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Navigating multiple pandemics: A critical analysis of the impact of COVID-19 policy responses on gender-based violence services

TARA MANTLER
Western University, Canada

C. NADINE WATHEN
Western University, Canada

CAITLIN BURD
Western University, Canada

JENNIFER C. D. MACGREGOR
Western University, Canada

ISOBEL McLEAN
University of British Columbia, Canada

JILL VEENENDAAL
Western University, Canada

Abstract
COVID-19 illustrated what governments can do to mobilise against a global threat. Despite the strong governmental response to COVID-19 in Canada, another 'pandemic', gender-based violence (GBV), has been

Corresponding author:
Tara Mantler, School of Health Studies, Western University, London N6A 5B9, Canada.
Email: tara.mantler@uwo.ca

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causing grave harm with generally insufficient policy responses. Using interpretive description methodology, 26 interviews were conducted with shelter staff and 5 focus groups with 24 executive directors (EDs) from GBV service organizations in Ontario, Canada. Five main themes were identified and explored, namely that: (1) there are in fact four pandemics at play; (2) the interplay of pandemics amplified existing systemic weaknesses; (3) the key role of informal partnerships and community support, (4) temporary changes in patterns of funding allocation; and (5) exhaustion as a consequence of addressing multiple and concurrent pandemics. Implications and recommendations for researchers, policy makers, and the GBV sector are discussed.

A pandemic can be understood as a condition that impacts people around the world (Grennan, 2019). When COVID-19 was declared a pandemic in early 2020 (World Health Organization, 2020), it became clear that governments would need to impose rigid public health restrictions to prevent the spread of this highly contagious disease. In Canada, as elsewhere, these restrictions included the use of masks/personal protective equipment, physical distancing, and stay-at-home orders (Cardenas et al., 2020; Crasta et al., 2020; Mohler et al., 2020). While these restrictions were necessary to reduce the transmission of COVID-19, there were significant unintended consequences for vulnerable populations, including those experiencing gender-based violence (GBV; Slakoff et al., 2020; van Gelder et al., 2020; Viveiros and Bonomi, 2020), those who are racialised (Addo, 2020; Leitch et al., 2020), and people using substances, especially street-procured opioids (Centers for Disease Control and Prevention, 2020; John Hopkins Bloomberg School of Public Health, n.d.). One consequence of COVID-19 being classified as a pandemic was the shift in public narratives used to describe GBV, i.e., that COVID-19 was a 'pandemic,' while GBV was a 'shadow' pandemic (Walters, 2020). However, the GBV pandemic is not new, having been deemed a major public health problem for decades (World Health Organization, 2021b).

GBV can be understood as any form of sexual, physical, mental, or economic harm perpetrated because of a person's gender. Physical and sexual forms of GBV within and outside intimate relationships impact an estimated one in three women globally (World Health Organization, 2021a), but this does not include other forms of gender-based harassment and exploitation, making actual prevalence rates much higher, especially among certain

groups (World Health Organization, 2021a). The risk of experiencing GBV increases during crises (United Nations, 2021), with the COVID-19 pandemic being no exception. Canada's Assaulted Women's Helpline, and Canadian police services reported about double the number of calls related to domestic violence during the first six months of the COVID-19 pandemic compared to the same time period in 2019 (Thompson, 2021). Both hotline and police service call measures are imperfect, and likely underestimate actual incidents of GBV, as using both services requires access to a safe telephone; however, these proxies highlight the alarming increase in GBV.

In addition to these concerning trends, emerging research has shown how COVID-19, and policy and practice responses to it, have impacted women's health and safety, barriers to accessing services, as well as GBV services' ability to respond to women's needs. Perpetrators have weaponised public health regulations such as 'stay-at-home' orders to increase their coercive control (Pfitzner et al., 2020) via increased surveillance and/or no longer allowing women to work outside the home, thus jeopardizing both the health and safety of women experiencing abuse as well as their ability to access services. There have also been major disruptions in GBV services as a result of COVID-19; specifically, maximum shelter occupancy has decreased substantially to adhere to COVID-19 policies for congregate settings, and there have been reported staffing challenges, as shelter workers were no longer able to work at multiple shelters (Ending Violence Association of Canada and Anova, 2020; Lyons and Brewer, 2021). Together, the increased health and safety concerns for women, barriers to accessing service, and disruptions to GBV services as a result of COVID-19 related policies and practices has further marginalised abused women during the COVID-19 pandemic.

We therefore argue that public health measures in response to the COVID-19 pandemic have had significant unintended consequences for the ongoing GBV pandemic, revealing and exacerbating longstanding issues regarding the vulnerability of both abused women and their children, as well as the organizations that serve them. Of note, we understand GBV has 'root causes' grounded in inter-related forms of structural violence. GBV is an inherently traumatic experience, while also having causal links with other forms of trauma and violence across the lifespan (Shonkoff et al., 2012). For example, GBV perpetration and victimization among adults is often rooted both in patriarchal gender norms, and in childhood experiences of violence in the home and the community (Courtois, 2008), and these traumatic experiences, and their consequences, accumulate (Scott-Storey, 2011). Given the high prevalence of trauma among Canadian adults, with about 76% experiencing at least one traumatic event meeting clinical thresholds in their lifetime (Van Ameringen et al., 2008; van der Kolk, 2015), it is little wonder that society's response to the COVID-19 pandemic has made GBV and its impacts worse.

The purpose of this study was to explore the effects of the COVID-19 pandemic, and policy responses to it, on the provision of GBV services, as described by staff and executive directors (EDs), in GBV organizations in Ontario, Canada.

Methods design

This qualitative interpretive description study (Thorne, 2016; Thorne et al., 2004) used an integrated knowledge mobilization (KMb) approach (Kothari and Wathen, 2013, 2017). Interpretive description is aligned with a pragmatic (Morgan, 2014) orientation aiming to generate knowledge that is relevant in the context of applied disciplines (Thorne et al., 2004). This is very consistent with our integrated KMb approach, i.e., partnering with community organizations and leaders to collaboratively engage in mutually beneficial research. Below we provide an overview of the methods specific to data collected for the present analysis. Additional methods detail is available in Mantler et al. (2021).

Sampling and recruitment

Purposive and snowball sampling were used, with our five partner EDs supporting recruitment of staff and their ED colleagues in selected regions in Ontario, supplemented by invitations for direct service staff to participate in the research sent via major GBV sector email list-servs in Ontario. Interested staff were asked to email the research team; individual interviews were conducted with shelter staff (n = 26) and five focus groups of four to six participants were completed with EDs (n = 24). Participants from this study were from 24 different agencies across Ontario, in both urban and rural areas.

Participants

Staff and EDs included in this study served communities ranging from 4,700 to 1,500,000 people. Ten EDs and eight staff worked at rural GBV service organizations. Two EDs were from Indigenous organizations. Staff had worked for their various agencies ranging from less than a year to 30 plus years with the majority of staff in full-time positions (65%). The majority of EDs had a bachelor's degree and were an average of 48 years old (SD = 9.53).

Procedures

Ethics approval was obtained from Western University's Non-Medical Research Ethics Board (Protocol 115865) and data collection occurred between June and October 2020. Participation for shelter staff consisted of a single video/

telephone-based interview of approximately 60 min, and for EDs consisted of one two-hour focus group conducted by videoconference. Table 1 presents the questions asked during the interviews and focus groups. No participant in either the interview or focus group declined to answer or skipped any questions. All participants completed basic demographic questions.

All interviews and focus groups were audio-recorded and transcribed verbatim by a professional transcription service. Each transcript was anonymised prior to analysis. The data collection and analysis process were guided by Lincoln and Guba's (1985) and Thorne et al.'s (1997) principles of auditability, fit, dependence, and transferability. To reduce barriers to participation, shelter staff received a $50 gift card in recognition of their time. EDs were not provided an honorarium.

Data analysis

Transcripts from both interviews and focus groups were organised using Quirkos qualitative analysis software (Quirkos, 2020). Interpretive description

Table 1. Questions asked during interviews and focus groups with shelter staff, and EDs.

Cohort	Questions
Interview with shelter staff	• Tell me about the last few months – how have things been at the agency?
	• What changed for you the most in your everyday work practice as a result of COVID-19?
	• How was the timeline from when the pandemic started, to now?
	• If you were giving your ED, or other shelters, advice right now about what changes to keep and what to get rid of, what would you say?
	• How have these changes impacted your clients?
	• Are there new stresses in your work, due to COVID-19 or other factors, that make it harder to care for your clients or yourself?
Focus group with EDs	• How are things going for you in your shelter/service?
	• What did you learn very quickly when COVID-19 restrictions emerged?
	• What are the decision processes now?
	• What is unique about values-based work?
	• What have the big changes been?
	• What lessons have you learned from COVID-19?

following Thorne's approach guided analysis (Thorne, 2016; Thorne et al., 2004). The 31 transcripts were each independently coded by two of the seven researchers involved. Initially, those who conducted the interviews/focus groups and the principal investigator who has extensive knowledge in the field, met and created a preliminary coding structure with definitions based on field notes, and what was known from the literature that had guided the interview questions. Each coding dyad was initially assigned two transcripts to analyse using open and line-by-line coding. The dyads met to discuss the applicability of the coding structure and code definitions, with refinements to the coding structure and definitions made, as needed. This process was repeated three times until the coding team was confident that the coding structure sufficiently covered the data, and was informed by extant practice literature, a fundamental principle of interpretive description. Next, all interview and focus group transcripts were assigned to two people for analysis. Once all transcripts were analysed, Quirkos files were merged across coders and queries were run to provide reports on each code and associated data related, for the present analysis, to the concept of 'multiple pandemics.' The coding team then met to theorise the relationship and structure of the data and extract meaning from it, an approach consistent with interpretive description (Thorne et al., 2004). Findings were then member-checked with the research partners during two half-day sessions, and recontextualised in the broader literature by the academic team (Thorne et al., 2004). For additional analysis details, see Mantler et al., 2021.

Results

Our analysis illuminated five distinct but inter-related themes including: (1) there are in fact four pandemics at play; (2) the interplay of pandemics amplified existing systemic weaknesses; (3) the key role of informal partnerships and community support, (4) temporary changes in patterns of funding allocation; and (5) exhaustion as a consequence of addressing multiple and concurrent pandemics.

Multiple pandemics at play

EDs and staff identified the emergence of pandemics beyond GBV and COVID-19, with one ED stating,

> I've been navigating three pandemics, triple. There's COVID, absolutely, and then there's the issue of gender-based violence, and then anti-Black racism during this very critical time. Which has been extremely challenging and needing to really focus on how I care for myself, and how do I show up as a

leader at a time where I need, a lot of support myself. Right? In order to just get through the day. Right? And deal with you know, look out for the needs of others. (FG5)

Moreover, these multiple pandemics are framed as inherently hierarchical, with the health implications of COVID-19 clearly, in the policies and guidelines being sent to services, outweighing all other concerns, including women's and children's safety, and efforts to counteract racism and provide a trauma- and violence-informed response to opioid use and overdose. These latter pandemics, as is the case historically, remained of lesser concern to governments and public health authorities. One ED described grappling with this realization and the impact it had on her, as follows,

Well, I mean, one of the pieces of cognitive dissonance that we've all had through this process is, holy crap, we've shut down society on a dime and have thrown everything we have at COVID, yet we've had our folks dying of overdose for years and there's been no resource, nothing that can be done. (FG3)

The fact that there was a swift and national public health response to the COVID-19 pandemic made evident this hierarchy. However, the public health response and restrictions that prioritised stopping the spread of COVID-19 also had very real ramifications on the GBV sector. Shelter staff and EDs struggled with the privileging of COVID-19 requirements and the associated changes in service provision, which were often in conflict with what was needed to address GBV and other factors affecting their clients. One staff member reflected on the intersection of COVID-19 and racism, explaining that she needed to lobby to allow women to participate in a Black Lives Matter march given the COVID-19 restrictions in shelter,

One of my personal, like, victories during Covid was I got approval to take a bunch of the women and their children to the Black Lives Matter march. … I fought pretty hard for it, just because we had a house of women who were all people of colour at the time. And it was something that was very important to me that these women be able to go. (S18)

The presence of multiple pandemics meant that shelter staff and EDs were contending with the impact of various requirements, which often clashed, on service processes and outcomes. The reality of the interaction of GBV, racism, and opioid use is not new; however, in a time where COVID-19 physical safety requirements were at the forefront of service delivery, this meant that women's needs, in terms of their abuse experiences and any substance use or racism-related issues, were not prioritised. Another staff member, for example, explained that Black women using shelter were often subjected to stricter

guidelines around physical safety as they typically did not feel safe advocating for themselves or for exemptions to the rules the same way White women did. This subtle example illustrates how systemic racism permeates the culture of what have historically been, in Canada's shelters, predominantly White spaces,

> So, then women return to the shelter, and it was, like, … stricter guideline put in place for [Black and Indigenous] women. Or the guideline that was in place for women to follow, while White women were able to make – give rationale of why they might need to be out and doing different things and excuse, and they know the system, while Black women and Indigenous women in the shelter were either afraid or don't want to ask for those pieces, but then you watch them suffer. (S14)

The interplay of pandemics amplified existing systemic & structural weaknesses

Simultaneously trying to manage multiple pandemics amplified existing system-induced organizational weaknesses in areas from finance to service provision. One ED highlighted the difficulty experienced by shelters before and after COVID-19 saying: 'In gender-based violence it feels like this is a pandemic … so it was bad before and [COVID-19] just kind of compounds things' (FG3). One longstanding system weakness in the GBV sector is inadequate and inflexible funding (Burnett et al., 2016; Macy et al., 2010). When chronic underfunding was coupled with COVID-19 and the service changes required to meet public health restrictions for congregate living, enormous stress was placed on GBV services, especially women's shelters. One ED explained, 'Covid amplified everything that already was. So, where we had weaknesses, I would say in our finance department, damn they got bigger' (FG1).

Another longstanding issue in the GBV sector is a lack of housing to support women transitioning out of emergency shelter, i.e., 'second-stage' housing (Baker et al., 2010; Burnett et al., 2016; Raphael, 2001). When COVID-19 swept the world, many services were shuttered. One that remained closed for an extended period of time in Ontario was municipal housing, resulting in significant delays for processing applications and moving women and families to safe and affordable accommodations. One shelter staff member said, 'the housing issue has been like a challenge for the last four years unfortunately. And now it's obviously gotten even worse during the pandemic' (S6). This was echoed by EDs with one explaining,

> So, you've got a community that's screaming 'she needs to get in.' We've got public health saying 'uh-uh, these are the rules.' And you've got women out

there desperate to get in. Right? It's a mess. Because there's no f**king housing and [of] all of the thing[s] that the pandemic did to us, it highlighted already the craters that exist in the system. We've known this all along and now the whole world knows. (FG5)

Informal partnerships and community support

In the face of multiple pandemics and increased stressors from amplified systemic weaknesses, GBV service organizations pulled together to support one another by sharing information and resources. Across Ontario, EDs created informal support groups to help navigate the pandemics. One ED, speaking to her peers within the focus group, described these informal partnerships as instrumental in supporting her through the early stages of the COVID-19 pandemic,

> And I just want to thank all of our partnering agencies, just – I must say that you have been our strength as well because we're able to collaborate with you and there's just so many different tables out there that we're able to participate in just so we can help each other through this challenging time. (FG3)

Informal partnerships helped EDs to navigate the multiple pandemics and the increased stressors they experienced both as leaders and individuals. Other groups of EDs took the partnership a step further and started sharing resource information with each other and had regional discussions, instead of individual meetings, with the funding ministry to improve transparency and service coverage in the area. One ED, in a rural setting, explained how the group pushed back against separate meetings and created a new normal in their area, saying, 'And it's been funny because historically you'd get the ministry kind of saying, "Oh no, I have to meet with you separately" and we don't see why. Like, we know each other and each other['s] budgets. So, this has just allowed a different level' (FG4). The power of informal partnerships afforded EDs the opportunity to build community during a time when people were experiencing extreme isolation and enabled them to work together to navigate the many challenges of providing service during multiple pandemics.

Beyond the informal partnerships leveraged during COVID-19, staff and EDs talked about an outpouring of support from their communities both in terms of recognition of the vital service that these organizations provide, and through increased donations. One staff member explained they received many donations because their shelter is 'well-established in the community and we get a lot of donations, goods and gifts and gift cards and clothing' (S3). Some EDs credited the increase in donations and success of fundraising efforts to the presence of multiple pandemics. As one explained, 'So our

fundraising has also gone through the roof. There's generosity in community. I found there is the parallel of Covid and Black Lives Matter super interesting and the way that organised bodies, like community services [fly into] action' (FG1). The generosity of many (but not all) communities during the COVID-19 pandemic provided organizations with funds to be able to react to the ongoing service change requirements; however, while fundraising efforts can help to support organizations, having to rely on fundraising for operations places them in a very precarious position.

During the first two months of COVID-19, GBV service organizations continued to experience underfunding; however, patterns of increased funding were observed once governments mobilised. For many EDs the sudden availability of funding from the government was shocking. One said,

> So, all of a sudden COVID impacts us all, so now all of a sudden there's money. There's a f**king tap of money. Right? And everybody's like, oh here's money for the shelters. Oh, don't spend a dime on this, don't spend a dime on it. Whatever you need, it's coming back to you, it's coming back to you … It created the case that funding isn't such a f**king big deal for shelters because there's all of a sudden more money than we've ever seen in terms of a sector. (FG5)

For EDs it wasn't merely the increase in funding resulting from COVID-19 but also the change in accountabilities surrounding funding. Reporting requirements for funding changed from rigid pre-COVID-19 requirements that interfered with getting the work done, to almost unfettered flexibility that allowed EDs to respond to intersecting crises as they emerged. One ED highlighted this change saying,

> And I mean we joked about it, that we had this COVID credit card, but we were spending money to meet need that needed to be met with this concept that we'll figure out what we're going to do as we roll into the third and fourth quarter of our budget year, but we just need to do what needs to be done to support that population. So, resource decisions were very equity-based, and that required us to make some choices about who needed our services the most. (FG3)

This change was reiterated by another ED who said,

> I think that all of our money comes with the caveat in all funders … you can spend the money as you need to get through this time. Right? Whereas before if you wanted to change one f**king line, it was like asking God for permission. Right? Now it's like, oh yeah, no, do what you need to do to get through. (FG5)

The flexibility in funding allowed EDs to do the work that needed to be done; however, as the pandemic progressed, EDs started to notice the funding

model reverting back to the previous more rigid approach. One explained, 'Yeah, at the beginning it was very much we were getting "the beans don't need to be counted anymore," and now we're starting to hear "yeah, we're going to start counting the beans again." It's a jarring return to reality' (FG3).

The re-implementation of rigid budgets was concerning for EDs, particularly when coupled with the fear of returning to a chronically underfunded and tenuous state. One said,

> So, for me, COVID is part, is part of the same thing, right? Like we're always, I feel we're always responding to the pressures and the challenges and the social inequities in this sector. It's not new. But you know, in the sense of whether we have the resources to do that, that's always been a challenge. And I think that as we talked about, you know, in some respects the government stepped up and gave us some resources to do that. But then what? Because we were, we were doing this as if it was going to end, right? So, and so now then what? Right? Because we can only, the security alarm can only ring for so long before it dies, right? The battery runs out. (FG5)

Unfortunately, the tension between flexibility and rigidity of funding and the impact on the ability to do the work of shelters is not new. This tension, cyclical in nature, moves from rigidity where funders require dollars be spent in strict accordance with budgets, to flexibility, where EDs are able to set budgets but then reallocate money to be responsive to the emerging needs of individuals who experience GBV. One ED said, 'We have this macro management system that seems to work really well for us and not so well for our funders. And then it goes back to micromanagement where it works really well for our funders and it really f**king sucks for us' (FG1).

Exhaustion as a consequence of addressing multiple and concurrent pandemics

Both EDs and staff found dealing with multiple pandemics was exhausting. This exhaustion stemmed from the daily changes to organizational policy, the lack of 'normal', and the reality that COVID-19 was one more pandemic to layer on to at least three others. The challenge of dealing with multiple pandemics meant that shelter staff and EDs were constantly changing policy and practice with no definitive end in sight. These fast-paced adjustments in the early stages of the pandemic were difficult for staff and EDs. One staff member said,

> Since March, there have been so many changes in our procedures that I think it's sometimes hard for staff to keep up and remember sort of where we're at and I think there can be a bit of exhaustion at some point when they're like, OK

one more change, then forget the last one and now we're moving onto something different. I think that can be challenging. (S23)

This constantly changing environment left shelter staff and EDs yearning for a state of normalcy, which was not on the horizon when we spoke with them. One ED explained, 'It's been challenging. I think that we're at the point right now where we're all just sort of tired of dancing as fast as we can, as are the women. They want some sort of normalcy in their lives and are looking for us to provide that, and so that's not necessarily forthcoming from us' (FG1). Not knowing how long the pandemic would last or when things would get back to normal compounded feelings of exhaustion. EDs explained that despite trying to deal with changes as they evolved during the pandemic, it seemed like there was another issue that always emerged; this led to burn out. One ED said 'And I probably was the first person in this group [of EDs] that said, "I'm done folks. I'm burnt and I really don't care anymore. And yeah, you all should have a day off too so, go ahead, take them all"' (FG4). Exhaustion and burnout are not unique to shelter staff and EDs; these are consequences of the COVID-19 pandemic that were a reality for most people around the world. What is unique for our respondents was that the exhaustion and burnout was compounded by the fact that they had already been living through the GBV, racism, and overdose pandemics long before the emergence of COVID-19 – tantamount to starting a marathon when another is already underway.

Discussion

This study explored the effects of the COVID-19 pandemic, and policy responses to it, on GBV service organizations in Ontario, Canada. Five inter-related themes were discussed : (1) there are in fact multiple pandemics affecting GBV services, including the two we set out to examine, along with systemic racism and the opioid-related overdose crisis; (2) the interplay of pandemics amplified existing systemic weaknesses in the GBV sector and beyond; (3) informal partnerships and community support were required for services to function according to their values, and indeed these flourished, (4) there were notable, but perhaps temporary, changes in patterns of funding allocation among GBV organizations; and (5) exhaustion among staff and EDs was an important consequence of addressing multiple concurrent pandemics. These are discussed below.

One impact of the confluence of having to address multiple pandemics in an already-stressed service environment was the emergence of a pandemic hierarchy. What became clear in policy decision-making was that the COVID-19 pandemic was the main priority, which resulted in new or revised discursive

framings of the various other pandemics: GBV was a 'shadow' pandemic, anti-racism a 'movement,' and opioid-related overdoses a 'crisis' (Gomes et al., 2021; Leitch et al., 2020; Norton and Kerr, 2020; Walters, 2020; Webster et al., 2020). Situating these pandemics in a hierarchy creates the illusion that these pandemics are distinct and should be dealt with individually, when in reality they intersect in time, have overlapping root causes and people may have lived experience of more than one at a time. For example, we know that many people who experience GBV also experience racism (as well as other forms of discrimination and social exclusion) and use substances to cope with the consequences of their trauma experiences (Dlamini, 2021; Goldenberg, 2020; Sullivan et al., 2021). The GBV, racism and opioid-related overdose pandemics are longstanding, with mounting evidence that they worsened at an accelerated rate during the COVID-19 pandemic (Crooks et al., 2021; Devakumar et al., 2020; Gomes et al., 2021; Norton and Kerr, 2020; United Nations, 2021; World Health Organization, 2021a). However, the response to these pandemics has been, and continues to be, underwhelming at best. In fact, it can be argued that not only are these long-standing pandemics generally ignored or minimized by policy actors during 'normal' times, but that policy decisions past and present have made them worse. For instance, there are policies that actively work against supporting solutions for the GBV, racism, and opioid-related overdose pandemics such as dual charging by police in domestic violence cases, the use of 'parental alienation' to support abusers' rights in cases of GBV that are being considered by courts, the Indian Act in Canada (which is explicitly racist and even genocidal), as well as the War on Drugs and anti-harm reduction approaches in policies being implemented across Canada, including using the COVID-19 pandemic as an excuse to close supervised consumption facilities (Cavalieri and Riley, 2012; Lapierre and Côté, 2016; Miller, 2001). In fact, Khanlou et al. (2021) noted that 'the pandemic's disproportionate risks and impacts bring into light historic, systemic, and structural inequalities at the intersection of racial and ethnic minority status, occupation, and class' (2021: 6) and underscore that purely biomedical solutions to COVID-19 (i.e. vaccines and treatments) will likely fail. Given the longstanding and intersecting nature of these pandemics before (Fronteira et al., 2021; Khanlou et al., 2021), and now during the COVID-19 pandemic, the reality is that, while they are capable and have found ways to support clients, GBV organizations and their staff are stressed to the brink of collapse.

The layering of multiple pandemics – what have been termed 'syndemics' (e.g. Khanlou et al., 2021) – is not the only stressor that GBV service organizations are experiencing; these pandemics intersect with longstanding systemic and structural weaknesses such as lack of adequate operational funding, funding inflexibility, and lack of safe and affordable housing for GBV survivors. This precarity of funding among marginalised organizations

in Canada has been well-established (Lavoie et al., 2018). The impact of the COVID-19 pandemic on funding contracts was that they were short term and no longer followed predictable patterns and cycles of availability. There is a need for longer-term and more stable funding for GBV service organizations, particularly during crises. As a result of this variability in funding, organizations were forced to over-rely on donations to maintain their operating budgets, which places them at financial risk. COVID-19 also led to changes in funding practices such that EDs and staff were free to use funds in ways that were responsive to the needs of their clients, which was in stark contrast to strictness of pre-pandemic funding and reporting guidelines. However, this positive change was starting to revert to the more restrictive and inflexible approach by the time we conducted our later focus groups and interviews.

The longstanding barrier to women's safety – the need for safe and affordable housing (Baker et al., 2010; Menard, 2001) – was also made worse during the pandemic. Delays in housing applications became the norm as housing services closed for extended periods of time, leading to even longer wait lists, and putting more stress on emergency shelter stay limits, which are usually approximately three weeks long. Existing housing programs need to operate during crisis situations to ensure people can access affordable housing and not create a domino effect in both the women's and homeless shelter systems. There is also a need for additional emergency housing options that meet the needs of individuals experiencing GBV, as emerging evidence suggests that short-term hotel use during the pandemic was antithetical to the feminist values that underpin GBV work (Mantler et al., 2021).

GBV organizations have been working in a state of constant crisis for years. Therefore, the fact that they were able to find ways to work supportively to get through the first eight months of the COVID-19 pandemic is a testament to staff and ED commitment to the work being done. Adding the COVID-19 pandemic, and the inequitable, 'one-size-fits-all', constantly changing public policy response to the existing pandemics has led to profound exhaustion in the GBV sector. Despite this, leaders and staff worked together to support one another and leverage their formal and informal partnerships. Fully utilizing coordinating committees (regional multi-agency tables that coordinate service responses and advocacy) or similar structures is important going forward to sustain this collaborative momentum. Moreover, rural GBV service organizations exist in lower-resourced environments and are well versed in navigating workarounds such as sharing resources and leveraging ongoing supportive networks for leaders (Mantler et al., 2018; Peek-Asa et al., 2011). While these strategies have allowed rural organizations to maintain service excellence during the pandemic, they involve additional effort (and stress) on the part of rural staff and EDs. The COVID-19 pandemic took a serious toll on GBV organizations; funding and policy adjustments are required to ensure their recovery and ongoing well-being.

Limitations and directions for future research

Data for this study was collected in the first eight months of the COVID-19 pandemic period; due to the ever-changing nature of the pandemic response, including lockdown restrictions and policy guidelines, the results reflect only its initial stages. Moreover, data were anonymised at the transcription level and as such, we are unable to conduct analysis in relation to participant characteristics. Longitudinal data collection as the pandemic evolved would have provided a more fulsome picture of the ongoing experiences of GBV service organizations during all stages of the pandemic. Follow-up studies would help us understand the latter pandemic stages, and the post-pandemic recovery. In ongoing analyses, our team has interviewed policy actors, public health personnel and sector advocates to examine decision-making as the pandemic continued. This will shed further light on how difficult it has been for all actors to address evolving risks and service requirements in a rapidly changing environment. Comparisons with findings from other policy jurisdictions, in Canada and internationally, would provide a broad picture of the interconnectedness of pandemics, lived experiences, and service and policy decisions and their impacts.

Conclusion

Our findings illustrate that, when looking at the response to the COVID-19 pandemic in the context of GBV services, the Ontario policy response has not been equitable, nor, for some sectors, effective. While we saw that governments can rapidly mobilise a response and funding when faced with a pandemic, they generally choose not to do so for GBV, systemic racism or opioid-related overdose, as these pandemics are deemed of lesser importance. Moreover, the unintended consequences of a response to one pandemic (in this case, COVID-19) can cause additional and significant harm to those in the throes of the GBV, and other inter-related, pandemics. GBV service organizations have been dealing with multiple pandemics since long before COVID-19, existing in a state of chronic crisis while advocating for their organizations, and for societal change; this meant they were near exhaustion well before March 2020.

GBV service organizations in Ontario played (and, at the time of writing, continue to play) a critical role during the COVID-19 pandemic, offering services to women and children at risk of harm and even death while other services shut their doors- despite the fact that it took the Ontario government almost six weeks to declare them an 'essential service,' along with grocery stores. Throughout their 40+ year history in Canada, GBV service organizations have been there for women and children experiencing domestic violence,

and they were there, despite significant policy-imposed barriers, during the COVID-19 pandemic. The strategies they used to continue to serve women required significant ingenuity, targeted opportunism, and formal and informal community support. We now need from government policy-makers and funders an acknowledgement of this crucial work, and serious policy attention to the ongoing pandemics of GBV, racism, and opioid-related overdose before the next crisis hits.

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Author biographies

Tara Mantler, PhD is an Assistant Professor in the School of Health Studies at Western University. Her program of research focuses on gender-based violence, rurality, and women's health with the aim of understanding and addressing inequities.

Recent publications: Mantler, T., Veenendaal, J., Wathen, C.N. and the Violence Against Women Services in a Pandemic Research Team. (2021). Exploring the use of Hotels as Alternative Housing by Domestic Violence Shelters During COVID-19. International Journal on Homelessness, 1(1), 32–49 and Mantler, T.1, Jackson, K.T., Walsh, E, Tobah, S., Shillington, K., and Jackson, B. (2020) Sharing Personal Experiences of Accessibility and Knowledge of Violence: A Qualitative Study. Journal of Interpersonal Violence. DOI: 10.1177/0886260520920867

Address: School of Health Studies, Western University, London, ON Canada N6A5C1

Email: tara.mantler@uwo.ca

Nadine Wathen, PhD is Full Professor and Canada Research Chair in Mobilizing Knowledge on Gender-Based Violence in the Arthur Labatt Family School of Nursing at Western University, and Academic Director of the Centre for Research on Health Equity and Social

Inclusion. Her research examines the health and social service sector response to gender-based violence, interventions to reduce health inequities, and the science of knowledge mobilization. A particular focus is developing person-centred interventions that enhance health equity, and take a gendered, trauma- and violence-informed approach to providing services for those experiencing violence and/or marginalization. See www.nadinewathen.ca.

Recent publications: Wathen, C.N., Schmitt, B., MacGregor, J.C.D. (2021). Measuring Trauma- (and Violence-) Informed Care: A Scoping Review. Trauma, Violence & Abuse. Online first (open access): https://doi.org/10.1177/15248380211029399

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Caitlin Burd, PhD (cand.) is a student at Western University in the Faculty of Information and Media Studies, supervised by Dr Nadine Wathen. She completed her Master of Arts in Sociology in 2018 and Honours Specialization Bachelor of Arts in Criminology in 2015, both at Western University. She is also a relief Residential Counsellor at a women's shelter in Ontario, Canada. Her research interests center on issues related to violence against women, including primary prevention efforts for intimate partner violence and Canadian public policy research.

Recent publications: Burd, C., MacGregor, J. C. D., Ford-Gilboe, M., Mantler, T., McLean, I., Veenendaal, J., & Wathen, C. N. (in press). The impact of the COVID-19 pandemic on staff in violence against women services. Violence Against Women.

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Jennifer MacGregor, PhD is a Research Associate in the Arthur Labatt Family School of Nursing at Western University and a Community Research Associate at Western's Centre for Research and Education on Violence Against Women and Children. She is a member of the Domestic Violence at Work Network (DVatWorkNet.org) and was a lead researcher on the first Canadian national study on the impacts of domestic violence on the workplace. Her recent projects include designing and evaluating trauma- and violence-informed care training initiatives and systematic evidence reviews related to domestic violence and work.

Recent publications: MacGregor, J. C. D., Naeemzadah, N., Oliver, C. L., Javan, T., MacQuarrie, B. J., & Wathen, C. N. (2020). Women's experiences of the intersections of work and intimate partner violence: A review of qualitative research. Trauma, Violence, & Abuse. https://doi.org/10.1177/1524838020933861

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Isobel Mclean is a first-year Master of Architecture student at the University of British Columbia in the School of Architecture and Landscape Architecture. She recently completed her Honours Bachelor of Arts in Architectural Studies at the University of Toronto (2021).

Her research takes a critical approach to space-making, specifically looking at the ways we can design better buildings that focus on community, and equity.

Recent publications: McLean, I., & Wathen, N. (2021). Planning Shelter Service Spaces and Structures for Resilience: A Spatial Analysis of Women's Shelters During COVID-19. International Journal on Homelessness, 2(1), 1–12.

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Jill Veenendaal is a PhD candidate in the Health Information Science program, Faculty of Information and Media Studies at Western University, supervised by Dr Nadine Wathen. Jill's broad research interests include the role that trauma- and violence-informed (TVIC) practices can play in the health and social service settings. Jill has a BA in Political Science (public administration) and MA in Sociology (policy and health) and has spent most of her career as a researcher and program evaluator in the social service and health sectors. Her current research includes an examination of provincially mandated policies that impact service provision in domestic violence shelters in Ontario.

Recent publications: Mantler, T., Veenendaal, J., Wathen, C.N. and the Violence Against Women Services in a Pandemic Research Team. (2021). Exploring the use of Hotels as Alternative Housing by Domestic Violence Shelters During COVID-19. International Journal on Homelessness, 1(1), 32–49.

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The Violence Against Women Services in a Pandemic Research Team – This is a group of authors- we thank them by name in the acknowledgement but also want them listed as a group of authors- sorry for any confusion.