre-existing communication and collaboration. Frontline and leadership reported that referrals to shelter, counselling, housing, legal, and healthcare posed the greatest challenges due to services being disrupted, closed, or at capacity.

Funding for VAW work presented several issues during the pandemic. Nearly half of leadership from residential organizations who participated in our survey indicated that, despite the extent of program adaptations they had to make during the pandemic, they did not receive adequate additional funding for all changes. Many frontline and leadership staff of all VAW service types described the challenges of managing increasing VAW caseloads or case complexity without matching increases to funding or resources. Those who spoke positively about funding often highlighted the benefits of funders allowing flexibility for organizations to use their monies as they saw fit to respond to pandemic conditions.

3. How well are adaptations meeting the needs of VAW survivors?

Virtual adaptations meant that some survivors had to access VAW services when they were at home with their abusers. Staff expressed this as a primary area of concern for safe service delivery. VAW survivors described feeling like they were getting less out of virtual programming, making less meaningful connections with others, and unsure of the services available to them during the pandemic. These challenges were exacerbated for women experiencing intersecting forms of marginalization, including, for example, those who were newcomers, living with disabilities, or living with young children. Staff and survivors

emphasized that the pandemic worsened existing problems, including poverty, housing insecurity, and employment precarity.

At the same time, both staff and survivors highlighted newfound benefits of virtual VAW services. These included, for instance, being able to access a wider range of supports without having to worry about the commute and feeling greater anonymity for those less comfortable with sharing their personal experiences.

VAW survivors and staff expressed major concerns around the implementation of COVID-19 infection prevention and control protocols. Some organizations benefited from strong internal knowledge or individual relationships with public health or healthcare professionals. However, many VAW staff described being left without public health guidance on how to best meet client needs in the face of rapidly changing information on coronavirus transmission; provincial mandates for congregate living settings; and inadequate personal protective equipment (PPE) and training on PPE use and other infection prevention and control protocols.

The uncertainty experienced by staff along with rising caseloads or dramatic programmatic changes at VAW organizations illustrates how the structural context of provincial mandates and inadequate funding, resources, and public health support could lead, in some cases, to further trauma for survivors when accessing services. Survivors shared stories of how they felt traumatized and revictimized when accessing residential VAW services at the intersections of different personal identities and social factors. These included, for instance, several women who expressed that quarantine protocols were used as punishment tactics or that infection prevention and control protocols did not account for different vulnerabilities or needs (e.g., children's or personal mental health, substance use, or religious dietary restrictions). Staff stories, including among those coordinating care with shelters, often paralleled survivors' narratives around the challenges that came with infection prevention and control protocols.

Despite the challenges experienced by the VAW sector in general, and especially during COVID, we heard stories of survivors receiving *lifesaving* services. We heard stories of staff going above and beyond to support women. We heard stories of survivors being so positively impacted by VAW workers and services that they have started volunteering and giving back to those organizations. Our research illustrates that VAW services are essential and the detrimental impacts of not funding or prioritizing the sector, and social care systems more broadly.

What are the recommendations moving forward?

Below is an initial set of recommendations based on our preliminary findings. We will include further recommendations in our forthcoming reports and papers.

1. Funders, including all levels of government, should provide increased resources and flexible funding to support VAW organizations in: responding to increasing caseloads and staff mental health needs; expanding provision of structural supports (e.g., flexible hours, pandemic pay); and securing equipment access. Funding mechanisms should be sustained and continuous as opposed to project-based or temporary.
2. It should be a policy priority to strengthen VAW referral pathways and intra- and inter-sectoral collaboration, including with health, housing, legal, child welfare, and social protection systems. This can be benefited by funding permanent coordinators who work across different VAW service types and VAW advocates based in intersectoral services (e.g., healthcare) to facilitate intra- and inter-sectoral coordination, respectively.
3. Organizations should use increased funding and collaborative support to ensure they are meeting the needs of women facing intersecting marginalization, including with appropriate housing, legal, employment, and economic advocacy and mental health supports that acknowledge a diversity of needs (e.g., those of women living with disabilities, who are caregivers, or experiencing racism or discrimination).
4. Governments should deem VAW services as essential services in public health emergencies and mandate appropriate PPE access, training on PPE and infection prevention and control protocols for congregate settings, and screening tools to determine who should be supported in person versus remotely.
5. Public health units should identify how VAW essential services will be engaged and supported to navigate ongoing COVID-19 impacts and future public health emergencies.
6. VAW services and health systems should collaborate to implement and evaluate best practices related to delivering trauma-informed VAW services during public health emergencies (including the implementation of infection prevention and control protocols) that are grounded in anti-racism and anti-oppression principles.
7. VAW organizations should be funded to train and develop staff capacity on monitoring and evaluation strategies, including engaging survivors to gain their feedback on services and priorities, across different types of VAW services to support rapidly responding to client needs in this continuously evolving pandemic context.
8. VAW services should collaborate to identify how community awareness can be raised to highlight different types of VAW services operating for women fleeing violence.

Affiliations

Dalhousie University: Alexa Yakubovich

Family Services Toronto: Marija Huijbregts

McMaster University: Amanda Sim

Ontario Brain Injury Association: Lauren Hough

University of Oxford: Bridget Steele

Unity Health Toronto: Ahmed Bayoumi, Michelle Firestone, Kimia Khoee, Patricia O'Campo, Alexa Yakubovich

University of Toronto: Ahmed Bayoumi, Janice Du Mont, Michelle Firestone, Robin Mason, Patricia O'Campo

WomanACT: Priya Shastri, Monique Arcenal, Catherine Moses, Bridget Steele, Elizabeth Tremblay

Women's College Hospital Research Institute: Janice Du Mont, Robin Mason