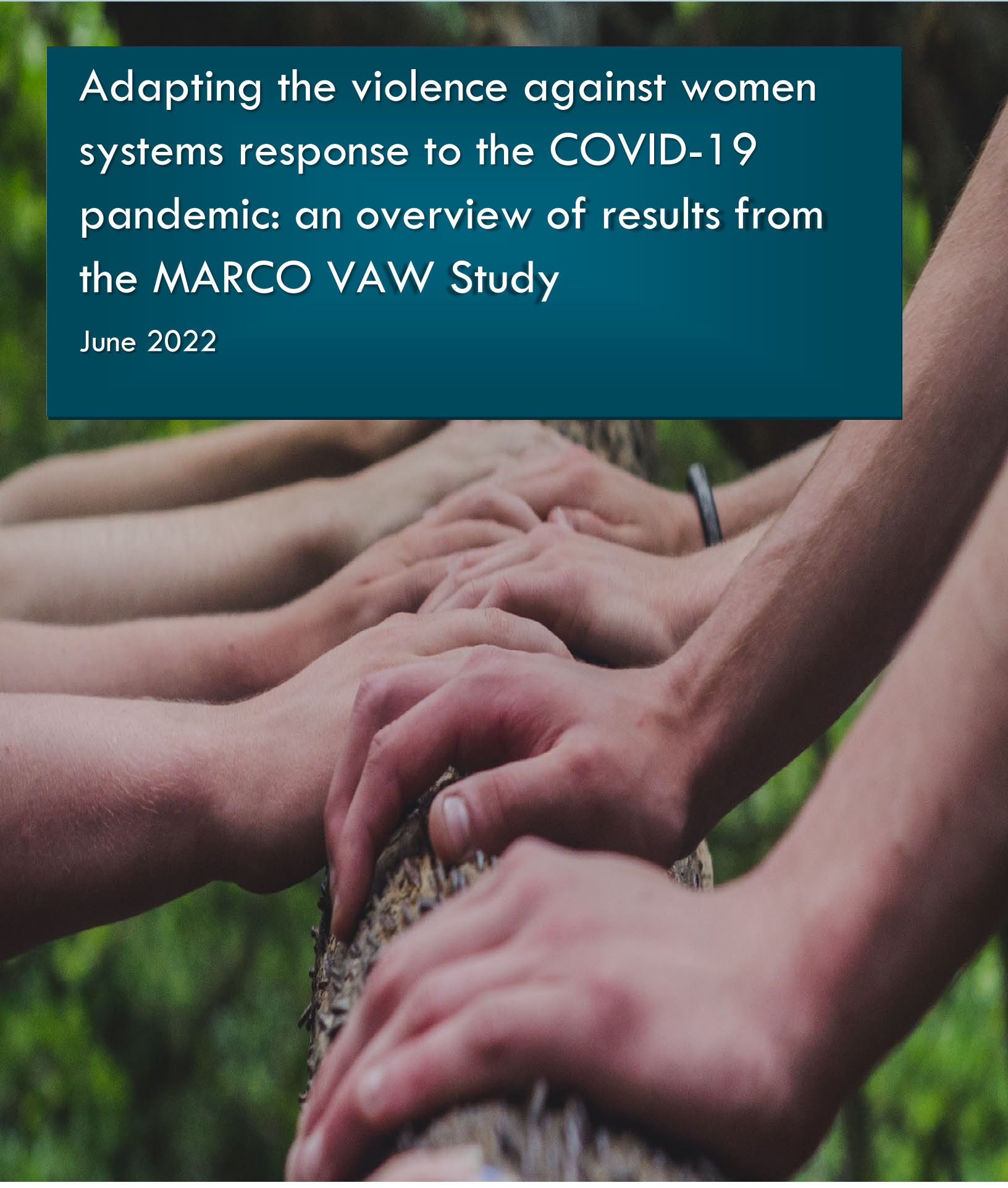
Adapting the violence against women systems response to the COVID-19 pandemic: an overview of results from the MARCO VAW Study

June 2022



MAP Centre for Urban Health Solutions

UNITY HEALTH TORONTO

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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.

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

About this Report

The MARCO-VAW team previously shared a short summary of some of our key findings.[1] The current report contains a fuller description of our results; we will share more in-depth analyses in forthcoming papers and presentations.

The views expressed 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 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.

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What we learned: A summary of the report

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 research 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 on services, and the experiences of survivors accessing services.

To answer these questions, from February to September 2021, we conducted:

- An online mixed-methods survey of 127 VAW frontline and leadership staff in the Toronto Region;
- A semi-structured focus group with 7 members of the Toronto Region VAWCC;
- 18 semi-structured interviews with VAW frontline and leadership staff; and
- 10 semi-structured 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?

1. How have VAW organizations in the Greater Toronto Area adapted their services and 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. 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.

Leaders at organizations with residential VAW services (including emergency shelters) tended to report making more dramatic programmatic overhauls compared to those at organizations with only non-residential services. These included, for instance, setting up hotel or motel supports for client quarantines and stays and implementing infection prevention and control protocols for essential in-person services. 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 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 they experienced significant symptoms of anxiety, depression, and vicarious trauma.

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 in 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.

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.

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 unsure of the services available to them during the pandemic, that they were receiving less support from virtual programming, and that they were making less meaningful connections with others. 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 commuting and, for those less comfortable with sharing their personal experiences, feeling greater anonymity.

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 needs.

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 the pandemic, we heard stories of survivors receiving *lifesaving* services and 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?

Our recommendations were co-developed by the research team and our Advisory Group as well as Toronto Region VAW service partners through our knowledge translation events, meetings, and communications.

For Funders:

- Funders, including all levels of government, should provide increased resources and flexible funding to support VAW organizations in: responding to increasing VAW caseloads and survivor needs; expanding provision of structural supports (e.g., flexible hours, pandemic pay); addressing staff mental health; and securing equipment access. Funding mechanisms should be sustained and continuous as opposed to project-based or temporary.
- VAW organizations should be funded to train and develop staff capacity on monitoring and evaluation strategies, including survivor-informed method such as engaging survivors on their programmatic experiences and priorities across different types of VAW services, to support rapidly responding to client needs in this continuously evolving pandemic context.

For Government bodies and policymakers:

- Policymakers should prioritize strengthening VAW referral pathways and intra- and inter-sectoral collaboration, including with health, housing, legal, child welfare, and social protection systems. This should entail funding permanent coordinators who work across different VAW service types and designated VAW advocates based in associated services (e.g., healthcare, social housing, social assistance) to facilitate intra- and inter-sectoral coordination, respectively.
- Further financial and social supports are needed for newcomer women experiencing violence. Policymakers should ensure that there are emergency routes via which newcomer women can be fully supported while awaiting permanent residency status (e.g., in terms of housing and social assistance). VAW organizations and associated services need to be funded to support interpretation and culturally competent programming where needed.
- All levels of government should invest in more affordable and accessible housing in safe neighbourhoods for women experiencing violence, in coordination with VAW and associated services to ensure wrap-around supports are provided as needed. This should include implementing gender-transformative policy on housing and homelessness that prevent women from being evicted from their homes when separating from abusers. City-run homelessness shelters and intake processes should be adapted in consultation with VAW experts (e.g., service providers, advocates, women with lived experience, and researchers) from a diversity of social locations to better account for the needs of women experiencing violence and homelessness.

- Governments should deem VAW services as essential services in public health emergencies and mandate appropriate PPE access and training on PPE use.
- Public health units should work in collaboration with VAW organizations, survivors, and other experts to design infection prevention and control protocols for congregate settings and screening tools to determine who should be supported in person and remotely.

For VAW organizations and service partners:

- Organizations should use increased funding and collaborative support to establish sustainable wrap-around services that meet 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). This should also include implementing trauma- informed organizational changes, ensuring that staff are appropriately trained in delivering trauma-informed services and have relevant mental health expertise.
- 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-racist, anti-oppressive, and harm reduction principles.
- VAW services should collaborate to identify how to raise community awareness about the different VAW services operating for women fleeing violence.
- Non-residential and residential services should plan for and implement a hybrid approach to their programming, including in-person and virtual programming options where possible to accommodate the diversity of needs and preferences of VAW survivors. In terms of virtual programming, where there is capacity and resources, organizations should consider both phone and video conferencing options. Where only one method is feasible, organizations should consider their clients' needs and preferences (including via formal client needs assessments) around technology use and face-to-face communication balanced against organizational capacity (including internet performance, availability of technology equipment and software, staff digital literacy, and training opportunities).

Introduction

Violence against women (VAW), sometimes referred to as gender-based violence against women, is the cause or threat of physical, psychological, or sexual harm to women.[1,2] While men are more likely to experience violence from strangers or acquaintances, women are far more likely to experience violence from someone they know well; this includes violence from intimate partners, which is the most common form of VAW.[3] Public health emergencies typically lead to rises in VAW due to increases in stressors (e.g., housing precarity, poor mental health, economic insecurity), high-risk environments (e.g., inadequate service responses, social and physical isolation), and social inequities (e.g., based on rigid gender roles, gendered power differentials).[4,5] Emerging research has shown that the COVID-19 pandemic has been no exception, with increases observed in VAW rates based on hospital, police, crisis support, and self-reported data.[6,7] This violence has severe consequences for women's health, including death, injury, mental health problems, and chronic disease and pain,[8,9] further exacerbating the gender-based impacts of the COVID-19 pandemic and other public health emergencies.

In response to the COVID-19 pandemic, VAW organizations have had to quickly adapt to address these emergency conditions, including the changing context of VAW and swiftly enacted public health mandates. Since then, a growing body of research across different countries has sought to document the experiences of VAW stakeholders – including organizational leaders, service providers, and VAW survivors. We conducted and updated a rapid review of VAW interventions during the COVID-19 pandemic throughout our study to inform our data collection and analysis (Table 1). The

The MARCO Programs

The Marginalization and COVID-19 (MARCO) study was started in spring 2020 by academic investigators, community investigators, and partner organizations working directly with people experiencing marginalization. Community investigators included people with lived experiences of marginalization, staff or leaders of community agencies, and people from advocacy organizations. We hosted a publicly available online survey to identify programs for evaluation. We considered a broad range of programs, interventions, and policies; these were not restricted to programs from MARCO partner organizations. A sub-committee of community and academic investigators selected programs based on: the potential for the research findings to have an impact on people experiencing marginalization; the need for the evaluation, relating to the current well-being of the population being served by the program; and the feasibility of completing the evaluation within available time and resources.

The MARCO programs are:

- COVID-19 Isolation and Recovery Sites for people experiencing homelessness
- Substance Use Services at a COVID-19 Isolation and Recovery Site
- Evaluation of Outreach Supports for People Experiencing Homelessness in Toronto Encampments During COVID-19
- Toronto Developmental Service Alliance's Sector Pandemic Planning Initiative
- Adapting the Violence Against Women Systems Response to the COVID-19 Pandemic

available research to date has produced an initial understanding of pandemic impacts, including, for instance, organizational pivots from in-person to virtual services delivery; the use of hotels as temporary shelters; survivors' needs during the pandemic; and documented service delivery challenges, such as resource and technology constraints as well as staff personal and professional workplace stress (e.g., Figure 1).[10-27] However, the evidence has mainly included relatively small cross-national or jurisdictional studies. Given the different sociocultural, policy, and public health restrictions at play in different municipalities, it is important to triangulate this broader evidence with a more localized approach. Armed with this knowledge, we can determine the response strategies that worked best and for whom, as well as the contextual factors that facilitated the success of different strategies in particular locales – maximizing the effectiveness of ongoing and future policy and practice.[28-31] Therefore in the current study, we aimed to develop a novel and in-depth understanding of how new and modified VAW interventions were implemented in the context of a large, multicultural city (Toronto), what factors internal and external to VAW organizations impacted these processes, and the outcomes for VAW survivors.

As part of the Marginalization and COVID-19, or MARCO, study, we were committed to exploring the experiences of women facing marginalization during the COVID-19 pandemic. We are aware of only two studies to date, one Canadian-based and one US-based, that included VAW survivors as participants (Table 1).[22,26] This is likely because of the greater ethical and practical challenges to research studies, especially in times of public health emergencies.[32,33] However, safely and supportively engaging with survivors in research can provide crucial information on how well their needs have been met by VAW services.[32,33] In addition, the Canadian study only sampled White shelter residents.[13] We are also aware of only one study (from the US) that intentionally analyzed the experiences of organizations serving specific communities (e.g., Black, sexual minority, or Indigenous populations), although the researchers only interviewed staff and not survivors.[12] In the current study, we aimed to capture and analyze the experiences of VAW staff and survivors across a diverse cross-section of personal identities and social locations as well as the types of VAW services participants worked on or accessed and the populations typically served by those services.

A Community-Based Study

MARCO included community-based investigators, many with lived experience, as full partners. The MARCO Community Committee has representatives from 11 community agencies, representing a broad spectrum of organizations. MARCO's steering committee includes both academic and community-based investigators. Each program evaluation team included at least 1 community investigator and hired people with lived experience as peer researchers. Across MARCO, researchers with lived experiences of marginalization were involved in all aspects of the study, from recruitment and interviewing to data coding and interpretation.

To advance the VAW systems response to the pandemic in the Toronto Region, this study aimed to answer three research questions:

1. How have VAW organizations in the Greater Toronto Area adapted their services and practices to the COVID-19 pandemic?
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?
3. How well have VAW services met the needs of survivors during the pandemic?

Table 1. Summary of a rapid review of literature on the adaption of VAW organizations or the experiences of VAW service access in high-income countries during the COVID-19 pandemic

Authors (year)	Location	Focus	Key finding(s)
Mantler et al. (2021)[13]	Ontario	Interviews with 8 shelter clients and 26 shelter workers and focus groups with 24 executive directors of VAW organizations across Ontario on the use of hotels	Hotels offered temporary shelter and safety for survivors when public health protocols limited the capacity of residential VAW services. Some women benefited from the autonomy hotels provided; many women lacked the relevant supports and supplies offered at shelters. The safety and security of clients and staff at hotels were compromised.
Wardell (2021)[19]	Ontario	Online survey of 160 members of the Ontario Association of Interval and Transition Houses on conducting VAW work at the start of the pandemic	There is capacity for technology use in the VAW sector but insufficient infrastructure and knowledge deficits around using technology for VAW work act as barriers. The increase in flexible and hybrid work during the pandemic offers an opportunity for online staff training and growth in service delivery.
Montesanti et al. (2020)[14]	Alberta	Interviews with 24 stakeholders in VAW and primary healthcare in Alberta on barriers and facilitators with virtual delivery of trauma-informed care	There are many barriers to delivering virtual care for survivors during a pandemic. It is challenging for staff to assess for client safety and to make the necessary connections with new clients in virtual settings to provide trauma informed care.
Trudell & Whitmore (2020)[18]	Canada	Online survey of 376 VAW staff across Canada on challenges, service needs, organizational changes, impacts on survivors	The prevalence and severity of violence increased during the pandemic. While there were adaptations made in the sector to meet the needs of survivors, pandemic protocols were at times re-traumatizing and technology barriers meant that many survivors were unable to access support.
Women's Shelters Canada (2020)[21]	Canada	Online survey of shelter/transitional housing staff across Canada in November 2020 on service demand, service adaptations, and challenges	Shelters and transitional housing faced staffing, funding, and capacity barriers to meeting the increase in client demand during the pandemic.
Nnawulezi & Hacskaylo (2021)[15]	USA	Online survey (1 question and demographic variables) of 840 domestic violence housing practitioners across the US on organizational concerns and needs at the beginning of the pandemic	Key concerns for practitioners centred on keeping themselves, their staff, and survivors safe and healthy in congregate settings, the housing crisis, and capacity limitations related workload, staffing, and advocacy.
Garcia et al. (2021)[12]	USA	Interviews with 53 IPV advocates across 25 US states between June- November 2020 on staff wellbeing, organizational changes, and challenges.	The mental health and well-being of IPV advocates suffered during the pandemic. Many agencies implemented new services to meet the needs of their staff. New virtual programming to respond to pandemic -related client needs brought about challenges and opportunities. The impact of the pandemic was exacerbated for newcomers and non-native English speakers.
Ragavan et al.[27]	USA	Interviews with 53 IPV advocates across 25 US states between June- November on the experiences of IPV survivors during the pandemic	Challenges survivors face related to isolation, structural inequities, and housing precarity were exacerbated during the pandemic. Further, the pandemic was often used by abusive partners to further perpetrate coercive control.
Wood et al. (2020)[23]	USA	Online survey in Spring 2020 of 352 VAW staff across 24 states on work changes, wellbeing	VAW staff experienced increased personal and professional stress during the pandemic. They found threats to client safety and lacked the necessary resources and organizational capacity to support themselves and survivors.

Table 1. (Continued)

Authors (year)	Location	Focus	Key finding(s)
Wood et al. (2021) 22	USA	Online 8-minute survey in Spring 2020 of 53 VAW survivors across USA on safety, wellbeing, service needs	During the pandemic survivors experienced health and work concerns, stress from economic instability, compromised safety, and challenges accessing support. The pandemic exacerbated existing structural inequities for survivors.
Ravi et al. (2021)[26]	Southwestern USA	Interviews with 10 IPV survivors on their experiences accessing services in March 2020	Survivors experienced varying levels of support from VAW service providers; some survivors feeling supported while others felt abandoned. Some survivors benefited from the safety isolation provided them. Others experienced exacerbated abuse or re-traumatization due to pandemic protocols.
Williams et al. (2021)[20]	Boston	Interviews with 18 VAW staff in Boston on challenges and opportunities	During the pandemic, VAW organizations faced uncertainty, limited resources, and reduced in-person services. Survivors faced challenges accessing resources and technology. These challenges were exacerbated for survivors who did not speak English or newcomers. VAW services adapted to meet survivor needs through video and telephone interactions, employing creative solutions, and intersectoral collaboration.
Carrington et al. (2020)[24]	Australia	Online survey of 362 VAW staff across Australia on organizational changes, challenges, and impacts on survivors	VAW organizations had an increase in number of clients during the pandemic and reported an increase in the complexity of client needs. Public health measures and lockdowns placed survivors at an increased risk of violence and provided an opportunity for perpetrators to apply coercive control.
Cortis et al. (2021)[11]	Australia	Online survey of 100 VAW staff across Australia on organizational changes, challenges, and service demand	Remote service delivery improved accessibility and efficiency in some cases. Some practitioners found it challenging to assess for client risk virtually and found that virtual services did not meet client need. Monitoring and evaluating the efficacy of service adaptations is essential.
Pfitzner et al. (2020)[16,17]	Victoria, Australia	Three online surveys (n=113 to 166 VAW staff) and focus groups with 28 family violence practitioners in Victoria, Australia on staff wellbeing, organizational changes, challenges, and impacts on survivors	The frequency and severity of VAW has increased during the pandemic along with the complexity of survivors' needs. New forms of VAW emerged because of social isolation, fear of contracting the virus, pandemic protocols, and barriers to accessing VAW services. The well-being and mental health of VAW staff was compromised.
Bergman et al. (2021)[10]	Norway	Online survey of 46 VAW shelter leaders across Norway on organizational changes, challenges, service demand, and impacts on survivors	Shelters generally met the needs of the clients they served during the pandemic. However, shelters saw fewer requests from survivors during the lockdown. Staff were concerned about the well-being of survivors with intersecting forms of marginalization. One third of shelters found that pandemic was used by perpetrators as a means of coercive control.
van Gelder et al. (2021)[25]	Netherlands	Interviews with 16 domestic violence practitioners on organizational changes, challenges, and impacts on survivors	VAW staff reported no change in the number of clients during the pandemic but found an increase in the severity of violence experienced by survivors. VAW staff working from home experienced frustration, insecurity, and loneliness. Virtual services were an opportunity to reach clients during the pandemic but were not always suitable for supporting survivors.

Note. This table summarizes the results of a rapid review on research conducted during the COVID-19 pandemic from March 2020 up until November 2021 on the adaptations made by VAW organizations or the experiences of VAW survivors accessing services in high-income countries. We have not included studies on the occurrence or experience of VAW during the pandemic. We searched MEDLINE and PsycINFO using a structured search strategy with terms for COVID-19, violence against women (e.g., domestic violence), and interventions (e.g., shelter, evaluation), conducted directed searches of Google Scholar and Scopus, and set up Google Scholar and PubMed search alerts.

Figure 1. An infographic demonstrating the early impacts of the COVID-19 pandemic on VAW sectors across Canada. Reproduced with permission from Trudell and Whitmore (2020).[19]

Methods

Approach

Full details on our methods are included in the appendix. The MARCO-VAW study was a community-based, mixed-methods study that aimed to build a shared understanding of the challenges and strengths in the response to VAW during the COVID-19 pandemic in Toronto and develop actionable recommendations for funders, governments, and organizations. Our research team included women with lived experience of gender-based violence, VAW and allied organizational representatives, and applied academic researchers. The team was co-led by an academic researcher (Yakubovich) and a community-based researcher (Shastri). We further relied on the guiding expertise of an Advisory Group comprised of VAW leaders from the Toronto Region Violence Against Women Coordinating Committee (VAWCC).

We collected data in four stages shown in figure 2. Each stage of data collection was designed with reference to available research; feedback from the research team and Advisory Group; and, in the case of the focus group and interviews, the aim of explaining and expanding upon our survey results. The majority of our interviews were conducted by peer researchers with lived experience of VAW partnered with a study co-lead (Yakubovich or Shastri). As shown in figure 2, knowledge translation (KT) was integrated throughout the study, with, to date, four VAW sector-wide and two intersectoral KT webinars along with regular KT meetings with relevant knowledge users (e.g., funders, VAW networks).

We relied on our partnerships and networks to facilitate the recruitment of participants. We distributed our online survey (hosted on REDCap) through VAW networks in the Toronto Region, including those funded by the Ministry of Children, Community, and Social Services (MCCSS). Staff received a $10 honorarium for participating in the survey. The survey was open to all frontline and leadership staff who had been working since 11 March 2020 at an organization with at least one VAW service in the Toronto Region serving women-identified clients experiencing violence. Survey participants had to be 18 years old or older, able to speak and read English comfortably, and able to provide informed consent.

We conducted staff interviews virtually (using Zoom) with a subset of the survey sample (who indicated they would be like to be contacted and were offered an additional honorarium of $40) and four additional participants recruited through the support of our VAW networks. We purposively selected participants based on personal factors (e.g., ethno-racial identity, age, language, caregiver status), types of VAW services where participants worked (e.g., healthcare, shelter, counselling, housing, legal), and the populations typically served (i.e., generalist or targeted to specific communities). The goal of staff interviews was to explain and expand upon our survey findings. Interviews were semi-structured to allow the interviewer(s) space to explore areas of greatest interest and relevance with each participant. Prior to the interview, participants provided informed consent over email using the study's consent form.

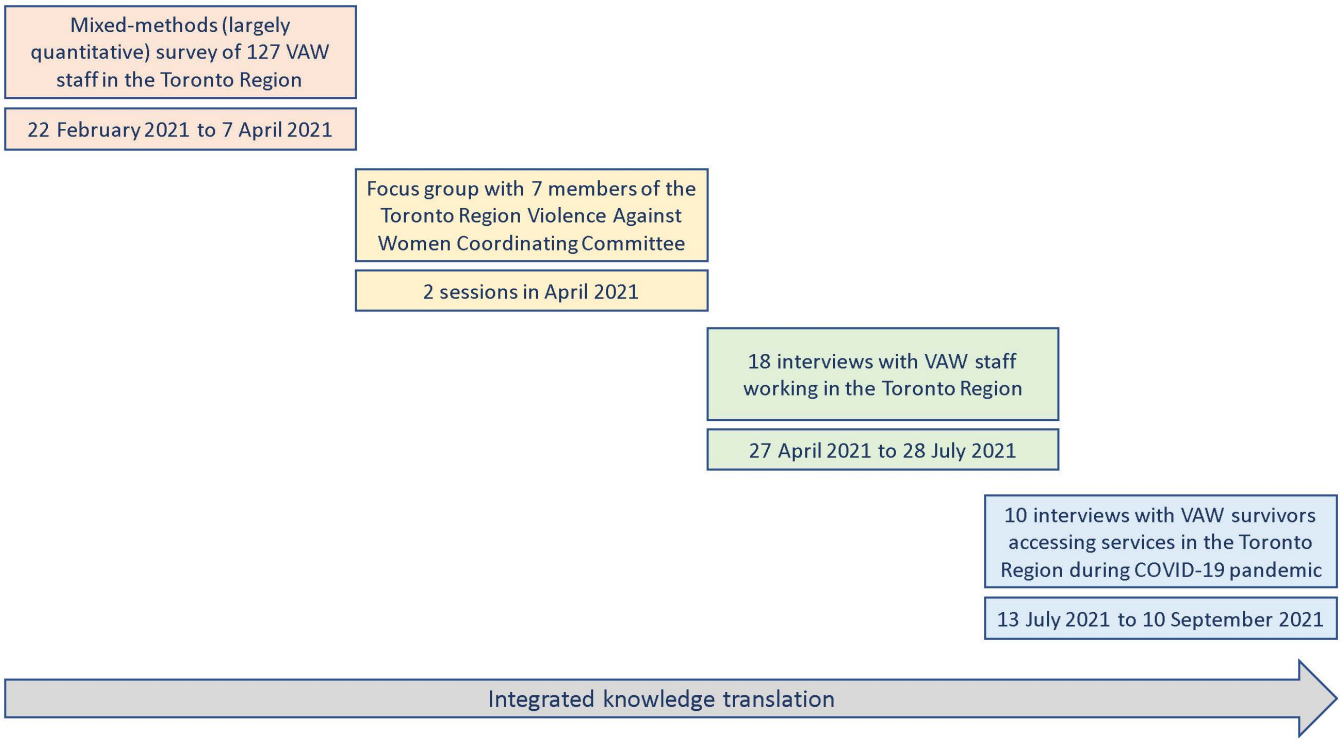

Figure 2. MARCO VAW mixed-methods design for data collection

We recruited participants for survivor interviews via staff contacts in our collaborating networks, aiming to purposively recruit a sample that was diverse in terms of personal factors and services accessed. VAW survivors were eligible to participate in interviews if they had used at least one service for women experiencing violence at an organization in the Toronto Region since March 11, 2020, were at least 18 years old, and were able to provide informed consent. With the support of staff, we also ensured that additional ethical criteria were met, including that survivors were in a physically and mentally safe space to participate, determined through staff and interviewer safety checks.[32,34,35] We used interpretation services to interview participants not fluent in English. Survivor interviews aimed to build on staff surveys and interviews and were also virtual (over Zoom) and semi-structured. As with staff, survivors provided their consent prior to the interviews over email and received an honorarium of $40 for participating. Survivor participants also received a list of VAW mental health resources and contact information.

One study co-lead (Yakubovich) descriptively analyzed the survey data and four members of the research team (co-lead Yakubovich, two other study interviewers, and a PhD trainee) collaborated on the qualitative thematic analysis of the interview and focus group data. The broader research team, our Advisory Group, and VAW sector stakeholders provided their feedback through meetings and knowledge translation events throughout data analysis. We have selected quotations for this report to support our analysis and included anonymized participant identification numbers to illustrate the scope of the data used in our analysis. Where relevant, we also provide relevant contextual information (e.g., whether a quote is from a leadership, frontline, or survivor participant). In this report, we focus on summarizing the initial outputs of our analytic work that are most meaningful to our three primary research questions. The final section of this report outlines our next steps, including some of our planned future outputs.

Results Summary and Discussion

A total of 127 VAW staff participated in our survey (71% [n=90] frontline and 29% [n=37] leadership). 103 of the 127 participants (78% [n=70] frontline and 89% [n=33] leadership) completed the survey from start to finish; we have analyzed all available data regardless of survey completion.

Table 2 summarizes the sociodemographic characteristics of our sample by participant type. The majority of participants were aged 31 to 56 years old and identified as heterosexual ciswomen. Just over half of staff survey participants (51%), 64% of staff interview participants, and 70% of survivor participants identified as an ethnic or racial minority. Close to half of the sample was born outside of Canada. Most survivor participants had less than a $20,000 income (90%), were unemployed (60%), and had a trades or college certificate (70%).

Table 3 summarizes the types of programs, services, and organizations where staff participants worked or survivors reported accessing during the pandemic. Staff participants represented at least 31 Toronto VAW organizations (4 participants did not name the organizations where they worked but indicated these were shelter or transitional housing organizations); 42% of the organizations represented (n=13) had both frontline and leadership participants. Survivors reported accessing an average of 10 (IQR: 7-11) different services or programs regarding experiences of VAW during the pandemic; for 5 participants (50%), the COVID-19 pandemic was the first time that they had accessed VAW services. In addition to what is shown in Table 5, 70% of survivor participants were accessing some form of social assistance (Ontario Works [OW] or Ontario Disability Support Program [ODSP]) and 50% had had some police contact regarding VAW during the pandemic.

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

Table 4 summarizes the diversity of VAW programming offered by organizations and how this changed during the COVID-19 pandemic as reported by leadership participants in our survey. During the COVID-19 pandemic, organizations were able to continue to offer many of their pre-pandemic programming. Most leadership participants reported that risk assessment and safety planning, telephone crisis support, advocacy, and service referrals offered pre-COVID continued during the pandemic and, as reported by residential service leaders, so did emergency residential services and donations of basic goods. In contrast, leadership participants most often reported that they stopped or paused in-person programming, such as group support, individual counselling, drop-in support, and social events or activities.

Most programs added during the pandemic were virtual, including virtual individual counselling or group support (table 4). Indeed, most leadership participants across residential and non-residential services reported that they adapted an in-person service/program to virtual or telephone format or created a new virtual or telephone-based service/ program during the pandemic (table 5). Reflective of this, most frontline and leadership participants across VAW service types reported that increased learning and capacity around the use of technology was the greatest opportunity they experienced during the pandemic (75% of survey participants). By the time our survey was completed (Spring 2021), staff

Table 2. Sociodemographic characteristics of the sample

Characteristic - N (%) or M(IQR)	Staff survey (n=103)*	Staff interviews (n=18)	Survivor interviews (n=10)
Age, years	42 (31—50)	47 (40—56)	43 (36—50)
Ethno-racial identity			
White	46 (49%)	7 (36%)	3 (30%)
Black	21 (22%)	4 (21%)	2 (20%)
Latino/Latina	8 (9%)	3 (16%)	2 (20%)
Southeast Asian	6 (6%)	2 (11%)	2 (20%)
South Asian	6 (6%)	0 (0%)	1 (10%)
Mideast	3 (3%)	2 (11%)	0 (0%)
Jewish	2 (2%)	1 (1%)	0 (0%)
Indigenous	2 (2%)	0 (0%)	0 (0%)
Gender identity			
Ciswoman	93 (92%)	18 (95%)	9 (90%)
Cisman	4 (4%)	1 (5%)	0 (0%)
Gender diverse**	4 (4%)	0 (0%)	1 (10%)
Sexual identity			
Heterosexual or straight	83 (83%)	15 (79%)	8 (80%)
Gay or lesbian	4 (4%)	1 (5%)	0 (0%)
Bisexual	6 (6%)	2 (11%)	1 (10%)
Queer	2 (2%)	0 (0%)	0 (0%)
Pansexual	1 (1%)	0 (0%)	0 (0%)
Not sure or questioning	2 (2%)	0 (0%)	1 (10%)
Other	2 (2%)	1 (5%)	0 (0%)
Country of birth			
Canada	59 (58%)	9 (47%)	5 (50%)
Other	43 (42%)	10 (53%)	5 (50%)
Total household income* **			
<$20,000	-	-	9 (90%)
$20,000-$50,0000	-	-	1 (10%)
Employment status* **			
Unemployed	-	-	6 (60%)
Casual paid employment	-	-	2 (20%)
Caregiver	-	-	1 (10%)
Highest level of education* **			
High school	-	-	1 (10%)
Trades or college certificate/diploma	-	-	7 (70%)
University certificate/diploma below bachelor's	-	-	2 (20%)

N is number. M is mean (i.e., average score). IQR is interquartile range (i.e., the 25th and 75th percentile).
*103 of the 127 survey participants answered at least one question from the demographic section.
**Gender diverse includes any participant who reported the following gender identities: (a) fluid, nonbinary, gender queer, or agender, (b) Indigenous or other cultural identity (e.g., two-spirit), (c) transman, or (d) transwoman. We have collapsed these categories to avoid any possible reidentification of VAW staff participants due to potentially low numbers of gender diverse staff in the city's VAW sector.
***Only asked of survivor participants.

Table 3. Types of VAW programs, services, and organizations where staff participants worked and that survivor participants accessed during the COVID-19 pandemic

	Survey participants		Interview participants		
	Leadership (n=36)	Frontline (n=82)	Leadership (n=7)	Frontline (n=11)*	Survivor (n=10)**
VAW programming* **					
Mental health, counselling, crisis support, case management	-	35 (43%)	-	3 (27%)	10 (100%)
Shelter	-	21 (26%)	-	2 (18%)	8 (80%)
Transitional housing support	-	14 (17%)	-	4 (36%)	4 (40%)
Children's Aid Society	-	3 (4%)	-	0 (0%)	6 (60%)
Partner assault response	-	3 (4%)	-	1 (9%)	0 (0%)
Other:					
Healthcare	-	3 (4%)	-	1 (9%)	5 (50%)
Harm reduction	-	2 (2%)	-	0 (0%)	1 (10%)
Legal advocacy and support	-	1 (1%)	-	1 (9%)	4 (40%)
VAW service					
Residential	21 (58%)	40 (49%)	2 (29%)	6 (55%)	8 (80%)
Non-residential	15 (42%)	42 (51%)	5 (71%)	5 (45%)	10 (100%)
VAW organization					
Generalist	31 (86%)	66 (80%)	4 (43%)	8 (73%)	10 (100%)
Community-specific organizations****	5 (14%)	16 (20%)	3 (57%)	3 (27%)	4 (40%)

*Specializations do not add up to 100% as one participant worked on both transitional housing support and counselling.
**Do not add up to 100% as all participants accessed multiple types of VAW services during the pandemic.
***Only frontline staff participants were asked to indicate their programmatic specialization as in most cases leadership were responsible for directing, managing, or supervising an entire VAW service or organization.
****Community-specific organizations included language-based and culturally specific organizations.

participants felt very comfortable with most forms of technology. From a scale of 0-100 (completely uncomfortable to completely comfortable), participants' average scores were high for: live video conferencing (e.g., Zoom, MS Teams) (mean [M]=83, IQR: 75-98), texting or app-based messaging (e.g., Whatsapp) (M=85, IQR: 80-100), email (M=94, IQR: 97-100), and telephone (M=94, IQR: 94-100). The only technology that staff participants reported feeling less comfortable with were online collaborative tools (e.g., Dropbox, Slack) (M=56, IQR: 35-84).

In interviews, staff highlighted the ways that technology has served as both an opportunity and a limitation for VAW services during the pandemic. Some participants heralded virtual service delivery for allowing them to broaden service access and engagement (e.g., audience size, geographic scope, provision of anonymous and discreet services). In addition, some participants described how virtual service delivery increased their own participation in VAW work, for instance, by not having to worry about time or money for commuting. In learning and expanding to new forms of technology, many staff emphasized the benefits of using video conferencing or instant messaging to mirror the unstructured and personal aspects of in-person work. This supported staff in working together while apart as well as more effectively connecting with and providing care to survivors. In many cases, participants recognized and valued the innovations achieved in their virtual service delivery but still felt the loss of in- person services. For instance, one shelter leader explained how they established weekly meetings where women accessing services could chat with each other virtually around topics of their own choosing:

Table 4. VAW programmatic changes during the COVID-19 pandemic, as compared with before, reported by leadership participants by service type (n=36)

	Only non-residential services (n=15)			At least one residential service (n=21)		
	Continued running	Stopped or paused	Added	Continued running	Stopped or paused	Added
Risk assessment/safety planning	13 (87%)	2 (13%)	0 (0%)	15 (71%)	0 (0%)	2 (10%)
Community referrals	12 (80%)	2 (13%)	0 (0%)	11 (52%)	0 (0%)	3 (14%)
Telephone support	10 (67%)	1 (7%)	2 (13%)	15 (71%)	0 (0%)	2 (10%)
Advocacy (e.g., housing, legal)	10 (67%)	1 (7%)	0 (0%)	12 (57%)	0 (0%)	2 (10%)
Emergency residential services	1 (7%)	1 (7%)	2 (13%)	15 (71%)	1 (5%)	2 (10%)
Basic good donations	6 (40%)	1 (7%)	0 (0%)	13 (62%)	2 (10%)	0 (0%)
Children's services or programming	2 (13%)	2 (13%)	0 (0%)	9 (43%)	5 (24%)	2 (10%)
In-person individual counselling	2 (13%)	7 (47%)	0 (0%)	9 (49%)	8 (38%)	1 (5%)
In-person group support	0 (0%)	7 (47%)	0 (0%)	3 (14%)	16 (76%)	1 (5%)
In-person couples or family counselling	0 (0%)	4 (27%)	0 (0%)	1 (5%)	6 (29%)	1 (5%)
Virtual individual counselling	1 (7%)	1 (7%)	8 (53%)	4 (19%)	0 (0%)	11 (52%)
Virtual group support	0 (0%)	1 (7%)	6 (40%)	3 (14%)	0 (0%)	12 (57%)
Virtual couples or family counselling	0 (0%)	2 (13%)	3 (20%)	5 (24%)	1 (5%)	2 (10%)
Primary prevention of VAW	7 (47%)	5 (33%)	0 (0%)	4 (19%)	3 (14%)	1 (5%)
Text-based or online crisis support	1 (7%)	1 (7%)	3 (20%)	6 (29%)	2 (10%)	3 (14%)
Financial assistance	4 (27%)	0 (0%)	0 (0%)	7 (33%)	1 (5%)	2 (10%)
Partner assault response (PAR) program	2 (13%)	2 (13%)	0 (0%)	3 (14%)	1 (5%)	1 (5%)
Social events/activities	2 (13%)	4 (27%)	0 (0%)	0 (0%)	10 (48%)	2 (10%)
Parenting support	2 (13%)	2 (13%)	0 (0%)	7 (33%)	2 (10%)	0 (0%)
Drop-in support	2 (13%)	5 (33%)	0 (0%)	4 (19%)	6 (29%)	2 (10%)
Permanent supportive housing	1 (7%)	3 (20%)	0 (0%)	4 (19%)	2 (10%)	0 (0%)
Harm reduction services	2 (13%)	0 (0%)	0 (0%)	8 (38%)	2 (10%)	2 (10%)
Transitional housing/second-stage shelter	0 (0%)	2 (13%)	1 (7%)	2 (10%)	0 (0%)	3 (14%)
Leadership programming	1 (7%)	1 (7%)	0 (0%)	4 (19%)	3 (14%)	1 (5%)

For each service type, the values in each row add to 100% minus the proportion of participants who indicated that their organization never had the program before or during the pandemic. Dark shaded cells indicate that at least 50% of participants endorsed the response. Light shaded cells indicate that 25%-49% of participants endorsed the response.

Table 5. Adaptations made to VAW services by organization type as reported by leadership survey participants (n=36)

	Only non-residential services (n=15)	At least one residential service (n=21)
Adapted an in-person service/program to virtual or telephone format	12 (80%)	20 (95%)
Created a new virtual or telephone-based service/program	12 (80%)	15 (71%)
Provided service to connect clients to hotel/motel for emergency shelter	9 (60%)	20 (95%)
Increased capacity of some services	9 (60%)	15 (71%)
Reduced capacity of some services (e.g., to comply with physical distancing guidelines)	8 (53%)	19 (90%)
Adapted group support programming to be one-on-one	3 (20%)	15 (71%)
Introduced food bank or emergency drop-in	3 (20%)	13 (62%)
Acquired additional shelter space	2 (13%)	14 (67%)
Adapted service/program eligibility criteria	6 (40%)	3 (14%)
Conducted additional home visits	3 (20%)	8 (38%)

Shaded values indicate adaptations for which more than 50% of leadership participants at residential or non-residential organizations indicated their organization made during the COVID-19 pandemic.

"Someone would say, OK, next week I will be talking about female genital mutilation in my country that is Somalia. Or I would talk about all the mysteries around different things. Or child brides or it could be a ceremony. Different themes. Some were talking about a religious group, one would be talking about Ramadan, one would be talking about Christmas in Nairobi, you know, things like that. It was weird themes, but it gave us the opportunity to know more, what was -- who is this person? What was her life experience? It was empowering to the women to talk about herself, to present an aspect that was, after six months, that nobody knew about her. It was liberating for us. And we knew we learned a lot about each other, about traditions, about the feminine condition around the world. And those are things that were created. But some of the things were lost. The regularity of women coming together and sometimes doing therapy sessions. We couldn't do that. Someone doing drawings and explaining why she draws this image and everyone coming around and looking at her paint, having to do it in your own room didn't have the same feeling." [Residential leader participant, P109]

As this participant exemplifies, staff valued the intimate environments that were created by some VAW organizations despite the physical distance of virtual service delivery; participants often recognized this peer connection as a crucial and in- tangible element to the effectiveness of group- based VAW support. Even still, it has been hard for staff not to mourn what has been lost. This was particularly felt by those who had to rely on phone contact alone in their service delivery. For instance, a direct service provider explained:

"I think the most challenging part is that I don't know, I cannot see the client. It's very challenging to build a rapport. I constantly have to check for, like, you know, signs, safety concerns. Are you alone? Can you talk to me right now? It's very stressful on me as well as a counselor … The initial contact is always by phone. And so, it's kind of really hard to understand where they're at, what's going on, to ask additional questions to ensure there's privacy and confidentiality." [Non-residential frontline participant, P23]

Many staff relying solely on service delivery by phone echoed P23's sentiments: not being able to see survivors (virtually or in person) added new complexity to safety planning and establishing the provider-client relationship and with it, a mental burden for frontline staff (discussed further in section 2A). Staff emphasized that this was especially difficult when survivors were at home with their abusers, may have sustained serious injuries, were at risk for serious mental health problems, or required interpretation support. Remote service delivery, across telephone and virtual formats, has been challenging for those staff working with survivors experiencing economic or housing precarity or survivors who are elderly or less technologically literate.

In our survey, leaders on residential VAW services tended to report running or adding more VAW programming during the COVID-19 pandemic compared to leaders on only non-residential services (Table 6). This was reflected in the COVID-19 specific adaptations that leadership participants reported making (Table 7). While all leadership participants reported making program adaptations during the pandemic, a greater proportion of residential leaders compared to non-residential leaders reported making all of the adaptations listed, with the exception of changing service eligibility criteria. Two of the most common adaptations that residential leaders reported making during the pandemic were connecting clients to hotels or motels for emergency shelter and reducing service capacity. The extent of adaptations required by residential services was exemplified in our interviews. For instance, one frontline shelter worker described:

"We had to move all our clients to a hotel setting. … So, we had 10 clients – 10 families, I should say. So, we had to facilitate this move as smoothly as possible. And then we had to create an office in the hotel so we are close to the clients. So, we ran our program from a hotel, which was… unfamiliar. There were so many things to adjust to making sure they have all their needs met. It was different, like it's - carrying all the files, carrying the food, making sure everybody is OK with them. Like, they've already been traumatized, coming to the shelter and now they had to be – the outside world looks at it as, 'Oh, you're going to a hotel, you should be happy, you have your own room.' … But it wasn't ideal. … The programs weren't run in the same way. We couldn't do the one-on-one counseling as much as we were able to do at the shelter because of the health and safety and all these new procedures that came with the pandemic and all the updates from Public Health. … It felt… uncomfortable. One of our staff actually couldn't cope with it and she just took time off because it was just too much for her to handle." [Residential frontline participant, P103]

As demonstrated by this participant's comments, not only were residential staff responsible for the transition of residents to hotels, but they were also required to respond to rapidly changing infection prevention and control guidelines for congregate care settings and the fears around COVID-19 among both survivors and other staff. As a result, adapting shelter programming required, in many cases, a complete overhaul of what programming could be run (e.g., in-person counselling) and how it could be structured (e.g., where, and how, resources could be stored and used). As this participant exemplifies, the burden of managing these factors was overwhelming for many staff; we discuss this further in Section 2 as well as the related impacts on survivors in Section 3.

On the other hand, organizations with only non-residential VAW services (including but not limited to counselling, advocacy, and healthcare), more often indicated in our survey that their VAW caseloads dramatically increased. In particular, 84% of frontline participants and 67% of leadership participants providing non-residential services reported that they experienced an increase in VAW clients during the pandemic. When asked about specific client groups, more non-residential than residential frontline participants observed increases in clients caring for children, living with disabilities, who do not speak English, who are refugees or immigrants, and who use drugs. Most frontline participants across residential and non-residential services reported increases in clients experiencing homelessness or housing precarity

and who are racialized minorities. Interviews with non-residential staff reflected these findings; participants frequently described experiencing increased VAW caseloads and/or case complexity. For instance, one non-residential leader explained:

> *"Our waitlist went from 2, 3 weeks to now closer to 6 months, like 200 names. Before the pandemic, our agency was the size of 22, right? Now our agency is the size of 32. And, most of those are frontline resources. But we're stuck with a very hefty waitlist – but we can't, like, farm content out and have someone share our load because we're the only one in our community."* [Non-residential leader participant, P136]

As demonstrated by this participant's response, increasing VAW caseloads necessitated expanded VAW workforces. Likewise, this participant illustrates the additional structural challenges experienced by community-specific organizations: a growing demand for VAW services that outpaced available funding and capacity to hire or train culturally competent direct service staff. Some VAW organizations were not resourced to increase staffing at all, regardless of need. In our survey, 33% of non-residential VAW leaders indicated that they increased their workforce during the pandemic; 47% reported no change and 20% reported staffing changes (e.g., increases or decreases) varied, depending on the VAW service. In contrast, 57% of residential leaders reported a decrease in their VAW workforce. As reflected in our focus group and through integrated knowledge translation, this was likely due at least in part to provincial mandates during the pandemic that barred employees from working at more than one congregate care setting.

In our survey, leadership participants indicated if they used any client engagement strategies to inform how they adapted or delivered their VAW services during the pandemic. Across residential and non-residential services, leaders most often reported using unstructured discussions between their direct service staff and clients (60% non-residential leadership; 81% residential leadership). However, in line with the greater amount of program adaptation required by residential leadership compared to non-residential leadership, the former more often reported using most types of client engagement strategies. In addition to unstructured discussions, these included surveying the acceptability or feasibility of new or adapted services among clients (38% residential, 7% non-residential leadership) and client satisfaction surveys (67% residential, 27% non-residential). The only exception was for assessing client needs before or during service delivery, which was more often used by non-residential leadership (53%) compared to residential leadership (38%).

2. How have contextual factors influenced these adaptations and service delivery during the pandemic?

The COVID-19 pandemic impacted the context of VAW service delivery and the experiences of providing those services; likewise, certain contextual factors served as a buffer to the impacts of the pandemic. In this section, we summarize four contextual factors that have been impacted by COVID-19 and in turn impacted the process and experience of VAW service provision during the pandemic: (a) staff mental health and supports, (b) organizational culture, (c) funding and resources, and (d) intra- and intersectoral coordination.

A) Staff mental health and supports

The challenges posed by the pandemic greatly impacted the mental health and well-being of VAW staff. Frontline and leadership both ranked keeping work life separate from home life (64% frontline survey participants; 44% leadership survey participants) and increased workloads (52% frontline, 71% leadership) as the most significant personal challenges they experienced during the COVID-19 pandemic. Frontline staff further cited personal concerns around COVID-19 infection (51%), and leadership stressed the difficulties of maintaining staff morale (53%). The majority of

VAW staff reported that their work was more distressing during the pandemic compared to pre-pandemic (61% frontline, 81% leadership) and showed symptoms of anxiety, depression, and vicarious trauma (Table 6).

Interview participants echoed and expanded upon the mental health challenges evident in our survey (discussed in Section 1). For instance, many staff reflected on how the switch to virtual service delivery, personal stresses of the pandemic and, in some cases, rising VAW caseloads, case complexity, or the need to implement or follow infection prevention and control protocols, significantly increased the burden of VAW work during the pandemic. The convergence of these factors is well captured in the following comment from a non-residential leader:

> *"You hold the issues that come, you're entrusted to hold those and to work and walk side by side with clients as they try to resolve them. Many of the issues that people are bringing forward are directly connected to the pandemic and are happening in real time in your own personal life as well. So, we're all living in a lockdown right now. We can say 'Self-care, go for a walk,' but like, where am I going for a walk? … And it's the fatigue factor of constantly being online and not being able to turn it off, like during a workday, let alone what you do outside your workday … Vicarious trauma is always an issue. But, as I've said often, if you have a particularly difficult situation with someone, a session, you can pop into your colleague's office and just sit with her and just talk … We can't do that right now. You have to 'ping' one another, 'Do you have time? Let's talk on Teams,' that sort of thing. It's very artificial. You can't hug one another, like you just can't. So, there's been a lot of tears of frustration and overwhelmedness, I think, in some of the team meetings. And we are trying to turn people towards solutions thinking as well, like, what can we do, given this pretty nasty context to do that? But it comes and goes. I think it comes in waves. And right now, I think we're in a particularly challenging place."* [Non-residential leader participant, P68]

This participant demonstrates that the challenges exacerbating survivors' situations – for example, physical and social isolation as well as fear of COVID-19 – were the same challenges impacting frontline and leadership staff. Despite the context of immediate support facilitated by some VAW organizations, it was still very much felt that staff have lost a key form of social support for managing challenging VAW work, which would have negatively impacted staff during non-pandemic times, let alone in the midst of pandemic stress. While frontline staff have found themselves struggling to respond to survivor needs during the pandemic, it is also clear that leadership have felt uncertainty in responding to their staff's needs. This has created, in many cases, a sense of hopelessness and despair at all levels of the VAW workforce (e.g., non-residential leaders, P3: "***the helplessness of leadership to support and assist frontline staff***," and P137: "***that rabbit hole of hopelessness as well around me, what can I do to help them?***"), including a perceived failure to meet what they have been "***entrusted***" to do (P68).

In terms of supports for VAW frontline staff during the pandemic, staff trainings were the most common (69% residential; 50% non-residential) followed by more frequent supervision meetings (58% residential; 70% non-residential). Non-residential leaders also reported that these were the two supports they most commonly provided to their VAW staff (83%-100%). While most residential leaders (79%) also reported providing these supports, the most common supports they reported implementing for staff were flexible working hours (90%) and pandemic pay (90%). Most frontline participants reported that each of the supports they received were very helpful or at least somewhat helpful. The highest-ranked supports among frontline participants in terms of helpfulness were flexible working hours, pandemic pay, additional personal days, and reduced workload or responsibilities.

B) Organizational culture

In addition to staff supports, our interviews demonstrated how VAW organizations with established cultures of staff teamwork and

Table 6. Mental health outcomes during the COVID-19 pandemic reported by survey participants (n=101)

	Frontline (n=68)	Leadership (n=33)
Vicarious trauma:* 1 (strongly disagree) to 7 (strongly agree), M (SD)		
My job involves exposure to distressing materials and experiences	5.9 (1.7)	5.0 (1.7)
My job requires exposure to traumatized or distressed clients	6.3 (1.3)	5.2 (1.7)
I find myself distressed by listening to my clients' stories and situations	4.2 (1.6)	3.9 (1.6)
I find it difficult to deal with the content of my work	3.2 (1.7)	3.2 (1.5)
I find myself thinking about distressing material at home	4.0 (1.8)	3.5 (1.8)
Sometimes I feel helpless to assist my clients in the way I would like	4.9 (1.8)	3.8 (2.0)
Sometimes I feel overwhelmed by the workload involved in my job	4.7 (1.8)	4.6 (1.8)
Sometimes it is hard to stay positive and optimistic given some of the things I encounter in my work	4.3 (1.7)	4.0 (1.8)
Total vicarious trauma score (range: 8 to 56)*	**37.5 (9.8)**	**33.2 (9.6)**
Anxiety and depressive symptoms over the last 2 weeks:0 (not at all) to 3 (nearly everyday), M (SD)**		
Been feeling nervous, anxious, or on edge	1.4 (0.9)	1.0 (0.7)
Not been able to stop or control worrying	0.9 (0.9)	0.9 (0.7)
Been feeling down, depressed, or hopeless	0.8 (0.8)	0.7 (0.8)
Had little interest or pleasure in doing things	0.6 (0.7)	0.8 (0.8)
Total anxiety and depressive symptom score (range: 0 to 12)**	3.6 (2.7)	3.4 (2.5)
Have you found work more upsetting or distressing during the pandemic compared to before? N (%)		
No, less upsetting	3 (4%)	3 (9%)
No change	25 (35%)	3 (9%)
Yes, more upsetting	43 (61%)	26 (81%)

M is mean (i.e., average score). SD is standard deviation (i.e., the extent to which most of the data vary from the average score). N is number.
*Measured using the Vicarious Trauma Scale.[47] Cut-points have not been validated but the scale developers defined 8-18 as 'low,' 19-42 as 'moderate,' and 43-56 as 'high.'[48] The scores in the current sample are thus considered on the higher end of moderate.
**Measured using the Patient Health Questionnaire (PHQ)-4.[49] The PHQ-4 is a brief measure of symptom burden and a screening indicator for determining whether further inquiry into clinical disorders is needed (it is not a definitive diagnostic on its own). Total scores of 0-2 are defined as 'none-to-minimal,' 3-5 are 'mild,' 6-8 'moderate,' and 9-12 'severe.' The scores in the current sample are thus considered mild, which, considering that this is a non-clinical sample, is significant

resourcefulness facilitated staff resilience and ability to adapt to pandemic-related challenges. For example:

Obviously, the level of crisis and complexity of issues increased. So, staff needed to be prepared, right, for that. We were so, I don't know, blessed or lucky that just months before, we had engaged the whole organization in this building resiliency program, right? And it was, yes, and it was about self-care and self-awareness and this and that. And so, I said to the team, "Guys reach deep and remember those strategies you guys learned because we are going to need it. We don't know when this thing is going to end, but we're going to need to use every internal and external resource we have.' So constantly checking in with the team, constantly reassuring the team that we are in this thing together, making myself available to support with things that the team couldn't do from home. [Residential leader participant, P110]

This leadership participant demonstrates that while the COVID-19 pandemic was novel for all, the strategies required to effectively navigate it were foundational to their organization's work. Leadership, and frontline staff, who fostered an ethos of being in partnership with each other created a sense of assurance that their team would be able to pull through the challenges of the pandemic and a drive to innovate to meet those demands. However, integral to the success of such a collaborative approach was the availability of resources, including in terms of staff capacity, training opportunities, and funding. Organizations benefited from drawing upon relevant past experience and training (e.g., in mindfulness or technology, or having historically made significant programmatic adaptations) but those that were able to arrange new training opportunities or rapidly reorganize staff structures (including flexible working hours) and funding were able to better support their staff and, resultantly, their clients.

C) Funding and resources

Historic and ongoing funding challenges, however, limited the capacity of VAW organizations to respond in this way to the COVID-19 pandemic. Perhaps most notably, nearly half (48%) 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 in interviews the challenges of managing increasing VAW caseloads or case complexity (including more severe or higher-risk situations) without matching increases to funding or resources. For example, participant P23 stated, ***We also need extra support, like we need extra funds […] to be able to provide that support. […] I feel like we're just understaffed.***" Those who spoke positively about funding during the pandemic often highlighted the benefits of funders allowing flexibility for organizations to use their monies as they saw fit to respond to pandemic conditions. For instance:

> "*That's probably the biggest help because [clients] don't have to be eating garbage [before we can help them]. And they could be, you know, 'too much money for that, but not enough money for this.' We can provide clothing. We can provide money for summer activities. We can provide computers. We can provide winter coats. We can provide upgrading. So, some very concrete support we can provide."* [Non-residential leader participant, P137]

As this leadership participant's comment illustrates, flexible funding empowered staff to better meet the needs of survivors during an otherwise disempowering time. However, what is also demonstrated here, which came across in other staff interviews, is that VAW organizations had to have enough funds to benefit from flexible conditions (e.g., having the capacity to help survivors before they are at their lowest point *["**eating garbage**"]* or having *"**too much money"*** in one area). A pattern that we observed across staff participants is that this was more often the case for multiservice VAW organizations (e.g., which had the ability to transfer funds across different services) with larger pools of charitable and private donations to draw upon.

With the switch to virtual or remote service delivery, equipment access became an important issue for VAW organizations. Most frontline participants of our survey reported that their organizations provided them with or reimbursed them for work computers (83%); leadership participants likewise reported providing computers for their staff (91%). However, a significant proportion of frontline staff participant reported being financially responsible for or not having adequate access to other types of equipment or services needed for their VAW work, including: phone or tablet (57%), cellphone plan or home phone service (58%), internet connectivity (67%), webcam (49%), headphones (70%), and, for non- residential frontline, a private room for confidential discussions (78%).

D) Intra- and intersectoral coordination

Nearly all survey participants (84% frontline; 94% leadership) reported that referring out to other services because they are closed, disrupted, or at maximum capacity was a challenge during the pandemic, including VAW or generalist shelter, counselling, criminal justice or family law, healthcare, and childcare. In interviews, participants also emphasized challenges with housing, partner supports, and interpretation services. These challenges persisted, despite evidence of pre-existing communication and collaboration: 84% of leadership participants reported their organization was a part of at least one VAW network, 94% had corresponded with cross-sectoral partners, and most leadership reported communicating with other organizations on a monthly or as-needed basis. In interviews, staff expanded upon how the challenges in coordinating and collaborating VAW work with other organizations and sectors had existed before but were severely exacerbated by the pandemic. For example:

> *Referrals, the answers were not there […] like I was talking about the continuum of services for [our community], it's just like some things need to be done with a translator. It's not the same thing or risks are that the translator belongs to the circle of the client. It's minorities and minorities. […] There's a big gap for [services specific to my community] already. But if you add to that, that most of the services were not done person to person no more, it had to go by virtual. And the risk that you see the face of the person [you know], some things you won't say. […] We did some referrals of almost a year ago at some time that we still do not have responses. We are fighting hard to provide services to the youth and children that we have and been waiting for forever. […] The referrals are already long, but it takes a lot more time."* [Residential leader participant, P109]

As this leadership participant's comment encapsulates, challenges with referrals were even more difficult for community-specific services, where the pool of potential service providers was already limited but became even more so due to the pandemic and the switch to virtual services. As a result, this heightened the risk of potential service providers having some connection to survivors, which can limit how much survivors feel comfortable sharing or, at worst, put survivors at risk for retributive violence. Inherent to this response are two other important points. First, many VAW organizations refer out to community services or programs to meet the varying needs of survivors (e.g., here, for child and youth supports) as part of their normal practice. When those services shut down or reduced their capacity, some VAW organizations no longer had the capacity to offer survivors such wrap-around supports. This also relates to intersectoral collaborations – for instance, getting survivors into housing or legal support, for which wait times were at times severely increased due to a lack of stock or closed courts, respectively, during the pandemic. Second, adaptations to external services during the pandemic created further obstacles to referrals for VAW organizations that increased workload and stress among VAW staff. In addition to what P109 described, this included, for instance, the implementation of public health guidelines that survivors could not comply with (discussed further in section 3D) and using technology for which staff or survivors lacked the resources or capacity (e.g., requiring certain software or reliable internet). Finally, organizations that managed referrals themselves have been struggling during the pandemic. For instance, one leadership participant described:

> *"They called or emailed 3000 agencies to say, 'Are you open?' Because we didn't want to refer women to an agency that's closed. […] That is something on a bigger scale that we're trying to look and say, 'How do we fix this?'"* [Non-residential leader participant, P5]

As is clear from this participant's comment, figuring out what services were or were not available during the pandemic has been a huge stress on VAW staff. There was a recognized need among staff participants for the strengthening of a systematic and centralized process for referrals to prevent these challenges from happening in future emergencies.

3. How well have VAW services been meeting the needs of survivors during the pandemic?

Staff participants shared their perceptions of their clients' circumstances during the pandemic compared to before. In our survey, staff were more likely to agree that their VAW clients were experiencing negative rather than positive outcomes during the pandemic, including more severe forms of violence, disempowerment, increased difficulty navigating available services and resources, and a stalling or reversal of progress (Table 7). In interviews, staff and survivors further highlighted that the pandemic exacerbated existing problems, including poverty, housing insecurity, and employment precarity. For instance, one survivor participant described:

> *Actually, he didn't have any job even before pandemic, but it's more difficult to get a job after a pandemic, so he got stressed a lot. So, before he met me, he got a lot of pressure from his own family already. He couldn't do whatever he wanted to do. And after a pandemic, he didn't have anybody else to explode his emotions except me."* [Survivor participant, C79]

As this participant's comment demonstrates, while the pandemic exacerbated existing socioeconomic challenges, many VAW survivors were also forced to shelter in place with violent partners or family members during the pandemic. As a result of this collision of risk factors, many staff and survivor participants noted increases in the incidence, frequency, or severity of family violence during the pandemic, including psychological, physical, financial, and sexual violence. This increased need among survivors accessing VAW services posed further strains on the VAW system amidst the challenges in funding, service and program referrals, case coordination, and VAW staff mental health described above.

We observed many parallels in interview data across staff and survivor participants in describing experiences of VAW and service access during the pandemic. Below we provide a summary of these parallels in five pertinent areas: (a) the collision of risk factors, violence, and barriers to service access, (b) barriers to therapeutic progress, (c) benefits of virtual services, (d) challenges related to infection prevention and control policies, and (e) resilience and the benefits of VAW services.

A) A collision of risk factors, violence, and barriers to service access

In addition to socioeconomic and pandemic restrictions, COVID-19 as an infectious disease played a role in the coercive and controlling dynamics of abusive relationships. For instance:

> *"I think COVID created a new way of abuse. Like the partners would say, 'If you go out, then you will get sick. You will bring this to the house. You have to stay indoors.' […] I think [the violence] is, like, more frequent because you're always in the same space and the person is there and it's like so much stress and tension. […] So, yeah, it's just like really that extra level, that stress, you know, really a lot of pressure on mental health for people. And also, I think substance abuse during COVID, not coping well adds another issue here in terms of severity and frequency of the violence. So, again, we have to think about what can we do? How can we eliminate these stressors if your partner is using at home?"* [Non-residential frontline participant, P23]

I think that it was hard for him to get a job, right? […] So, he was a stress. The lease of the house where we were living it was going to end and we were looking for another place, but they were very expensive. So, the baby in the house, we sharing the space all the time. All the time because everything was closed. I couldn't go to a mall because I had to be there, because it was a lockdown. So, it was all the time, no job, you know, like he was drinking. […] And you know what? He's one of these persons that they don't believe in COVID. They don't believe that is true. It's all a lie for the government it's, you know, so he was like, 'I'm not going to wear a mask. It's against my beliefs.' […] So, it was all of this stuff because we were fighting about that, right? Like, 'You have to take care. You have to, you know, like you have to think about us.'" [Survivor participant, C78]

In P23's comment, we see how some abusive partners further limited women's freedom of movement by using COVID-19 as a fear tactic and pandemic restrictions as another means of control in the relationship. In contrast, we see in C78 how some abusive partners flaunted COVID-19 restrictions, thereby heightening women's fear and disempowerment within the relationship, while intersecting social factors (e.g., a new baby, economic and housing precarity) exacerbated the power imbalance. Across both participants' responses there is an undercurrent of how the stress of pandemic conditions worsened existing issues around mental health and substance use, which further reduced the capacity of staff and survivors to maintain the latter's safety and stability. P23 and C78's comments also illustrate a finding shared across our participants: some survivors had to access VAW services when they were sheltered at home with their abusers. This was a huge challenge indicated by staff, especially those delivering virtual services, as noted earlier. For instance, one non-residential frontline participant, described a situation where:

"The sister-in-law disconnected the internet, so she wouldn't be able to contact me through the email, but just the phone. But sometimes, we need internet access […] Then those times […] she went to Tim Horton's with her young children. And then her extended family stated that she does not care about children." [Non-residential frontline participant, P138]

Here, in relying on a resource under the control of the abuser(s), the survivor's access to virtual VAW services was in jeopardy and the steps she had to take were resultantly used as a means for further coercion and

Table 7. Frontline staff perceptions of outcomes among their VAW clients during the COVID-19 pandemic, from 1 = strongly disagree to 5 = strongly agree (n=73)

Compared to before the COVID-19 pandemic, since March 2020, VAW clients…	Average score (SD)
Are experiencing more severe forms of violence	4.0 (0.9)
Have a lower sense of power due to pandemic restrictions	3.9 (1.1)
Have increased difficulty in navigating available services and resources	3.9 (1.1)
Are experiencing a stalling or reversal of their progress	3.7 (0.8)
Have greater access to emotional or informational support	2.9 (1.2)
Have new referral opportunities	2.7 (1.0)
Have greater access to financial or resource supports	2.6 (1.1)
Have increased opportunities for community building and support	2.4 (1.1)

Note. SD is standard deviation. Outcomes 1-4 are 'negative' outcomes and outcomes 5-8 are 'positive' outcomes. Outcomes were presented to survey participants alternating negative and positive; here, they are presented in order of highest to lowest agreement on average.

abuse. Barriers to service access were not limited to those seeking non-residential services; survivors attempting to safely leave their homes with limited time away from their abusers were also impacted. For instance, C78 described:

> *"So because of the lease was going to end, I tricked him. […] I'm going to start packing some stuff for the baby and me, you know, like I'm going to do this be- cause we are going to move. […] But he was like, 'Are you going to leave without me? He was like suspicious, right? So, he was upset.'"* [Survivor participant, C78]

This example further shows how survivors needed to be resourceful in finding ways to access VAW supports and, in many ways, this added to their mental burden and safety risks, as well as feelings of helplessness among staff who were providing that support.

B) Barriers to therapeutic progress during the pandemic

Survivors echoed the challenges of virtual VAW services that staff shared (discussed in section 1) in meeting survivors' needs. For example:

> "*Interactions with clients] changed quite a lot. How could I put it? […] Just being with somebody, even if you didn't say anything, even if they didn't talk, just having that support there that they knew somebody was available to them, that they could talk to or even sit with silently, it made such a big difference. Just having -- losing that contact with somebody was -- it was hard. It was hard for us because we knew in many cases that just being there with somebody was a big help to them. You know, could be holding their hand, putting your hand on their shoulder, just sitting across from them, just being somebody who's not family who, but who understands what they're going through, made a very big difference in how they felt and how they were getting through it."* [Non-residential frontline participant, P43]

> "I*'ve actually had more things like it seems like more using services now than I was before. I was using the services before, but because they were being more active in person and social, it helped a lot more, you know. But now it's just like you talk to someone on the phone, like I'm going to talk to you on the phone and then we're going to get off the phone. And then I have to deal with the rest of the situation by myself and learn how to cope with that. […] I found [virtual services] very difficult to use, to download the program and all this kind of thing. And all of those type of things are for me personally -- my 'I statement' was really difficult because I get very overwhelmed, very easy. So those are, when all of a sudden I find myself like having a seizure on the floor and, you know, and normally prior to the pandemic, all of my access, peer access were people who were able to help me with those type of, you know. So it's a double edged sword for me. It took me a while to try and learn and be capable to adjust to sitting online while people are watching me twitch and, you know, just. Try and get through a whole conversation, but also to – it also gives you the experience on how to be more independent."* [Survivor participant, C76]

As C76's comments illustrate, some survivors described feeling like they were getting less out of programming, making less meaningful connections with others, and more isolated. Staff participants, as in P43, reflected these barriers to therapeutic progress in their descriptions of feeling a sense of loss around the intangible benefits of in-person supports, and the ramifications they felt this had for supporting their clients. Some survivors also described being unsure about what services were and were not available to them due to some VAW

VAW services going virtual or reducing capacity. For instance, one participant without permanent residency in Canada described:

> "*So I had hard time finding help. I was only reaching out to female friends I have and I have to talk about it. And it was very embarrassing also because they could see the signs of being beaten. […] I managed to get in touch. But they told me that everything was closed."* [Survivor participant, C81]

Taken together, C76 and C81's comments demonstrate that challenges in VAW service access and making therapeutic progress were exacerbated for women experiencing other forms of marginalization – here, those who were living with disabilities (e.g., ***"to adjust to sitting online while people are watching me twitch"***) or newcomers (e.g., due to some services requiring residency status, not speaking English, and cultural expectations). The process of seeking out VAW services often involved difficult disclosures that survivors had to manage the emotional consequences of on their own, in some cases while waiting long periods of time before actually gaining access to any services (e.g., as with C81). Other intersecting forms of marginalization that impeded therapeutic progress included, for instance, caring for young children alone, experiencing economic or housing precarity, and experiencing multiple forms of abuse (e.g., from other family members or neigh-bours). Across the diversity of these situations, survivors were often experiencing additional stressors that either physically precluded them from accessing virtual services (e.g., not having sufficient funds) or limited meaningful engagement (e.g., childcare responsibilities).

C) Benefits of virtual services

At the same time, both staff and survivors highlighted some newfound benefits of virtual VAW services. For instance:

> *"In my position, providing service for phone and email is more, more practical to my client, because my client doesn't really want to (laughs) disclose who they are for the first. Also, before pandemic, the client must visit the office to get a service or at least for initial intake registration. But some clients, when they have to come to our office through the public transit or if they're still living with their perpetrator, want the money to, for their transportation fee, and to, they can't really come out of the house because of their perpetrator. But those people, they could still access our service through phone, email, and Zoom. I found that there are a lot of advantages for them."* [Non-residential frontline participant, P138]

> *"Actually, I thought to telephone service was the most comfortable way to me, because if I want to show my face, it was really uncomfortable and it was just a shame to me. And then if I get a service through a telephone, I can cover my face so I could open one hundred percent of my story. If I have to open my face I was really ashamed about what happened to me I couldn't tell exactly what happened. Right now, I'm I feel much better because I had a lot of online Zoom meetings so I could open more than before. At the beginning was a real shame to talk to somebody else while I was open and my face to them."* [Survivor participant, C80]

As shown by P138 and C80, benefits of virtual VAW services included being able to access a wider range of supports without having to worry about the commute or location of services, and feeling greater anonymity for those less comfortable with sharing their personal experiences.

This was especially the case for participants who felt more cultural expectations (e.g., around gender roles, the acceptability of violence, and maintaining privacy around family matters) and those accessing community-specific services. In addition, as exemplified by C76's comment in section 3B, even among those participants who struggled with virtual services, there was at times value found in learning new forms of technology and new coping mechanisms (*"**experience on how to be more independent**"*). The unexpected benefits of technological learning for survivors was also reflected among some staff participants; for instance one non-residential leader described:

> *"It has been interesting to see the interest from our clients, even though it has been quite difficult for some of them to adapt to the new technology […] But I think a lot of them have adapted well to that, you know, whereas many months ago we wouldn't have thought that they would have been able to join a support group on Zoom or on Google Meets."* [Non-residential leader participant, P7]

As reflected here, there was a lot of concern, especially in the beginning of the pandemic, that virtual service delivery would pose insurmountable challenges to VAW programming. However, mid-pandemic, many staff described a commitment or desire to run hybrid services (i.e., in-person and virtual options) as part of their post-pandemic VAW work. Our data from both staff and survivors suggests that this hybrid approach has the potential to meet the widest scope of survivors' diverse needs -- including those who prefer what physically distanced services can offer and those that need in-person supports.

D) Challenges related to infection prevention and control policies

As described in Sections 1 and 2, VAW organizations were provincially mandated to implement infection prevention and control protocols during the study period to protect the health and safety of clients and staff (March 2020-September 2021). However, as borne out by our interview and survey results, this was in the face of rapidly changing information on coronavirus transmission, at times limited personal protective equipment (PPE), and inadequate training on PPE use and other methods of infection prevention and control. As a result, VAW survivors and staff expressed major concerns, uncertainty, and stress around the implementation of COVID-19 infection prevention and control protocols. In some cases, VAW organizations benefited from strong internal knowledge or individual relationships with public health or healthcare professionals. For instance, one residential leader shared:

> *"We got positives, two positives [in late 2020]. And again, you think you're going to call this line [for shelter support from Toronto Public Health] and get the help you need? No, you don't get a call back. You don't get a call back after leaving four messages saying, 'I really need this.' So thankfully, I had built a relationship with [a hospital in Toronto] and their IPAC team. I called and […] the next day, we had on site testing for everybody through them and still hadn't made the contact with Toronto Public Health."* [Residential leader participant, P142]

This response, however, is also an example of how, even in such cases where beneficial collaborations were established, many VAW staff, including those managing or based in congregate settings, were left without public health guidance and support on how to best meet survivor needs. Another leadership participant, P110, shared, *"**We weren't given any contact [with Public Health]. Like, this should have been a streamlined process for VAW shelters to be in contact with Public Health. That – because, I mean, congregate setting, hello**?"* While

health systems were themselves grappling with the unprecedented challenges posed by the pandemic, a lack of systematic public health guidance and support to organizations across the VAW sector exacerbated the already significant challenges that staff were managing.

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. For instance:

> "And *then she said, 'So we have to ask you to go into isolation.' And I'm like, 'OK, but what about the family that I'm calling about? Who told me about the exposure? Shouldn't they be going into isolation?' And she said they haven't called and made a test yet. […] I remember being behind the Plexiglass saying, 'What is this going to look like? Like how are you going to feed us then? Can you tell me now what your policies are about this?' And they said, I kid you not 'We don't know. We're going to have to talk to management.' […] Shelters within COVID without any active cases are very restrictive. Like, I can't, we can't go to the park. You have to petition, you have to get, like it's an ordeal. So now it meant that we couldn't leave the property and, in isolation, you can't leave the building. […] And then we were the people who made the isolation happen, which changed how everybody reacted to us -- including the caseworkers*." [Survivor participant C74 on her shelter stay in 2021]

> "*One time they isolated for personal reason, like to punish me, they isolated me in the room for four days. […] And they said, 'You can't come out of this room until we ask you to come out.' I said, 'OK, so what about the food?' [My child] was a little baby […] She said 'Whatever you need, we will give you at your door, whatever you need, we will give you your food at the door.' OK. In the morning, I called at, it was 10 o'clock. I said, 'I didn't get breakfast. [My child] wants milk,' because [my child] was drinking a lot of milk at night. […] So, they punished me, they abuse me because I raised voice then nobody's giving you food and nobody's giving you respect you deserve*." [Survivor participant C77]

C74 and C77 comments exemplify the accounts that some survivors shared around how they felt traumatized and victimized when accessing residential VAW services and how this was impacted by different personal identities and social factors. Here, for instance, these accounts included feeling that infection prevention and control protocols were opaque, used as punishment tactics, or not responsive to different vulnerabilities or needs. Additional examples of the latter were: childcare needs (e.g., C78: "***They say that daycares are closed, so at this time nobody can help me, right?***"); children's or personal mental health (e.g., C73: "***I think it was just ten times harder just for the sake of my daughters came through the journey with me and how they're autistic and new scenery and like this mask and pandemic, it made it twice as hard for them.***"); and religious dietary restrictions (e.g., C77: ***"The custom thing like for my country, just boil some lentils and give it to me […]. And they said, 'Nobody can make specific things for you.' […] I said, 'Can you allow me to go to the kitchen? I do fast and I come out.' So they said, 'No, it's a COVID restriction.'"***). Managing VAW shelters as congregate care settings during a pandemic with limited funding, fears around COVID-19, major programmatic shifts, and a lack of public health training around infection prevention and control created opportunities for power imbalances between service users and providers to widen and some survivors to feel their unique needs were, at times, left unaddressed and or disregarded. In many cases, mandated restrictions by their nature were recognized as revictimizing for survivors or challenging for those with additional needs (e.g., sensory overload). Survivors expressed being adversely impacted by the implementation of restrictions without a trauma-informed and intersectional lens in certain instances – which, ultimately, requires appropriate systems-level capacity.

Staff stories, including among those coordinating care with shelters, often paralleled and expanded upon

each other and survivors' narratives around the challenges that came with infection prevention and control protocols. For instance:

"A shelter said we have one bed, I'm like, 'OK, great.' And the specific survivor, she was a GHB user who needed every single [day] with the hospital at an outpatient for GHB counseling and medication. She was in withdrawal, acute withdrawal. So, with this shelter, they said that this client has to isolate two weeks, not allowed to leave the room. And with this client, I'm like, 'No, no. She has to see her doctor every single day at 12:00 or she can have a seizure and she can overdose in her room.' 'No, no, no. We can't have that. They have to be locked in a room for two weeks.' So, it's like we have shelters, but a lot of our folks are substance abuse, NFA [no fixed address], we have sex workers and they're just not able to isolate. […] So that has been a huge challenge […] substance abuse, mental health, like they need so much support, you can't lock them in a hotel room for two weeks for isolation." [Non-residential frontline participant, P115]

"In one of our meetings, we said we missed that point, because when we were asking a woman to stay in quarantine for 14 days, we didn't take into consideration what if she has addiction issues and she needed to get out to get something to cope with? Or if you're alcohol dependent, like did we create (pause) a dangerous situation for the women? […] But the quarantine, those 14 days of quarantine , it's almost slipped our mind that, oh, what if she needs to go out to get something, like we're putting her in jail. So that just was, it was for us, it's a reminder like, oh, there's a new adjustment you have to do. So, we have to talk to the women, like I know this is a conversation very challenging. And it's not pretty to ask someone, are you using? Do you need to go out to get something? And that is actually OK. But we had to do this conversation. So, just to make sure their safety is not being jeopardized. […] But we missed it, the first couple of, like, we missed it the first couple of-weeks." [Residential frontline participant, P103]

Here, P115, a non-residential participant, and P103, a residential participant, share corresponding accounts of how survivors' holistic health needs were not always considered in the implementation of safety protocols and the lack of systematic guidance to support this implementation. Collectively, these examples (combined with the results shared in sections 1 and 2) show how VAW and coordinating systems being overwhelmed, underfunded, and underprepared for a public health emergency contributed to significant negative outcomes for some survivors during the pandemic, and especially those with intersecting needs.

E) Resilience and the benefits of VAW services

Despite the challenges experienced by the VAW sector during the COVID-19 pandemic, we heard from survivors that they received *lifesaving* services and we heard stories of staff going above and beyond to support women. For instance:

"*I love the work that I do, this pandemic happened and I wasn't going to make the pandemic stop me from providing the support that I enjoy providing to women and the kids that need that kind of support because I'm very passionate about what I do. I'm a very, very strong advocate and I don't stop until I feel satisfied."* [Residential frontline participant, P140]

I learned that everything is possible. No matter where are the obstacles. Because it's going to be obstacles in your life always, but you need to go around and work around that. And if you are (pause), how did you call that, like, perseverant? If you have perseverance, you will do whatever you need to do to help or to do your work done. Like do your work and do the best you can. […] I learned that I have to work what I have right now and do the best with that (laughs). You don't have a choice sometimes." [Non-residential frontline participant, P92]

"*From that one-on-one interview with [my VAW support group leader], I got the strength and the courage and actually the confidence to be able to break up finally with – like, for good – with [my abusive partner].*" [Survivor participant, C72]

Some survivors were so positively impacted by VAW workers and services that they told us about how they started volunteering and giving back to those organizations or that they aspire to in the future. For instance, C72 carried out clothing and toy drives for the shelter she stayed at during the pandemic, explaining, ***"Every time I can kind of kick oppression in the butt, so to speak, kick it in the ass and do kindness and give it up to the universe and send out positive vibes and help people, then that's something that I'm able to do."***

In sharing their positive experiences with VAW services during the pandemic, participants often emphasized instances where staff fostered a sense of belonging while also meeting their basic needs. For instance, one survivor participant explained:

"They teach me independency. I had somebody to talk to. Staff was always there 24/7. […] They would literally sit down with me. They will ask me, they're like, 'Do you want to sit down? You want to talk? Do you want to close the door?' So we could actually physically talk. Like, I had some awesome mornings just standing right by the door and like talking to them and I felt more comfortable with the -- if the girls fall asleep, I wasn't scared to go downstairs if I needed to talk to the staff. […] [The organization] actually gave me that support I need. They gave me a little bit more hope 'cause I didn't had to spend money every single day. I could physically cook food for my kids. They really helped me out a lot more." [Survivor participant, C73]

This participant emphasized how critical it was to be given space to share her story and treated as an autonomous person for her healing journey and, likewise, the necessity of human connection when accessing services. This was reflected in other participants' responses as well, including those who had also had negative service access experiences earlier in the pandemic. For instance, regarding a second shelter stay, C77 shared: ***She was treating me with like love. 'Honey,' you know? For me these words are like [a] big thing. And I was so emotional, I wanted to give her a hug. And for long we were, we wanted that thing: somebody treat us, like, with love. And I was crying. I told her my story****."* Human connection was also an essential element for survivors who described the benefits of meaningful peer support during the pandemic. For example:

"They do amazing work and these are the women who -- this organization has kept me alive. […] You're surrounded by women from a variety of different life experiences. And some are newcomers. Some are abuse survivors. Some are addicts. Some are… you just get a beautiful cross-section of women and their lived experience. And it's incredibly rich, and it is not maudlin, and it is full of love and support." [Survivor participant, C74]

"The women in the group are so amazing. […] It's really amazing to see and hear some of these women where they were and where they're going [...] In the end, no matter where I go in my life, I'm going to take back I'm not a victim anymore." [Survivor participant, C76]

These examples show the importance of applying a human-centred, trauma-informed lens to pandemic strategies within VAW systems: where services may be physically distant or guided by infection prevention and control policies, but the establishment of a meaningful therapeutic environment

remains a priority along with the provision of wrap-around supports that meet survivors where they are at (and where they hope to go). When this happened, survivors often made transformative progress in terms of their emotional and, in some cases, socioeconomic wellbeing, including securing housing and seeking out educational or employment opportunities, even amidst pandemic conditions. It is clear that such transformative progress can only be accomplished when VAW organizations have the appropriate funding, training, and intersectoral support. 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.

Conclusion and Next Steps

Our study has demonstrated that VAW organizations in the Toronto Region have had to make dramatic adaptations to their services and practices while managing increasing workloads during the pandemic. In many cases, these significant changes were undertaken with insufficient funding and resources. The changing service context of the pandemic, including services switching from in person to virtual formats, shutting down, or reducing capacity, created unprecedented obstacles to coordination and collaboration on VAW cases and referrals. Many VAW organizations had to implement infection prevention and control policies without sufficient public health support, resources, and guidance. These challenging conditions, along with the personal stress and uncertainty caused by the pandemic, has had harmful impacts on the mental health and wellbeing of the VAW workforce, from frontline to leadership and across residential and non-residential services.

At the same time, the pandemic exacerbated psychological and socioeconomic risk factors for VAW and gave abusers a new means of exerting coercive control, leading to increases in the incidence and severity of violence. Pandemic restrictions created additional complexities for survivors seeking out services, who, in many cases, were sheltering in place with their partners. This environment and, more broadly, contexts of physical isolation, were difficult spaces to navigate and engage with virtual services – especially for those experiencing intersecting forms of marginalization, such as sole caregivers to young children, newcomers, those living with disabilities, and those experiencing multiple forms of abuse. Yet, the sector-wide integration of virtual services also brought new benefits to service delivery, including allowing survivors to access services without having to commute or show their faces, warranting a commitment to a new future of VAW work that includes more hybrid options. Some VAW survivors struggled in residential settings, where reductions in external programming and infection prevention and control protocols led to stress, frustration, and sometimes even further trauma.

Despite the challenges that the COVID-19 pandemic brought, all of our survivor participants who accessed VAW services had meaningful positive experiences to share. In many cases, survivors highlighted the transformative and lifesaving process of being seen and treated as a whole individual, given the opportunity to share their story and learn from others, and provided with the means to meet their basic needs, such as financial and food supports. Likewise, in the face of the many personal and professional obstacles created and perpetuated by the COVID-19 pandemic, many VAW staff were resourceful and resilient, deeply committed to advocating for and meeting the needs of their clients and their teams. It is because of this commitment that many VAW survivors were able to secure housing, create distance from abusive relationships, improve their emotional and mental wellbeing, and begin volunteering with community and VAW organizations to show their appreciation.

This study strove to develop strong partnerships with the VAW sector and women with lived experience of violence. We used recruitment strategies that allowed us to safely and successfully recruit more than 140 VAW staff participants from over 30 organizations in Toronto alone during the pandemic (compared to other Canadian pandemic

studies, which recruited up to 376 VAW staff *across the country*) as well as 10 VAW survivors.[13,18,21] We were committed to capturing the stories of staff and survivors with a diversity of personal and social identities and especially those experiencing different forms of marginalization. For instance, 70% of our survivor participants identified as ethno-racial minorities, compared to the only other pandemic study in Canada to date that interviewed survivors, which included only White participants.[13] Nonetheless, most of our sample identified as heterosexual ciswomen and most survivor participants were economically marginalized. We also found that community-specific organizations and racialized frontline staff tended to face more barriers to participating in this study (e.g., time in their workday) – which speaks, at least in part, to the structural disadvantages that disproportionately impact them.

In light of these limitations, there are nuanced experiences and perspectives within different communities that warrant further study. An important area for future research is how Indigenous VAW organizations and survivors have been impacted by the pandemic, which should be led by Indigenous communities. Our research provides an in-depth snapshot of the experiences of certain VAW staff and survivors in the Greater Toronto Area during the study period (March 2020-September 2021). While not necessarily representative of the whole sector or generalizable to other places or periods of time, our results illustrate important examples of successes and challenges in VAW systems work during the first 18 months of the pandemic that can inform areas for systematic improvement and best practices in this and future public health emergencies.

Our participants told us rich and in-depth stories. Because of them, we have many more important lessons to share on strengthening the VAW systems response during and beyond the COVID-19 pandemic. Some of the next outputs we plan to prepare include:

- **Recommendations for Canada's National Action Plan to Prevent Gender-Based Violence**
- **Virtual service delivery: experiences and lessons learned**
- **PPE, infection and prevention control, and pandemic preparedness: experiences and lessons learned**
- **Monitoring and evaluation practices**
- **Mental health needs among VAW staff and survivors**
- **Hidden homelessness and securing housing for VAW survivors during the COVID-19 pandemic**
- **Study methods: strengthening community-based research in public health emergencies**

We will continue to share our results with the VAW sector and wider community, with the goal of drawing actionable recommendations that im- prove the lives of women experiencing violence and those that support them. In the following section, we outline some of our recommendations for government and policymakers, funders, public health bodies, and VAW organizations based on the results in this report.

Recommendations

Our recommendations were co-developed by the research team and our Advisory Group as well as Toronto Region VAW service partners through our knowledge translation events, meetings, and communications.

For funders:

- Funders, including all levels of government, should provide increased resources and flexible funding to support VAW organizations in: responding to increasing VAW caseloads and survivor needs; expanding provision of structural supports (e.g., flexible hours, pandemic pay); addressing staff mental health needs; and securing equipment access. Funding mechanisms should be sustained and continuous as opposed to project-based or temporary.
- VAW organizations should be funded to train and develop staff capacity on monitoring and evaluation strategies – including survivor-informed methods such as engaging survivors on their programmatic experiences and priorities across different types of VAW services – to support rapidly responding to client needs in this continuously evolving pandemic context.

For Government bodies and policymakers:

- Policymakers should prioritize strengthening VAW referral pathways and intra- and inter-sectoral collaboration, including with health, housing, legal, child welfare, and social protection systems. This should entail funding permanent coordinators who work across different VAW service types and designated VAW advocates based in associated services (e.g., healthcare, social housing, social assistance) to facilitate intra- and inter-sectoral coordination, respectively.
- Further financial and social supports are needed for newcomer women experiencing violence. Policymakers should ensure that there are emergency routes via which newcomer women can be fully supported while awaiting permanent residency status (e.g., in terms of housing and social assistance). VAW organizations and associated services need to be funded to support interpretation and culturally competent programming where needed.
- All levels of government should invest in more affordable and accessible housing in safe neighbourhoods for women experiencing violence, in coordination with VAW and associated services to ensure wrap-around supports are provided as needed. This should include implementing gender-transformative policy on housing and homelessness that prevent women from being evicted from their homes when separating from abusers. City-run homelessness shelters and intake processes should be adapted in consultation with VAW experts (e.g., service providers, advocates, women with lived experience, and researchers) from a diversity of social locations to better account for the needs of women experiencing violence and homelessness.
- Governments should deem VAW services as essential services in public health emergencies and mandate appropriate PPE access and training on PPE use.
- Public health units should work in collaboration with VAW organizations, survivors, and other supported in person and remotely.

For VAW organizations and service partners:

- Organizations should use increased funding and collaborative support to establish sustainable wrap-around services that meet the needs of women facing intersecting marginalization, including 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). This should also include implementing trauma-informed organizational changes, ensuring that staff are appropriately trained in delivering trauma-informed services and have relevant mental health expertise.
- 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-racist, anti-oppressive, and harm reduction principles.
- VAW services should collaborate to identify how to raise community awareness about the different VAW services operating for women fleeing violence.
- Non-residential and residential services should plan for and implement a hybrid approach to their programming, including in-person and virtual programming options where possible to accommodate the diversity of needs and preferences of VAW survivors. In terms of virtual programming, where there is capacity and resources, organizations should consider both phone and video conferencing options. Where only one method is feasible, organizations should consider their clients' needs and preferences (including via formal client needs assessments) around technology use and face-to-face communication balanced against organizational capacity (including internet performance, availability of technology equipment and software, staff digital literacy, and training opportunities).

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Appendix: Further details on study methods

Approach

The MARCO-VAW study was a community-based participatory, mixed-methods study that aimed to build a shared understanding of the challenges and strengths in the response to VAW during the COVID-19 pandemic in Toronto and develop actionable recommendations for funders, governments, and organizations. Our research was grounded in a transformative paradigm, which centres the experiences of people experiencing marginalization and aims to make social and structural changes that reduce social inequities.[35] This lent itself well to our community-based approach, which involved partnering and collaborating with community members affected by the problem of concern at all stages of the research.[36] In our case, community members included both women who have experienced violence and VAW service providers, leaders, and advocates. Our research team included women with lived experience of gender-based violence, VAW and allied organizational representatives, and applied academic researchers. The team was co-led by an academic researcher (Yakubovich) and a community-based researcher (Shastri). We further relied on the guiding expertise of an Advisory Group comprised of VAW leadership from the Toronto Region Violence Against Women Coordinating Committee (VAWCC).

Our approach was guided by principles of intervention science and complexity science.[29,32] In particular, we conceptualized intervention design, evaluation, and implementation as an iterative process and complex interventions like those in the VAW sector as events within complex social systems. This informed the importance we placed in this study on understanding the role of context and the processes underlying the implementation and outcomes of interventions in VAW support systems during the COVID-19 pandemic. Our goal was to use our results to identify strategies that can effectively improve these systems (or 'disrupt systems functioning'), which was benefited by mixed methods and the co-production of knowledge with our community partners.[31,39]

Study design

At the start of the study in summer 2020, we established our community-based team structure and identified and engaged an initial six 'core' VAW organizations in Toronto to serve as key recruitment sites and provide feedback on study priorities, methods, and results. These organizations spanned a diversity of VAW service types (e.g., shelter, counselling, criminal justice, partner assault response). As the study progressed and our partnerships developed, we were able to open study engagement from our six initial core organizations to any organizations providing VAW services across the Toronto Region.

In the first few months of the study, we worked with the Advisory Group and initial core organizations to develop a conceptual framework, or an overall theory of change, of how VAW systems are expected to improve women's lives (Figure A1). This work was guided by existing evidence syntheses and conceptual papers[40-45] as well as the initial literature on COVID-19 and VAW published at that time.[14,18,23] As part of our conceptual framework, shown below, we defined short-term (e.g., improved safety) and long-term goals

(e.g., de-normalization of violence) of VAW programming. We then described the strategies that go into achieving these goals (e.g., safety planning; trauma-informed care) and the contextual factors important to understanding where this work is situated (e.g., sexist and misogynistic norms in society). Finally, we hypothesized the different ways in which the COVID-19 pandemic may have impacted VAW systems (e.g., reduced capacity to run in-person services) and how these altered strategies (e.g., changing service eligibility criteria) and short-term outcomes (e.g., increased difficulty in navigating available services). We used the hypotheses generated in our conceptual framework to inform our data collection materials.

Figure A1. Hypothesized conceptual framework of VAW systems

CONTEXT

- Sexism and misogyny; cultural and societal norms around gender
- Limited funding (federal, provincial, municipal governments; fundraising) and differential funding mechanisms by service type (e.g., shelter; harm reduction services)
- Many intersecting systems involved in VAW (e.g., criminal justice; child protection) with different priorities, training
- Challenges in information sharing and collaboration across VAW organizations and with other sectors
- Tension between and challenges of response versus prevention orientation; challenges in organizing programming with perpetrators
- Challenges of engaging clients outside of urban areas
- Perceived sense of shame in accessing VAW services
- Vicarious trauma among staff

STRATEGIES

Who:

- Full time and part-time in-house staff
- On-call staff
- Volunteers
- Trauma counsellors
- Peer supports
- Managers
- External consultants to support work
- Social workers
- Housing workers

Training:

- Safeguarding of adults and children
- Trauma informed care
- Mental health
- Local available services and resources for referral

Referral/contact strategies:

- Community resources
- Organization/agency referral
- Self referral

Activities:

- Risk assessment and safety planning
- Crisis support
- Emergency shelters
- Transitional housing
- Counselling
- Group support
- Drop-in support
- Leadership/capacity building
- Social supports: e.g., community get-togethers, teas
- Harm reduction services
- Advocacy (e.g., legal, housing)

SHORT-TERM OUTCOMES

Program-related:

- Client satisfaction
- Number of people entering/engaging with service
- Location of people entering/engaging with service
- Level of collaboration with survivors in informing programming
- Women are treated with dignity and respect
- Level of advocacy or collaboration with the multiple systems survivors are or need to be involved with

Client-related:

- Increase in knowledge about available services, rights, and options
- Improved safety (e.g., safe, immediate shelter; learn effective safety strategies)
- Improved coping skills
- Women identify their goals
- Women's immediate needs are met
- Women feel empowered
- Connection with others and decreased feelings of isolation
- Understand experiences and trauma
- Improved knowledge about IPV and healthy relationships
- Increased trust and confidence to discuss concerns with someone else

LONG-TERM VISION

- De-normalization of violence
- Removal of self blame among survivors
- Prevention of family violence and VAW: violence free lives
- Safety and stability for people who have experienced violence
- Empowerment
- Gender equity
- Equitable access to services and resources
- Equitable participation in society
- Justice
- Healthy families
- Safety for perpetrators: opportunities to learn to not use violence and alternative coping strategies
- Women build their own capacity to identify and achieve their goals
- Improved resilience
- Higher quality of life
- Social connectedness
- Improved mental health


CONTEXTUAL FACTORS BROUGHT ON BY COVID-19
• Implementation of public health regulations
• Reduction in shelter capacity
• Inability to run or reduced capacity to run in-person services
• Need for personal protective equipment
• Limited capacity for emergency preparedness
• Limited funding: including funding being devoted to other sectors (e.g., homelessness, healthcare) and not VAW or being reallocated from VAW to other programs
• New funding opportunities emerging with the COVID-19 pandemic
• Challenges in information sharing in a timely manner
• Challenges related to coordinating services due to some teams/staff working remotely
• Challenges in recording changes to services internally (e.g., updating call-in numbers, points of contact)
• Varying levels of collaboration and coordination among different organizations across the sector
• Increased in the prevalence and severity of violence:
• Unemployment, economic insecurity, and sense of frustration: exacerbators of violence
• Anxiety, depression, isolation
• Sheltering in place means many women are isolating with abusive partners
• Lack of privacy becomes all the more challenging
• Women feel even less safe contacting services
• Lack of technological infrastructure for organizations and clients
• Poor mental health among clients and staff (including vicarious trauma for staff)
• Decreased engagement due to fear of exposure to the coronavirus
• Difficulty in connecting women to resources and services when these have closed or have restricted capacity
• No school or external community activities

Changes to CONTEXT (see slide 2)

- Challenges (and opportunities) brought about by the COVID-19 pandemic (slide 3)

Changes to STRATEGIES (see slide 2)

Who:

- Typically a more limited number of the staff and volunteers listed in slide 2
- In many cases, significant reductions in volunteer engagement
- Many working remotely
- Higher staff turnover

Training:

- More frequent supervision with staff because of the severity and complexity of issues arising with clients
- Technology training

Referral/contact strategies:

- Changed eligibility criteria depending on organizational capacity (e.g., focus only on existing clients; focus only on most vulnerable clients; focus only on women not living with abusive partners)

Activities:

- Building technological capacity in organizations
- (Limited) visits of support staff with women in safe places following public health regulations
- Shelter services running at reduced capacity to allow physical distancing
- Hotel support for shelter clients and enhanced partnerships with the city
- Restricting movement of shelter residents as a pandemic precaution
- Virtual engagement and support
- Prioritization of services based on what is essential (e.g., crisis management)
- Updating confidentiality and consent for virtual services
- Transforming group support work to one-on-one support

Changes to SHORT-TERM OUTCOMES (see slide 2)

Program-related:

- Staff mental health (burnout, vicarious trauma, resilience)
- Infrastructure to deliver virtual programming
- Level of coordination and collaboration with other VAW organizations
- Level of integration of VAW services with general homelessness programing (e.g., for hotel space)
- Expanding definition of 'providing safety'
- Increased learning and capacity around use of technology
- Finding a safe place to participate
- Level of coordination of staff on a case (including those working remotely)
- Opportunities for group support/sharing
- Feasibility for clients to access virtual services
- Confidentiality of conversations
- Capacity of organizations with limited staff/public health regulations
- Modified safeguarding due to higher client vulnerability
- Modified safety plans due to closures and quarantine restrictions
- More frequent engagement
- Waitlist demand

Client-related:

- Client progress stalled or reversed due to arising challenges (e.g., isolation, lack of control, anxieties)
- Increase in multiple and intersecting complexities: impacts of violence and impacts of COVID-19 (e.g., income loss, social isolation, mental health, economic insecurity)
- Lower sense of power for shelter residents due to pandemic restrictions
- Level of emotional and financial support (e.g., food vouchers) felt by clients (e.g., in some cases, enhanced gratitude for not being abandoned)
- Increased difficulty in navigating available services and resources

LONG-TERM VISION

- De-normalization of violence
- Removal of self blame among survivors
- Prevention of family violence and VAW: violence free lives
- Safety and stability for people who have experienced violence
- Empowerment
- Gender equity
- Equitable access to services and resources
- Equitable participation in society
- Justice
- Healthy families
- Safety for perpetrators: opportunities to learn to not use violence and alternative coping strategies
- Women build their own capacity to identify and achieve their goals
- Improved resilience
- Higher quality of life
- Social connectedness
- Improved mental health

We implemented an explanatory sequential mixed-methods study design (with each stage of data collection informing the next) that prioritized the qualitative strand of the study (quantàQUAL) to answer our three research questions.[46] We collected data in four stages shown in figure A2. Each stage of data collection was designed with reference to our conceptual framework; feedback from the research team and Advisory Group; and, in the case of the focus group and interviews, the aim of explaining and expanding upon our survey results. As shown in figure 2, knowledge translation (KT) was integrated throughout the study, with, to date, four VAW sector-wide and two intersectoral KT webinars along with regular KT meetings with relevant knowledge users (e.g., funders, VAW networks).

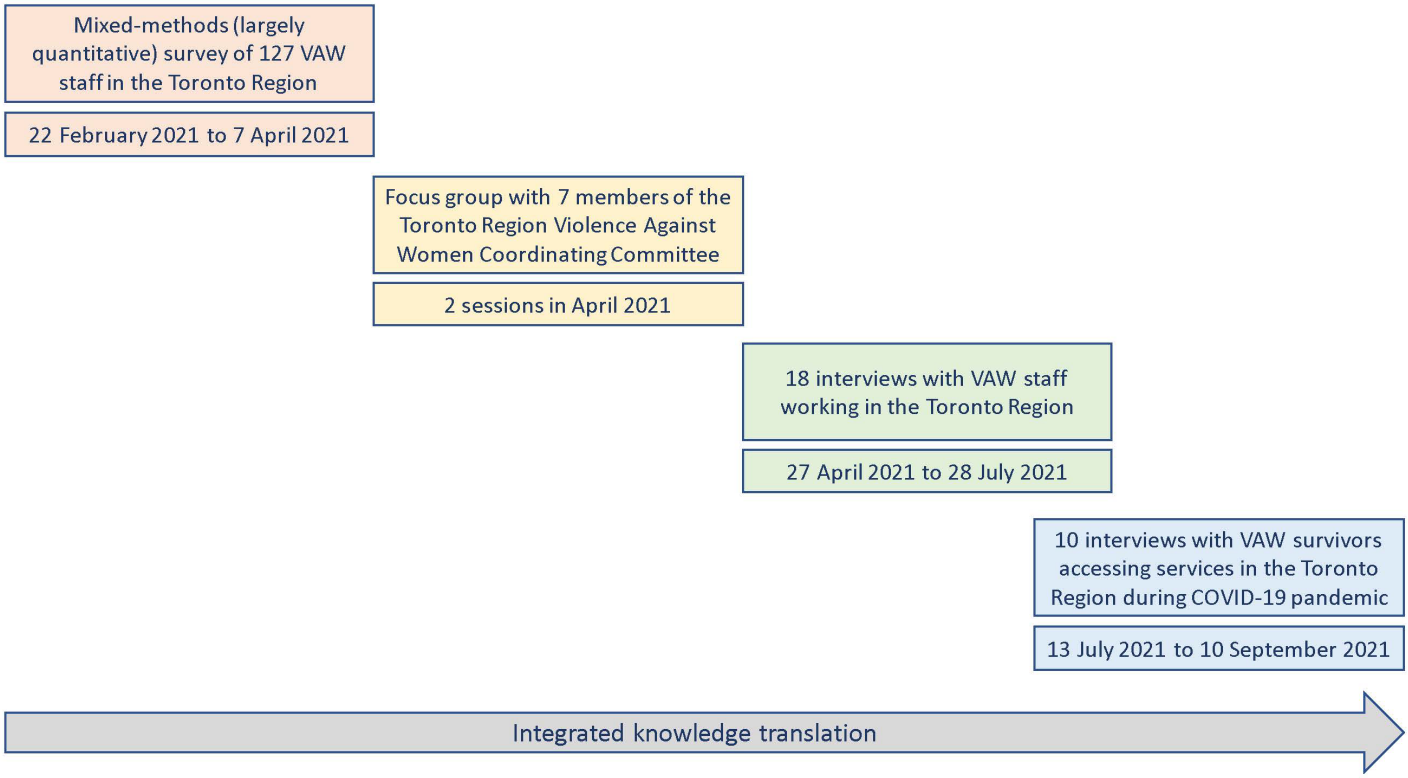

Figure A2. MARCO VAW mixed-methods design for data collection.

A central component of our study was partnering with women with lived experience of violence. We hired three women with lived experience of gender-based violence to work as part of our research team on all aspects of the study (design, recruitment methods, data collection, data analysis, results interpretation, and preparation of KT materials). Our hiring criteria were based on relevant lived experience, communication skills, commitment to working to ending VAW, commitment to creating an inclusive and safe space for participants, relevant or translatable experience for research, and interest in developing new skills. Peer researchers were supported by a VAW organization (WomanACT) and the study co-leads, who led several workshops on VAW research methods and qualitative data collection and analysis; the co-leads also held regular check-ins with the peer researchers throughout the study. Peer researchers on the MARCO-VAW team further received broader orientations to research and methods alongside other peer researchers as part of the overall MARCO study.

The majority of our interviews were conducted by peer researchers partnered with a study co-lead (Yakubovich or Shastri). Three out of five interviewers participated in data analysis and all interviewers provided feedback on results interpretation and participated in KT activities. These strategies strengthened the co-production of knowledge in this study, including our ability to integrate varied perspectives in our data collection and analysis, and allowed us to develop greater familiarity with our data for more in-depth analysis.[47]

Recruitment and Data collection

VAW service providers and survivors are a hard-to-reach population, the latter of whom are also especially vulnerable, particularly during pandemic conditions.[32,34,48] We relied on our partnerships and networks to facilitate the recruitment of participants.

Staff survey

We distributed our survey (hosted on REDCap) through our six core VAW organizations and VAW networks in the Toronto Region, including those funded by the Ministry of Children, Community, and Social Services (MCCSS). Staff received a $10 honorarium for participating in the survey. The survey was open to all frontline and leadership staff who had been working since 11 March 2020 at an organization with at least one VAW service in the Toronto Region serving women-identified clients experiencing violence. Survey participants had to be 18 years old or older, able to speak and read English comfortably, and able to provide informed consent. Figure A3 summarizes the content of the survey for frontline and leadership participants.

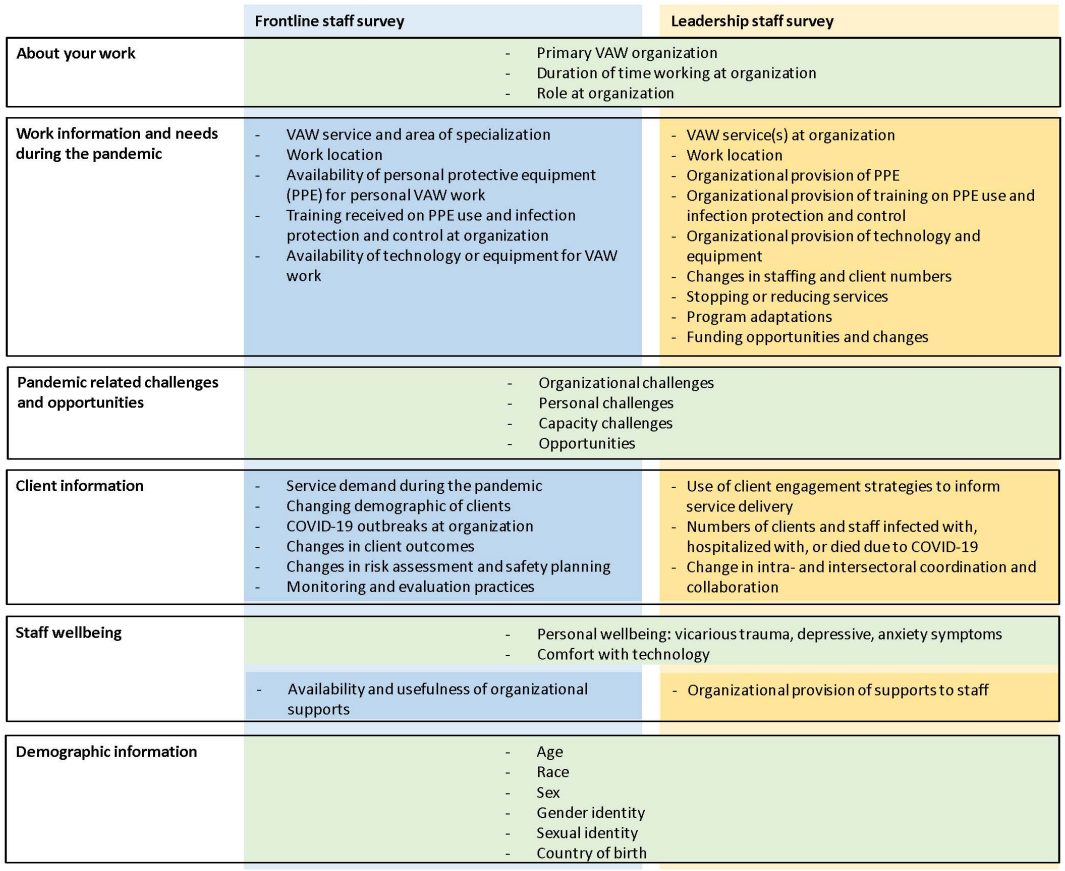

Figure A3. Summary of the survey for frontline and leadership participants.

Note. At the start of the survey, participants indicated whether they were currently in a leadership (i.e., executive director, director, manager, or supervisor) or direct service role. Leadership and frontline participants subsequently completed targeted versions of the survey: the blue panel indicates topics that only frontline participants answered, the yellow panel indicates topics that only leadership participants answered, while the green boxes are topics that all staff participants answered. In general, leadership had more questions around organizational-level resources, capacity, and staffing, whereas frontline had more questions around personal access to resources and client experiences. The survey consisted of 6 sections in total. The median time (i.e., middle of all values) to complete the survey was 25 minutes for frontline participants (interquartile range [IQR]: 15 minutes [25th percentile] to 37 minutes [75th percentile]) and 21 minutes for leadership (IQR: 14 to 27 minutes).

Staff interviews

We conducted staff interviews with a nested subset of the survey sample (who indicated they would be like to be contacted and were offered an additional honorarium of $40). We purposively selected participants based on personal identities and social locations (e.g., ethno-racial identity, age, language, caregiver status), types of VAW services where participants worked (e.g., healthcare, shelter, counselling, housing, legal), and the populations typically served (i.e., generalist or targeted to specific communities). We found that in our subsample of staff participants willing to be interviewed, there was limited representation of different ethno-racial identities and community-specific organizations represented. Therefore, we also recruited four additional participants recruited through the support of VAW networks. At the end of their interviews, these four participants completed the staff wellbeing and demographic sections of the survey so we could better describe our full interview sample. The goal of staff interviews was to explain and expand upon our survey findings. Interviews were semi-structured to allow the interviewer(s) space to explore areas of greatest interest and relevance with each participant. The interview guides were specific to frontline and leadership participants but covered the same nine topics (table A1). Staff interviews ranged from 65 minutes to 115 minutes and were recorded over Zoom. Prior to the interview, participants provided informed consent over email using the study's consent form. We transcribed interviews using Trint (trint.com); two members of the research team double checked each transcript for accuracy and removed identifying information (including participant and organization names).

Table A1. Summary of staff interview guides

Topic	Frontline participant: example prompts	Leadership participant: example prompts
Role in VAW organization	What VAW services or programs do you work on?	What VAW programs and services does your organization provide? Which do you manage?
Program adaptation	What did the process of adapting the VAW service you work on look like during the pandemic?	What did the process of adapting your organization's VAW services look like during the pandemic?
Challenges in VAW work during the pandemic	How have client concerns around the pandemic impacted your VAW work?	How have client concerns around COVID-19 impacted your organization's VAW work?
Client reach and demographics	In what ways have the VAW client groups you're supporting changed during the pandemic?	In what ways have the VAW client groups that your organization is supporting changed during the pandemic?
Monitoring and evaluation	How do you define your clients' progress?	How does your organization define VAW clients' progress?
Staff management	How have staffing changes affected your VAW work during the pandemic?	How did staffing at your organization change during the pandemic? How did this affect your organization's VAW work?
Mental health and wellbeing	On a personal level, what has been your experience in conducting VAW work during the pandemic?	In our survey, leadership reported very high levels of personal distress and vicarious trauma as a result of their work. Why do you think we are seeing these results?
Infection prevention and control protocols	What has your experience with PPE for your VAW work been like during the pandemic?	Can you describe your organization's experience with PPE and infection control during the pandemic?
Contextual factors	In what ways has collaborating or corresponding with other workers in the VAW sector informed your VAW work during the pandemic?	In what ways has collaborating or corresponding with other organizations in the VAW sector informed your VAW work during the pandemic?

Note. Interviews were semi-structured. Not all questions in the interview guide were answered in all interviews or in the same order and some questions asked in interviews were not on the interview guide.

Survivor interviews

We recruited participants for survivor interviews via staff contacts in our collaborating networks, aiming to purposively recruit a sample that was diverse in terms of personal factors and services accessed. VAW survivors were eligible to participate in interviews if they had used at least one service for women experiencing violence or abuse at an organization in the Toronto Region since March 11, 2020, were at least 18 years old, and were able to provide informed consent. With the support of staff, we also ensured that additional ethical criteria were met, including that survivors were in a physically and mentally safe space to participate, determined through staff and interviewer safety checks.[32,34,35] We used interpretation services to interview interviews and were also semi-structured (table A2). In general, survivor interviews tended to be more narrative in nature as compared to staff interviews, and often delved into participants' life histories that provided context for their experiences during the pandemic. Survivor interviews ranged from 90 to 150 minutes. At the end of their interviews, survivor participants completed the demographic portion of the staff survey with three additional questions on education, employment status, and income. As with staff, survivors provided their consent prior to the interviews over email and received an honorarium of $40 for participating. Survivor participants also received a list of VAW mental health resources and contact information. Interviews were again recorded on Zoom, transcribed using Trint, and double checked and anonymized by two members of the research team.

Table A2. Summary of survivor interview guides

Topic	Example prompt
About you	Can you tell me a little bit about your day to day?
Impact of the pandemic	How has your life changed during the pandemic?
Experiences of violence	Can you tell me about your most recent relationship where there was violence or abuse?
Service access and outcomes	Related to the abuse or violence you experienced, where did you seek help in Toronto? What were your experiences like in accessing these services?
Contextual factors	During the pandemic, were there other issues happening in the world or your community that impacted you on a personal level (e.g., Black Lives Matter, COVID-19 related protests, anti-Asian racism, anti-Black racism, politics, recession)?
Closing	Thank you for answering my questions. We are at the end of the interview and we've talked about difficult things today. How has talking about these things made you feel?

Note. Interviews were semi-structured. Not all questions in the interview guide were answered in all interviews or in the same order and some questions asked in interviews were not on the interview guide.

Analysis

One study co-lead (Yakubovich) descriptively analyzed the survey data with feedback provided first from the research team, followed by the Advisory Group, and finally through KT events with the Toronto Region VAW sector and intersectoral audiences as well as core organizational partners. A subcommittee of four members of the research team (co-lead Yakubovich, two other study interviewers, and a PhD trainee) collaborated on the qualitative data analysis. Analysis is currently ongoing and operates from a reflexive thematic methodology, which recognizes and embraces the subjectivity of researchers, encourages the use of deductive and inductive coding practices as relevant, and emphasizes the need for iterative and in-depth engagement with the data.[47,49] This approach to thematic analysis conceptualizes a 'theme' as a pattern of ideas within a dataset that is meaningful to the research question(s) (i.e., it captures different facets of a 'central organizing concept'). Researchers generate these themes by analyzing coded excerpts of data.

We used Dedoose to support collaborative data analysis. First, the analysis team coded the same two staff interview transcripts and met to discuss initial codes. The goal of this exercise was to incorporate the diverse perspectives of each analyst to develop initial priorities for coding across interviews in reference to our research questions and highlight aspects of the data to be mindful of. Each analyst was then assigned a subset of the dataset for coding, using and building upon this initial codebook. Analysts met regularly to discuss the coding process and new features and patterns that they were noticing in the data and shared their observations with the

wider research team for feedback. Once all the data were initially coded, each analyst was assigned a portion of the data to double code. The goal again was to incorporate diverse perspectives and identify where people disagreed with coding or saw opportunities for additional codes. The team met regularly to resolve discrepancies (often by expanding meanings of codes or creating new codes) and further develop the codebook. After the initial double coding of staff interview data, the analysis team repeated the same process for the survivor interview data. This time, however, after the initial simultaneous coding of two transcripts, the team refined or added codes based on the staff interview codes to facilitate comparisons across these two datasets and continued to do throughout the coding process.

The lead author (Yakubovich) then read through each code to develop an initial summary of the most salient data for our research questions, which was then shared with the analysis team for their input. The broader research team, our Advisory Group, and VAW sector stakeholders subsequently provided their feedback through meetings and KT events. We selected quotations for this report to support our analysis and included anonymized participant identification numbers to locate and demonstrate the scope of the data used in our analysis. Where relevant, we also provided relevant contextual information (e.g., whether a quote is from a leadership, frontline, or survivor participant). In this report, we focused on summarizing the initial outputs of our analytic work that are most meaningful to our three primary research questions. The final section of this report outlined our next steps, including some of our planned future outputs.

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