COVID-19 PANDEMIC GUIDELINES FOR MENTAL HEALTH SUPPORT OF RACIALIZED WOMEN AT RISK OF GENDER-BASED VIOLENCE

INITIAL KNOWLEDGE SYNTHESIS REPORT (22 June 2020)

Project Title: COVID-19 pandemic guidelines for mental health support of racialized women at risk of gender-based violence

Multidisciplinary Team: Nazilla Khanlou (*PI*) and Andrew Ssawe (*Principal Knowledge User*) with *Co-Investigators*: Yvonne Bohr, Jennifer Connolly, Iris Epstein, Thumeka Mgwigwi, Soheila Pashang, and *Collaborators*: Farah Ahmad, Negar Alamdar and Sajedeh Zahraei

Project Coordinator: Luz Maria Vazquez

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Knowledge User
Nira Elgueta, Ontario Council of Agencies Serving Immigrants

Collaborator
Suzanne Tinglin, School of Nursing, Faculty of Health, York University

Research Volunteers
Amirtha Karunakaran, Office of Women's Health Research Chair in Mental Health, York University
Sheena Madzima, Office of Women's Health Research Chair in Mental Health, York University

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Contact

Nazilla Khanlou, RN, PhD
Women's Health Research Chair in Mental Health, Faculty of Health
Academic Lead, Lillian Meighen Wright Foundation Maternal Child Health Scholars Program
Associate Professor, School of Nursing
Editor-in-Chief, INYI Journal https://inyi.journals.yorku.ca/
York University, HNES 3rd floor
4700 Keele Street
Toronto, ON, Canada, M3J 1P3

Tel: 416 736 2100, ext. 20166
Fax: 416 736 5714
E-mail: nkhanlou@yorku.ca
Twitter: https://twitter.com/YorkUOWHC
https://twitter.com/NazillaKhanlou
Website: https://nkhanlou.info.yorku.ca/

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ACRONYMS

The following is a list of acronyms that we cite in our review from key international organizations.

Name of organization	Acronym
European Institute for Gender Equality	EIGE
Inter-Parliamentary Union	IPU
International Agency Standing Committee	IASC
National Commission for Lebanese Women	NCLW
United Nations Children's Fund	UNICEF
United Nations Development Programme	UNDP
United Nations Population Fund	UNFPA
United Nations Women	UN Women

SUMMARY OF EMERGING PUBLIC MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT GUIDELINES: MACRO, MESO, AND MICRO LEVELS

Area	Guidelines
Macro level	
Approaches and frameworks to policy responses	✓ Integrate gender-responsive programming to COVID-19 responses ✓ Apply intersectional, human rights and community-based and participatory approaches to emergency health responses ✓ Ensure that COVID-19 policy frameworks integrate women's safety approaches into their multisectoral strategic responses ✓ Provide safety principles (e.g. safe mobility measures) should be integrated in the responses
Decision-making	✓ Ensure meaningful participation of women and girls, and that of their organizations, in decision-making processes - plan development, implementation and monitor, recovery plans, longer-term solutions to address GBV during and after COVID-19 ✓ Promote women and girls' leadership and representation in national, provincial and local and community level COVID-19 policy spaces
Data Collection	✓ Follow the United Nation (UN) guiding principles and recommendations for data collection to ensure women and girls' safety. Principles must be informed by the socio-economic and environmental realities of women and girls. Produce disaggregate data - race, gender, sex, ethnicity
Funding	✓ Increase dedicated funding for specialized services and supports, including essential social determinants of health - income supports, housing, child-care, food security
Meso level	
Service provision	✓ As per WHO's guidelines, ensure services for women and girls are a priority and considered essential in the context of the COVID-19 response. ✓ Ensure that these services remain open, accessible, inclusive, and are well-funded ✓ Expand access points to mental health services ✓ Apply holistic survivor-centred principles and trauma-centred supports to service provision ✓ Prevent racism and discriminatory practices in service provision ✓ Adapt and strengthen online supports, helplines, online counselling and technology-based solutions ✓ Apply media safeguards to online supports ✓ Address barriers and the digital divide to access remote services ✓ Promote cultural safety models to service provision ✓ Strength women and girls' safety nets -health coverage, basic income, housing, childcare
Capacity building	✓ Increase awareness and training on GBV across systems – health, social, education, protection, security, justice ✓ Promote mechanisms to enhance GBV capacities of frontline workers – healthcare providers, law enforcement and court officials, etc. – including online and hybrid education training ✓ Promote capacity building, and training. More inclusion of racialized populations in the health care system
Micro level	
Awareness, sensitization and advocacy	✓ Ensure campaigns to raise awareness among service providers – health, justice - and to sensitize the population. Need a stronger integration of race and intersections with gender, immigration status, income/poverty ✓ Support advocacy efforts from racialized women, grassroots organizations and initiatives, cross-sectoral collaborations in advocacy and campaigns ✓ Engage community "gatekeepers"

INTRODUCTION

Global statistics reveal a drastic increase in violence against women during the COVID-19 pandemic. The United Nations has referred to this alarming societal problem as the "shadow pandemic" (UN Women, 2020e). Fear, uncertainties and stressors among the population during the pandemic contribute to anger and aggression against women and female partners (IASC, 2020a). In the 12 months previous to the COVID-19 pandemic, 243 million women and girls (aged 15-49) around the world were subjected to sexual and/or physical violence (UN Women, 2020e). Worldwide, gender-based violence (GBV) affects 30–60% of women, impacting their mental, physical, and sexual health (Dunkle & Decker, 2013). Violence against women contributes to high levels of morbidity and mortality (Rees et al., 2011). It is associated with life-long impacts related to psychological distress and mental health concerns including anxiety disorders (post-traumatic stress disorder), depression, and substance use disorders (Gevers & Dartnall, 2014; Tol et al., 2013). Studies find higher rates of past suicide attempts (Rees et al., 2011) and social exclusion and isolation among women (Tol et al. 2013). Experts report that experiences from previous epidemics show women's physical, psychological and time burdens increase during health emergencies (IASC, 2020b). This is because the measures that governments implement to control the spread of the disease, such as social distancing and reduced community interactions, restriction of movement and closure of services, increase GBV risks by limiting women's ability to distance from their abusers and to access the supports they need (IASC, 2020b; WHO, 2020b).

The COVID-19 pandemic has worsened the violence against women and girls; worldwide warnings are raised on the increasing domestic violence during the crisis (UN Women, 2020e; WHO, 2020a). In Canada, community agencies have reported on the types of violence perpetrated against women, including the power control tactics that perpetrators use, such as withholding health cards, access to information (radio, news, phones), communication with their children and other immediate family members, and soaps and sanitizers (TVO, 2020). Victimization from trafficking is also highly related to financial insecurity (such as during a pandemic), and sex trafficking is an extreme form of GBV. As finances dry up, girls and women with precarious status become vulnerable to trading sex for survival. The COVID- 19 pandemic create a disruption in service, funding and delivery, ultimately compromising the care, support (physical, mental) and connections the survivors rely on (UN Women, 2020e). The United Nations Secretary-General has asked for the prevention and rectification of violence against women as a crucial part of all governments' national response plans for COVID-19 (UN Women, 2020e). Growing evidence also indicates that racialized groups are especially at higher risk of COVID-19 related morbidity and mortality (Eligon, et al, 2020; Keung, 2020; Morrison, 2020). Taken together, racialized women at risk of GBV are a priority group to focus on for immediate mental health support and care during the pandemic.

Our project's overall goal is to advance trauma-informed mental health care for racialized women at risk of GBV during the COVID-19 pandemic response and recovery phases. The CIHR priority populations considered in our proposal are: i) women and girls at risk of domestic or intimate partner violence, and ii) racialized individuals who have less social support structures and lower economic stability. Our objectives are to:

1) Conduct a rapid review to critically assess the state of knowledge on: a) the racialized and gendered social determinants of mental health among women and girls exposed to GBV

during the COVID-19 pandemic, and b) the emerging promising practices for detection, referral, and service provision for equity informed mental health promotion and care;

2) Identify knowledge strengths and gaps, applicability and transferability of findings and emerging public mental health and psychosocial support guidelines; and

3) Engage in gender-specific knowledge exchange and mobilization.

METHODS

To conduct our rapid review we applied the Cochrane Rapid Reviews method (Cochrane, 2020; Ganann, Ciliska, & Thomas, 2010). The process included the following six steps:

Step 1. Setting the Research Question. We identified the research questions as follow: "What are the racialized and gendered social determinants of the mental health among racialized women and girls with experiences of GBV?"; and "What are the emerging best practice/evidence of effectiveness of services or implementation for equity-informed mental health promotion and health care provision for this population during the current COVID-19 pandemic?"

Step 2. Identifying Criteria for considering studies - PICO. PICO refers to population, intervention, comparators, and outcomes. *P*opulation: inclusion criteria included a) women and/ or girls at risk of GBV, and b) 15 years and older. *I*ntervention: studies assessing GBV and mental health outcomes, interventions, initiatives, during the COVID-19 pandemic. *O*utcomes: We identified emerging guidelines. We did not apply the *C*omparators criteria because we conducted qualitative synthesis.

Step 3. Searching methods for identification of studies. We included all study designs (qualitative, quantitative, mixed methods). Searches were conducted across 4 electronic databases: 1) Cochrane CENTRAL, 2) Medline, 3) ProQuest (PsycInfo, Sociological Abstracts, Women's Studies International), and 4) EBSCO (CINAHL, Social Services Abstracts, Social Work Abstracts). We also examined ongoing/unpublished studies through grey literature searching of websites, including electronic news media, Google Scholar, policy documents, and editorials. We also used the electronic database ProQuest to review grey literature. For peer-reviewed studies we included articles published in English and/or French and/or Spanish language, for all other sources we included material published only in English, between the years 2019 to present. Screening: Standardized title and abstract forms was applied. Abstracts of identified articles were reviewed to assess if they met the inclusion and exclusion criteria. For peer-reviewed literature, two reviewers conducted dual screen of abstracts. One team member screened all titles and abstracts for eligibility and a second reviewer checked all excluded records. Full texts were reviewed by one reviewer and second reviewer checked all excluded studies. The reviewers did not find discrepancies. For grey literature one team member screened all title and abstracts for eligibility. In the PRISMA diagram (Figure 1) we present the search results and the process of selecting the material for this initial rapid review report. Search and keyword strategy were developed by research team members and approved by the study Principal Investigator (Khanlou) and the health sciences librarian and team member (Mgwigwi) (Table 1). In this *Initial Knowledge Synthesis Repor*t, we are reporting on 28 selected sources from a total of 221 search results (see Appendix 1. Description of peer-reviewed selected articles, and Appendix 2. Description of grey literature selected articles). In the following 5 months before the completion of this project, we will expand our review. We have

reached out across our team's networks to gather literature. To this date we have collected a total of 18 peer-reviewed journal articles, and 120 grey literature materials, to be reviewed during the next weeks.

Figure 1. PRISMA diagram - Rapid Review Search Results

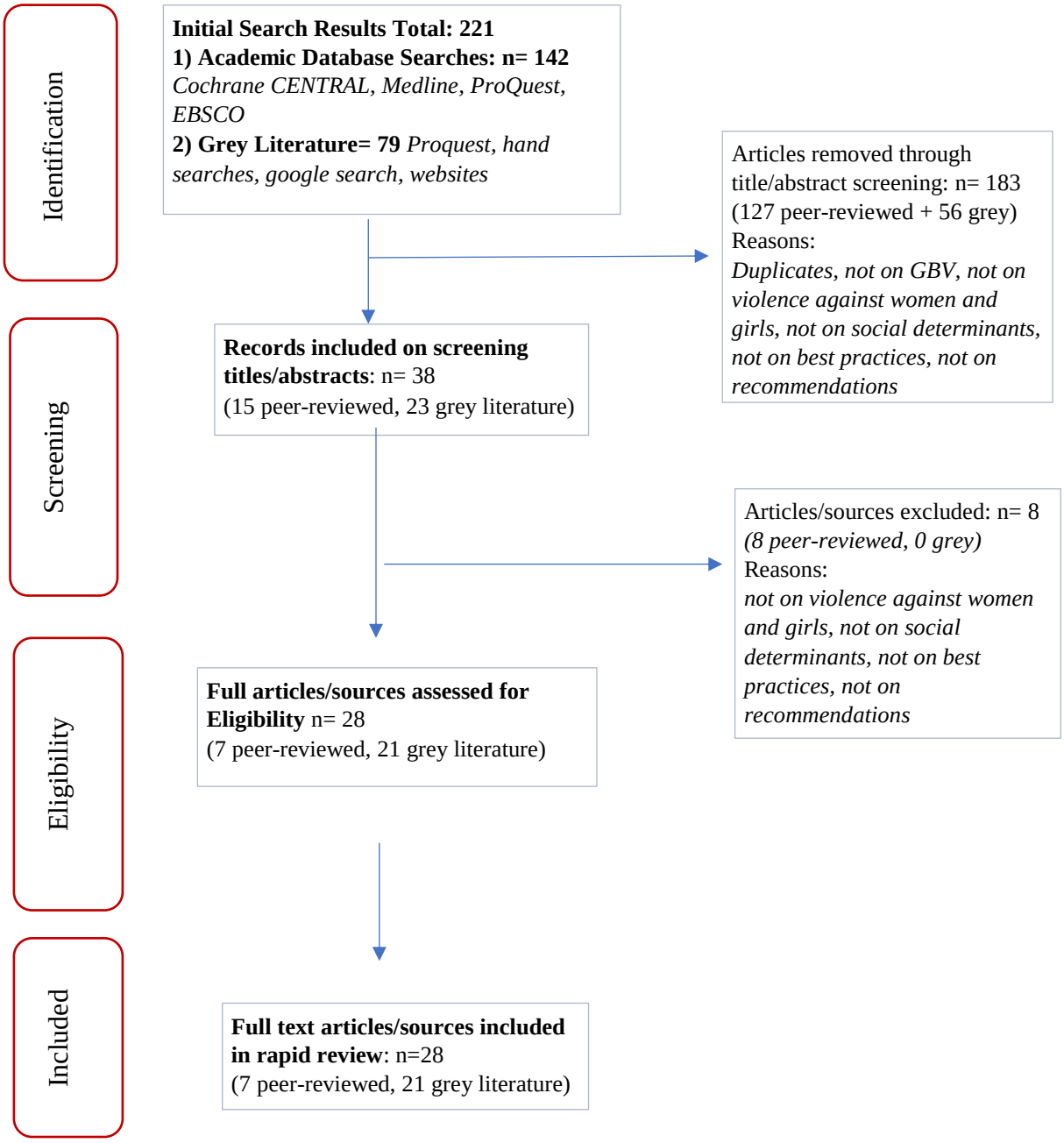


Table 1. Search words

a) women, woman, gender
b) violence, abuse, stress, domestic violence, intimate partner violence
c) health, mental health, wellbeing, well being
d) pandemic, COVID, coronavirus
e) migrant*, immigrant*, precarious status, racial*, race, asia*, latin*, Hispanic, black, African American, indigenous, aboriginal, native, ethnic minority, minority, ethnocultural

Step 4. Data collection. Full text screening was conducted on standard forms, using an Excel sheet to record key characteristics (e.g. date, study design, participant characteristics).
Step 5. Analysis and Synthesis. Emerging review findings were organized applying a systems approach (Bronfrenbenner ecological systems—micro/ meso/macro) (Bronfenbrenner, 1992), and interpreted through an intersectionality-informed lens of identity markers (Crenshaw, 1989; Hankivsky & Cormier, 2011).
Step 6. Applicability and Transferability of Findings. We adapted the international guidelines such as the pyramid of interventions approach, identifying multilevel interventions from the macro (social considerations in basic services and security), meso (strengthening community and family supports and person-to-person non-specialized supports) and the micro level (specialized services), and embedding social and cultural considerations, promoting principles related to human rights and equality, building on existing resources, adopting multi-layered interventions and working with integrated support systems (IASC, 2020b).

Key Concepts

Social Determinants of Health (SDOH) refers to factors and processes that have an impact on the health, mental health and wellbeing of people. Health conditions are related to a large number of social influences including race, aboriginal status, gender, disability, income, education, working conditions, job security, housing, and food security (Mikkonen & Raphael, 2010). These determinants are social "because they are not biologically based, as a characteristic intrinsic to the individuals, but they are socially created, external to the individual, and arise out of inequities existing in society" (Khanlou & Vazquez, 2018, p. 263). Findings on social and physical determinants have produced evidence of inequalities along socio-economic lines, resulting in inequalities in health status (Raphael, 2004). An understanding of social determinants of health and health status enables a more comprehensive understanding of systemic problems that currently exist in the area of health, social justice and human rights.

Violence Against Women (VAW) is defined as "any act of gender-based violence that results in, or is likely to result in, physical, sexual, or mental harm or suffering to women, including threats of such acts, coercion or arbitrary deprivation of liberty, whether occurring in public or in private life" (UN, 1993, p. 2). VAW may include physical, sexual and psychological violence occurring within the family, - battering, sexual abuse of female children, dowry-related violence, marital rape, female genital mutilation, the general community – rape, sexual harassment and intimidation at work, trafficking in women and forced prostitution, and it also includes violence perpetrated by the state (UN, 1993, p. 2).

Gender-Based Violence (GBV) "is violence that is committed against someone based on their gender identity, gender expression or perceived gender" (Status of Women Canada, 2020, para 1). GBV includes a range of human rights violations - rape, domestic violence, sexual assault and harassment, trafficking of women and girls and sexual abuse of children. GBV defies universal definition (Hynes & Lopes, 2004), given its type and nature are interchangeably influenced by women and girls' nationality and citizenship status, geopolitical and environmental conditions, the law and the enforcement of the law, socio-economic and relationship/family status, the

availability of support system and access to resources, health, mental health and [dis]ability as well as other intersecting factors.

Intimate Partner Violence (IPV) "refers to behaviour by an intimate partner or ex-partner that causes physical, sexual or psychological harm, including physical aggression, sexual coercion, psychological abuse and controlling behaviours" (WHO, 2020c, para 2). Violence against women is based on inequality supported by all social institutions. The family is no exception. Violence against women is a symptomatic outcome of patriarchal ideology and patriarchal relations in the family (Lenton, 1995). That is, the traditional ideologies of the family legitimate violence by favouring gender-determined power differentials. The wider patriarchal culture prepares men ideologically to preserve and protect their dominance in the family.

Mental Health. According to World Health Organization, mental health is define as a state of well-being in which anyone realize their own potential to cope with numerous life stressors and be able to productively make a contribution in society (WHO, 2020b). Mental health is inseparable part of ones' health. According to Khanlou and Pilkington (2015), the definition of mental health needs to move away from focus on individual factors to the larger environmental influences affecting women's mental health. Interdisciplinary health researchers have drawn from critical theory in their analyses of the continuing gender differences that disadvantage women's health and mental health and access to care across social groups.

Intersectionality. Intersectionality is an analytical tool for studying, understanding and responding to the ways in which gender intersects with other identity markers – including race, socioeconomic status, dis(ability), sexual orientation, migration status, ethnicity - and how these intersections contribute to unique experiences of oppression and privilege (Crenshaw, 1994). Intersectional analysis allows for the recognition that people live multiple, layered identities derived from social relations, history and the operation of structures of power. It is therefore an approach for development and human rights work, and to promote a social justice action agenda.

Trauma-Informed Care is conceptualized as an organizational change process centered on principles intended to promote healing and reduce the risk of re-traumatization for vulnerable individuals (Wolf et al., 2014). The literature indicates a growing interest in trauma-informed care among service providers, researchers, and government agencies, with this interest focusing on direct service settings. Policy in the trauma-informed care literature is usually discussed only at the institutional level, for example in terms of ensuring that an agency's policies and procedures adequately promote clients' confidentiality and safety (Bowen & Murshid, 2016)

Findings

1. The racialized and gendered social determinants of mental health among women exposed to GBV during the COVID-19 pandemic

We are mindful of simultaneous pandemics that have long existed but have come to public attention most recently, the pandemic of systemic racism and the pandemic of gender-based violence that continue to characterize society. Structural socioeconomic and health inequalities attributed to systemic racism explains the disproportionately impacts that the COVID-19 pandemic is having on racialized populations (Enekwechi, Hardeman, & Powell, 2020).

Women are experiencing the COVID-19 pandemic very different from men, evidencing the historic gender disadvantages women and girls have in society (UNFPA, 2020a). There are multipe social determinants that are placing women and girls at a disadvantage during the current pandemic. The UN recognizes that women are more vulnerable to shocks for two main reasons: first, they are more likely than men to work in informal and precarious jobs, and second, they carry on most of the unpaid caregiving work at home (UNFPA, 2020a). Given their marginality, women will experience the economic downturn disproportionately (IPU, 2020). A key factor determining increasing risks and vulnerability to COVID-19 is the fact that women are frontline providers, representing 70% of the health and social care workforce provided around the world (UNICEF, 2020). The literature highlights the racialized and gendered nature of those who are deemed essential frontline workers (nurses, social workers, cashiers) working in frontlines in grocery stores and pharmacies, which put them at higher risks (IPU, 2020).

Associated **risk** factors found in our synthesis that increase the vulnerability of women and girls to violence during the pandemic include economic distress (e.g. unemployment), household stress, social isolation, shelter-in-place, parental stress, substance misuse, psychological distress contributes to violence against women (Onyango, 2020; Roush, 2020). According to Roesch et al. (2020), the sense of distance and dislocation, and more importantly the uncertainty of family income and the disruption of work are risk factors. This stress is heightened or compounded with the anxieties that accompany an inability to secure even the most basic subsistence needs and services.

Racism is a fundamental risk factor. Racialized members of society bear a disproportionate burden of stress, illness and health inequities. Alarming rates of COVID-19 infections and deaths amongst Black Americans, and overall disproportionate impacts on people from ethnic minority backgrounds illustrate health inequalities and the result of structural racism (Enekwechi, Hardeman, & Powell, 2020). Racialized populations are the hardest hit in this pandemic due to social determinants including poverty, inequitable access to medical care or health advice, inadequate housing, precarious employment, that increase their vulnerability to COVID-19 (Enekwechi, Hardeman, & Powell, 2020). Racism, however, is universal and equally felt in other sectors. Fraser's (2020) notes the increased risk of racial and sexual harassment (online and offline), of targeted sexualised attacks against women of East Asian ancestry. From the blaming of Chinese Canadians, especially restaurant owners, as guilty of transmitting the virus to refusing to hire East-Asian looking Uber drivers (Gopal & Adesara,

2020). Systemic racism with its accompanying discrimination and stigma contribute to barriers in accessing sexual and reproductive health care for racialized women (Hall et al., 2020). Research shows the negative impacts of racialized violence against black individuals and the health system. For example, studies have found that people who have experienced racism and/or who have been mistreated by the police are more likely to have a mistrust of health institutions. Having a mistrust in health institutions lead to delays in COVID-19 screening and other negative outcomes for racialized populations (Enekwechi, Hardeman, & Powell, 2020).

Related to racism is the dynamics of power relations. For Hall et al. (2020), the recognition of inequitable power structures, the unequal distribution of resources and a much needed mobilization of collaborative engagement are long overdue. Indeed, the COVID -19 pandemic cannot be exploited to restrict access to essential sexual and reproductive health services, particularly abortion, and targets immigrants and adolescents (Hall et al., 2020). Women typically do not occupy positions of power compared to their male counterparts. Decision making during the virus outbreak about women's general needs and health, including sexual and reproductive health, are consequently overlooked (UNFPA, 2020a).

The United Nations (UN) reports that pandemics like COVID-19 exacerbate not only violence within the home, but other forms of violence against women and girls. Workplace violence has increased as a result of the pandemic, for example against female healthcare workers in China, Italy and Singapore (Fraser, 2020; UN Women, 2020d). Fraser (2020) reports that prior to the COVID-19 pandemic, research reported that violence is mainly perpetrated against female nurses in isolated spaces at patients' homes, emergency departments, and in geriatric and psychiatric departments. Risks of abuse and exploitation increased for vulnerable women workers. In the United States for example, Fraser (2020) found reports of increased violence directed at street-based sex workers (Fraser, 2020). Victims of sex trafficking are among the most vulnerable and marginalized groups at risk.

In past humanitarian crises, families have experienced a drastic reduction in family services. Previous emergencies show reduced access to services – e.g. abortion, HIV, GBV, mental health – which resulted in "increased rates and sequelae from unintended pregnancies, unsafe abortions, sexually transmitted infections… post-traumatic stress disorder, depression, suicide, intimate partner violence, and maternal and infant mortality" (Hall et al., 2020, p. 1176). The Ebola outbreak in West Africa showed the disproportionate impacts that diversion of funding for essential services have on women and girls; for example, in Sierra Leone more women died of obstetric complications than of the virus itself (IPU, 2020; UNDP, 2020). More broadly disruptions in service provision are felt disproportionately by families who have no or very limited health care insurance and for people on low incomes, locally and globally (Hall et al., 2020; IPU, 2020). UNICEF (2020) notes that life-saving care and support services to GBV survivors including clinical management of rape, mental health services and psycho-social support, are disrupted in tertiary level hospitals given that health service providers are overburdened and preoccupied with handling COVID-19 cases. Hall et al. (2020) note that international responses to COVID-19 are perpetuating a disregard for sexual and reproductive

health and contributing to justice inequities that impact negatively on the health, wellbeing, and economic stability of women, girls, and vulnerable populations in general.

2. Emerging recommendations and best practices for detection, referral, and service provision for equity informed mental health promotion and care

The findings from the literature review on emerging recommendations are thematically presented in terms of three levels: from the individual, psychological and situational (micro) perspective; the institutional, organizational and agency-based (meso) perspective; and the structural, systemic (macro) perspective. We are presenting the findings from macro to meso to micro levels as we believe this is more in line with an upstream approach to public mental health support, but also recognizing their contextual fluidity. These themes are inter-related and influence each other, as per an ecosystemic interpretation of influences.

1) Macro level - Gender and intersectional, human rights and community approaches to policies and programming

The integration of ***gender-responsive programming*** into countries' strategic plans for COVID-19 preparedness and response is recommended (John et al., 2020; UNICEF, 2020; UN Women, 2020a). Strategies should take into consideration gendered roles and dynamics, and responsibilities (IPU, 2020; UNICEF, 2020). By integrating a gender lens, we may be able to consider invisible issues such as the burden of paid and unpaid care work for women during the health emergency, and the GBV risks, into planning and response programming (UNICEF 2020). According to the IPU (2020), by applying a gender lens we are able to oversee governments' responses to the health emergency by asking whether these interventions ensure that women and girls have access to protection, resources and shelters as essential services; what is being done to curb the impact of the outbreak on support services for survivors, particularly health-care, police and justice services; how specific actions to protect women survivors of violence have been adapted and included in the emergency measures; about the codes of conduct in place to address the endemic violence against female health workers and sexual harassment in the health and social sectors; and finally, about measures to protect girls at risk of sexual violence in the context of schools closures (IPU, 2020, p. 4).

There are also calls to integrate ***intersectional, human rights, and community-based approaches*** to emergency health responses, in order to address unique and "complex health and social adversities for women, girls, and vulnerable populations" (Hall et al 2020, p. 1176). The United Nations highlights the need to ensure that COVID-19 measures "uphold international human rights standards and that civic spaces for civil society, including human rights defenders, are protected" (UNDP, 2020, p. 2). An intersectional approach will ensure policies and interventions response focus on women and girls' specific needs. This is an important step towards the recognition of the differentiated primary and secondary effects of the health emergency on people living in poverty, persons with disabilities, indigenous people, internally displaced persons, immigrants, refugees, LGBTIQ individuals, and others who face intersecting and multiple forms of discrimination (UNFPA, 2020b). An ***intersectoral*** approach to the COVID-19 response will allow us to identify who "are at heightened risk of different forms of GBV and understand how these may vary across settings" (Fraser, 2020, p. 4) or across other

identity markers such as socioeconomic status, race, ethnicity, migration status, among others. Finally, researchers highlight the need to apply a sexual and reproductive health and justice framework to the COVID-19 impacts and response so we can monitor and address the inequitable gender, health, and social effects of the pandemic in specific sectors of the population (Hall et al, 2020). These approaches look at the human rights dimensions and recognize the existence of intersecting injustices and power structures across identities.

2) Macro level - Policies and protections need to include women's safety approaches and put women and girls at the center of the COVID-19 response

It is necessary to ensure that COVID-19 policy frameworks integrate women's safety approaches into their strategic responses. State policies should recognize that lockdown measures increase women's vulnerabilities, that social distancing at the home may not be a safe place for women and girls (UNFPA, 2020b), therefore, protection of women and girls from the beginning of an emergency crisis should be in place (Onyango, 2020). Violence against women, in all its forms, should be seen as a priority and integrated in national and sub-national COVID-19 response plans (EIGE, 2020; UNDP, 2020). Risks of violence against women must be assessed, monitored, and addressed as an integral part of the COVID-19 responses (Siangyen, 2020). Examples of this may be to give high priority to incidents of violence against women and girls by police and judicial institutions in the context of the pandemic. ***Safety principles*** should be integrated, for example, into the process of re-purposing public spaces, such as parks, libraries, parking lots, for health and food security and temporary shelter during the response phase of the pandemic (UN Women, 2020b). At this stage authorities should also ensure women's ***safe mobility measures*** include, for example the provision of accessible, illuminated and safe alternative routes (UN Women, 2020b). These types of measures will benefit health workers and first responders, the majority of whom are women (UN Women, 2020b). COVID-19 related initiatives also need to be integrated across sectors (Onyango, 2020). Information about COVID-19 prevention and containment should be ***inclusive***, ensuring women and girls with disabilities or those who face barriers have accessible information, including in sign language and accessible formats, easy-to-read and plain language, accessible digital technology, relay services, captioning, and text messages (UNFPA, 2020a). Finally, an important long-term recommendation is that local ***multisectoral policy frameworks*** – housing, health, local economic development, management of safe public spaces - integrate into their budget and resources to specifically address GBV (UN Women, 2020b).

3) Macro level - Women and girls' participation in program design

To prioritize women and girls' meaningful participation, and that of their organizations', in decision-making processes, in plan development, implementation and monitoring, recovery plans and the longer-term solutions to address the increase of violence against women and girls during COVID-19 is considered essential (UN Women, 2020a). Women's roles within communities place them in a position to positively influence design considering the barriers they face and their unique needs (Fraser, 2020; John et al., 2020; Siangyen, 2020; UNDP 2020; UNFPA, 2020a). Strengthening women's leadership and representation in national, provincial and local and community level COVID-19 policy spaces may ensure that responses are not

discriminatory or excluding vulnerable population at risk (UNFPA, 2020a). To promote participation it is important to engage and support women and girls' community networks through ***in-person and digital platforms***, which are good vehicles in decision-making as well as for sharing key communications, including GBV hotlines and other services and support mechanisms, and to scale program reach (UNICEF, 2020). There are digital platforms that women and girls can use, such as the UNICEF U-report (https://ureport.in/), which is described as "a tool to provide dialogue toward joint solutions and insights" (UNICEF, 2020, p. 2).

Furthermore, it is important to ensure support for grassroots women's rights organizations that provide essential services to remote, hard-to-reach, vulnerable populations (UN Women, 2020a). Research shows that women's groups are "the single most important factor in addressing violence against women and girls" (Onyango, 2020, para 22). It is then crucial that these organizations participate in development and delivery of services, and in the design of recovery plans and the longer-term solutions of GBV during COVID-19 (UN Women, 2020a). In the context of the United States, culturally specific organizations and programs to address the needs of particular marginalized populations such as indigenous individuals, should receive additional funding to support survivors (Cortez, 2020). These organizations are unique in that they are able to provide services that are language-accessible to hard-to-reach populations to keep victims and their families safe (Cortez, 2020). Fraser (2020) highlights the effectiveness of the "twin track" approach to GBV in her review of lessons we can learn from previous health emergencies like Ebola, cholera, and Zika. It combines support to GBV local and grassroots organizations, and the integration of violence against women into sectoral approaches. Therefore, is recommended that ***women's organizations*** be considered in recovery plans and long term GBV solutions to address violence during lockdown, slowdown and recovery phases of COVID-19 in urban, rural, and online settings (UN Women, 2020b).

4) Macro level - Data collection

Data collection is a strategic tool for understanding how and why emergencies such as the COVID-19 pandemic increased violence against women and girls around the world (UN Women, 2020d). There is ***inconsistency in data collection***, disaggregation and reporting for girls and women around the world (Siangyen, 2020). Governments and global health institutions should consider the direct and indirect age, sex and gender effects of the COVID-19 when they analyze the impacts of the pandemic (UNFPA, 2020a). Specifically, there is a need to collect data disaggregated by sex, age, ethnicity, disability and race on: i) the incidence of domestic violence - including psychological and economic violence - and sexual violence, including place of occurrence; and ii) the needs and capacity of services to respond to the increased demand in the context of COVID-19 (UN Women, 2020a). The collection of these data will help researchers and institutions to identify risk factors, the impact of the crisis on service availability, how the networks of formal and informal sources of help and services that women and girls use are being impacted, about the type of new needs that are arising as a result of COVID-19, and about the progress institutions have made to reduce the prevalence of violence (Fraser, 2020; Knaul et al., 2019; UN Women, 2020d).

The UN Women identifies important challenges to gather data and to difficulties of adhering to methodological, ethical and safety principles in the context of physical distancing measures during the pandemic (UN Women, 2020d). The feasibility of data collection methods

due to social distancing measures may be an important challenge; COVID-19 measures impact the way traditional service-based data are being collected and stored. In emergencies these services are provided remotely, which brings with it issues of security of data storage, and in relation to reliable data protection systems (UN Women, 2020d). Efforts should be made to review and improve the functionality of pre-existing data protection mechanisms for the COVID-19 response (UNFPA, 2020a). ***Safety risks*** are also at stake when collecting data remotely; as we explain further below, even though mobile phones and web platforms facilitate data collection, they can also put women and girls at risk of breaching privacy, since the conditions to guarantee confidentiality cannot be met (UN Women, 2020d). Finally, it is important to recognize that in times of crisis the collection of data may not be possible, therefore policy makers instead will need to rely on pre, during, and post COVID-19 reports from helplines, police, shelters and other relevant services (UN Women, 2020d). Cautions to interpret data are important, and data triangulation is recommended (UN Women, 2020d).

It is in light of these challenges and risks to women and girl's safety, that the United Nations proposes the following guiding principles for data collection. First, protecting and supporting women and girls who experience violence should be the priority in crisis situations; even though robust data is needed, the focus should be on targeting resources for survivors so they can have access to quality services and supports. Second, efforts should be made to use and apply existing data to inform COVID-19 responses; of special relevance is secondary data collected in the contexts of similar crisis. Third, ethical and safety principles for collecting data are preeminent, especially during crisis. Drawing on these principles, the United Nations Women (2020d) provides four recommendations: **1.** Drawing on the third principle that states that "doing no harm should be the highest priority"; it is recommended to not proceed with data collection if women and girls' safety is at risk of violence and distress. **2.** A second relevant recommendation refers to the type of data collection methods and sources chosen – including for example rapid mapping of services, media reports, case reports, participatory approaches, service-based data. Ensuring the safety of women and girls respondents should be the priority when selecting these methods. **3.** The UN Women recommends not to include questions related to violence against women as part of population-based rapid assessment. To protect the safety of women and girls, the recommendation is to include broader questions, instead, related for example to respondents' feelings of safety in the community or at home, rather than direct questions about their experiences. **4.** Finally, an important recommendation is to promote both, advocacy and inclusion in data collection. Advocacy efforts to ***promote the rights of marginalized groups*** - including adolescent girls, older women, women and girls with disabilities, refugee women, female migrant workers, and racial and ethnic minorities – should be included. As we elaborate below, research should be inclusive of the voices and experiences of women and girls' experiences and they also should play a role in research design including fieldwork instruments (UN Women, 2020d).

5) Macro level - Increase dedicated funding

There is a need to increase funding for services to address protection needs for women and girls experiencing violence before and during the COVID-19. Support services for GBV survivors are in increased demand during crises, however lessons from past emergencies show that funding for these services is deprioritized and limited (Fraser, 2020). Previous health emergencies show a disruption, diversion and defunding of essential services including for

example sexual and reproductive health care (Hall et al., 2020) and care and support to GBV survivors (UNICEF, 2020). During the COVID-19 pandemic actors should think creatively to promote coordination and funding across sectors, to aim for community outcome investment and plans applying an ***intersectoral lens***, and overall to strengthen social supports (Enekwechi, Hardeman, & Powell, 2020). Furthermore, all protective services should be classified as essential during emergencies (UN Women, 2020a). Therefore additional resources are needed in response plans (UN Women, 2020a). Advocacy for additional financial resources for essential GBV services is needed (UN Women, 2020a). Finally, and as we discussed previously, economic insecurity is a fundamental barrier for vulnerable individuals (van Gelder et al. 2020). Therefore, a key measure is the provision of ***cash assistance and in-kind assistance*** for GBV survivors (NCLW, et al., 2020).

6) Meso level - Strengthen services for women and girls

The World Health Organization's guidelines for health emergencies stipulate that services for individuals experiencing GBV should be a priority and part of a package ***of essential services*** to be provided during emergencies (John et al., 2020). Sexual and reproductive health services, domestic violence hotlines, post-rape care services, referral pathways, safe spaces, and justice related processes are much needed during pre-pandemic times, with the COVID-19 emergency these services are even more necessary (Onyango, 2020; Roesch et al., 2020; UNDP, 2020). These services remain open and accessible (UNDP, 2020). During the pandemic, there is a need to expand remote case management services, increase accessible shelter capacity, funding to provide internet and phone credit for remote service access, and for other services – such as trauma-centred support for family members, clinical care for survivors (Onyango, 2020; NCLW, et al., 2020; van Gelder et al., 2020).

Furthermore, international organizations highlight the need to adopt ***survivor-centred*** principles to service provision, including addressing women and girls' multiple health, mental health and safety needs, conducting risks and vulnerabilities assessments, and overall applying principles of privacy and confidentiality (UN Women, 2020c). A call for preventing racism and discriminatory practices in service provision was found; health authorities at multiple levels should pay attention and support non-discriminatory access to services (Siangyen, 2020). The following are the recommendations to ensure psychosocial support for women and girls:

a) Strengthen and adapt services, related to capacity rapid assessments, risk assessments, safety planning and case management (UN Women, 2020a).

b) Shelters. Expand their capacity, including re-purposing public and private spaces, such as empty hotels, or education institutions (UN Women, 2020a).

c) Strengthen helplines, online counselling and technology-based solutions such as SMS, online tools, and social support networks. (UN Women, 2020a). National helplines should remain functional and available 24/7 during the COVID-19 crisis (Fraser, 2020; UN Women, 2020c)

d) GBV referral pathways should be updated to reflect care facilities availability, and mechanisms to inform communities and service providers about updated pathways needs to be incorporated (UNFPA, 2020a; UN Women, 2020c). Updates in service directories are needed, and dissemination of this information regularly among strategic networks should be conducted (UN Women, 2020c). Collaborations between the health sector and GBV organizations are

needed during emergencies, to provide services creatively and to strengthen referral pathways in accordance with COVID-19 mitigation measures (Onyango, 2020). Updates to referral pathways are important to prevent overwhelming of tertiary hospitals (Fraser, 2020).

e) Mental health access points should be promoted to address mental health gaps in communities at greater risks and with higher disparities (Enekwechi, Hardeman, & Powell, 2020).

f) Online supports need to be guaranteed 24/7. It is important to strengthen the capacity of national hotlines (UNFPA, 2020a). Innovative approaches to address the women and girls' needs during the health emergency should be implemented. For example, cellphone apps, WhatsApp, online channels should be used for filing complaints (Souza et al., 2020). It is necessary to scale-up remote online services including case management, mental health, and psychosocial supports, with trained staff support and following quality of care guidelines (UNFPA, 2020a; UN Women, 2020c).

Internet-based service platforms are considered effective for replacing in-person supports (van Gelder et al 2020). An example is the use of *telemedicine*, which is identified as a good strategy to provide access to services including GBV trauma-informed care, post-traumatic stress disorder, depression, and suicide (Hall et al, 2020). It is recommended that *mobile health* and telemedicine should be explored as potential safe strategic resources for women experiencing violence, especially in humanitarian settings or when women do not have access to mobile phones or internet is limited or inexistent (Roesch et al., 2020). For web-based services and interventions, it is recommended to design ***gender-specific*** materials (Day & White, 2020). Levels of literacy – e.g. digital – and information that address the specific needs of racialized and low socioeconomic status populations are also relevant to consider in designing interventions and materials. Discussion about the digital divide is relevant in the context of online remote supports. The United Nations recommends building partnerships with the private sector to address the needs of disadvantage populations so they can have access to the supports they need, from education to services (UN Women, 2020b). The media is recognized as a key actor that should provide information and web links to supports – hotlines, only channels (van Gelder et al 2020). Social media is also strategic in supporting a "buddy system" and emergency contacts (van Gelder et al 2020). Recommendations about ***media safeguards*** when providing online GBV services include safety mechanisms to protect women and girls accessing services and their electronic communications so they do not leave a trail that can be accessed by their abusers – e.g. clear browsing history (UN Women, 2020d; van Gelder et al 2020). Other measures, especially for extreme situations, include cellphone protections (Souza et al. 2020). International organizations call for GBV holistic responses including, for example, the integration of mobile justice units, much needed during social-distancing measures, especially to support women and girls in remote areas (UN Women, 2020b). It is also recommended that community organizations explore entry ways for women to access services, such as to supermarkets or pharmacies (Onyango, 2020).

The health and mental health sectors are identified as strategic in mitigating GBV risks; they can, for example, identify local support services for survivors – shelters, hotlines, counselling, crisis centres – to refer women and girls (Roesch et al., 2020). Along this referral role, it is important to highlight the allied professional capacity that these sectors have on staff (such as psychiatrists, psychologists and/or connectivity, social workers, clinicians, trauma

specialists) to mitigate violence against women and girls. Networking to enhance dissemination and communication about services needs to be promoted among existing GBV women's and youth rights organizations. They are essential to promote connectivity and information flow (UNICEF, 2020).

Calls for the maintenance of ***safety nets***, including for example healthcare for all people, ***universal health coverage***, were found in the review. There is a need to ensure that individuals from any age, nationality, legal status, physical and mental health capacities, socioeconomic background, and sexual orientation have access to GBV services (NCLW et al, 2020). More broadly, COVID-19 response should ensure that universal health coverage includes marginalised groups (Enekwechi, Hardeman, & Powell, 2020), and "must designate sexual and reproductive health, family planning, and community health centres as essential health providers, reallocating resources accordingly" (Hall et al, 2020, p. 1177). Other social safety nets of relevance to face GBV during crisis are, for example, paid sick leave, healthcare insurance, as well as short-term financial aid, which may guarantee the independence that women need to be able to leave their abusers (NCLW et al, 2020; van Gelder et al., 2020). Finally, it is highlighted that ***cultural safety models*** to healthcare provision need to be incorporated "to mitigate influences of biases and power imbalances that propagate racial disparities" (Gopal & Adesara, 2020, para 6).

Examples of Alternative services and accommodations in the context of the COVID-19 pandemic

Online supports

- ✓ In China advocacy efforts to address violence include the hashtag #AntiDomesticViolenceDuringEpidemic with links to online resources (UN Women, 2020a)
- ✓ The National Domestic Violence Hotline in the United States offers online chat or texting services (John et al. 2020)
- ✓ The national network of domestic violence shelters in Italy use Skype and emergency telephone and support services: approximately 60 out of 80 local domestic violence organizations have emergency cell phones and are answering calls (John et al. 2020)
- ✓ Online guidance on services provision to survivors of violence was provided in Fiji. The UN also reports that it has been applying a code of conduct to do no harm in working with community leaders (UN Women, 2020a)
- ✓ In Guyana, intervention challenging violent masculinities and CSOs advocacy on ending violence against women and girls are adapted to COVID-19 context, including through technology (UN Women, 2020a)
- ✓ Jamaica and Grenada are being supported for technological capacity building, the law enforcement sector and the judiciary, to respond to COVID-19 (UN Women, 2020a)
- ✓ In Antigua and Barbuda, and South Africa, governments are engaging with private telecom mobile companies to deliver messages and provide services (UN Women, 2020a)

Innovative service provision

- ✓ In Beijing a judicial court is applying online court hearing and cloud-based platforms to process GBV cases during the epidemic (UN Women, 2020a)
- ✓ In Italy instead of the survivor having to leave the house of an abuser, prosecutors have ruled that in situations of domestic violence the perpetrator must leave the home (UN Women, 2020a)
- ✓ In Ecuador a local organization adapted its business to the COVID-19 outbreak and started offering counseling services over the phone (John et al. 2020)
- ✓ In Italy, France, Spain and the US, women can alert pharmacies about a domestic violence situation with a code message that has been specifically created to facilitate police and other support (UN Women, 2020c)
- ✓ Countries in the Caribbean and France are exploring or providing alternative accommodations for women, for example the use of hotels as shelters (UN Women, 2020a)
- ✓ In the Eastern Cape, South Africa, support to accelerate community-level service delivery for survivors of GBV is being allocated. The focus is on women in the informal economy, and girls and women affected by HIV and AIDS (UN Women, 2020a)
- ✓ Rapid assessments of violence against women and girls are being undertaken Fiji, Malawi, South Africa, Tonga, and Vanuatu. In these countries there are efforts to build service providers capacity, support helplines, and disseminate relevant guidelines (UN Women, 2020a)
- ✓ Efforts to update referral pathways and service delivery protocols are implemented in Trinidad and Tobago, Vanuatu, Sudan (UN Women, 2020a)

7) Meso Level – Build capacity

Increase in awareness and training on the rising risks of different types of violence against women and girls during the COVID-19 pandemic among frontline workers across sectors such as physicians, nurses, social workers, and settlement workers, and the public in general, is recommended. It is critical that different systems – health, social, education, child protection, security and justice, social protection – ensure that frontline workers are aware of the intersections of gender and the COVID-19 outbreak, and how to address the issue safely and ethically during the emergency crisis (NCLW et al., 2020; UNFPA, 2020a,b; Roesch et al., 2020). Healthcare workers are key in detection, referral, and service provision, but they need the training to be able to support victims (Onyango, 2020; Fraser, 2020; van Gelder et al., 2020). Training can be conducted remotely - through e-learning, webinars and should be based on ***survivor centred approaches***, to ensure respect, sympathy and confidentiality (NCLW et al., 2020; UNFPA, 2020a,b; UN Women, 2020c). Enekwechi, Hardeman, and Powell (2020) highlight that there is a need to have more members of racialized communities trained in the health care system, within the healthcare workforce. Key reasons to promote is that chances are higher that racialized individuals return to their own communities after receiving training. Black and racialized individuals may be able to serve better their communities because they understand better the nuances and specificities of their communities; they also understand better people's distrust of the medical system. Enekwechi, Hardeman and Powell (2020) explain that reasons of this distrust are rooted in the historic racism, where Black people have felt that they have not received treatment for their pain, they feel disrespected as ***structural racism*** is rooted in medical practices against these communities. Finally, racialized people understand better the health inequities of the population they are serving in their communities. These are key reasons to promote more ***medical/healthcare training for individuals from racialized com***munities (Enekwechi, Hardeman & Powell, 2020). Awareness and mechanisms to enhance capacities are also needed in the police and judiciary systems (UN Women, 2020a).

8) Micro level - Strengthen Awareness, sensitization and advocacy

Awareness-raising campaigns are also suggested to prevent and address violence against women, girls and children (Souza et al., 2020). These campaigns should focus on proactively question gender stereotypes which are being evident and acute under the current COVID-19 pandemic (UN Women, 2020a). For example, increased societal awareness is needed about the impacts of increased household care work or about precarious work and financial insecurities experienced by women. Media outlets organizations and institutions can increase the ***visibility of violence against women***, focusing on the risk factors during emergency crisis (van Gelder et al., 2020).

The UN (2020) calls for community members to engage in efforts to prevent and address GBV. ***Community "gatekeepers"*** (Onyango, 2020) may include for example, postal service workers, pharmacists, neighbours, among others, and may play an active role looking out for women and girls who may be at risk of experiencing violence. If possible, they may also be a medium to offer support and information on available resources (UN Women, 2020c). Other important actors are religious and local women and youth leaders, who can be

instrumental as an early warning and alert groups (Onyango, 2020). In addition, ***informal social networks*** such as neighbors, families, coworkers, and friends are also identified as key actors that can support these efforts (Junker, 2020; Souza et al., 2020); they form part of the "capillary", "primary detection system" for intimate partner violence (van Gelder et al 2020). In emergency times new approaches to tackle the issue are needed; the situation calls for "an army of volunteers" to reach out to families, checking in on how things are going, and overall to support families who are struggling with the COVID-19 pandemic, to make their needs visible (Bielski, 2020; Astrup, 2020).

Examples of awareness, sensitization, and advocacy efforts

- ✓ Women's groups are publishing manuals and organizing livestream workshops that provide guidance on how to protect oneself during a crisis, including how to access legal aid. They are organizing campaigns in social media to raise awareness as well as setting up support networks to help survivors. A network called 'Vaccines Against Domestic Violence' has over 2000 volunteers, who provide counseling and support families to resolve conflicts peacefully (John, et al 2020)
- ✓ The UN reports that in Antigua and Barbuda, Malawi, Sudan, Tanzania, Uganda, Zimbabwe and Morocco, governments are promoting mass media/social media sensitization on COVID-19, increase of violence against women and girls and its prevention. Themes include positive masculinities/sharing of household responsibilities and supporting domestic and vulnerable workers (Women, 2020a)

Discussion

Evidence from this preliminary synthesis suggests that racialized women and girls are experiencing a **syndemic,** which is defined as "a cluster of two or more epidemics and the various factors that precipitate their interaction within a population", resulting from the interaction of health related and social structural factors (Nicholson et al., 2019, para 23). The simultaneous pandemic of ***gender-based violence*** and the pandemic of ***systemic racism*** have long existed but have come to public attention more so in the current *COVID-19 pandemic* context, resulting in what we name as *the **2020 syndemic:*** **COVID-19, GBV, racism**, placing the wellbeing of racialized women at a disproportionate risk.

Experts recognize that during emergency crises, the needs for supports increase. Unfortunately, from past health emergencies we have learned that girls and women experience limited access to essential gender-responsive health information and services (Fraser, 2020). During difficult times, disruption, diversion and defunding of essential services can take place, including for example sexual and reproductive health care (Hall et al., 2020) and care and support to GBV survivors (UNICEF, 2020). From Fraser's (2020) literature review on violence and COVID-19, it is clear that there are limited rigorous data available on how epidemics have changed levels of violence. Fraser (2020, p. 1) found important lessons from previous emergencies, which suggest that it is essential to attend to the significant evidence gaps from both the COVID-19 pandemic and other similar outbreaks:

i) limited data on how levels of violence change and are transformed;

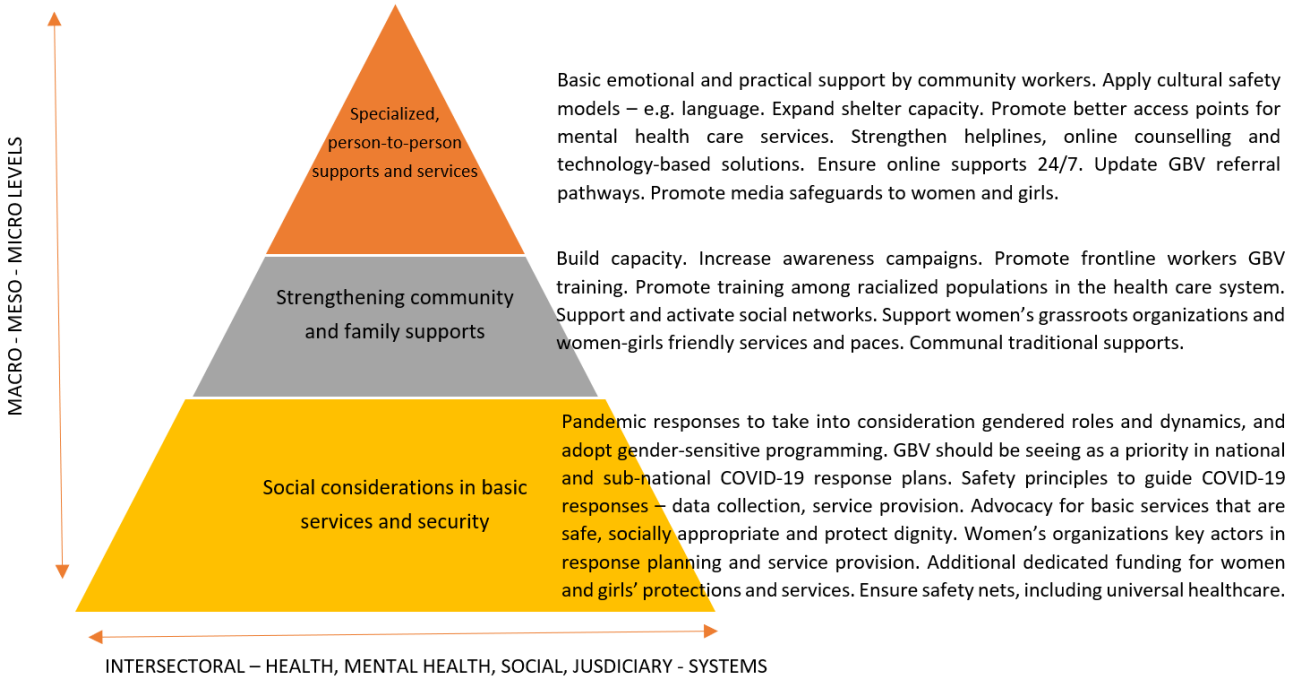
ii) lack of disaggregated data – e.g. sex, race, ethnicity - particularly for vulnerable groups such as adolescent girls, women and girls with disabilities, older women, and refugee and migrant women;

iii) limited research on the pathways of violence against women and girls and health crises; and

iv) lack of documented evidence of good practices in preventing and responding to violence against women and girls during outbreaks

Evidence from our synthesis corroborates the need to address these issues identified by Fraser (2020). Specifically, we point out the need to generate specific evidence and recommendations taking into consideration the particular social determinants of the mental health of racialized women and girls, who have experienced various forms of violence during the pandemic. Evidence-based tailored practices to address the specific needs of racialized populations are needed. In Figure 2, we adapted the intervention pyramid for mental health and psychosocial supports found in our review (IASC, 2020). Interventions at the macro (social considerations in service provision), meso (community supports) and micro levels (specialized services, and mobilization of close contacts) are identified within multiple sectors of intervention.

Figure 2. Intervention pyramid for GBV mental health and psychosocial support in the context of the COVID-19 pandemic



Source: Adapted from Inter-Agency Standing Committee.(2020). Interim Briefing Note. Addressing Mental Health and Psychosocial Aspects of COVID-10 Outbreak. IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings.

Reiterating the caveat of the current limitation in availability of quality COVID-19 mental health related primary data, interventions highlighted in this pyramid can guide in implementation of practice and policy, taking into account that the mental health risks of racialized women and girls with GBV experiences during the current COVID-19 are impacted by complex and inter-related social determinants.

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Appendix 1: Description of Peer-Reviewed Selected Articles

Author	Type of document/Title	Focus/purpose/objectives/ goal	Findings	Recommendations
Day & White, 2020	Article. Gender-specific online content is important and timely for women receiving treatment for substance use disorders	Gender-specific interventions for women seeking drug and alcohol treatment	Sugarman et al. have found in their study that substance use and relapse are increased during pandemics. Due to curtailing the spread of COVID 19, many drug and alcohol services have decreased their hours of services, online service delivery or through telehealth. According to some studies, telehealth may a weak intervention especially for much marginalized populations. Government issued isolation measures further implicate the risk of family or intimate partner violence. Women with substance use histories are vulnerable to family or IPV. Gender-specific treatment are more effective for women with substance use histories, but due to the constraints of services and resources means women are receiving substance use treatment in a mixed-gender settings.	Web- based gender-specific materials are an efficient alternative for treatment programs to ensure compliance. Differing levels of literacy (including digital literacy) needs to be considered in regards to accessibility and usage. Substance use disorders are more than its psychiatric health history, as there are social determinants that can influence it. Women- only services allow their children to be present while attaining treatment or appointment. They also serve as a form of escape for that experiencing intimate partner violence. Women who have been sexually abused can find working with a male damaging and triggering. Therefore, women-only services will ensure quality of care.
Hall, et al., 2020	Commentary. Centring sexual and reproductive health and justice in the global COVID-19 response	Intersectional approaches and community driven interventions to tackle gendered disparities during COVID 19	The global response to COVID-19 pandemic is inflicting downstream economic and social consequences on women, girls and vulnerable populations. Those who have little protection to their human rights will face exacerbation infringed by the restrictions in place to control the spread of the virus. A reproductive health and justice framework needs to be implemented, it focuses on human rights, intersecting injustices, power structures and unifies various identities. Women make up 70% of the global health and social care workforce and do three times as much unpaid care work at home as men. This heightens the chance of contracting COVID-19 as many women are on the frontlines and providing care to vulnerable populations. Due to the prioritization of resources in controlling COVID-19, there has been a disruption in sexual and reproductive health care services. This in turn can increase the risks of maternal and child morbidity and mortality. In addition, systematic racism, discrimination and stigma perpetuate logistical hurdles in accessing sexual and reproductive healthcare for women and marginalized groups.	Public health responses need to incorporate intersectional, human-rights centred, transdisciplinary science-driven theories and community-driven approaches that will counteract the complexities and social disparities faced by women, girls and marginalized populations. Community driven efforts are crucial especially when it comes to COVID-19 research in which sex disaggregated data on mortality and morbidity should be prioritized. In addition, it is prudent to vocalize the importance of sexual and reproductive health and justice policy as an essential service during COVID-19 response. Due to the lack of in-person health services, telemedicine can be utilized in certain services such as medication abortion, contraception education and trauma-informed care for managing mental health issues such as gender-based violence.
John, et al., 2020	Article. Lessons Never Learned: Crisis and gender-based violence	Use experiences from previous emergencies as lessons to address GBV during the COVID-19 pandemic.	Over 80 countries have exemplified that 1 in 3 women who have been in a relationship have experienced physical and/or sexual violence by an intimate partner at some point in their lives. This is further worsened during global emergency crises such as pandemics. During the Ebola epidemic, reports of violence were neglected, uncounted and unrecognized. Women and young girls were unable to attend community meetings to receive instructions on how to protect themselves from the disease. Unfortunately, with COVID-19 there has not been any deviation with these issues, with early data stating there is an increase in domestic violence and disruption of gender-based violence and sexual reproductive health services for women and girls.	Caregivers roles (paid and unpaid) are highly feminized across the public or private sector. This results in a bigger burden during periods of crisis when there are cuts to care services due to financial constraints while there are increasing expectations, exposure and susceptibility for women to provide care. There are guidelines in place by UN Women and UNFPA in which governments can utilize a gendered lens when developing policies and solutions in response to COVID 19.
Knaul, et	Comment.	Knowledge	Over ⅓ of the world's population of women and girls experience IPV or	The Lancet Commission on Gender-based Violence and

al., 2019	Countering the pandemic of gender-based violence and maltreatment of young people: The Lancet Commission	creation to counter the pandemic. The Lancet Commission of GBV and Maltreatment of Young People intend on producing new tools and data.	non-partner physical or sexual violence in their lives. Nearly ¼ of all adults worldwide report physical abuse as children although more frequent for girls which stands at about 20% than boys at almost 10%. GBV decreases global gross domestic product by roughly 2% per year. In some countries, the annual costs of GBV have been estimated at more than 3.5% of GDP, which is double what many governments invest in educating their populations. The continuing, cumulative economic burden in terms of lost income-generation capacity is much higher. The gains of reducing the effects of violence against women and young people are massive since they will catalyse human and economic development in ways that are vital for meeting many of the Sustainable Development Goals.	Maltreatment of Young People will generate new tools and data to empower policy makers and promoters to scale up effective programmes in health, education, income-generation, and gender equality. The work will use the latest analytic frameworks and methods on Gender-based Violence and Maltreatment of Young People which has been grossly under-researched. An inter-sectoral, interdisciplinary approach will engage communities of thought that rarely connect, including public health, health systems, mental health, economics, law, gender, digital health and artificial intelligence, and children´s rights.
Roesch, et al. 2020	Editorial. Violence against women during covid-19 pandemic restrictions	Gendered effects of the COVID-19 pandemic	An average 30% of women are subjected to physical or sexual violence by an intimate partner in their lifetime. This is especially prominent during humanitarian crises, including conflict and natural disasters. However, the gendered impacts of infectious disease epidemics are less understood. For women stuck in abusive relationships, or at risk of abuse, staying in cramped conditions with family and spending more time in close contact with their abuser increases their risk of intimate partner violence. The breakdown of social and protective networks may further increase intimate partner violence. Women may have less contact with family, friends, and coworkers who provide support and protection from violence by a partner. Children staying at home during COVID 19 quarantine measures not only put them at risk for exposure to seeing domestic abuse but also being victims of abuse.	Violence against women during COVID-19 responses plans should be an integral component of essential services provided by governments. These outlines should provide strategies and make them available for marginalized populations. Local support services such as hotlines, shelters, rape crisis centers and counselling should be allies to health facilities, so that survivors can be directed to such services by health services. Health care providers should be educated and trained to identify risks and consequences of domestic violence against women. Mobile health and telemedicine can serve as an asset during a time of pandemic as it can provide support in a safe and confidential manner.
Souza, et al., 2020	Article. Violence against women, children, and adolescents during the COVID-19 pandemic: overview, contributing factors, and mitigating measures	Effects of social distancing on interpersonal relations, such as intimate partners and between parents and children.	The measures recommended by the WHO to fight the pandemic highlight isolation of suspected cases, which entail negative repercussions on economic endeavours at all levels and life and society. And making such measures mandatory has triggered conversations and conflicts between researchers, business, and government officials on public policy to provide economic support for poor communities. One issue that has received little attention from members of the COVID-19 crisis committees involves the repercussions of social distancing on interpersonal interactions, especially between intimate partners and between parents and children. The dynamics of families with young children and adolescents have required greater effort by parents and guardians who need to resolve, housework, and care for the children. At the community level, competition for limited resources, restricted functioning of many services for the protection of children's and adolescents' rights, and the reduction of social networks can increase the risk of violence.	Services for children's rights via person or telephone (WhatsApp or other cell phone apps) should be accessible 24/7. Complaints should be processed quickly to ensure establishing urgent protective measures. Advertising campaigns with a focus of bringing awareness of spousal and child abuse should be more prominent. Support programs for women, children and adolescents in situations of violence should be strengthened. These programs should provide services like social assistance, legal aid and psychological and physical healthcare. Women in situations of violence should practice social isolation in the company with other family members besides the abusive husband and children. Women should have their cellphones secure, as well as the telephone numbers of family members and friends that they can count in emergency situations.
Van Gelder,	Comment. COVID-19:Reducing the	Effects of the COVID-19	There are similarities in the measures implemented to control the spread of COVID-19 and tactics used by partners that are abusive.	Health care providers need to be appropriately trained to identify signs of violence and individuals that are at risk. They

2020	risk of infection might increase the risk of intimate partner violence	pandemic in the rise of IPV	Survivors have characterized these abusive tactics in their relationship as social isolation, functional isolation, surveillance and monitoring of daily activities. Hence, COVID-19 measures can exacerbate the exposures, worsen psychological and economical issues and perpetuate negative coping mechanisms such excessive alcohol consumption. Recent data suggests increasing IPV due to quarantines in Australia, Brazil, China and the United States. Consequently, other nations should expect similar increasing rates and ensure preparedness for such issues.	should be aware of increased risk and implementations of interventions. Public awareness on IPV during COVID 19 through means of media and social media will help disseminate information to the general public and provide resources for those who need it. A buddy system and emergency contacts can foster the creation and sustaining of a support network when an IPV victim feels isolated. Websites can replace in person support in which those experiencing IPV can be aware of quickly exiting page and clearing browsing history as their abusers may be monitoring phone and internet use. Services such as shelters and trauma informed counselling for victims should be available for those who need protection during quarantine is crucial. Funding should be increased for such services to ensure their availability for those who need it at dire times.

Appendix 2. Description of Grey Literature Selected Articles

Author/institution	Type of document	Focus/objectives	Findings	Recommendations
Astrup, 2020	News Article	Explores the worrying surge in domestic abuse during the Covid-19 lockdown and what is being done to address it.	About 76% of domestic abuse services have significantly reduced the amount of services they provide since the pandemic with a third of 119 services report a decrease in staff. More than one out of five of these services are not prepared to accommodate adult victims of violence under pandemic regulations with 42% stating they would not be able to support children.	A team of volunteers working towards increasing the visibility of victims of abuse is essential by making calls and checking in on them. This will alleviate some pressure currently faced by services. Adverts can raise awareness of violence and provide information on available resources. This strategy has been effective on social media through hashtags such as #YouAreNotAlone that remind people that help is still available.
Bielski, 2020	Newspaper article	Provides recommendations to address intimate partner violence during the COVID-19 pandemic	Staff at Interval House Toronto reverted to helping women through emails as several women who had called for assistance where not able to call again for lack of privacy in the home. Most victims of IPV leave when the perpetrator is at work. However, with mass layoffs, the perpetrator is mostly at home with increased economic stress that also limits women's ability to leave as some may be financially dependent on their partner. Additionally, the abusive partner may be financially supporting the entire family, with daycare and school closures, this leaves children vulnerable to violence as well. Therefore, mandated self-isolation is dangerous in enabling perpetrators to actively isolate women from their social network and support.	Educating the public on the warning signs of abusive relationships, how to support victims, building safety plans for leaving, and providing references to resources are strategies that have been implemented at the Western University centre. Neighbours, friends, family members and co-workers should pay special attention to those at risk of domestic violence and are encouraged to provide any assistance. Women who are not able to call centres for assistance may be helped via email. In shelters, a few provincial shelter associations are advocating for prioritized COVID-19 testing for symptomatic women and members of staff.
Cortez, 2020	Congressional Documents and Publications.	Letter led by U.S. Senator Bob Casey urging Senate leadership and appropriators to support emergency	In the USA, the Coronavirus Aid, Relief and Economic Security Act provided funds to address the demands in services and supports for victims of domestic violence. Although it was a great start to addressing the issue, more funding is required to cater to the needs of victims and survivors. Therefore, there is an increased demand in victim service providers across the country, but the providers are not	Tribal sovereignty should be acknowledged, and resources channeled in response to violence and equity in American Indian and Alaska Native communities. Increasing capacity of shelters and establishing Tribal advocacy programs can increase the safety and well-being of Native women. Relationships should be established between these communities and federal

		funding to the Department of Health and Human Services for family and domestic violence programs.	equipped to deal with the novelty and complexity of cases during the pandemic. Rural/remote areas a experiencing the same influx in cases with further limitations as they do not have the resources or capacity to shelter these women and girls. As such, disparities in shelter and resources in American Indian and Alaska Native communities is intensified by the virus as many of these communities already experience overcrowding in homes and compromised sanitation or running water.	departments as they do not have access to information and responses online. Regarding children at risk of violence, face-to-face visits may be required, in that case, appropriate protective equipped should be provided.
EIGE, 2020	Website	The gendered issue of COVID-19. Makes suggestions to policymakers.	The is currently no European Uion-wide data on GBV that can be compared but countries such as France and Lithuania have started reporting cases during the lockdown and comparing them to previous years' cases. This has revealed a significant increase of cases during the pandemic.	The issue of gender-based violence should be at the front and centre of policy decisions, multiple sectors in society should be involved in a coordinated response to COVID-19 and gender-based violence, and data collection should be centralized to facilitate an efficient analysis revealing drivers and trends.
Enekwechi, Hardeman, & Powell, W. (2020)	Webinar	Health inequities, social determinants of health in the context of COVID-19 - Black, indigenous, and racialized population (Latinx, American Indian, Alaskan Native)	In the context of the United States, structural racism is the root cause of health inequities/disparities, and more evident during the COVID-19 pandemic. Disparities exist among Black, Latinx, American Indian, Alaskan Native, and Pacific Islander populations. Disparities are associated to complex and interrelated issues, related to access to health and mental health services, socioeconomic disparities, and the impacts of structural inequities and discrimination.	Promote leadership, and put in place funding, investments, to support vulnerable marginal racialized communities. Provide universal health care regardless of employment status. Transform the current health insurance model that runs counter the actual needs of vulnerable populations. Ensure everyone has access to housing, and other SDOH. Address issues around the closure of health facilities in rural and African American communities, so to address access issues in the context of the COVID-19 is essential. Promote policy changes at the local level, for example childcare, and other related to SDOH. Address mental health gaps in communities at greater risks and with higher disparities, promote better access points to increase access for vulnerable populations.
Fraser, 2020	Research report	Review of literature. Evidence on the impact of the COVID-19 virus pandemic and other similar epidemics on violence against women and girls	The literature review provides insights about lessons from previous health emergencies. There are gaps in the literature regarding changes in the level of violence and the process through which this occurs, context-specific data on overlapping identities e.g. older women, refugee or migrant women, specific influences of pandemics on violence against women and girls and reliable documentations of effective responses to violence during the pandemic. Impacts of the pandemic on violence against women and girls is most likely to be severe in countries with weak health and justice systems.	Based off previous epidemics, we may benefit from a 'twin track' approach which combines directing organizational support to survivors and incorporating VAWG into responses through health, education, child protection, security and justice, social protection and financial security. Many other relevant recommendations from around the world are provided.
Gopal & Adesara, 2020	Blog	Addresses racism and health inequalities	Ethnic minorities disproportionately seek intensive care and are among a large portion of COVID-related deaths in the UK. This has also been reflected in the USA. Maternal mortality rates among Asian and Black women are double and five times higher than white British women. Social factors such as increased unemployment, stress, and poverty in combination with disparities in health and life expectancy. Therefore, these vulnerable communities are severely impacted by cuts in funding especially among racialized women. These socio-economic factors have been highlighted during the pandemic.	Healthcare providers should incorporate a cultural safety model or culturally sensitive practices to combat the effects of bias and unevenly distributed power dynamics that perpetuate racial disparities. Politicians should be aware of the harmful effects of budget cuts in public services. A race equality observatory was launched to collect and assess race-based data to reveal disparities in health and healthcare.
IPU, 2020	Guidance Note	Provides guidance to parliaments around the world in	Women make up about three quarters of healthcare workers providing services during the pandemic and play key caring roles in other dimensions of society as heads of households and various	The COVID- 19 response should be based on gender-related decisions and actions. Resources should not be channeled away from sexual and reproductive health services as this violates the

		relation to COVID and gender.	essential work. Women also form the majority of refugee and internally displaced communities. Accessing services, in these conditions, is difficult and women are at higher risks of domestic violence and exploitation under these circumstances. Most women are marginalized from tax-funded health coverage and other social benefit protections because they work in the informal sector. In the formal sector, they are mostly the first to lose their income in crisis.	rights of women and girls by jeopardizing their health and agency.
Junker, 2020	News article	Explores the different ways the pandemic may hide domestic violence and probable strategies and responses to help women	Findings appear to be contradictory as some police report an increase in cases and others a decrease in cases. However, those experiencing a decrease in cases report an increase in the severity of the cases. Edmonton Police have encountered a lot of cases such as aggravated assaults and sexual assaults that require specialized investigation by domestic crimes detectives. Domestic violence is characterized by power dynamics and controlling behavior that isolates women from their family and friends. Therefore, with pandemic restrictions, forced isolation may be hard to identify which enables perpetrators to withhold necessities from victims such as hand sanitizer or threaten to cancel insurance.	Responses to counter domestic violence during the pandemic include increased vigilance and preventing forced isolation of women by formulating new means of communication to check in on them. Family, friends and coworkers may also help victims by learning the signs of domestic violence that could be hidden during the pandemic. Women's shelters are innovative and learning from the pandemic to cater to the indications of domestic violence that are unique to the pandemic. It may be effective to look at an alternative service delivery that addresses the current gaps in service, leading us toward resolve. Incorporating over the phone counselling, support, organizing various arrangements and working with different safety plans that consider the needs of women at the core.
NCLW et al., 2020	Issue Alert	Provides updates on gender issues in Lebanon, complies data to inform programs and offers recommendations to combat gender issues related to GBV	It has been expressed that some forensic doctors were unable or reluctant to officially document physical abuse of survivors at police stations in fear of contracting or spreading COVID-19. The most vulnerable are victims of trafficking who are forced into sexual favours despite the risk of contracting and spreading COVID-19.	Violence against women should be carefully monitored across diverse identities and groups (e.g. immigrants, those with disabilities and elders). Recommendations for the government of Lebanon include making services accessible e.g. making domestic violence hotlines free of charge, equal gender representation in police dealing with GBV, ensuring survivors can attend court proceedings via video conferencing and provide access to life-saving by training responders and healthcare providers in the current conditions.
Onyango, 2020	Blog	Draws lessons from Ebola that apply to the COVID-19 pandemic.	COVID-19 disproportionately threatens the health of women and girls because the pandemic safety regulations leave them in vulnerable situations. They experience domestic violence, IPV, child abuse, and various forms of sexual and GBV because a crisis intensifies gender inequities and power hierarchies coupled with economic tensions, stress, and uncertainty. Under these regulations, survivors of abuse do not have the opportunity to distance themselves from their abusers or seek and attain support. This was observed in West Africa during the Ebola crisis of 2013-2015, specifically the response to control the spread of the virus.	Preventative and controlling measures of GBV must be implemented governing bodies in society as well as different sectors to achieve a top-bottom and bottom-up response. Independent women's groups are the single most influential force in addressing GBV. Therefore, women should be involved in the development of responses. Governments should channel resources to organizations that are already involved in addressing issues related to GBV and supporting women and girls. Community leaders should also play a central role in containing the virus and mitigating violence within the community.
Roush, 2020	Blog	Critically analyzes the 'invisible' danger of pandemic 'safety' measures	The frequency and intensity of IPV is increased by the uncertainty, stress and unemployment that has developed during the pandemic. This trend also occurred during the 2007-2008 economic recession. However, the pandemic poses a threat to physical and mental heath as victims spend more time with their abusive partners and become hypervigilant (increased possibility of post traumatic stress disorder).	It is important to proactively communicate with anyone at risk of abuse by not waiting for them to initiate communication. A strategy may be to video call them. Be aware that the abuser may be listening in even in textual communication, but it is important to provide emotional support despite limited freedom to communicate on the side of the victim.

			Furthermore, survivors of IPV may fear contracting the virus at the hospital and may not adequately nurse or treat their injuries. This reduces the possibility of seeking and attaining support as medical practitioners usually refer survivors to mental health and social services.	
Siangyen, 2020	Blog	Addresses gender inequalities in Asia's response to COVID-19.	About half of the women and girls in the world are in Asia and in many regions of the continent, they are predominantly disadvantaged due to poverty, violence, exclusion, and discrimination. Plan International assessed the circumstances faced by women and girls across six domains: health, education, protection, economic opportunity, representation and laws and policies to assess where countries in the region stand in relation to gender-equity. This showed that, before the pandemic, discriminatory attitudes, and actions marginalized women, limiting their ability to navigate through their own lives and goals.	Non-discriminatory health information and services are a priority. Data on the impacts of COVID-19 should be sorted by sex, age, and disability and assessed along those trends, consistently across the world. This is important to facilitate differential responses accord to the context-specific demands of that population.
UNDP, 2020	UNDP brief	GBV during COVID	243 million women and girls have been subjected to abuse by their intimate partner (includes sexual and/or physical abuse).	Strategies targeting GBV should be implemented in COVID responses. The brief provides guidelines to approach this issue. Strategies include incorporating women's organizations in COVID response plans, implementations, and assessments by connecting extensive networks and formulating strategies through diverse perspectives (e.g. legal or human rights).
UNICEF, 2020	Technical Note	Recommendations for gender equality in the COVID-19 response.	Tertiary hospitals and frontline service providers may be overwhelmed by COVID-19 cases and momentarily incapable of providing life-saving care and support to GBV survivors. Women and girls disproportionately bare the burden of pandemics because they are the primary caregivers to ill family members and with school closures, they spend more time caring for the children (unpaid care work). School, for girls, provides nutritional benefits and social connection. Most girls do not go back to school after pandemics. This and other factors increase the gender livelihood gap.	The GBV Pocket Guide and app (https://ureport.in/) can teach service providers how to handle GBV disclosures (includes unique approaches for teenage girls) and provides resources at the community level addressing different approaches to and aspects of GBV during the pandemic. Support women's and girls' networks to provide connectivity and information to substitute for conventional social support during social distancing. Provide women with financial tools toward economic empowerment and resilience in severe conditions that may occur again in the future.
UNFPA, 2020a	Interim Technical Brief	To advocate for the rights of women and girls during the COVID-19 pandemic	Epidemics make inequalities between women and men and other vulnerable/marginalized groups worse. They possess less power to influence decisions, rendering issues that directly affect them invisible. Women are more likely to be informally employed or carry out informal work which does not guarantee them financial security in difficult and uncertain times. Responses may benefit from different perspectives that will counter for intersecting forms of violence against women and men.	Expand service delivery through remote modalities (case management and psychosocial support) with adequate training and support for staff in this new territory. Additionally, clinical, forensic and dignity kits should be available. Programs should ensure the safe and ethical collection and use of gender-based data GBV data which includes reviewing and improving current programs.
UNFPA, 2020b	Technical brief	Providing recommendations for pandemic responses with a specific focus on pandemic effects on women and girls	Gender inequalities increase in extreme conditions like pandemics, which heightens the risk of abuse, affecting the treatment and care women and girls receive. This is because increased tension in the household exposes women and girls to intimate partner or domestic violence and other gender-related abuses such as sexual exploitation. It is important to highlight that social discrimination and inequalities predispose certain groups and individuals to infection, influencing women's vulnerability to infection, exposure, and treatment, for example.	Services should adapt a survivor-centred approach that equips healthcare workers with the skills and resources to address the instances of gender-based violence, as disclosed to them by the survivor. Service providers are advised to maintain confidentiality and practice empathy and sympathy. An efficient feedback mechanism is critical in keeping details of changing services up to date through out the extensive referral pathway. National partners should be wary of the intersection of gender and pandemic regulations (among multiple overlapping

				identities such as disability, sexuality) to formulate sensitized responses to the pandemic whilst ensuring that the safety, dignity, and rights of the people are not infringed. This can be achieved by investigating the primary and secondary effects of health emergency on communities and individuals with the protection of women and girls at the centre, preventing the reproduction or perpetuation of gender inequalities.
UN Women, 2020a	Brief	Emerging evidence on the effect of the pandemic on GBV and recommendations	Although Intimate partner violence is the most common violence against women and girls, violence toward women occurs in various contexts at the familial, community and societal level.	Several recommendations are suggested, including treating services for survivors of violence as essential services, providing psychosocial support for these women and girls and repurposing different spaces such as empty hotels to accommodate survivors that would depend on shelters (increases capacity).
UN Women, 2020b	Brief	Reveals a trend in violence against women and children in public spaces, provides recommendations	One out of three women experience sexual harassment in public spaces, in Canada. This continues to occur during the pandemic with other forms of violence in parks, public transport, the streets and online. Social distancing measures have decreased the amount of people on the streets which also decreases the safety of women in these public spaces.	Strategies should reach vulnerable groups such as women experiencing violence and incorporate far-reaching technology-based solutions (SMS, online tools and social networks) with a sensitivity to connectivity and digital literacy. Mobile justice units that adhere to social distancing regulations can be used to reach survivors of violence in remote areas.
UN Women, 2020c	Brief	Trends and implications of providing essential services for survivors	Frontline service providers in the UK have expressed remote technical difficulties (e.g. IT problems) when delivering services online or by phone under the current pandemic regulations. Other challenges are analyzed in the context of the current COVID-19 pandemic.	Interventions and programs should be monitored and evaluated on success or effectiveness to determine their efficiency and efficacy. To address implementational needs, for example, police in other departments can be deployed to address the influx of cases on violence against women and girls.
UN Women, 2020d	Complementary note	Summarizes data collection principles and recommendations	Domestic helplines, police and shelters report an influx of calls since the onset of the COVID pandemic. Others report a significant decrease in calls and use of services since lockdown measures were implemented, decreasing women's access to these services. Pandemics pose a threat of increasing, not just domestic violence but other forms of violence against women and girls. Some may have intersecting marginalized identities that make them more vulnerable e.g. immigrant women.	Challenges to data collection and storage should be addressed (e.g. remote services may not provide necessary privacy, confidentiality, and protection of sensitive information). If it is not addressed adequately then prevalence data of violence against women that could shape and inform policy and programs will not be attained during the pandemic. Provides recommendations for data collection in the context of the COVID-19 pandemic.