Unveiling the Hidden Pandemic: Service Provider Perspectives on the Rise in Intimate Partner Violence (IPV) in Northwestern Ontario Amidst the COVID-19 Pandemic

by

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A thesis
presented to Lakehead University
in fulfillment of the
thesis requirements for the degree of
Master of Public Health
with specialization in
Social-Ecological Systems, Sustainability, and Health

Thunder Bay, Ontario, Canada
December 05, 2023

Lakehead University

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12/05/2023

Author's Declaration of Originality

I hereby declare that I am the sole author of this thesis.
This is a true copy of the thesis,
including any required final revisions, as accepted by my examiners.
I understand that my thesis may be made electronically available to the public.

Abstract

Intimate partner violence (IPV) is a public health concern that can affect individuals regardless of gender, socioeconomic status, sexual orientation, ethnicity, and geographic location (Moreira & Pinto da Costa, 2020). However, women are disproportionately represented in victimization rates worldwide with the World Health Organization reporting that on average 35% of women - more than one in three women - have experienced at least one form of physical, psychological and/or sexual violence perpetrated by an intimate partner throughout their lifetime (Moreira & Pinto da Costa, 2020; UN Women, 2020). Rural, remote and northern (RRN) regions in Canada present the highest rates of IPV and femicide compared to urban centres, while having limited availability of IPV services (Moffitt et al., 2022). In times of crisis, IPV cases increase drastically; this is documented, for example, during Hurricane Katrina and the Ebola crisis (Meinhart et al., 2021; Schumacher et al., 2010). The COVID-19 pandemic has followed this trend as the amalgamation of risk factors including heightened stress, increased rates of substance abuse, economic uncertainty due to loss of employment, and stay-at-home orders contributed to unfavourable violence-prone domestic environments across the globe (Kaukinen, 2020; Kofman et al., 2020).

The primary objective of this research is to understand the challenges faced by IPV service providers and survivors during the COVID-19 pandemic in the context of Northwestern Ontario (NWO), from service providers' perspectives. Service providers were asked to share their perspectives on the following three guiding questions: (1) What are the unique challenges that service providers and IPV survivors, as understood by service providers, in NWO have faced due to the implementation of emergency protocols during the COVID-19 pandemic? (2) How might public policy support IPV related organizations and the individuals that access their services in times of crisis such as pandemics? (3) What is needed in the development of inclusive, gendered, and equitable health policy and emergency protocols in times of crises? Semi-structured, in-depth interviews were conducted with five IPV service providers located in different communities across NWO.

Five major themes and twenty subthemes were identified using thematic analysis methods. These themes were organized into five levels, policy, organizational, community, interpersonal, and individual, following a social-ecological framework (CDC, 2021). Most notably, service providers recognized the following barriers and

facilitators to service provision and access in NWO over the COVID-19 pandemic: (1) inequitable health policies coupled with an overburdened and extensively bureaucratic justice system; (2) the limited resources available to IPV service providers and the unexpected benefits of the pandemic for IPV service providers; (3) the limited availability of transportation and connectivity across NWO; (4) the violent relational dynamics due to quarantine and social distancing measures; and (5) the links between social location and increased risk of IPV.

These findings highlighted the need for gendered and equitable emergency policy, specifically, to recognize IPV organizations as essential services in times of crisis and provide adequate funding, address the structural barriers to service provision in NWO, and address existing inequities faced by IPV survivors.

Acknowledgments

Writing this thesis has truly been a marathon, and I could not have completed this journey without the aid and support of countless people who, in various ways, contributed and offered their valuable assistance.

First and foremost, I would like to express my deepest gratitude to my supervisor, Helle Moeller, whose unwavering support, guidance, and expertise through this process have been instrumental in shaping this thesis. Your kindness and dedication to your students and every project you undertake have truly made this research a transformative experience. Thank you for your mentorship.

I thank my thesis committee, Dr. Lori Chambers and Dr. Rebecca Schiff, for their guidance and support throughout the research process. Your expertise, constructive feedback, and commitment to excellence from each member have played a crucial role in shaping this thesis. I am fortunate to have had such a knowledgeable committee. I am grateful for the time and effort you dedicated to reviewing and providing your insights.

I am profoundly grateful to the study participants who generously shared their perspectives and experiences, making this research possible. Your willingness to participate and contribute to the understanding of IPV during the COVID-19 pandemic is invaluable.

I extend my appreciation to all advocates of gender-based violence, whose tireless efforts in raising awareness and promoting change have inspired and informed this work. Your commitment to creating a safer society for women is commendable, and I am honored to contribute to the discourse you champion.

Finally, to my sister, my mother, my grandmother and my father, who have been a constant source of support and encouragement, I am deeply grateful. Your love, understanding, and encouragement have been my anchor throughout this academic journey. Thank you for standing by my side and believing in my project.

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List of Abbreviations

DV	Domestic Violence
GBV	Gender-Based Violence
IPV	Intimate Partner Violence
NWO	Northwestern Ontario
RRN	Rural, Remote, Northern
SA	Sexual Assault
SES	Socioeconomic Status
VAW	Violence Against Women

Chapter 1: Background

1.1 Introduction

Intimate partner violence (IPV) is a public health concern that can affect individuals regardless of gender, socioeconomic status, sexual orientation, ethnicity, and geographic location (Moreira & Pinto da Costa, 2020). However, women are disproportionately represented in victimization rates worldwide with the World Health Organization reporting that on average 35% of women - more than one in three women - have experienced at least one form of physical, psychological and/or sexual violence perpetrated by an intimate partner throughout their lifetime (Moreira & Pinto da Costa, 2020; UN Women, 2020).

In Canada, according to statistical reports from 2018, women represented 79% of survivors of IPV cases reported to the police (Burczycka, 2018). The highest rates of police reported IPV were experienced by women aged 25 to 34 and living in northern and rural areas (Burczycka, 2018). Indigenous women were three times more likely than non-Indigenous women to experience spousal violence (Burczycka, 2018). From 2017 to 2018 shelters for IPV survivors across Canada reported over 68,000 admissions with the vast majority being women and their children (Statistics Canada, 2019). Of particular concern, women are the primary victims of intimate partner homicide, with an average of 69 women being murdered by a spouse or common-law partner every year in Canada (Canadian Femicide Observatory for Justice and Accountability, 2020).

1.1.1 Intimate Partner Violence: A Human Crisis

An alarming trend has been documented during several major global emergency crises and epidemics: the escalation in cases and severity of IPV (Kaukinen, 2020). For

instance, reports of increased rates of violence against women were documented post-hurricane Katrina and during the Ebola crisis in West Africa (Meinhart et al., 2021; Schumacher et al., 2010). However, these reports are often under prioritized, uncounted, and unrecognized under the weight of failing social and health systems (Chandan et al., 2020; Silva et al., 2020). Unfortunately, the COVID-19 pandemic followed the same trend. On April 5, 2020, Antonio Guterres, Secretary-General of the United Nations, issued a plea for "peace at home – and in homes – around the world" in response to a global surge in domestic violence and the number of women calling support services doubling with the implementation of worldwide lockdown measures (Guterres, 2020).

Countless systemic and individual behavioural changes triggered by the pandemic exacerbated social inequities while, simultaneously, limiting access to support systems (Evans et al., 2020; Kaukinen, 2020; Kofman et al., 2020). COVID-19 social distancing mandates severely impacted the socio-economic status of families worldwide (Alon et al., 2020). For instance, the U.S. unemployment rate surged from 3.8% in February 2020 to 14.4% in April, 2020, disproportionately impacting women (Alon et al., 2020). Women's unemployment and housing instability, has been associated with higher risk of IPV victimization, even when considering factors such as poverty and demographics (Peitzmeier et al., 2022). The amalgamation of risk factors including heightened stress, increased rates of substance abuse, economic uncertainty due to loss of employment, and stay-at-home orders contributed to unfavourable violence-prone domestic environments across the globe (Kaukinen, 2020; Kofman et al., 2020; Moreira & Pinto da Costa, 2020).

In a Canadian context, IPV rates increased dramatically prompting several organizations, advocacy groups, and news outlets across the country to sound the

alarm about the surge in domestic violence (DV) (Ghoussoub, 2020; Patel, 2020; Thompson, 2021). Crisis helplines and women's shelters experienced a 30% to 50% spike in call volume and online enquiries in the first few weeks of lockdown in March and April 2020 (Bradley et al., 2020). However, due to social distancing measures and travel bans, residential facilities for victims of abuse saw a considerable decline in intakes (-31%) compared to the previous 2017/2018 report, with 47,000 people - compared to 68,000 in 2017/2018 - accessing these services in 2020/2021 (Statistics Canada, 2022). According to the most recent report by the Canadian Femicide Observatory for Justice and Accountability, from 2018 to 2022 there were 850 femicides across the country of which 51% were perpetrated by an intimate partner (Canadian Femicide Observatory for Justice and Accountability, 2022; Statistics Canada, 2022). Ontario was the province with the highest number of femicides with rural areas and small towns being disproportionately impacted by higher rates compared to urban areas (Burczycka, 2018; Canadian Femicide Observatory for Justice and Accountability, 2022).

1.1.2 The Significance of an Increase in IPV Cases for Population and Public Health

The rise in IPV cases during COVID-19 and its aftermath is an urgent public health issue. The ramifications are far-reaching and multidimensional, affecting the mental and physical well-being of survivors and their surrounding community (Gerber et al., 2008; Sánchez et al., 2020; Smith et al., 2011). The effects are long-lasting and transcend generational divides as domestic abuse can affect both survivors, potential children, and other family members (Ehrensaft et al., 2003; Sánchez et al., 2020; Smith et al., 2011). Individuals in communities with pre-existing risk factors for interpersonal violence, including higher rates of unemployment, lower socioeconomic status,

geographic isolation and more, are increasingly vulnerable to IPV victimization and/or perpetration (Wenham, Smith, Davies, et al., 2020).

As previously stated, the COVID-19 pandemic followed alarming trends seen in previous emergency crises, contributing to the rise in IPV while simultaneously reducing accessibility to support systems and services (Wenham, Smith, Davies, et al., 2020). While stay-at-home orders were necessary in the fight against the spread of COVID-19, they had significant unintended consequences for individuals in vulnerable environments as "safe-at-home" does not apply to everyone (Anurudran et al., 2020; Bradbury-Jones & Isham, 2020). Although the Canadian federal government made significant efforts to address this phenomenon by announcing increased funding to aid survivors and service providers, the pandemic exposed a clear lack of emergency preparedness from governmental authorities (Bradley et al., 2020; Government of Canada, 2020).

On May 5, 2023, the WHO issued a statement officially downgrading the COVID-19 pandemic, reporting it is no longer a global emergency (WHO, 2023). However, IPV rates continue to skyrocket, with Thunder Bay declaring IPV an epidemic on October 2, 2023 (TBNewsWatch, 2023). This is consistent with trends reported in past disaster and emergency crises (Parkinson & Zara, 2013; Schumacher et al., 2010). Following Hurricane Katrina, advocates reported a surge in IPV as the aftermath of disaster left vulnerable communities with increased economic instability, homelessness, and mental health symptoms including depression and anxiety (Schumacher et al., 2010).

Advancement of knowledge in this area is of utmost importance considering the future is uncertain, with a potential for new pandemics and natural disasters that may have similar impacts on IPV rates (Bradley et al., 2020). Further, the need for innovative action has come to light as technological advancements and social media have

improved awareness of this phenomenon worldwide (Bradley et al., 2020; Chandan et al., 2020; Slakoff et al., 2020). Responsible media reporting is increasingly important; it aids in raising awareness of trends and available resources for survivors (Menon, 2020). Enhanced accessibility to communication tools and increased funding and research in this area, may help survivors with restricted access to conventional services in accessing the support they need (Bradley et al., 2020; Emezue, 2020). However, IPV survivors in rural, remote, and northern (RRN) regions often have limited or unstable access to internet services, therefore, it is imperative for governments and stakeholders to prioritize equal access to these resources for all communities (Emezue, 2020; Moffitt et al., 2022; Slakoff et al., 2020). The need for inclusive emergency protocols is a matter of health equity and human rights. Hence, a thorough exploration of this phenomenon may contribute to anticipating these trends and inform emergency planning, the distribution of funds for resource development, and the execution of prevention and mitigation strategies prior, during, and post-emergencies.

1.1.3 Study Setting and Population Background

This thesis will limit its scope to studying IPV trends during the COVID-19 pandemic in the region of Northwestern Ontario (NWO). Northern Ontario is subdivided, for some purposes, into two major regions - Northwestern Ontario and Northeastern Ontario (Thunder Bay Public Library, n.d.). The Northwest is constituted of the westernmost districts of the province of Ontario namely Rainy River, Kenora and Thunder Bay (Northwestern Ontario Municipal Association, n.d.). Geographically, this region lies north and west of Lake Superior and west of Hudson Bay and James Bay (Northwestern Ontario Municipal Association, n.d.). It includes most of subarctic Ontario and shares a border with the province of Manitoba to the west (Northwestern

Ontario Municipal Association, n.d.). Demographically, the region is the largest but least populated in the province with a total of 231,691 people according to the 2016 national census (Statistics Canada, 2017). Thunder Bay is the largest urban centre in the region and hosts more than 50% of NWO's population (Statistics Canada, 2017). Other major communities include Kenora, Dryden, Fort Frances, Sioux Lookout, Geraldton, Red Lake and Marathon, as well as many Indigenous and Francophone communities (Statistics Canada, 2016). Ontario is home to 23% of First Nations communities in Canada, with the majority located in Northwestern Ontario (Ontario, n.d., 2022). Thunder Bay is the urban centre with the largest Indigenous population (12.7%) in Canada (Ministry of Indigenous Affairs, 2018). Indigenous women represent a large portion of the population living in rural, remote, and northern areas of the country but constitute only 4% of the entire population (Moffitt et al., 2022).

Northwesterners have less access to health services compared to the rest of the province with only 24% being able to see their primary care provider within a day compared to 45% in the rest of the province (Health Quality Ontario, 2018). At the same time, Northern Ontario faces worse health outcomes compared to the rest of the province (Health Quality Ontario, 2018). For instance, measures of population health including low life expectancy and premature death rates are highest in the Northwest compared to the rest of the province (Health Quality Ontario, 2018). Specifically, life expectancy in the Northwest is 78.6 years compared to the overall provincial average of 81.5 years (Health Quality Ontario, 2018). Premature death rates are 258/100,000 compared to the 163/100,000 provincial rate (Health Quality Ontario, 2018). These statistics come as no surprise when viewed in relation to the Social Determinants of Health (SDOH) (WHO, n.d.-a).

SDOH including socioeconomic status, employment and education are also unfavourable in Northern regions of Ontario compared to the rest of the province, illustrating the many health inequities that Northerners face (Health Quality Ontario, 2018). Northwestern Ontario's major employment sectors are forestry, mining, and manufacturing (North Superior Workforce Planning Board, 2023). Nevertheless, the unemployment rate in Northern Ontario was 6.5% in 2017 compared to 5.6% of the provincial average (Health Quality Ontario, 2018). The number of citizens with secondary and postsecondary level education is fewer in Northern regions compared to the rest of the province (Health Quality Ontario, 2018). Health inequities are also present within Northern communities, for instance, Indigenous populations experience the most adverse health outcomes both regionally and nationally (Health Quality Ontario, 2018). Linguistic minorities, including Francophones, are also at a disadvantage as they encounter barriers in accessing services in their own language (Health Quality Ontario, 2018).

1.2 Purpose

The purpose of this research is twofold - first to identify and document gaps in knowledge by performing a review of the literature addressing the following question: What challenges and barriers did emergency protocols create for IPV service providers and their clients (IPV survivors), through service providers perspectives, during the COVID-19 pandemic? And - second, from the viewpoint of service providers, to shed light on the unique challenges that IPV survivors and service providers face in rural and remote regions of Northwestern Ontario. The goal is to raise awareness about these issues and inform future health policy and programming.

Chapter 2: Literature Review

A comprehensive literature review on intimate partner violence during the COVID-19 pandemic was conducted through two databases: PubMed and the Cumulative Index to Nursing and Allied Health Literature (CINAHL). The search terms used were “Domestic Violence” OR “Intimate Partner Violence” OR “Domestic Abuse” AND “COVID-19” NOT “Children” NOT “Elderly” NOT “Seniors”.

Article selection was based on the following inclusion criteria: (1) Article title or abstract included a combination of the search terms previously identified or related terms. For example, “spousal” was accepted as it relates to intimate partner dynamics; (2) Article title or abstract included “COVID-19” or “Pandemic” or “Lockdown”; (3) Article’s focus was domestic violence between intimate partners; (4) Article was published after the onset of the pandemic in March 2020; (5) Article was available in English with full text online; (6) Article was a systematic review/analysis or empirical study; (7) Article focused on the issue in Canada or countries with similar social contexts including the United States, the United Kingdom, Australia and New Zealand. However, articles that provided contextual information or new information pertinent to the subject were included even though they did not fit the last criteria, keeping in mind sociocultural differences. For instance, Naghizadeh et al. (2021) was the only article that explored the experiences of pregnant women and IPV during the COVID-19 pandemic through an empirical study taking place in Iran.

Exclusion criteria included the following: (1) Article delved into other types of violence or criminal activity. For instance, interpersonal violence between persons not in an intimate/romantic relationship; (2) Article focused on domestic violence affecting other family members including children and the elderly, instead of an intimate partner; (3) Article focused on other subjects (e.g., mental health during COVID-19); (4)

Article did not specify the period of interest to the study; “COVID-19”, “Pandemic”, “Lockdown”, “Stay-at-Home” etc.

Based on the eligibility criteria, the search on PubMed yielded 177 articles and CINAHL yielded 43 articles. Following title, abstract, and full text review 74 articles were selected for inclusion. Additionally, grey literature, commentaries, anecdotal accounts, news reports, and statistical reports from reputable sources were included and used to expand on the current social-ecological context and trends in Canada and worldwide. Findings from the literature review are reported narratively (Baker, 2016).

The literature review highlighted several trends that have contributed to the aggravation in frequency and severity of intimate partner violence (IPV), creating a “shadow pandemic” within the ongoing COVID-19 pandemic (Buttell & Ferreira, 2020; Evans et al., 2020; Sharma & Borah, 2020; UN Women, 2020). The identified literature has been analyzed and synthesized narratively based on Urie Bronfenbrenner’s social-ecological theory (Jill F. Kilanowski, 2017). This framework was originally applied to behavioural science but has been adopted in several health research studies (Jill F. Kilanowski, 2017; Rural Health Information Hub, n.d.). It offers a multidimensional lens allowing us to understand and systematically synthesize the wide variety of risk factors contributing to a phenomenon (Jill F. Kilanowski, 2017). Often depicted in a Venn diagram with all levels overlapping, the social-ecological model focuses on the complex relationships that govern a phenomenon, studying the interplay between the individual, societal, and the environmental aspects (e.g., political climate, historical period etc.) that contribute to specific health outcomes (CDC, 2021; Jill F. Kilanowski, 2017; WHO, n.d.-b). Departing from the notion that no single factor can comprehensively account for an individual or group’s heightened risk, through this framework we can explore not only the risk factors but the interactions that contribute

to an increased vulnerability to an outcome (CDC, 2021; WHO, n.d.-b). It is this composite network of factors at the social and ecological levels that more accurately describes why a rise in IPV has been documented in every major emergency crisis across the globe. Finally, this framework allows the researcher and audience to explore the full extent and nature of the phenomenon on the individual, interpersonal, organizational, community and public policy levels (Jill F. Kilanowski, 2017). This holistic approach to health research enables improvements in program and policy development and successful implementation (Eriksson et al., 2018; Jill F. Kilanowski, 2017). Consequently, the findings presented in this review are divided into two major sections, each addressing the risk factors that play on the "social" and "ecological" levels. The social risk factors will focus on the individual and interpersonal levels and the ecological risk factors focus on the community, organizational and public policy levels.

2.1 Social Risk Factors

This section focuses on IPV risk factors on the individual and interpersonal levels. Several studies highlighted the multitude of factors that heighten an individual's risk of experiencing intimate partner violence, and how the COVID-19 pandemic has compounded these individual and interpersonal dynamics, leading to an eruption in cases over a short period of time (Evans et al., 2020; Goh et al., 2020; Moreira & Pinto da Costa, 2020; UN Women, 2020). For instance, the inherent stresses associated with a pandemic coupled with increased unemployment have led to financial strains in many households, contributing to augmented rates of mental distress symptoms and substance abuse as coping mechanisms (Akel et al., 2021; Lange et al., 2020; Usher et al., 2020). Reports have indicated that nearly 25% of

Canadians increased alcohol consumption during the COVID-19 pandemic to manage stress or boredom (Statistics Canada, 2021). This is a concerning trend considering excessive use of alcohol is a risk factor for not only violence but the ultimate violent act of intimate partner homicide in about 40% of cases in Ontario (Canadian Femicide Observatory for Justice and Accountability, 2020; Lange et al., 2020; Royal Canadian Mounted Police, 2015; Yahya et al., 2020). It is important to mention that community is also a part of the broader social risk factors and will be talked about sporadically in this section. However, it has not been explicitly included in this section as it pertains to the "bigger picture" and is tied to the broader historical and political context as well as the cultural social norms that encompass the ecology in which an individual resides. Therefore, it will be addressed in depth in section *2.2 Ecological Risk Factors*.

2.1.1 Individual Risk Factors

Individual risk factors explore the root causes for a person's increased risk of victimization or perpetration of IPV. Although IPV can be experienced by any person, certain conditions increase vulnerability and susceptibility in specific demographics (Matoori et al., 2021). For instance, young women are more susceptible to experiencing different types of intimate partner violence than their older counterparts (Bennett et al., 2021; Bradley et al., 2020). In fact, rates of IPV decrease significantly with age as studies have found that younger age and developmental stage is correlated with higher risk of IPV victimization and perpetration (Bradley et al., 2020; Moreira & Pinto da Costa, 2020). Acceptance of aggressive behaviours appear to be higher in this demographic (Bradley et al., 2020; Moreira & Pinto da Costa, 2020). Available data demonstrates that women are the victims of more severe types of IPV including

physical and/or sexual violence compared to their male counterparts (Day et al., 2023; Mazza et al., 2020; Moreira & Pinto da Costa, 2020).

Other demographic factors also shape risk, including race/ethnicity and marital status (Kaukinen, 2020). In general, women belonging to a racial and ethnic minority exhibit increased risk of IPV as do women in dating and common-law relationships compared to married women (Bennett et al., 2021; Kaukinen, 2020). Research shows that dating and sexual violence is an alarming public health issue as on average 40% of college students experience sexual violence and 22% experience dating violence (Bennett et al., 2021). Furthermore, several studies have identified disproportionate victimization rates among women of colour (Bennett et al., 2021; Moreira & Pinto da Costa, 2020). These studies indicate that racial discrimination plays a significant role in the development of PTSD among minority students following experiences of dating or sexual violence (Bennett et al., 2021). Importantly, research suggests that belonging to a minority in specific societies has a more substantial impact on IPV victimization than belonging to an ethnic group in itself (Moreira & Pinto da Costa, 2020). Intersecting identities, systemic racism, and the cultural acceptance of gender-based violence contribute to the heightened risk of dating and sexual violence among young women, especially those who belong to an ethnic/racial minority (Bennett et al., 2021; Moreira & Pinto da Costa, 2020). Pregnant women are also at increased risk of IPV compared to women who are not pregnant due to the inherent psychological, physical, and financial stresses pregnancy brings onto the family unit (Hildersley et al., 2022; Krishnamurti et al., 2021; Naghizadeh et al., 2021). These risks have been exacerbated by confinement during the pandemic as social and functional isolation may lead to increased familial tensions and escalated conflict (Krishnamurti et al., 2021; Naghizadeh et al., 2021).

Furthermore, low socioeconomic status, low educational achievements and unemployment increase a person's susceptibility to IPV as they navigate the social margins (Haq et al., 2020; Moreira & Pinto da Costa, 2020; Zero & Geary, 2020). Similarly, persons of lower socioeconomic status are also at increased risk of IPV perpetration, inflicting more severe forms of violence onto their partners compared to persons in higher socioeconomic standing (Moreira & Pinto da Costa, 2020). This trend seems to be related to increased stress in the family due to financial burdens and/or similar risk factors that may lead to the escalation of intrafamilial arguments (Moreira & Pinto da Costa, 2020). Concerningly, women are disproportionately affected by employment loss during human crises, and in the current pandemic, as they often hold part time and informal professions, which are hardest hit by business closures (Alon et al., 2020; Ayittey et al., 2020; Wenham, Smith, Davies, et al., 2020). Women are not only impacted by increased financial burdens due to employment loss, but their social wellbeing is also often disregarded (Ayittey et al., 2020; Javed et al., 2021; John et al., 2020). Traditional gender roles unevenly distribute unpaid caregiving responsibilities in the household with women bearing most of the workload (Ayittey et al., 2020; Béland et al., 2020; Power, 2020). These dynamics became increasingly prevalent during lockdown due to school closures, rendering women more vulnerable to infection, abuse, and declining mental health (Ayittey et al., 2020; Power, 2020). The unintended consequences of emergency protocols and lockdown measures on women's wellbeing have historically persisted long after crises subside (Ayittey et al., 2020; John et al., 2020). For instance, research shows that men were able to regain their normal income post-Ebola crisis much faster than women, making this demographic increasingly vulnerable to the risk factors for victimization during and after human crises (Ayittey et al., 2020).

Additionally, a strong predictor for victimization and/or perpetration of violence in adulthood is a history of exposure to physical, psychological, or sexual violence within the home, especially during formative years (Mazza et al., 2020; Roseboom, 2020). Studies suggest that parenting skills and maternal mental health significantly decline as a result of intimate partner violence (Carter et al., 2022). Consequently, children may exhibiting internalized symptoms (e.g., depression and anxiety) and externalized behaviours (e.g., poor anger management, reactivity etc.) that can progressively escalate into violence in adulthood if no treatment is sought (Carter et al., 2022; Mazza et al., 2020). Similarly, up to 60% of veteran women report experiencing IPV, which is often compounded with experiences of sexual harassment and abuse during their time in service (Rossi et al., 2020). From a public health standpoint, this is a concerning trend as the increased rates of IPV during this pandemic may lead to long-lasting and intergenerational trauma (Roseboom, 2020). Moreover, neuropsychiatric disorders, particularly substance abuse, play a significant role in the increased risk of escalated intimate partner violence (Kaukinen, 2020). Unfortunately, these risks have been heightened by reported overconsumption of alcohol and other substances during the COVID-19 pandemic (Usher et al., 2020; Yahya et al., 2020). Finally, geographic location appears to also be a risk factor (Hansen & Lory, 2020). Women in rural, remote, and northern areas tend to experience higher rates of IPV with more frequency and severity than their urban counterparts (Hansen & Lory, 2020; Moffitt et al., 2020). These factors are further explored in section *2.2.1 Community Risk Factors*.

Emergency protocols, lockdowns, and social distancing mandates contributed to drastic social and behavioural changes that compounded all the aforementioned individual risk (often systematically created) factors, exacerbating inequities, and

increasing susceptibility to violence in the home (Carballea & Rivera, 2020; Moffitt et al., 2022; Usher et al., 2020). Temporary lockdowns and the closure of nonessential businesses has led to increased unemployment adding to the uncertainty and stressful circumstances of marginalized individuals in already precarious conditions (Boserup et al., 2020). Shutdown of in-person legal services paired with bureaucratic barriers to accessing services and supports, also contributed to increased individual vulnerabilities to IPV (Bennett et al., 2021; Michaelsen et al., 2022; Riddell & Haighton, 2022; Sacco et al., 2020; Taylor, 2022). All in all, the literature indicated pre-existing risk factors and social inequities at the individual level that are inherently magnified/aggravated in times of crisis (Akel et al., 2021; Evans et al., 2020). The restrictions implemented to halt the spread of COVID-19 have undeniably and disproportionately affected vulnerable individuals leading to patterns of increased violence among intimate partners (Bradbury-Jones & Isham, 2020; Buttell & Ferreira, 2020). Hence, addressing this complex issue requires an intersectional and feminist approach that takes into account individual vulnerabilities and systematic barriers to service access (De Coster & Heimer, 2021; Drew, 2020).

Considerations Specific to Indigenous Populations.

According to reports, Indigenous women experience the highest rates of IPV compared to non-Indigenous women (Moffitt et al., 2020). They are most at risk of experiencing spousal violence, and more often experience severe forms of violence including sexual assault, physical abuse, and homicide (Boyce, 2016; Moreau et al., 2020). These trends are a symptom of the historical oppression lived by Indigenous peoples due to colonialism, forced relocation, residential schools, largescale abuse of Indigenous children in child protective services, and all its consequences (Brassard

et al., 2015; K. M. Campbell, 2007). These systemic and violent assimilation practices imposed by governmental authorities evolved into transgenerational trauma, disrupting familial bonds, relationships, traditions, and normalizing violence within the household (Brassard et al., 2015; Campbell, 2007).

2.1.2 Interpersonal Risk Factors

The amalgamation of individual risk factors directly influences interpersonal relationships, leading to violence prone environments. The Centre for Disease Control and Prevention (CDC) identifies four major types of IPV: physical abuse, sexual violence, stalking, and psychological aggressions (CDC, n.d.). Relationships with violent tendencies between partners often exhibit power imbalances where one partner exerts control over the other on different levels (Bradbury-Jones & Isham, 2020; Kaukinen, 2020; Moreira & Pinto da Costa, 2020). In many cases, mistreatment follows a "scale of violence" where perpetrators begin with intimidation, devaluation, isolation and slowly escalate towards full-blown emotional, physical, or sexual abuse (Kaukinen, 2020; Sacco et al., 2020).

The propensity for violence in domestic environments can be attributed to various interpersonal risk factors. These include heightened stress, financial strains stemming from loss of employment, increased anxiety and depression, social isolation, and substance abuse (Bouillon-Minois et al., 2020; Leslie & Wilson, 2020; Silva et al., 2020; Usher et al., 2020). Consequently, the COVID-19 pandemic and stay-at-home mandates have drastically impacted familial dynamics as lockdown and business closures imposing forced isolation and economic distress among the most vulnerable demographics (Benoit et al., 2022; Boserup et al., 2020; Gelder et al., 2020).

Internationally, many organizations have reported a considerable spike in call volume to IPV services and hotlines, digital traffic, and police reports exposing the irony of “safe at home” campaigns (Gregory et al., 2022; Kofman et al., 2020; Leslie & Wilson, 2020). This is consistent with exposure reduction theory, where more time spent together leads to increased altercations that can turn violent between partners in abusive relationships (Hsu & Henke, 2021). This trend was seen worldwide with the United Nations, various advocacy groups, and news outlets raising concerns and demanding the prioritization of this issue as the pandemic revealed a grim reality (UN Women, 2020; Usher et al., 2020; Weller et al., 2021). Locally, in Canada, several IPV service providers in British Columbia, Alberta, and Ontario experienced significant increases in call volume compared to the same period in previous years (Bradley et al., 2020). On the other hand, some regions reported up to a 50% drop in call volume (Evans et al., 2020); it was speculated that this was a symptom of confinement and isolation preventing survivors from safely contacting services (Carballea & Rivera, 2020; Emezue, 2020; Jetelina et al., 2021; Sorenson et al., 2021). In many cases, stay-at-home mandates created coercion prone environments in which individuals were constantly monitored by perpetrators and unable to safely seek help from social support systems including family and friends (Anonymous, 2020; Bouillon-Minois et al., 2020; Hegde, 2021; Neil, 2020). Of concern, femicide, also tied to these factors, increased significantly nationally and internationally during this time (Bonomi et al., 2021; Standish, 2021).

In addition, evidence suggests that economically disadvantaged partners of abusers were less likely to file IPV police reports due to their financial dependency (Hsu & Henke, 2021). Thus, the ongoing pandemic amplified vulnerabilities, created environments in which coercive dynamics within partners lead to violence and,

simultaneously, limited victims' capacity to access support systems (Bradley et al., 2020; Lyons & Brewer, 2021; Usher et al., 2020). For instance, reports of cases in which perpetrators used the dangers of COVID-19 to exert control and further isolate their partners from support systems are rampant (Jarnecke et al., 2020; Lyons & Brewer, 2021; Ragavan et al., 2022).

Reports have pointed at the escalation not only in frequency but severity of physical and sexual IPV (Hansen & Lory, 2020; Jetelina et al., 2021; Roseboom, 2020; Sharma & Borah, 2020). A study on victims treated at a radiology clinic illustrated a significant increase in the incidence of physical abuse (42%) during the first lockdown compared to the same period (12%) during the previous year (Gosangi et al., 2021). The results emphasized the increased incidence and severity of high-risk injuries which included strangulation, use of weapons, stab wounds, and burns (Gosangi et al., 2021). In brief, the literature clearly emphasized that emergency protocols, while implemented to curb the spread of COVID-19, placed many individuals in precarious and even dangerous situations and diminished their capacity to seek help or navigate the end of an abusive relationship (Buttell & Ferreira, 2020; John et al., 2020; Kaukinen, 2020).

2.2 Ecological Risk Factors

Ecological risk factors include the broader cultural, socioeconomic, and political aspects that shape the systemic issues giving rise to an increase in IPV rates. This section will focus on the community, organizational, and policy level risk factors that have contributed to this surge in cases. The COVID-19 emergency response heavily impacted marginalized communities and IPV service providers by adding financial and logistical strains on an already underfunded sector, as efforts were redirected towards

COVID-19 (Gulati & Kelly, 2020; K. Johnson et al., 2020; Wenham, Smith, Davies, et al., 2020). For instance, social distancing measures have limited shelters' ability to accommodate individuals seeking temporary housing, with some centres having to turn women and children away due to overcapacity, and in the more extreme cases having to close their doors to the public (Bagwell-Gray & Bartholmey, 2020; Leslie & Wilson, 2020; Michaelsen et al., 2022; Nnawulezi & Hacskaylo, 2021; Riddell & Haighton, 2022). In rural areas, these factors have exacerbated the already precarious circumstances that IPV survivors face due to their remote geographic locations with services often situated hours from home (Hansen & Lory, 2020; Lanier & Maume, 2009; Moffitt et al., 2022). Additionally, for women living in fly-in communities, or communities without year-round road access, or inter-city bus services, leaving a violent domestic environment may require extensive planning, deterring individuals from seeking help (Moffitt et al., 2020). These factors and more will be explored further in each of the following sections.

2.2.1 Community Risk Factors

Community risk factors are dependent on cultural values, expected gender roles, socioeconomic status, geographical location, and any other factor that characterizes the community (Moreira & Pinto da Costa, 2020). These factors often overlap, at times giving rise to increased susceptibility to violent environments (Moreira & Pinto da Costa, 2020). For instance, rural, remote, and northern areas tend to adhere to more traditional and patriarchal views concerning gender roles as men are expected to fill the role of breadwinners and women bear the brunt of housework and caregiving roles (Javed et al., 2021; Jeffrey et al., 2019; Moreira & Pinto da Costa, 2020). Conflicts may arise when these traditional views are not upheld due to economic

strains and the increased need for double income households, leading to coercive and controlling behaviours that can escalate into physical confrontations (Jeffrey et al., 2019; Moffitt et al., 2022; Moreira & Pinto da Costa, 2020). These factors are further exacerbated by the financial strains that the COVID-19 pandemic has put on households across the country with many people being left unemployed, ramping up stresses, and leading to tensions between partners (Moffitt et al., 2020). Furthermore, although rural areas have tight-knit communities, this may act as barrier to individuals experiencing IPV as they lack privacy and anonymity when seeking services (Moffitt et al., 2022). Individuals may fear that seeking help could strain close relationships due to relatives, friends, and acquaintances working in all sectors including emergency services (Jeffrey et al., 2019; Moffitt et al., 2022). In addition, some rural, remote, and northern communities exhibit a prominent hunting culture at times leading to looser perspectives around firearm control and ownership (Hansen & Lory, 2020; Moffitt et al., 2020). Unfortunately, easier access to firearms is correlated with higher rates of femicide in rural areas and small towns across the country (Jeffrey et al., 2019).

Furthermore, women often bear the brunt of caregiving in their communities, as their traditional gender roles place them on the front lines of catastrophes in the home and in the workplace (Ayittey et al., 2020; Wenham, Smith, & Morgan, 2020). For instance, women represent over 70% of the health professionals working on the frontlines of the current pandemic (Sánchez et al., 2020). Coupled with their expected role of primary caregivers for children, the sick, and the elderly, women are at increased risk of experiencing “caregiver burden” as they manage heightened stresses across social environments often leading to escalated conflict (Ayittey et al., 2020; Connor et al., 2020; Sánchez et al., 2020).

Communities that are historically marginalized have been seriously impacted by the pandemic and its restrictions, further exacerbating their already precarious conditions (Kaukinen, 2020). These communities generally consist of individuals facing low socioeconomic status, residing in impoverished areas, or experiencing homelessness (Mazza et al., 2020; Ragavan et al., 2020). People belonging to ethnic minorities within these communities also face an increased risk of experiencing abuse from an intimate partner or family member (Bennett et al., 2021; Mazza et al., 2020). This heightened risk is linked to the inherent stresses associated with their challenging circumstances (Mazza et al., 2020; Ragavan et al., 2020). For instance, research suggests that undocumented immigrants experience additional obstacles when seeking IPV supports (Cleaveland & Waslin, 2021; Emezue, 2020). These challenges include fear of law enforcement due to legal status, limited information about resources available near them, and language barriers (Emezue, 2020; Ragavan et al., 2020; Zero & Geary, 2020). Moreover, Indigenous women in Canada experience the highest rates of intimate partner violence and intimate partner homicide (IPH) compared to non-Indigenous women (Bailey & Shayan, 2021; Jeffrey et al., 2019; Sutton, 2023). This is due in part to historical oppression stemming from colonialism that led to the marginalization of Indigenous populations and indoctrination of systemic racism and upheld patriarchal views and capitalism (Demkiw, 2023; Jeffrey et al., 2019; Moffitt et al., 2022).

Finally, quarantine restrictions have systematically isolated individuals from their communities, limiting, and in some cases completely cutting access to support networks, increasing the challenges of navigating the end of abusive relationships (Jarnecke et al., 2020). Consequently, the increasing rates of intimate partner violence are in direct correlation with existing social inequities which disproportionately affect marginalized and impoverished communities (Evans et al., 2020; Hansen & Lory, 2020).

In order to address these rates, we must first invest in public health policy and programming that accurately represent the voices of those in the margins and tackle the social determinants of health on a community level, especially in the context of a global crisis that has caused systematic isolation among vulnerable individuals (Evans et al., 2020; John et al., 2020; Wenham et al., 2020).

2.2.2 Organizational Risk Factors

Organizational risk factors pertain to the challenges faced by IPV service providers that influence an individual or community's ability to seek support systems. These organizations include social services, shelters, counselling services, as well as clinical, legal, and emergency services (e.g., 911) (Johnson et al., 2020). Service providers faced significant and sometimes insurmountable obstacles as governmental authorities deprioritized this sector and shifted the allocation of funds and human resources towards the COVID-19 effort (John et al., 2020; Johnson et al., 2020; Roseboom, 2020).

At the organizational level, many service providers were forced to quickly adapt to the ever-evolving situation without much support as they scrambled to meet newly implemented operational restrictions (Johnson et al., 2020). For instance, shelters were forced to restructure their facilities to abide by social distancing rules, significantly decreasing their capacity to house individuals seeking shelter (John et al., 2020; Michaelsen et al., 2022; Moreira & Pinto da Costa, 2020; Wood et al., 2020). This resulted in shelters having to turn away clients fleeing abusive households (John et al., 2020; Moreira & Pinto da Costa, 2020). In the worst cases, several organizations were forced to shut down operations due to their inability to accommodate increasingly restrictive guidelines to halt the spread of COVID-19 (Johnson et al., 2020; Moreira &

Pinto da Costa, 2020). Work from home mandates also had a considerable impact on several services, social workers were faced with great challenges in reaching their clients and offering adequate support (K. Johnson et al., 2020; Riddell & Haighton, 2022; Wood et al., 2020). These logistical issues along with the ominous presence of a deadly virus, greatly contributed to IPV survivors' inability and reluctance to access traditional protective services and support systems, having to weigh the risk of contracting COVID-19 while seeking alternative accommodations (John et al., 2020; K. Johnson et al., 2020; Papadimos, 2020; Sánchez et al., 2020). These findings suggest a critical need for improvements in training, infrastructure, and support for the workforce (Emsley et al., 2023; Riddell & Haighton, 2022; Wood et al., 2020). Additionally, IPV service providers should be classified as first responders in order to increase support and access to economic resources, and address burnout and occupational stresses among the workforce associated with the COVID-19 pandemic (Michaelsen et al., 2022; Riddell & Haighton, 2022; Wood et al., 2020).

Geographic location of organizations is an important factor that determines accessibility to IPV support systems for survivors. IPV service providers tend to be limited and scarce in rural, remote, and northern regions (Hansen & Lory, 2020; Moffitt et al., 2020). This affects their ability to reach and help survivors with safety planning as individuals are often unable to travel long distances due to weather conditions and/or unavailable public transit – conditions that are worsened in times of crisis (Hansen & Lory, 2020; Moffitt et al., 2020). For instance, a survey reported that the average distance an individual travelled to the nearest IPV resource in rural areas was three times higher than the distance travelled by their urban counterparts (Hansen & Lory, 2020). Furthermore, police response time in rural and northern areas is also impacted by long distances (Hansen & Lory, 2020). This situation has been intensified

by the pandemic as dispatchers are required to ask additional questions related to COVID-19 with some opting to resolve matters over the phone due to the risk of contagion (Hansen & Lory, 2020). These operational changes increased the barriers individuals face while seeking help from service providers. It is a concerning situation as women living in rural, remote, and northern areas are at higher risk of experiencing IPV with increased frequency and severity compared to women living in urban areas (Hansen & Lory, 2020). In a Canadian context, these findings are of grave concern given the population distribution across a vast territory, leaving many vulnerable individuals isolated and unable to access formal services or informal social support systems (Moffitt et al., 2022). The literature review indicated a gap in knowledge on the subject as only two articles delved into the unique challenges that persons living in rural, remote, and northern areas of the country experience. Increased research focusing on these populations is needed to properly address their needs and inform policy and emergency preparedness.

Finally, other resources that are integral for IPV survivors such as clinical and legal services were also faced with increased challenges during the on-going pandemic. For instance, in-person visits to physicians were in some cases completely unavailable, limiting clinics' ability to screen for IPV and/or perform necessary services such as collection of specimens for examination and legal purposes (Coulthard et al., 2020; K. Johnson et al., 2020; Neil, 2020; Rossi et al., 2020). The legal field was also impacted, with courts and legal services being closed during quarantine and court dates being postponed indefinitely, limiting survivor's ability to take protective legal action such as restraining orders (Gulati & Kelly, 2020; K. Johnson et al., 2020; Mazza et al., 2020). All in all, the literature demonstrated a need for inclusive and properly informed emergency preparedness as well as increased funding and governmental support

towards organizations that provide services to IPV survivors in marginalized and isolated communities (Bettinger-Lopez et al., 2022; Bettinger-Lopez & Ezer, 2020; Moffitt et al., 2022).

2.2.3 Public Policy Risk Factors

Public policy has played an important role in shaping societal structures over the pandemic. Emergency protocols preceded most administrative functions and all efforts were diverted to prioritizing the fight against COVID-19 over other health issues (Johnson et al., 2020). The deprioritization of IPV, clinical, legal, and emergency services as well as the lack of emergency preparedness were identified as key barriers in addressing the increased rates of IPV during this pandemic (John et al., 2020; Olding et al., 2021). In the initial stages of the pandemic, IPV services were flagged non-essential with governments diverting resources to the COVID-19 response, leaving underfunded organizations unsupported (Johnson et al., 2020). IPV service providers faced several challenges in adapting to the fast-evolving environment as they were ill equipped to face a crisis of this magnitude due to the lack of policy surrounding emergency protocols (John et al., 2020; Johnson et al., 2020). This led to increased tensions within organizations, as staff often struggled to adapt to the continuous changes throughout the pandemic, leaving workers with a poor understanding of guidelines (Johnson et al., 2020). The literature demonstrated a clear gap in policy surrounding emergency preparedness in different sectors.

In addition, the literature expressed the need for cohesion between all service providers, organizations, and stakeholders involved in all aspects of IPV prevention and treatment (Jetelina et al., 2021). Addressing the risk factors and consequences of IPV requires an extensive network of social, clinical, and legal services (Gulati & Kelly,

2020; Johnson et al., 2020). For instance, medical centres are a crucial first line of defense as health care workers are able to assess a person for physical signs of abuse (Gulati & Kelly, 2020; Hudson et al., 2020). These institutions are also able to provide resources, educate, raise awareness on service availability, and connect survivors with legal services (Gulati & Kelly, 2020; Hudson et al., 2020). However, clinics often lack established policy on IPV surveillance and/or health care workers are not fully briefed on protocols (Bhavsar et al., 2021; Coulthard et al., 2020; Gulati & Kelly, 2020; Telles et al., 2020). Several sources have indicated an increase in injuries caused in domestic altercations between partners (Olding et al., 2021). Thus, it is important for medical centres to implement standard policy for IPV screening, intervention, and support for their patients considering they may be the only resource that these individuals are able to access (Matoori et al., 2021; Rossi et al., 2020; Telles et al., 2020; Zero & Geary, 2020). Studies point at the need for specialists such as plastic surgeons, radiologists, and maxillofacial surgeons to have IPV screening tools and questionnaires (Abbate Ford et al., 2021; Coulthard et al., 2020). This is crucial because most injuries due to domestic violence are perpetrated on the upper body (Abbate Ford et al., 2021; Boserup et al., 2020; Coulthard et al., 2020; Matoori et al., 2021). Telehealth and digital public health tools can be useful resources; however, they pose barriers in the identification of subtle IPV signs (Grimes & Uppal, 2021; Jeyaraman & Chandan, 2020; Ver et al., 2021). It is crucial to improve these resources and establish clear protocols that can be used to successfully screen and support out-of-reach patients (Grimes & Uppal, 2021; Jeyaraman & Chandan, 2020; Ver et al., 2021). Hence, investing in screening, prevention, and intervention tools for IPV in the medical sector is critical, and these protocols can be modelled after available resources offered by the WHO or the UN (Di Franco et al., 2020).

Psychiatrists are also key stakeholders in IPV screening, treatment, and recovery as access to therapeutic services allows survivors to treat mental illness, recover from past abuse, or navigate the end of a relationship (Fares-Otero, 2020; Gulati & Kelly, 2020). Further, perpetrators can also benefit from these services to treat underlying trauma, mental illnesses, and substance abuse that increase their susceptibility to violence (Fares-Otero, 2020; Gulati & Kelly, 2020; Telles et al., 2020). Therefore, a well-established network of service providers catering to IPV survivors as well as perpetrators is needed in many areas. These networks should be guided by inclusive, gendered, and equitable policy informed by care provider and survivor voices (Connor et al., 2020; John et al., 2020).

Finally, the literature clearly highlights the direct consequences of COVID-19 restrictions on the rising rates of IPV (Viero et al., 2021). This can be a jumping off point to establish the need for inclusive and equitable emergency preparedness plans. Collaboration across researchers, organizations, and community members would benefit the continuous collection of qualitative and quantitative data on IPV and the risk factors contributing to this issue on all levels (Bagwell-Gray & Bartholmey, 2020; Chandan et al., 2020). These partnerships would help highlight survivor voices and improve policy (Bonomi et al., 2021). Innovative digital solutions for screening, safety planning, and intervention need to be included in emergency protocols in order to prevent dramatic increases in IPV rates and the more extreme consequences including intimate partner homicide (Bonomi et al., 2021; Grimes & Uppal, 2021; Krishnamurti et al., 2021).

This pandemic has been a learning curve for many organizations and governmental institutions, and it is crucial to establish new policy surrounding emergency protocols taking into account the many social inequities that reign the

prevalence of IPV in vulnerable populations (Chandan et al., 2020; John et al., 2020; Wenham et al., 2020). Decision-makers need to include survivor and service provider voices in the policy development process in order to fully understand and address the risk factors that have led to the significant rise in IPV worldwide and prevent this phenomenon in any future emergency crisis (Bradbury-Jones & Isham, 2020).

2.3 Gaps in Knowledge

Through the literature review several gaps in knowledge concerning IPV in times of crisis have been highlighted. Much of the literature available concerning this phenomenon derives from news reports, anecdotal evidence, commentaries, and letters to the editor, pointing at the prevalence of these trends but the lack of extensive research in the field (Viero et al., 2021). This has considerably improved with more literature being produced during and in the aftermaths of the pandemic, especially focusing on service provider perspectives on what is needed to tackle the surge in IPV in times of crisis (Michaelsen et al., 2022; Montesanti et al., 2022; Riddell & Haighton, 2022).

The literature also lacks depth on the socioeconomic consequences of the increased rates of IPV on the broader public health system (Sharma & Borah, 2020). For instance, high incidence of IPV is a health burden for governments and can indirectly contribute to an economic crisis as people most affected are in their most productive ages (Sharma & Borah, 2020). Further, aspects of IPV such as its long-term cognitive effects, including chronic depression and anxiety, loneliness, and maladaptive coping mechanisms are often not explored in depth (Elvey et al., 2022; Goodman & Epstein, 2020; Hildersley et al., 2022; Smith et al., 2011).

Studies focusing on minorities and marginalized populations are very scarce with only a handful addressing the unique challenges that rural communities, Indigenous populations, and ethnic minorities have faced while navigating violent home environments during the COVID-19 pandemic (Cleaveland & Waslin, 2021; Hansen & Lory, 2020; Moffitt et al., 2022). Moreover, a significant knowledge gap exists regarding sexual minorities and IPV. Only two articles touched upon this subject presenting very concerning statistics. Walsh et al. (2021) reported a significant increase in IPV among surveyed coupled men. Additional research into IPV predictions, possible interventions, and inclusive support systems that protect the safety and confidentiality of LGBTQ+ IPV survivors is urgently needed (Stephenson et al., 2021; Walsh et al., 2022).

Similarly, IPV is often a gendered issue that is thought to mostly affect women, however, men can also experience high rates of IPV (Warburton & Raniolo, 2020). Although men exhibit lower rates of victimization, these are speculated to be significantly underrepresenting real rates as men are more likely to underreport abuse and seek help due to social prejudice, embarrassment, and shame (Warburton & Raniolo, 2020). However, organizations such as The Mankind Initiative in Britain, reported a 35% increase in call volumes during lockdown (Warburton & Raniolo, 2020). Unfortunately, this is a huge gap in knowledge as only one out of the selected articles focused on IPV experiences of male survivors.

Finally, several studies have listed the investment into virtual tools as a crucial step in providing support to hard-to-reach survivors (Carballea & Rivera, 2020; Emezue, 2020; Jeyaraman & Chandan, 2020). However, very little information on innovative tools, guidance on competencies, and employability is present in the literature (Emezue, 2020; Jeyaraman & Chandan, 2020). These initiatives to combat the

current crisis, especially from equitable and properly informed perspectives, are both needed and lacking (Carballea & Rivera, 2020; Emezue, 2020; Jack et al., 2021; Jeyaraman & Chandan, 2020).

2.4 Updates to Literature Review

This literature review was updated for the last time in November of 2023. Using the same search engines (i.e., PubMed and CINAHL), and search terms outlined at the beginning of this chapter. 87 additional articles were selected for review. Following abstract and full text review based on the predetermined inclusion and exclusion criteria above, 74 articles were included in the updated literature review. New themes and trends found in these additional articles have been documented in the section below *2.5 Arising Post-Pandemic Trends and Findings.* These trends were included as they relate to the social-ecological brought on by the pandemic and its public health mandates.

2.5 Arising Post-Pandemic Trends and Findings

Research conducted in the aftermath of the pandemic regarding domestic violence and intimate partner violence (IPV) has substantiated earlier speculations (Hodgkinson et al., 2023). Advocates, organizations addressing IPV, and existing literature all point to a spike in rates both during and after the pandemic (Peitzmeier et al., 2022). An examination of domestic crimes documented by the UK police force revealed a decrease in cases during the initial lockdown, followed by a prolonged increase in the post-lockdown period (Hodgkinson et al., 2023). Advocates had forewarned about these patterns in the early stages of the pandemic, attributing the surveillance of abusers as a deterrent for IPV survivors to seek help, in turn driving the

rates of reported IPV down (Bagwell-Gray & Bartholmey, 2020; Kaukinen, 2020; Leigh et al., 2023; Schrag et al., 2022; Slakoff et al., 2020).

As more reports and research become available post-pandemic, certain trends are starting to shed light on the experiences of IPV survivors, the provision of IPV services, and access during the pandemic. Emerging literature underscores the risks and advantages of technology, particularly as the pandemic reinforced digitalization of services. Researchers highlight the fact that abuse took on a modern twist, with a surge in reports of abuse manifesting in a digital form (Hegde, 2021; Sower & Alexander, 2021). For IPV survivors, the ability to connect with hotlines, counselors, and the police is crucial, and having internet access and smartphones facilitates this (Hegde, 2021). However, technology can play a dual role in both supporting and challenging the systemic inequality and injustices inherent to abusive relationships (Hegde, 2021). Advocates reported that abusers exert control through constant monitoring of communication, cracking passwords, tracking search histories, or using devices to surveil their partners (Emezue, 2020; Hegde, 2021; Leigh et al., 2023; Sower & Alexander, 2021). In addition, emerging literature on the experiences of IPV service providers underscores the need for new occupational regulations as the industry has shifted to a work-from-home model (Baffsky et al., 2022; Riddell & Haighton, 2022; Wood et al., 2020). A study on the needs of the IPV/SA workforce, highlighted the need to separate IPV/SA workers' home life from their work in order to avoid burnout and turnover rates (Emsley et al., 2023). Overall, new literature confirms trends foreseen by advocates in the beginning of the pandemic, with new literature focusing on COVID-19 specific forms of abuse, and an increased interest in the occupational needs of IPV service providers as a way to improve service delivery.

As previously mentioned, the end of the pandemic was declared in May 2023; however, we are just beginning to understand the hidden and long-term effects of the pandemic. Most recently, IPV has been declared an epidemic in over 40 municipalities across the province of Ontario (CBC News, 2023b; Khan, 2023). The province has not yet declared IPV an epidemic (CBC News, 2023b). The implications of this declaration are discussed in *Chapter 5: Discussion*.

2.6 Research Question and Specific Objectives

The literature review revealed there is a considerable gap in the literature on the topic of intimate partner violence in a Canadian context, especially in underserved rural and remote regions in Northwestern Ontario. Further, the literature does not present much information on inclusive emergency protocols that take into account vulnerability to IPV. This research study is timely and of great significance as IPV has been declared an epidemic in Thunder Bay and various other municipalities across the province (TBNewsWatch, 2023).

Based on the results from the literature review outlined in this chapter, the proposed qualitative research project seeks to (1) explore the challenges that service providers and IPV survivors - as understood by service providers - have faced during the COVID-19 pandemic due to the implementation of emergency protocols in rural and northern areas of Ontario, and (2) identify ways in which public policy could support IPV related organizations and the individuals who access these services in times of crisis.

This study aims to bridge the knowledge gap on IPV during the COVID-19 pandemic in NWO, providing insights to shape public policy and guide fund allocation. The focus is to inform the development of inclusive and equitable emergency planning

from a feminist perspective, taking into account the social-ecological determinants of health. This knowledge may help mitigate risk factors contributing to the rise in intimate partner violence cases during and post times of crisis.

The following questions are at the forefront of the proposed qualitative enquiry and have guided the development of the research methodology throughout the study:

(1) What are the unique challenges that service providers and intimate partner violence survivors - as understood by service providers - in Northwestern Ontario have faced due to the implementation of emergency protocols during the COVID-19 pandemic?

(2) How might public policy support IPV related organizations and the individuals that access their services in times of crisis such as pandemics?

(3) What is needed in the development of inclusive, gendered, and equitable health policy and emergency protocols in crises such as pandemics?

Chapter 3: Methodology

This chapter describes the methodology behind the qualitative research study performed from March to May 2022. I start with my positionality as lead researcher, disclosing my social location and the lived experiences that have led me to take an interest in this topic. In this way, I position myself within the socio-ecological context of the study. Next, I delve into the conceptual paradigm guiding this inquiry and the feminist point of view behind the conception of this research. Leading into the theory and approach section, I explain my choice for a phenomenological leaning qualitative study as the basis for this inquiry and the socio-ecological framework through which data was interpreted. Finally, I describe the study design, including data collection and analysis methods, research rigour, confidentiality procedures, and ethical considerations.

3.1 Positionality

Understanding my positionality is a critical element of a qualitative researcher. My position and identity can influence the research design, collection, analysis, and interpretation of data (Holmes, 2020). Positionality is often identified by locating the researcher in relation to the following three areas: (1) the study subject, (2) the research participants, and (3) the research context and process (Holmes, 2020). This process requires the researcher to reflect on and acknowledge their views, values, and beliefs relating to the research design, conduct, and output (Holmes, 2020). I hereby disclose my positionality about this research study.

I am a Master of Public Health student at Lakehead University. I have a diverse research background in the health sciences and graduate level training in qualitative research. I am an immigrant cis-gendered woman, born in Latin America and raised

there until the age of 10, when my family immigrated to Canada. I have lived in the Greater Toronto Area for the majority of my adolescent and young adult life. Growing up as a visible minority in a low-income household in Canada, considerably shaped the development of my understanding of the world, beliefs, political stance as well as personal goals. Politically, I am left leaning. My cultural background has led me to align with an intersectional view on feminism, coined and developed by Kimberlé Crenshaw (1991), with my geopolitical context, cultural and religious norms shaping my view of women in society, gender roles, and feminism as an inclusive movement.

To position myself in the study context - I have always lived in or near major metropolitan as well as small urban centres - Toronto, Sudbury, and Thunder Bay. I have spent a few summers working as crew lead in smaller towns located in Northwestern Ontario, including Kenora, Red Lake, Fort Frances, Dryden, and Wawa. This role allowed me to familiarize myself, firsthand, with the geographic and social context of NWO. I have experienced some violent behaviours in past romantic relationships, none being physical in nature. Nevertheless, I do not have personal experiences with extreme cases of IPV but have experienced it through the lens and stories of women who are a part of my extended family.

My background, experiences, and world views have shaped my chosen career path in the health sector. My interests in pursuing this research endeavour lie in my innate curiosity for understanding the “full picture” and the factors that shape our social structures and that lead to social inequities. This topic captured my interest, first, because it is the consequence and violent manifestation of the historical oppression of women in a patriarchal society (K. L. Anderson, 2013; Dobash & Dobash, 1984; Hunnicutt, 2009; M. P. Johnson, 2011). This perpetuation of violence against women in the home does not only affect the victimized individual, but also those who

surround them, leading to intergenerational trauma and a damaged society at the core (Ehrensaft et al., 2003; Smith et al., 2011). Second, I am particularly interested in relational dynamics from a psychological, and sociological lens. The rise of IPV in times of crisis is a testament to how much damage humans can cause to each other when feelings of uncertainty and increased stressors are not effectively processed in a healthy manner (Ehrensaft et al., 2003; Sharma & Borah, 2020; Smith et al., 2011). Finally, my interest in this field stems from the belief that, through the acquisition of this knowledge, I am able to contribute to a solution both as a researcher and as an individual navigating my own relationships.

3.2 Conceptual Paradigm

This study aimed to understand the complex relationships between existing inequities and risk factors for IPV, as well as the compounding effect that the COVID-19 pandemic and emergency protocols had on both vulnerable individuals and IPV service providers. Mainly, the study sought to acquire an in-depth understanding of the "why" and "how" that led to an alarming rise in intimate partner violence since the onset of the pandemic in March 2020. This inquiry was guided by an intersectional feminist point of view, taking into account the interplay between gender, race, sexual orientation, gender identity, and socioeconomic status (Crenshaw, 1991). It is important to mention that although IPV is a gendered issue - women being the primary victims at the hands of male partners - this does not negate intersectionality (Ayittey et al., 2020; Johnson, 2011). In fact, emerging literature suggests that individuals of diverse gender identities and sexual orientations experience equal and sometimes higher rates of some forms of IPV compared to cis-gendered women in heterosexual relationships (Pistella et al., 2022).

Contextualizing intimate partner violence through a feminist lens is crucial in understanding the inherent power dynamics that are endemic to gender relations within our society and that lead to the systemic nature of this issue (Stark, 2007). It also serves in understanding the construction of power imbalances in relationships of any kind – not simply heterosexual relationships (Malik & Lindahl, 1998). In brief, this guiding theory establishes this issue as a social and cultural problem rather than an outlying occurrence to the individual (Malik & Lindahl, 1998; Stark, 2007).

I employed an interpretivist paradigm to guide the focus of the study methodology as I aimed to explore the breadth and depth of the realities faced by IPV survivors and service providers in rural and remote areas of Northwestern Ontario during this global emergency (Tolley et al., 2016). This framework allowed a holistic understanding through methods that encouraged interviewees to express themselves freely and provide their "emic" perspective on their own lived experiences (Creswell, 2012; Tolley et al., 2016). As a researcher living through the same historical, political, social, and environmental contexts, I was able to formulate interview questions with a base understanding of the issue, leading to socially constructed knowledge (Tolley et al., 2016). I, the investigator, entered the study with an open mind and the necessary flexibility to explore this complex topic with the aim to bridge the gap in qualitative research on IPV in emergency crises (Tolley et al., 2016).

Although this research study would have benefited from the progressive methodology brought forward by the transformative paradigm, due to time and logistical constraints it was not feasible to incorporate signature elements such as community participatory research (Tolley et al., 2016). However, some elements were borrowed from this paradigm to frame my inquiry as the phenomenon pertained to issues driven by social and health inequities and a violation of human rights (Creswell,

2012; Tolley et al., 2016). For instance, elements of transformative research, which emphasize highlighting the voices of marginalized groups not always represented in the literature, were incorporated (Tolley et al., 2016). This was achieved by exploring the experiences of service providers offering IPV aid in regions with scarce monetary and human resources due to geographical barriers (Tolley et al., 2016). This inquiry focused on bridging the gap in knowledge regarding these disparities and revealing service provider experiences as they navigated social, political, economic, and structural impediments through unprecedented circumstances.

3.3 Theory/Approach

Complimenting the interpretivist paradigm highlighted above, a phenomenological approach guided the study design as the principal research goal was to understand the "emic" perspective of the group being studied and their lived experiences and ethical dilemmas (Tolley et al., 2016) while attempting to provide accessible and sufficient aid to IPV survivors during the COVID-19 pandemic. The phenomenological approach aims to provide a textual and structural description of the commonalities across participants' experiences leading to an in-depth understanding of the phenomenon (Tolley et al., 2016). In the context of this study, the phenomenon pertains to how the COVID-19 pandemic, along with the ensuing health guidelines and restrictions, impacted health and social service providers' ability to assist IPV survivors amidst a reported rise in intimate partner violence rates.

As highlighted in the literature review, social-ecological determinants of health theory guided the interpretation and classification of IPV risk factors on five levels: individual, interpersonal, organizational, community, and policy (CDC, 2021; Jill F. Kilanowski, 2017; WHO, n.d.-b). The findings and deep understanding of the

interrelation between all levels acquired through the literature review formed the basis for the development of the interview guide (Appendix I), considering existing knowledge and gaps in research.

All in all, through this methodology, I assessed the organizational, community, and policy level factors that contributed to worsening social inequities on an individual and interpersonal levels by compounding vulnerabilities in times of crisis. Through the eyes of IPV service providers, a middle ground between the individual and the broader community and policy levels, I acquired access to insights into this phenomenon that systematically impacted vulnerable individuals.

3.4 Study Design

Qualitative methodology is essential in achieving a rich understanding of topics surrounding IPV, enabling in-depth formative data to be identified through the voices of service providers who work directly with those affected by the phenomenon in question, a feature not available through quantitative analysis (Patton, 2014). The methodology highlighted above guided the design of one-on-one, semi-structured interviews with representatives from IPV organizations, servicing a wide audience in rural and remote regions of Northwestern Ontario. This study sought phenomenological insight into the lived experiences, challenges, and changes the COVID-19 pandemic brought on to organizational operations of service providers, leading to decreased access to services for their clients and the aggravation in reported cases during the pandemic. As such, participants were provided with a safe space to speak about their realities (Tolley et al., 2016). Moreover, the study design was emergent and iterative (Tolley et al., 2016). Data collection and analysis occurred in conjunction, allowing for flexibility to modify protocols or adopt new processes as

successes and challenges within the interview process and/or patterns in data emerged (Tolley et al., 2016). Hence, the research was nonlinear and fluid, allowing me, the researcher, to engage in self-reflection actively and continuously throughout the research process (Patton, 2014). Finally, statistical data derived from organizational reports was collected to evaluate and contextualize the breadth and depth of the phenomenon, validating the findings from the qualitative data.

3.4.1 Study Population and Recruitment

This study utilized purposive sampling in the participant selection process to allow for the inclusion of a diverse group of IPV service providers who were able to provide rich data on the object of study (Patton, 2014). The target participant pool was IPV-related service providers servicing rural and remote areas in Northwestern Ontario. Eligibility to participate was based on the following criteria: (1) the organization offered services to survivors of IPV in any aspect whether financially, emergency services, counselling services, and other; (2) the organization was open during most of the pandemic; (3) the organization services individuals in Northwestern Ontario, particularly in rural and remote regions; (4) representatives of each organization held a variety of positions within the organization with advanced insights into the operational capacity of the institution and firsthand experience with the affectations that the COVID-19 pandemic had on organizational and community levels. Purposive sampling was mixed with snowball sampling by asking participants to refer to other organizations in their network (Patton, 2014; Tolley et al., 2016). However, all participants were recruited through purposive sampling. A priori sample was determined based on prearranged characteristics, saturation, and redundancy (i.e.,

once additional data did not provide new insights) (Tolley et al., 2016). Consequently, the data analysis was done in conjunction with data collection processes.

Recruitment initiated with cold calls and emails sent out to selected organizations to establish first point of contact. These emails/calls included a letter of invitation stating the intent and purpose of the study and full contact information of the main investigator, myself, with the purpose of recruitment (see recruitment and follow up E-mail templates in Appendices D and E and call script in Appendix F). Once candidates demonstrated interest and intent to participate in the study, appointments for interviews were set up and consent forms sent to be filled out before the interview date. The information letter and consent form (see Appendix G and H) highlighted the voluntary nature of the study as well as the rights of participants, including their ability to retreat from the study at any time during the interview process and up to one month after they received a copy of their interview transcript. This information was highlighted and prioritized throughout the recruitment, data collection, analysis, and dissemination process in order to ensure participation was strictly voluntary (Tolley et al., 2016).

A preliminary list of 38 potential participant organizations was compiled, from which I interviewed 5 service providers. Participating organizations included shelters, counselling and social service providers, and healthcare providers, with representatives working as frontline workers, organization directors, counsellors, and healthcare providers. Contact information of representatives and corresponding organizations was collected and stored in a masterlist for follow up purposes. All personal information has been kept confidential in a password protected computer. This information was not and will not be shared with third parties for any reason unless previously specified. The participant pool was also demographically diverse,

and provided a wide range of services catered towards a diverse clientele in Northwestern Ontario, which allowed for an in-depth exploration of the nature of the experiences faced by different communities and individuals (Patton, 2014). The selection of a diverse population in a clearly defined geographic region (i.e., Northwestern Ontario, Canada) contributed to the transferability of the research findings increasing research rigour (Thomas & Magilvy, 2011).

3.4.2 Data Collection

Data was systematically collected through one-on-one semi-structured interviews using an initial but flexible interview guide (Appendix I), that was developed based on the literature review (Tolley et al., 2016). Three broad and general questions were asked: "what did you experience in terms of a rise in IPV frequency and severity among your clients during the COVID-19 pandemic?", "what contexts or situations typically influenced or affected your experiences of this phenomenon?", and "what legislations/policies worked as facilitators or barriers to meet the needs of IPV service providers and survivors in Northwestern Ontario?" (Creswell, 2012). The goal of the inquiry was not to quantify the issue but rather to explore the underlying factors that led to the aggravation in IPV services and the unintended consequences of emergency protocols during times of crisis.

As a Master of Public Health student enrolled at Lakehead University in the Thunder Bay campus, I conducted all interviews. As such, I, as the interviewer, was the main instrument of data collection and interpretation; I conducted the interviews, I took field notes, and I performed the data analysis (Tolley et al., 2016). In accordance with COVID-19 guidelines instituted by the province of Ontario's health authorities, all interviews were conducted virtually using the application Zoom or by phone. Each

interview was audio or video recorded after informed consent was obtained. Interviews were then transcribed and archived removing any personal identifiers, unless otherwise agreed upon with the participant (Tolley et al., 2016). Interviews followed a relaxed and conversational style, allowing participants to express their experiences fully and freely in a safe and comfortable environment (Tolley et al., 2016). After every interview, recorded interview files were saved under a label without the use of any identifiers that could be linked back to the interviewees. These files were stored in a personal password protected computer, in a folder specifically created for the purposes of the study to which only I and my direct supervisor had access. All folders pertaining to this study were kept confidential and password protected throughout the research process. The masterlist containing the list of participant information and identifiers was kept under password in a separate folder from the interview data. All "raw data" including audio and video recordings will be securely kept for a minimum of five years as per Lakehead University policy and auditing purposes.

3.4.3 Data Analysis

Prior to the start of the data analysis process, I engaged in the process of "bracketing", which is a method used in phenomenological qualitative research to situate the investigator in the research context itself to prevent the researcher's preconceptions from "tainting" the research process and findings (Tufford & Newman, 2012). The bracketing process is adapted from German philosopher Edmund Husserl, father of the school of phenomenology, and entails the researcher actively engaging in self-reflection and describing their own experiences, perceptions, and opinions on the subject matter in written form (Tufford & Newman, 2012). Describing and attempting to minimize the interviewer's own perceptions and prior judgements allows for

transparency and neutrality throughout the analysis and reporting of study findings and shifts the focus completely towards the participants' experiences (Tufford & Newman, 2012). This method can also be used to protect the researcher from "the cumulative effects of examining what may be emotionally challenging material" by allowing for self-reflection throughout the research process (Tufford & Newman, 2012). The practice of "bracketing" was especially helpful in this research endeavour as the nature of the topic was emotionally taxing at times. Hence, throughout this research, I engaged in a process of personal journaling which is not included in this paper as it solely served the purpose of self-reflection. Even though this tool was helpful in examining my own preconceived notions of the topic I researched, I acknowledge that it is impossible to completely remove myself and my biases from the interpretation of these results.

Soon after each interview, I conducted a full verbatim transcription to capture the voices of participants and original nature of all qualitative data collected (Tolley et al., 2016). Data collection and analysis were conducted parallel to each other as transcription and analysis of narrative data was performed soon after every interview, allowing emerging patterns to guide the research process (Tolley et al., 2016). Transcripts were sent to the interviewees for validation to allow them to expand on or delete information to ensure accuracy and prevent omissions (Tolley et al., 2016). Following this, the data was analyzed according to thematic framework analysis procedures used by Heywood et al. and adapted from Braun and Clarke (Braun & Clarke, 2006; Heywood et al., 2019). This framework is a systematic process employed to find themes emerging from the narrative data within and across interviews. The qualitative analysis software NVivo was utilized throughout the analysis process from

transcription and establishment of thematic framework, to reporting (Maher et al., 2018). A detailed account of the steps utilized is outlined below.

(1) *Familiarization with transcripts:* Once the interview was transcribed and compiled in one document, I actively read the transcript multiple times, highlighting key words and terminology used, annotating passages, and writing memos along the margins of the document as key ideas and concepts came to light. This step was crucial in my analysis process as I developed a sense of the breadth and depth of the narrative data collected (Braun & Clarke, 2006; Heywood et al., 2019).

(2) *Initial code generation:* Then, I organized key concepts, ideas, and terms into meaningful groups (codes) that related back to the research question and purpose (Braun & Clarke, 2006; Heywood et al., 2019). These codes were compiled on a "code sheet" which I uploaded to qualitative research manager software NVivo.

(3) *Thematic framework:* Subsequently, I uploaded all interviews to NVivo and manually coded them, using the aforementioned code sheet. These "codes" formed the basis of my main themes and subthemes, used to find patterns across interviews and establish relationships, similarities, and differences (Braun & Clarke, 2006; Heywood et al., 2019). Themes with little to no supporting evidence were removed. Selected themes are directly tied to the main research question and purpose of the study. Main themes were charted in a table that can be found in *Chapter 5: Discussion*, with a short description of their interpretation, accompanied by subthemes to provide context and richness to the data. This process allowed me to examine the research process and

become aware of information saturation and modify procedures as needed (Tolley et al., 2016).

(4) *Refining findings:* The literature review conducted was used to compare findings and themes prevalent in existing data and themes identified through the qualitative inquiry. Revision of thematic framework was conducted in conjunction with the researcher and thesis supervisor to ensure the findings reflected the purpose of the study.

(5) *Final report (thesis):* Findings were compiled into a cohesive written report, which constitutes this thesis, presenting detailed accounts of each theme as they relate to the research question and study purpose, providing a structural description of the phenomenon and experiences of participants (Tolley et al., 2016). Exact quotations from interviews are included in *Chapter 4: Findings* to provide a textual description of participants' experiences and represent their voices throughout the research process (Tolley et al., 2016). The written report was primarily prepared by myself, the main investigator, with follow up revisions and contributions from first my thesis supervisor and then my thesis committee members.

In order to validate the findings of this study and continue the ethos of data co-production, participants were sent a copy of the interview transcript for review prior to data analysis. Most participants did not send back any corrections, except for one participant confirming their catchment area as the recording was mumbled. This thesis highlights these findings and forms the basis for a list of recommendations aiming to inform policy on the development of inclusive, gendered, and equitable emergency protocols and preparedness planning. Once this thesis is defended and approved, an outline of the findings, in the form of a short document and infographic, will be sent

to all participants. Participants will also have access to the publication of the final thesis upon request.

3.5 Research Rigour

Research rigour is defined in qualitative research as the validity of the research according to qualitative inquiry standards which makes the findings trustworthy (Thomas & Magilvy, 2011). Measures of this validity include truth-value (credibility); applicability (transferability); consistency (dependability); and neutrality (confirmability) (Thomas & Magilvy, 2011). This section was adopted from Thomas & Magilvy (2011).

Credibility is the accurate representation of the experiences of participants through the research process and final reporting (Thomas & Magilvy, 2011). This study employed reflexibility, use of participants' voices, peer examination, and informant feedback methods to ensure credibility through the research process. As a qualitative researcher, I was consistently aware of my role as a learner and co-interpreter of narrative data (Tolley et al., 2016). Therefore, reflexibility (i.e., critical self-awareness) was vital and was performed by reflecting on my personal preconceived notions on the topic and remaining open-minded through analysis and interpretation procedures (Holmes, 2020). Further, as previously stated, peer review by my thesis supervisor and thesis committee will ensure credibility and accuracy (Thomas & Magilvy, 2011). Lastly, the study employed direct quotations from interviewees to support findings and stay true to the participants' experiences and voices (Thomas & Magilvy, 2011).

The ability to transfer research findings or methods from one group to another is called transferability in qualitative language (Thomas & Magilvy, 2011). One way I employed to establish transferability was to provide a dense description of the

population studied by describing the demographics and geographic boundaries of the study (Tolley et al., 2016). In this way, findings may be beneficial in presenting the wide range of experiences of IPV service providers and their perception of survivors' experiences, challenges, and strengths in rural and remote areas. This can help inform policy, funding allocations, and emergency protocol development.

Dependability was established through the in-depth and detailed description of the methodology framing the study and the methods employed to carry out data collection, analysis, and interpretation (Thomas & Magilvy, 2011). The study design closely followed the conventions and guidelines of qualitative research in the public health sector (Patton, 2014).

Finally, confirmability is established through credibility, transferability, and dependability (Thomas & Magilvy, 2011). Throughout the research process I, the investigator, remained reflective, self-aware, and open to the exploration of emergent themes and findings (Holmes, 2020; Thomas & Magilvy, 2011). I actively kept track of my own perspectives, attitudes, and potential biases immediately after every interview through the repeated process of "bracketing", in the form of journaling, to let participants' experiences guide the data collection process (Tufford & Newman, 2012). Confirmability yielded reflective research leading to new and insightful findings that established trust and applicability of the study (Tufford & Newman, 2012).

3.6 Ethical Considerations

This investigative study was based on semi-structured interviews conducted via Zoom or phone. As such, consent and confidentiality considerations were integrated in the study design to protect all persons involved - participants and researchers alike. This study posed minimal risk to participants as interview questions pertained to their

organizations' experiences and touched upon subject matter related to their daily lives. However, I recognized that the sensitive subject matter of the interviews could have elicited an emotional response from some participants related to their work experiences with clients living through violent circumstances. To counteract these potential risks, I compiled a list of referral numbers and resources accessible to participants. Moreover, through each interview, I made sure to emphasize the voluntary nature of participation in this study, outlining the participant's rights to choose to not answer any question that made them feel uncomfortable and/or withdraw from the study at any point during the interview and/or one month after receiving a complete transcript of their interview.

Although not routinely assessed by research ethics boards, I recognized and anticipated any risks to my person as I undertook this project (Webber & Brunger, 2018). The possibility of experiencing burnout and/or emotional distress due to the sensitive nature of the topic was taken into account throughout the research process. In order to counteract these risks, I was diligent in communicating with my supervisor on an ongoing basis regarding the research and its impact on my well-being. Further, I compiled a list of available mental health resources I could access at any moment to support my ongoing research process. One of these resources, a government sponsored mental health website, provided self-paced modules that proved beneficial in helping me address any mental or emotional hurdles that came up from researching such a heavy topic. Additionally, as an avid hiker, the outdoors were always a safe space to decompress and ground myself after long hours of research.

3.6.1 Consent Procedures

Research consent procedures were based on the *Respect for Persons* principle of the Tri-Council Policy Statement 2 (TCPS2) of Canada. Prior to each interview, participants were provided with an Information Letter and Consent Form (see Appendix H) outlining the following:

(1) The nature and purpose of the study (i.e., objectives of the research, study procedures and logistics)
(2) The role the participant plays in the study, the type of data that will be collected, and how this data will be used.
(3) The identity of the researchers and any financing body, including contact information.
(4) The privacy and confidentiality properties of the study.
(5) The knowledge translation strategy (i.e., how the results will be disseminated, published and the target audience).

The consent form was written in lay language for ease of comprehension. All parts of the consent form were reviewed with the participants prior to the start of each interview. Further, each participant was given enough time to review the consent form on their own and questions or inquiries were encouraged. I recognize that the participant pool were service providers for IPV-related concerns, which may have influenced their willingness to participate in the study. In order to counteract any possible coercive influences, the voluntary nature of participation was explicitly expressed and reinforced at the beginning, throughout, and at the end of each interview, this included reiteration that there was no compensation provided for participation. Finally, participants were assured that they could choose to not answer any questions with which they felt uncomfortable, as well as request to have their data removed from the study up to one month after receiving their interview transcript.

3.6.2 Privacy and Confidentiality Considerations

Privacy and confidentiality throughout the investigative process was assured to the highest extent possible. Information collected was anonymized to ensure the lowest degree of identifiability. Personal information and identifiers were collected but not linked to other information provided by participants (e.g., employment position, educational records) unless full consent to do so was obtained.

3.6.3 Data Storage

As previously stated, data collected included audio or video recordings of virtual or phone interviews. Filing systems were established prior to the start of the data collection process to ensure the effective organization of data and safe storage. Files were stored in a password protected computer that was only accessed by myself - the lead researcher. Video and voice recordings were stored only for transcription purposes and will be securely kept for five years as per Lakehead University policy. Lastly, videos and/or pictures of participants will not be included in data dissemination materials.

3.6.4 Sharing and Security

Collected data was only available to myself, the researcher involved in collecting, analyzing, or monitoring the data for study purposes, and my thesis supervisor. Participant data was not and will not be shared, at any point, with third parties, unless permission to do so has been explicitly granted. Data identifying participants has not been included in the dissemination process.

Chapter 4: Findings

A thorough search for gender-based violence prevention and response services across Northwestern Ontario yielded a complete list (Appendix B) of available organizations serving IPV survivors. These include emergency services, emergency and women's shelters, health services, counselling services, advocacy and legal aid, and telephone and online helplines. In total, there are eight women's shelters across the region, serving communities within the three districts that compose NWO. Several organizations operate out of Thunder Bay and have satellite offices across the territory. Numerous Indigenous-led organizations are also available, offering culturally focused programming for GBV/IPV, sexual assault, and human trafficking survivors. Within First Nations communities, there are crisis prevention centres and/or nursing stations that can intervene and refer IPV survivors to necessary services. Further, there are 5 hospitals and health care centres offering integrated and trauma-informed medical services to GBV/DV and SA survivors. A complete list of available resources in NWO can be found in Appendix B, and Appendix C lists all Indigenous-led resources on and off reserve.

The following section captures the opinions and lived experiences of five IPV service providers located across NWO. While these five organizations account for a small portion of the available service providers in the region, enough data saturation was reached to draw conclusions. Although their experiences are not to be generalized, these findings reflect the IPV service provision landscape in NWO - small and few organizations overseeing large catchment areas that encompass several rural and remote communities. The organizations' mandates include sexual assault, human trafficking, and other forms of domestic violence. Although some of the interviews

delve into these social issues, the scope of this research project is solely IPV, therefore these topics will be mentioned briefly but not fully explored.

Throughout this section, I will use *women-identifying persons* or *self-declared women* as inclusive terms. The term *women* will also be used to report on what service providers have said, acknowledging that the scope of this research has been primarily focused on the experiences of cis-gendered women navigating heteronormative relationships. Although some of these findings may apply to all women-identifying persons experiencing IPV in NWO, further research is needed as people belonging to the LGBTQ+ community may experience additional barriers to safe access to IPV services that may not be reflected in this research.

Organizations are kept anonymous throughout, and each participant has been given a pseudonym with the intent to 1) personalize the data and emphasize participants' experiences in their own voice (Tolley et al., 2016), and 2) conceal their identity. Direct quotations from interview data have been included to support findings. Quotations have been edited to remove marks of hesitation such as "um", repetitions, and other disruptions in speech for clarity and conciseness. Edits have not altered the meaning of the data.

The thematic phenomenological analysis of the raw data resulted in the emergence of five themes constituting the findings section: 1) the context of safe access to IPV services in Northwestern Ontario; 2) the structural and operational changes to the organization resulting from the COVID-19 pandemic and ensuing public health mandates; 3) trends in IPV, from service provider perspectives, during and post COVID-19 pandemic; 4) the broader systematic changes to the service provider context of NWO; and 5) provider perspectives on what is needed in pandemic and emergency crisis preparation and policy development. Each theme is enumerated beginning with

the number 4 and followed with the numbers 1-5 for each theme. Themes comprise related sub themes depicting the complexity of the realities faced by service providers and IPV survivors during the COVID-19 pandemic in NWO.

4.1 The Context of Safe Access to IPV Services in Northwestern Ontario

The interviews highlighted the following: 1) the services available to IPV survivors in NWO; 2) the geographic landscape of IPV services in NWO; 3) the demographic profile of IPV survivors seeking services; 4) the barriers to safe access of IPV services; and 5) IPV service accessibility in Indigenous communities across NWO.

4.1.1 Services Available to IPV Survivors in NWO

Interviewed organizations provide four types of services: outreach services, emergency shelter and affordable housing programs, advocacy and referrals, healthcare services, and cultural services.

Outreach.

These services vary amongst organizations, however, the types of services most reported by participants were safety planning, community services, harm reduction initiatives, and community building activities. Safety planning took place with clients who are not ready/able to leave their abuser “maybe [because] they're planning to leave, or they don't need to access physical shelter, but they need safety planning and just support around housing” (Erin). Community services include food banks and donation drives and are available for “women in the entire community to come access, they do not have to be a client at the shelter to be able to access it” (Taylor). Similarly, harm reduction initiatives and community building activities also tended to be

available to the whole community, not just to immediate clients. Erin's organization "partners with the Thunder Bay District Health Unit" (Erin) to "give all harm reduction supplies to anyone in the community that needs it" (Erin).

Outreach services aim to relieve some of the most basic necessities among the population in their catchment area, provide a social safety net, and target some of the social issues related to IPV. Moreover, organizations offer a variety of workshops with the aim of creating community among their clients such as "social-ish kind of activities" (Morgan), with the understanding "that a lot of our women, especially in French, are pretty isolated" (Morgan). This approach simultaneously targets persistent social issues in the region with the organizers talking "about topics like violence against women" (Morgan). In their organization, Jordan offers a weekly online cooking workshop over Zoom called "make and take" (Jordan) where they "package up food and deliver it to people" (Jordan). The aim of these workshops is to provide a nutritious meal, teach easy meal preparation, and incentivise community building and support networks among participants in their catchment area.

Emergency Shelter and Temporary/Affordable Housing.

The services include helping women-identifying persons escape violent and dangerous situations by arranging all logistics involved in getting them to emergency shelter and providing safe haven. If providers deem they do not "need to bring them out, [they] do safety planning with them" (Taylor). Organizations are conscious that the process of leaving an abusive relationship can be lengthy and not all women are prepared or able to leave these situations due to a range of factors tying them to their partner. Their services are designed to provide IPV survivors with the support they need at whatever stage of the process they are at, including finding alternative housing

options. This was emphasized by Alex: “we're here to provide a safe place for women to just kind of escape from their abusers, and then if they want to, we help them get out into the community and on their own”.

Organizations will often transfer clients to “satellite shelters” when perpetrators are released on bail or service providers deem the situation particularly dangerous for their client’s safety. In Erin’s words: “we get a lot of transfers from Thunder Bay. So it might be that Thunder Bay has a woman living in shelter and the partner is being released from jail and it's not safe for her to be there”. In these cases, service providers will have clients “shelter hopping” (Erin), arranging travel from one shelter to the next until they reach their final destination, which may be safe housing with family or friends. In this “underground railroad” as Erin describes it, each shelter will pay for the client’s travel ticket to get to the next shelter or destination, for example;

> If a woman is in Southern Ontario and she's trying to get to safety with her family out in Alberta…one shelter will pay, say six, seven-hour stock to the next shelter. They'll stay for a couple days, get a break, have some good food, and then they'll [the shelter] pay for the next. So, we just kind of hop them along Canada. (Erin)

Concerningly, shelters in smaller communities across the region typically receive funding for a maximum of ten beds, as noted by Alex: “so we have four rooms and 10 beds”. However, the majority of service providers interviewed acknowledged that they frequently exceeded capacity, as mentioned by Alex: “we have had it where we were full in all the rooms”. More on this topic in later sections.

Advocacy and Referrals.

Shelters not only provide temporary safe housing options but their staff also frequently act as a first point of contact. They refer women to relevant services, such as “counselling, medical, [and] legal [services]” (Erin) based on their circumstances, they help survivors navigate the system, and they advocate on their behalf through the process of leaving an abusive relationship. They are also “a liaison with the police quite often with women” (Erin) as well as legal services. Morgan recounts a typical situation that they have encountered at the workplace depicting the range of supports they provide to IPV survivors:

> I had a client who needed to go to the hospital, but the system was a little bit scary for her. So, I don't navigate that system necessarily, but I go there and I kind of advocate for her, make sure she's getting the services she needs.

Healthcare Services.

Healthcare centres provide a range of comprehensive trauma-informed services dedicated to assessing and addressing injuries and medical conditions resulting from domestic violence, intimate partner violence, and sexual assault. In their practice, Taylor utilizes a “documentation tool to do a comprehensive assessment” of assault injuries, which may involve “written or photo documentation” (Taylor). For instance, Taylor recounts: “we do strangulation assessments, we can do pelvic exams, [and] forensic evidence collection”. These assessments can serve as evidence for legal purposes, and providers often “connect [people] to police if they want” (Taylor). Healthcare centres also offer sexual health services including “baseline testing for sexually transmitted infections [and] prevention of STIs” (Taylor), “HIV prophylaxis medications” (Taylor), and “pregnancy testing and prevention” (Taylor). Finally, they

provide referrals to a network of services available to IPV survivors, including counselling, legal assistance, and social services.

Linguistic and Cultural Services.

Some service providers cater to language minorities. For instance, one organization offers services in French in areas "where there are small pockets of French speaking people" (Morgan). These organizations play an important role in providing services to communities and individuals whose mother tongue is not English, as explained by Morgan: "women are experiencing violence in either English or French, but if your mother tongue is French, you always kind of revert back to that right? So that's why it's super important to have the French services for our clients" (Morgan). Translation services are also available, albeit not as accessible in the region: "…we do non-certified translations [and] I also have contacts with people who do medical translation, who are certified" (Morgan).

Finally, there are a number of IPV organizations that serve Indigenous communities, providing culturally competent services to Indigenous women-identifying persons across NWO. However, the perspectives and experiences of Indigenous IPV service providers are not reflected in this research, as none of the interviewed organizations were Indigenous-led. Further, although Indigenous women-identifying persons make up approximately half (40%-60%) of the population that interviewed service providers serve, providers did not mention cultural services as a part of their available portfolio.

Tied to the culturally diverse population of NWO is the vastness of the territory. Providers across Northwestern Ontario serve large catchment areas with diverse

populations. The following section details service providers' catchment areas and the demographic characteristics of their client pool.

4.1.2 Geographic Landscape of IPV Services Across NWO

Northwestern Ontario lies northwest of Lake Superior, comprising three districts: Thunder Bay district, Rainy River district, and Kenora District (OACAS, n.d.). Its boundaries constitute east of White River to the Manitoba border in the west, and from the Hudson Bay to the north to the United States border in the south (OACAS, n.d.; TBRHSC, n.d.-b). The region comprises most subarctic communities of northern Ontario. The territory is an astonishing 526,417.35 Km² (OACAS, n.d.), comparable to "the size of France" as Taylor mentions in their interview. Most of the region comprises rural and remote communities, including fly-in communities, with the biggest urban centre being Thunder Bay (TBRHSC, n.d.-a).

Catchment Areas.

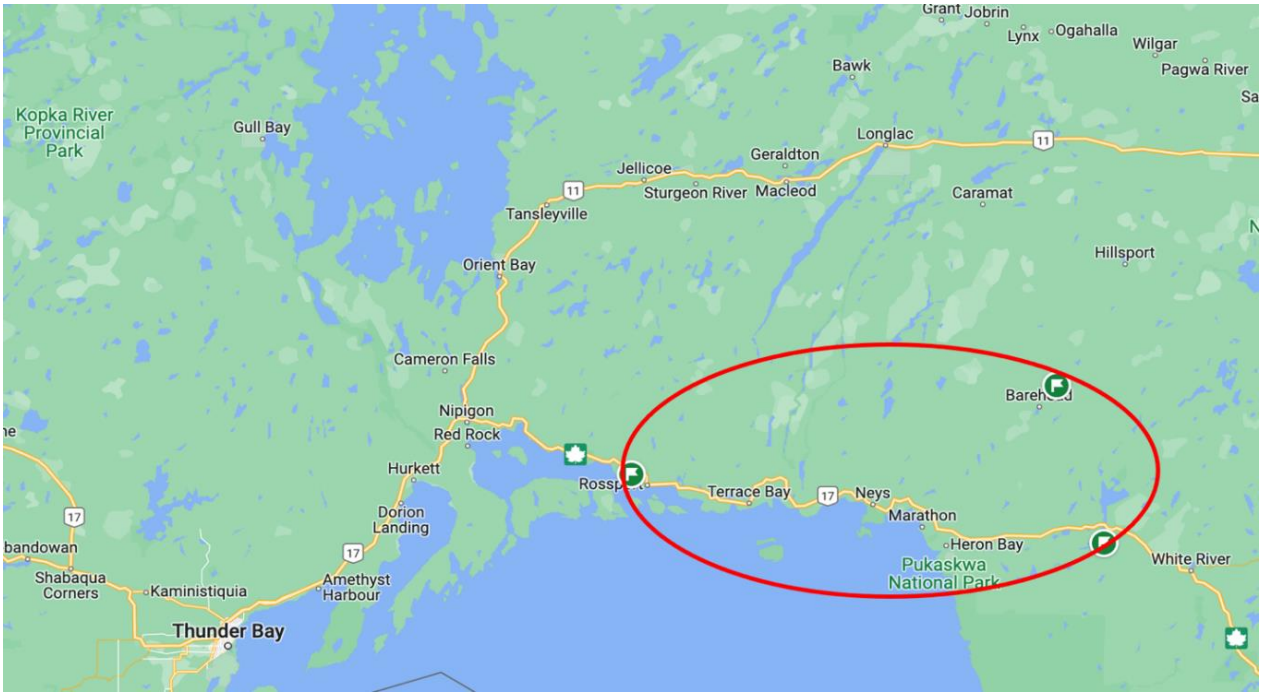
Figures 1-5 depict the catchment areas for each individual interviewed organization. The area within the circle is an approximation of the catchment area. Maps are not specifically labelled and do not constitute specific addresses in order to keep the anonymity of the organizations involved.

Based on my own tabulations, the average catchment area of women's shelters in NWO covers just under 250 Km along a main highway or an average of 2.5-3 hour drive. This does not include fly-in communities. Organizations whose headquarters are located in Thunder Bay have satellite offices along the territory with similar catchment areas. Providers serve various communities along the Trans-Canada Highway, Highway 17, and Highway 11, and all communities and reserves in-between. As Erin and Jordan

explained: “our catchment area is Pays Plat all the way up to Manitouwadge, so we have one of the largest catchments in the north area, geographically” (Erin). Figure 1 depicts this organization’s catchment area.

Figure 1

Catchment Area of Organization 1

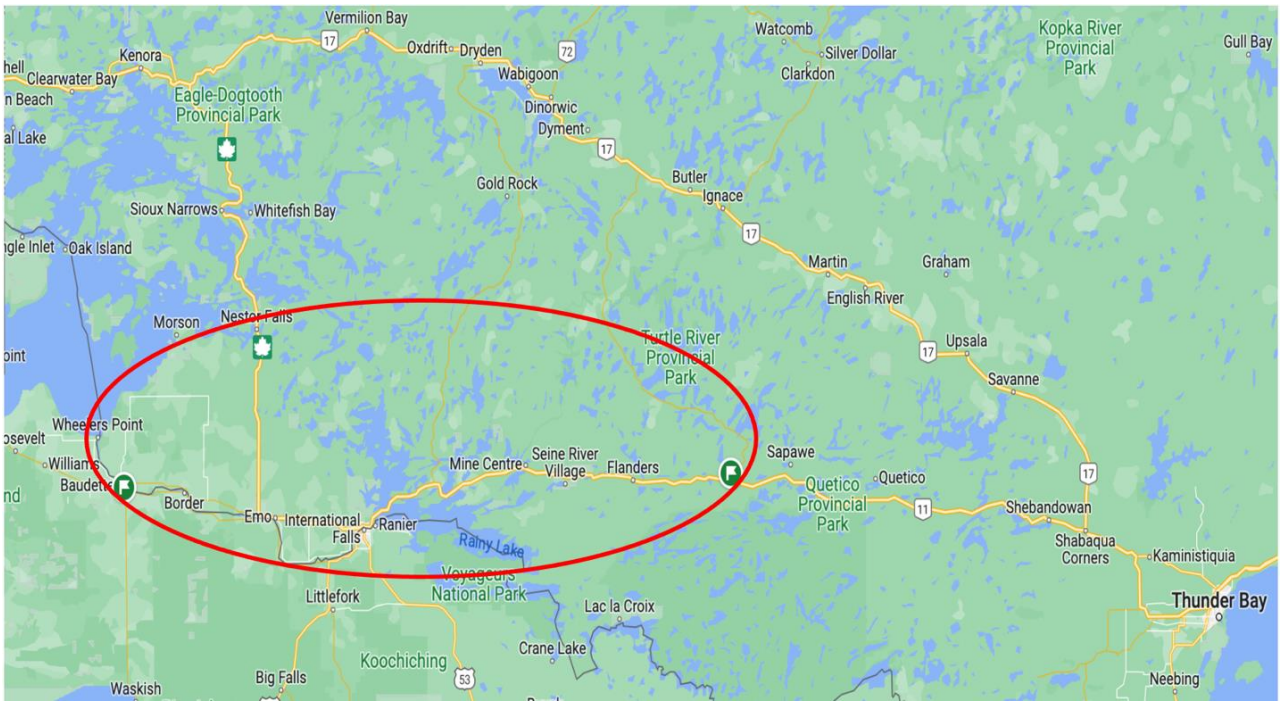


Note. Map of the catchment area of organization 1 covering East of Thunder Bay District. The green flags enclose the catchment area limits. Adapted from Google Maps. https://www.google.com/maps/@49.3050582,-86.3250967,8z?authuser=1&entry=ttu [Retrieved November 9, 2023].

“We are the Rainy River district, we serve from [Atikokan] all the way to Rainy River in our catchment area, we have 10 more remote communities as well” (Jordan). Figure 2 depicts this organization’s catchment area.

Figure 2

Catchment Area of Organization 2

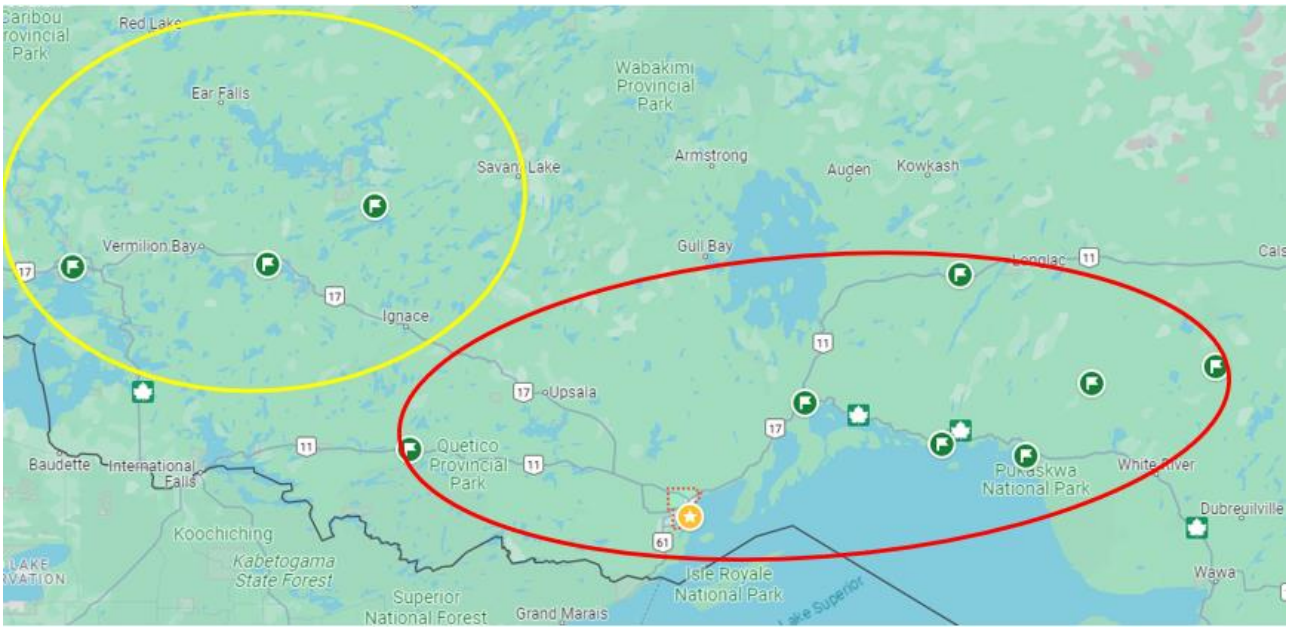


Note. Map of the catchment area of organization 2 covering Rainy River District. The green flags enclose the catchment area limits. Adapted from Google Maps. https://www.google.com/maps/@48.8191521,-93.0212637,8z?authuser=1&entry=ttu [Retrieved November 9, 2023].

Organization 3 being the Northwestern Ontario regional support centre "covers all of [the city of] Thunder Bay" (Taylor) and serves "seven other emergency departments that fall under [their] catchment area" (Taylor). These include hospitals and healthcare centres in Atikokan, Geraldton, Hornepayne, Manitouwadge, Marathon, Nipigon, and Terrace Bay. Through their "lead support program" (Taylor), they assist additional municipalities including "Sioux Lookout and their catchment area" (Taylor) as well as the "Dryden and Kenora programs" (Taylor). Figure 3 depicts this organization's catchment area.

Figure 3

Catchment Area of Organization 3

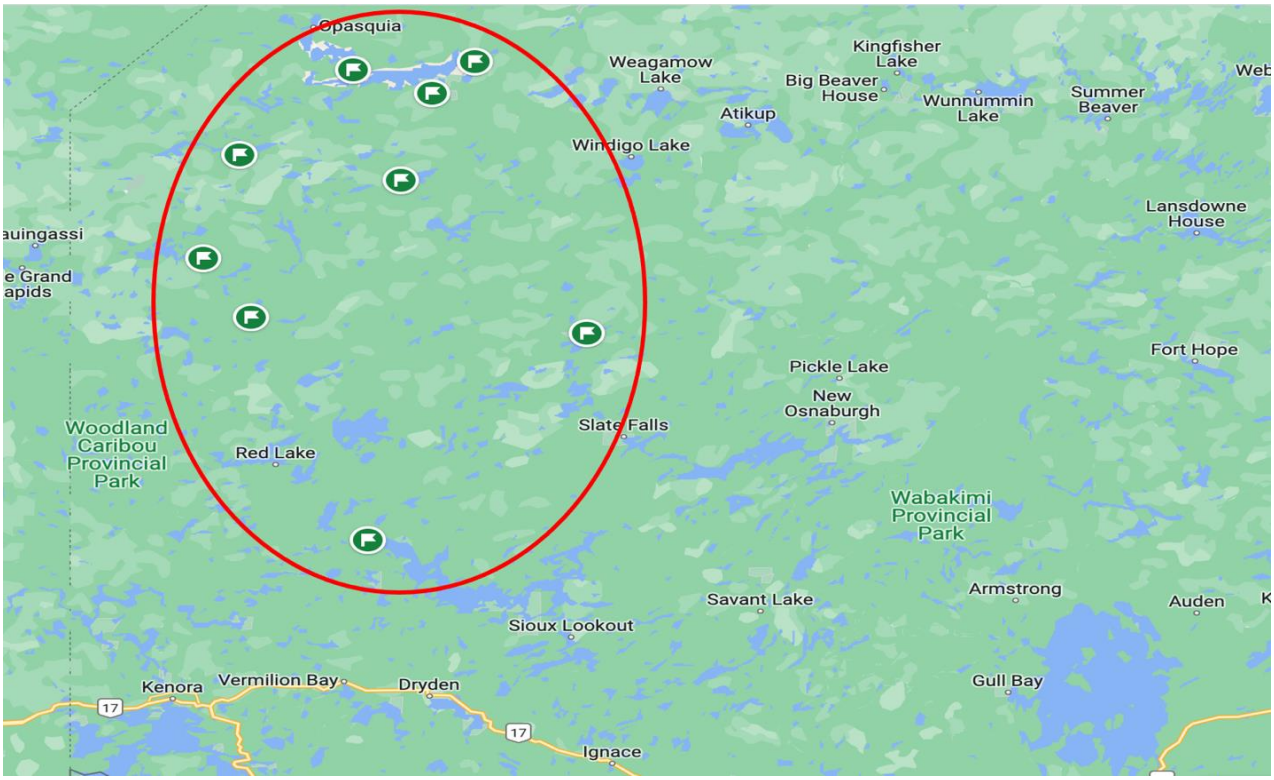


Note. Map of the catchment area of organization 3 covering the city of Thunder Bay and District enclosed within the red circle, and additional communities within the Kenora and Rainy River Districts enclosed in the yellow circle. The green flags locate the main communities served. Adapted from Google Maps. https://www.google.com/maps/@49.3248006,-87.4130277,7z?authuser=0&entry=ttu [Retrieved December 3, 2023].

Although a few of the interviewed service providers served remote communities and Indigenous reserves, only one of the providers had a catchment area that included fly-in reserves on top of their surrounding communities, serving a total of 19 communities. As Alex explains, “we are one of the only two shelters who actually have funding for flying clients out because it is so expensive to fly them out”. Figure 4 depicts this organization’s catchment area.

Figure 4

Catchment Area of Organization 4



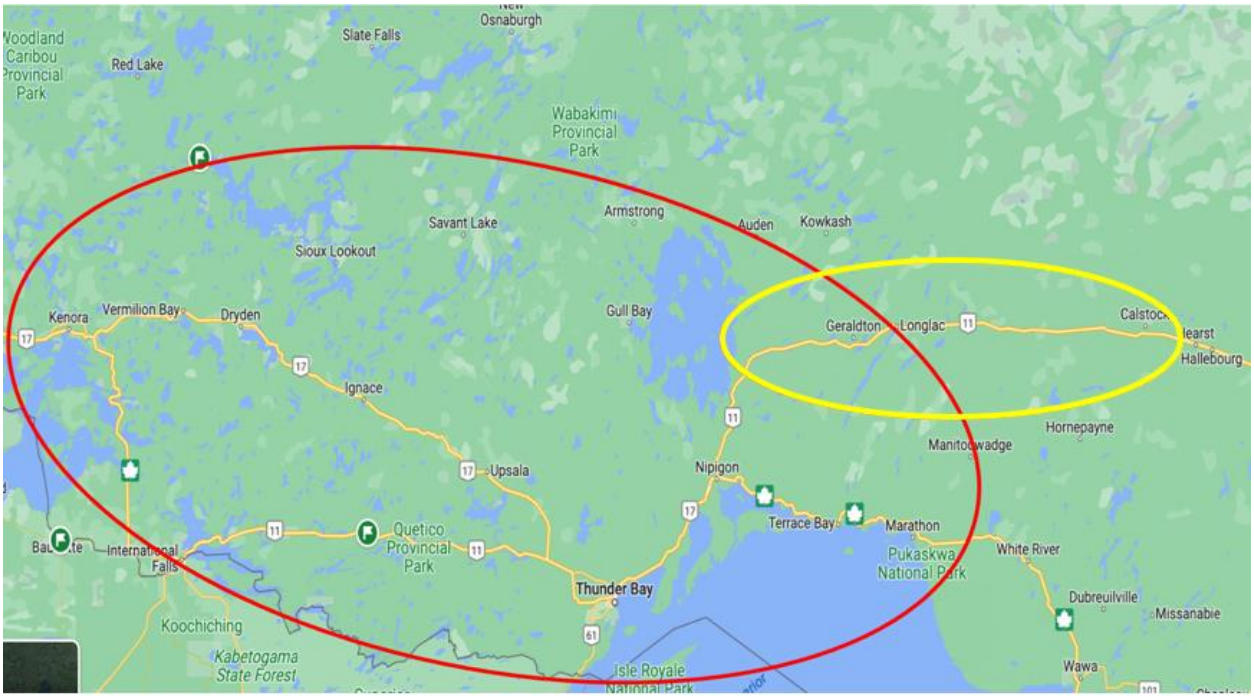
Note. Map of the catchment area of organization 4 covering the Northern part of Kenora District. The green flags locate the main communities served and enclose the catchment area limits. Adapted from Google Maps. https://www.google.com/maps/@51.5558108,-91.0787723,7.07z?authuser=1&entry=ttu [Retrieved November 9, 2023].

Some organizations that offer more specialized services, such as Morgan's organization, being the only French speaking organization in the region, cover a larger area composed of "essentially 52% of the province of Ontario for French services in sexual assault, domestic violence" (Morgan). This organization works out of two offices; a "head office in Thunder Bay, …[and] a satellite office in Greenstone" (Morgan) that provides services to "small pockets of French speaking people" (Morgan). The

Thunder Bay office provides services to communities off of Highway 17 to the east, including “Manitouwadge, Marathon, Terrace Bay…” (Morgan), all the way to the Manitoba border to the west. Essentially, their catchment area includes all of Northwestern Ontario. Their second office, off of Highway 11 services “Geraldton, Longlac, Caramat, Nakina, like all of those little communities” (Morgan). In communities that are farther from the headquarters and the satellite office, the organization has “community champions” (Morgan) providing “women's support groups that are run by people who we contractually hire” (Morgan). Figure 5 depicts this organization’s catchment area.

Figure 5

Catchment Area of Organization 5



Note. Map of the catchment area of organization 5 covering all three districts in Northwestern Ontario. The green flags enclose the catchment area limits. The red circle encompasses the catchment area of the organization’s head office, and the yellow

circle encloses regions served by the satellite office. Adapted from Google Maps. https://www.google.com/maps/@51.4258533,-87.8957864,6.07z?authuser=1&entry=ttu [Retrieved November 9, 2023].

From service providers' perspectives, the immensity of their catchment areas and the fact that there are so few organizations offering IPV resources to women-identifying persons in these areas create a challenging context in which providers are often unable to keep up with demand. This socio-geographic context plays a critical role in the scope and reach these organizations can have in their communities as they face strenuous circumstances. These factors also dictated the way they adapted to the ever-changing public health mandates during the COVID-19 pandemic.

4.1.3 Demographic Profile of IPV Survivors Seeking Services

Age.

"The age range [of IPV survivors] is anywhere from 60 to 20" (Jordan), with the average age being 35. Although women-identifying persons of all ages are present in the demographic, most organizations interviewed had a minimum age of 16 years. Organizations often will "bend the rules", however, in favour of supporting younger service seekers who find themselves in dangerous situations, as explained by Jordan: "although with extenuating circumstances, we have been in situations where we have taken a younger buddy, there has to be special circumstances that go with it".

Some organizations, such as in Morgan's case, will provide services to "anybody over 12 [years old], [as they] can consent themselves to [their] services" (Morgan) under

their regulations. In the case of younger children, the organization will “bridge them to a children's center or something like that…if they're under 12” (Morgan).

Socioeconomic Status.

Although intimate partner violence is observed across social classes, all service providers agreed that women seeking shelter, specifically, tend to be of low socio-economic status looking for a last resort to leave their abusive relationships. As Erin explained, the clients seeking support from their organization are:

> Almost exclusively low income and poverty. I always say that no one chooses to go to a shelter. Right? It's the last resort. People with privilege go to friends, family, they buy bus tickets, plane tickets, they can go, they have a lot more options.

To note, the age and socio-economic distribution of IPV survivors is very much tied to the geographic and demographic profiles of individual communities. For instance, Morgan explains that the population seeking services in Geraldton, a small community with a couple thousand residents off Highway 11, is “older people who have experienced past violence, [and] who are still working through that trauma”. Generally, “when it comes to economic status, they're retired people, lower income people” (Morgan), requiring different services compared to the population their organization serves in Thunder Bay. In comparison, they explain that the population they serve in Thunder Bay, the biggest urban centre in NWO, tends to be working-age, French speaking, and of higher SES as “a big majority of the people who speak French in Thunder Bay are from our school board. So, a lot of those people are well educated, a little bit higher economic status…a lot of them are professionals” (Morgan).

While, as a general rule, persons of lower socioeconomic status are overrepresented in rates of IPV, individuals of all social classes can experience this form of GBV as reflected by the demographic profile served by Morgan's organization. The higher SES of Morgan's clients may be due to the fact that their organization is not a shelter, their services consist mostly of case workers aiding women in their processes, providing counselling services, outreach programming, and referrals to different legal and medical services, although this is just speculation. Additionally, the difference of socioeconomic status between the population they serve may be due to the origins of the Francophone population in Thunder Bay. Morgan continues:

> I'm noticing, it's more like professionals or women who come here with their husbands to work. Their husbands are working, say in the mine, in the logging industry, in the forestry industry because a lot of francophone people from Quebec come here to work in those sectors. (Morgan)

Families and Dependants.

All interviewees confirmed that their organizations take into account their clients' dependents: "we're a women's shelter…so we take women and families who have been involved in domestic violence" (Jordan). They serve and support the survivor seeking safety along with their dependents. Dependents in this case refers to their children, and, also as Erin explains, any person directly under the person's care according to government regulations:

> So, years ago the ministry had, it was just children and then they changed it because they realized that what about if a woman is caring for her 90-year-old father that lives with them and she needs to escape with her children for safety,

what happens to him? So now he would come into the shelter as well. So, it's anyone that is a dependent under that woman. (Erin)

Gender and Sexual Orientation.

These organizations mostly serve clients who identify as women, no matter the sex assigned at birth or the gender showing on official documents: “I don't ask, that's not like something that we are really interested in… if they present as a woman, that's totally fine with me if they're presenting as that” (Morgan). However, providers concurred that the majority of their clients are cis-gendered women in heterosexual relationships. Only one service provider explicitly mentioned having current clients of diverse sexual orientation, and two participants directly mentioned serving clients of diverse gender identity. This may be due to the fact that “there’s less disclosure from those populations, even though the research shows that they experience intimate partner violence at greater rates sometimes” (Taylor).

Marital Status.

In terms of marital status, various service providers acknowledged that their clients tend to be “a higher percentage of common law over marriage” (Erin) or “most of it is common law and dating” (Alex).

Ethnicity and Cultural/Language Minorities.

Service providers serve a diverse population of women-identifying persons from different ethnic backgrounds, however, several organizations pointed at a higher percentage of Indigenous individuals accessing services: “[I] think 60% of our women and children were from an Indigenous background or Indigenous communities” (Erin).

All organizations comprised Indigenous reserves within their catchment areas, as Jordan noted: “our whole district include[s] 10 Aboriginal communities”. Service providers agreed that they have “[seen] an increase with newcomers the last probably three years” (Morgan), incentivized by northern immigration initiatives. In addition, there is a minority Francophone population that is divided up into small French language designated communities across the region. They comprise a very small portion of folks accessing IPV services.

Co-morbidities.

A great portion of service seeking IPV-survivors have underlying “trauma which also equals a lot of mental health, [and] addictions” (Jordan). Morgan mentioned working with folks who are homeless, use substances, and live with mental health concerns, which makes them vulnerable to various types of violence:

> Systematic violence, like violence within the system, and then in their day-to-day lives, right? As somebody who's a homeless woman, they were experiencing sexual assaults or violence or also had other kinds of things going on (...) they were experiencing addiction and violence. (Morgan)

Service providers will often address their clients’ immediate and basic needs in addition to abuse-related trauma and underlying factors, such as mental health and substance abuse concerns, directing their clients to a variety of services and programs as discussed in section *4.1.1 Services available to IPV survivors in NWO*.

NWO population diversity may pose different challenges to service providers as they cater their services to an ever-changing and ever-growing population. The section below highlights, from service provider perspectives, the most persistent challenges to

service provision in the region and how these challenges affect accessibility for IPV survivors seeking help from their organizations.

4.1.4 Barriers to Safe Access to IPV Services in the Region

Five main barriers to IPV service provision and safe access in NWO were highlighted: 1) the underfunding of IPV services and shelters; 2) transportation challenges; 3) the limited capacity of emergency shelters; 4) poor telecommunications connectivity; and 5) the lack of cultural and language diversity in services. This section presents the barriers that are inherent to the context of NWO. These barriers were exacerbated by the COVID-19 pandemic and ensuing public health mandates; however, this will be touched upon in later sections.

Funding.

Service providers agreed that the underfunding of their organizations was a primary challenge in service provision and impeded properly reaching their clientele and providing them with adequate care. In Erin's words: "we were one of the lowest funded shelters in Ontario, all shelters are underfunded. Years ago when they set the funding formula, it was very convoluted, so we didn't have adequate funding to start with".

Funding from the federal government is not directly given to service providers. Rather, through different funding formulas, it "trickles down through the province, but we never received money directly from the federal government" (Erin). This poses a huge barrier to delivering safe care, as the high demand for services forces providers to go overcapacity and provide care to a larger population than their funding allows.

Erin explains: “we used to frequently go over capacity. So even though we're funded for 10 beds, it wasn't unusual for us to have 18 to 20 women living in the shelter”.

Lack of funding for service provision becomes even more apparent when individuals from remote or fly-in Indigenous reserves seek help as “the only way to get women out of their community is to fly them out on a charter plane” (Alex). As previously stated by Alex, there are only two shelters in the region with funding to fly clients out of these communities and into safety.

Transportation.

In NWO, according to service providers, transportation is “definitely one of our largest challenges” (Erin). Organizations in smaller communities face multiple barriers trying to arrange transportation to and from the shelter for women accessing their services, Alex explains:

> We only have one taxi company in town with only like two [or] three drivers. So that is very, very difficult sometimes trying to get women from the airport to here or to their medical appointments, that kind of stuff. So, and not really to do with the pandemic, but just an overall obstacle we have to deal with.

Service providers also do a lot of outreach initiatives in smaller communities, travelling from headquarters to outreach sites. Jordan explains their role: “I was going into some of the communities weekly for women's groups and so on” (Jordan). These outreach activities were hugely impacted by travel restrictions during the COVID-19 pandemic, Jordan continues: “we haven't been able to do it. And it's really impacted the community”.

Shelter.

Shelters have very limited space available and transitional housing options are sparse. These organizations often prioritize safety of their clients and take them in even if they have reached capacity: “we would just take them in anyway, because you need a safe place, you know, we put your mattresses in the toy rooms and double bunk, and we made it work to keep people safe” (Erin). Additionally, organizations in Thunder Bay, the biggest urban centre in NWO, often run into overcrowding, in which case “they'll pay for the transportation to go to the outreach areas [sister shelters] until there is space that is available. And then we'll transfer them back” (Erin).

Connectivity and Access to Digital Devices.

Internet connection is an inherent issue in NWO as the large territory and remoteness of its communities pose infrastructure challenges. As Erin explains, organizations operating out of smaller communities still use paper records and faxes for administrative purposes, this became a challenge during the pandemic as they were catapulted into a digital era:

> We have very poor internet where I live. Some people didn't have internet. And just figuring out how that looks, like we're still pretty much a paper world. So, trying to have people work remotely when it just wasn't how we worked. So that was very difficult. (Erin)

Access to the internet and telecommunications devices is a challenge that a lot of IPV survivors face as they try to leave violent situations. Women will often access public spaces to:

> Use the phone at the library or the computer at the library, like a general walk-in clinic. I have a handful of people that are connected to Norwest, where they

> would go and see whoever was there and they'd use the phone. I think some people would use the day programs through like MHA or Alpha Court or something like that. (Taylor)

Sometimes service providers were only able to reach clients "if they landed somewhere where they had a phone or they had internet, and then other times it was not super accessible because it just made the lack of resources more apparent" (Taylor), highlighting the inconsistencies in access to devices and connectivity, especially for survivors who do not have stable housing.

Culture and Language.

There are several issues with language that constitute barriers to access of IPV services. NWO has a minority French population, some towns are "French language designated communities" meaning services need to be available in both official languages which, in service providers' words, can be quite challenging due to lack of bilingual human resources and extra administrative tasks. Erin affirms "we are a French language designated community; we wish we weren't because there's a lot of work involved in that" (Erin). Although most providers stated their client pool was predominantly Indigenous, none of the interviewed organizations mentioned culturally specific programming being a part of their services.

4.1.5 IPV Service Accessibility Context in Indigenous Communities

Service providers agreed that on average 40 to 60% of the population they serve is Indigenous. All interviewed organizations offering shelter had large catchment areas that included several Indigenous reserves. Access to IPV services for persons living in Indigenous reserves can be inconsistent. Indigenous communities differ greatly in

administrative procedures and services offered by on-site crisis intervention centres and/or nursing stations:

> One for example is much more organized, if that's the right word, they have many more services and they have much more support for the women, from their communities. We know that if a woman's coming from that place, that she's going to have more support to follow her while she's staying with us. (Erin)

These differences depend largely on policies established by the Chief and Council. Leaving a violent domestic environment can be challenging if available supports are not adequate in survivors' home communities. However, “once the woman is here [women’s shelter], it doesn't matter where she is from, we’re able to get them equally to whatever services are in [town]” (Erin). Having explored the social-ecological context of IPV service provision in NWO, we now dive into the impacts of the COVID-19 pandemic and emergency public health measures on organizational operations.

4.2 Structural and Operational Changes to the Organization Brought on by the COVID-19 Pandemic and Ensuing Public Health Mandates

The COVID-19 pandemic and its ensuing public health mandates greatly impacted the already challenging field of IPV service provision in NWO. Directors and managers were faced with the task of reimagining their practices in order to fit the new public health protocols and safeguard their staff and clients from COVID-19 contagion. The data highlighted several changes that these new health and social policies imposed on the structure and operations of these organizations. The following section narrates service providers’ experiences in combating the growing rates of IPV cases while managing new restrictive policies and health mandates. The headings dive into 1) how organizations adapted to new public health mandates and emergency

policies; 2) the effects on staff work-life; and 3) the unexpected benefits to the organization brought on by the COVID-19 pandemic.

4.2.1 Adapting to New Public Health Mandates and Emergency Policies

Changing Priorities and Bureaucracy.

The moment the pandemic was announced, directors and managers across organizations found themselves developing and implementing emergency policies overnight. The new policies were based on governmental directives with the dual aim of safeguarding both workers and clients from COVID-19 contagion while ensuring the continued delivery of services. One of the most persistent challenges faced by organizations was adapting to the continuously evolving flow of public health mandates. Erin recounts their experience:

> I felt that there was so much information so quickly and it kept on changing. Every day we felt that there [were] different directives from whether it was a Ministry of Health or our own Ministry of Public Health, they weren't the same, we were getting different things to do, honestly, we didn't know what we were doing. (Erin)

Morgan echoes this sentiment:

> In the beginning it was difficult because, you don't know what the hell is going on, and I understand, I'm not bashing the government, but it was also always changing. So, what was good last month is no longer adequate this month, you know? (Morgan)

Shelters that fall under “congregate care” were asked to implement new and increasingly difficult health policies. These guidelines were conveyed through tough-

to-follow, lengthy, and unclear documents containing a myriad of information that often did not apply to IPV services, contradicted other mandates, and was not designed to accommodate the specific needs of IPV survivors and the organizations that support them. Erin explains their experience:

> So, they put this mandate in that no one's allowed to go for overnights unless it's essential, and there's all these rules underneath that right? So, if you go to try to find a document that tells you what those rules are, you would be redirected multiple times within that document to go also look at this [other] document. People will look there and there's multiple links again for different documents. Like everything was just so big and convoluted. (Erin)

In the face of these new protocols, executive directors and managers' priorities "shifted from a hundred percent safety of women to policy and bureaucracy and figuring out the rules of how we're supposed to stay open and keep people as safe as we can" (Erin). COVID-19 health policies took priority to the detriment of "important advocacy work and work with the government for changing laws and all of that stuff" (Erin). Although these organizations had previous emergency and pandemic policies, these protocols "didn't come close to what we needed to do" (Erin) to combat the spread of COVID-19.

Further, mandated operational changes meant directors had to develop new procedures to fit the new health policy demands. Reduced contact rules restricted the number of individuals who were able to stay at shelters, consequently, organizations had to implement new protocols:

> We've never thought that we would have women in hotels before COVID, to keep them safe. So that created a whole other realm of our job that we'd never done before. How do you keep a woman safe in a hotel? How do you get her food in a

> hotel? How do you get her to appointments in a hotel? All of these things we never considered before as part of a pandemic policy were all of a sudden there. (Erin)

Work-from-home mandates forced all service delivery to transition to phone and online platforms, rendering these services inaccessible to clients who did not have easy or safe access to devices and internet connection:

> [The] counselling agency in our community, the mental health support groups, even the employment office, like everyone just went remote. So, whereas before women could go there to seek services or to see people, they didn't have internet, they didn't have devices to contact them. They didn't have safe phones. (Erin)

Travel Restrictions.

Interestingly, service providers "saw a drastic decrease in intakes, crisis calls went up, but intakes went down" (Erin). Confinement with an abuser, due to quarantine measures, was cited by providers as a significant barrier to accessing these services over the phone and/or in-person. This was especially the case in Indigenous reserves as these communities implemented strict quarantine and travel restrictions where "they would not let you leave unless you went through the Chief Council, and they had to approve it because it was for medical reasons or something like that" (Alex).

Isolation within Shelters.

Additionally, women staying at shelters would have to go through mandatory quarantine. Service providers expressed how the sole act of having to isolate became a huge deterrent for clients seeking shelter: "the numbers [of clients] have been down…I

suspect that is because when they arrive, particularly if they have not been vaccinated, they do have to self-isolate and it's really difficult when you have the little children" (Jordan). In view of these changes, service providers proactively tried several ways to keep their clients comfortable once they reached the shelter: "we put TVs with internet in the rooms…[and] baskets with all kinds of snacks and stuff. We just keep replenishing them. We have to deliver the food to the rooms…" (Jordan).

Mental Health.

The demands of their clients also changed significantly. Service providers agreed that clients "coming in were a lot more unwell [and] the mental health needs were a lot more complex" (Taylor). Hence, their service priorities changed, and providers would "spend the same amount of time trying to do assessments and figure out what's with their mental health versus their assault" (Taylor). All of these changes to the workplace greatly impacted staff's working conditions, roles and responsibilities, and work-life balance. The next section delves into service providers' experiences with some of these changes.

4.2.2 Staff Work-life

Work-from-home mandates entailed developing new workplace management guidelines and rapidly switching over to the digitalization of services. This transition meant that "staff [were] working from home using their own computer, using their own wi-fi, their own internet, their own electricity, all that kind of stuff" (Morgan). Luckily, organizations were able to tap into COVID-19 relief funds to provide their staff with the needed support to continue their work remotely.

On the other hand, emergency personnel had “to be in the shelter, but all that administrative support, myself and outreach, we all were sent [home]” (Erin). Emergency personnel faced increased health risks due to their vulnerability to contracting COVID-19 in the workplace, evidently increasing stress among the staff, especially with the lack of administrative and leadership support on-site.

Fear was rampant among workers and clients alike: “the women were scared, the staff were scared” (Erin), especially at the beginning of the pandemic when little to no reliable information about COVID-19 was available and a vaccine had not been developed. Erin shares their experience: “and the fear was so, so, so high! Right? I feel that the health fear has deteriorated over the last couple of years just with the changes in the variants and everything, and with the vaccines” (Erin).

The initial fear of infection and pandemic panic were strong among staff and clients alike. Mundane activities “became big, things [like] picking up prescriptions and walking to appointments and getting groceries. All those things were just a regular part of life that became complex” (Erin). Directors had to weigh risks and delegate “which staff is going to take that risk to go into the community, to get our groceries and get the mail once a week?” (Erin).

Administrative staff, especially in higher up roles, felt “the [frontline] staff really needed support” (Erin) as they were “in a shelter all by themselves with no support, no one to talk about options or which way do we do this? How do we get this woman here safely? Like all those things, it's really hard to do it completely solo” (Erin). Consequently, they felt their duty was to “remain in shelter quite a bit even though [they weren’t] supposed to” (Erin) in order to assist their staff and ensure sufficient care to their clients.

Moreover, due to quarantine and close contact rules, emergency staff's work-life balance was greatly impacted. Even as pandemic restrictions eased, due to the nature of their work and the risks to the organization, emergency staff were asked to "continue to reduce [their] exposure to people, continue to mask when [they're] in public" (Erin). Becoming a close contact or infected with COVID-19 could drastically impact operations, especially for small organizations, with the risk of temporary closure, Erin explains:

> If you become a close contact, you can't come to work for 10 days, and if two of my staff have COVID and someone else with a close [contact], like we're a small organization, so everyone has to be really careful to make sure we can stay open. (Erin)

Complying with public health mandates meant acquiring supplies such as Personal Protective Equipment (PPE), HEPA air filters etc. However, this posed a significant challenge as PPE, hand sanitizer, filters and other supplies sold out quickly and were inaccessible, especially in more isolated communities that do not have access to larger chain stores. Erin recounts their experience:

> We couldn't get PPE, getting hold of hand sanitizer was, oh my God! I don't know how many hours we went into trying to get hand sanitizer. We didn't have masks. We live in a small community. There's one drugstore in our community that sells masks and gloves, and that was sold immediately, right? So, we had no place to go to a Walmart, no place to access what we needed. (Erin)

Due to the nature of their work involving vulnerable populations and congregate living, these organizations had to maintain health mandates for longer in order to keep risks low. Even when quarantine restrictions and masking rules were lifted, these organizations continued on with these protocols: "we're still masking, and we have

now been mandated to test three times a week prior to coming to work, we have to do PPE…" (Jordan).

Even though public health mandates posed several challenges to organizations, there were a few systematic changes that greatly benefited IPV service providers during the pandemic. For instance, the strong partnerships that were formed among organizations and the collaborative spirit arising from a need to navigate the endless array of policies and health mandates during the pandemic, and the new opportunities for funding that became available from the government. The next section explores, from service providers' perspectives, the unexpected benefits to their organizations brought on by the COVID-19 pandemic.

4.2.3 Benefits Brought on by Systematic Changes Experienced During the Pandemic

Partnerships and Collaboration Among Organizations.

Local service system planning tables are a crucial part of the service provider landscape, as organizations within a district "meet 3 to 4 times a year" (Erin), to discuss different topics and form collaborative partnerships. These tables became a first line of support for service providers during the pandemic. Erin explains:

> So very early on, we started meeting…once a week to kind of figure it out, as a group of executives, what are you doing with this? How is that working for you? It just made it easier. We still maintain that. Now [2022] we meet every two weeks. That has definitely been one of the biggest assets throughout the pandemic. (Erin)

Specifically, these collaborative spaces helped organizations collectively navigate the uncertainties of the pandemic. Erin recounts their experience: "We had all

these emails and stuff coming from other ministries with all these directives, but then we had this other side that were smaller, broken-down meetings that made it more manageable" (Erin). Additionally, several institutions came together to support smaller organizations within their communities that were in need of resources "the hospital was great, they were able to give us a bit [of PPE] to start" (Erin). The pandemic unexpectedly fostered stronger collaborative partnerships among IPV organizations and with other institutions within their communities. Encouraging this level of communication and collaboration amongst service providers is imperative in strengthening the network of services across the region and province.

Changes to the Workplace.

Work-from-home mandates brought about interesting and beneficial workplace changes. Morgan explained how their organization implemented a four-day week and a hybrid work schedule where staff decide on their own availability for office hours and in-person appointments with clients or co-workers. This system had considerable benefits for staff and the organization:

> We've seen a big increase in productivity, and mental health, [and] overall wellbeing of staff has improved. And I think maintaining that hybrid [work schedule] has also helped…during the pandemic we've realized some of the stuff that we did before as an agency didn't have to be that rigid anymore. (Morgan)

The rapid and drastic onset of quarantine and social distancing measures sped up the digitalization of the workplace. This switch, although not without consequences, opened up the opportunity to explore other ways of service provision, in some cases increasing the reach of providers, "having the flexibility of doing virtual

or in-person, whereas before that wouldn't have been something we would've done" (Morgan).

Organizations that have historically been underfunded were able to access additional COVID relief funds, helping them get a jump start. Most service providers agreed that an impactful change during the pandemic was the increased funding available to them from the provincial and federal governments. This is further discussed in the next section.

Increased Funding, but Looming Economic Crisis?

Interestingly, all participants agreed that, although the pandemic had impacted IPV rates and service provision, they had also greatly benefited financially during this time as they tapped into new funding streams made available by the provincial and federal government: "shelters have, it's gonna sound horrible, really benefited financially and been able to tap into a lot of things that we never, ever could have had before because of the pandemic" (Erin). Early on in the pandemic, the federal government provided emergency shelters with increased funds in an attempt to counter the increases in reported violence. These new streams of funding significantly benefited service provision, Erin shares their experience:

> Very early on in the pandemic, they gave every shelter, I think it was $32,000. That was huge. Then they've now had two further open-ended grants that we've received funding for. So, the first one, I think we received 142,000 this year. It's over a hundred thousand…it has increased our services, it's made us better, increased our technology, increased so many things. (Erin)

Federal grants also included provisions for these shelters: "we got $10,000 for food for the shelter, we used to fundraise for food. We have food now!" (Erin).

Organizations “were able to get cell phones for all of [their] outreach workers because they were now working remotely” (Erin) allowing them to keep up with remote service provision. Erin exclaimed: “We never could have afforded that. Last year I prepaid for two years’ cell phones” (Erin). Consequently, organizations were able to escalate the reach of some of their services with the extra funding they received: “we had this other specific online texting one [service] that we had funding for” (Alex).

Contingency reserve funds (CRF) were very quickly made available to organizations in order to pay for “essentially everything that has to do with extra expenses for COVID” (Erin). These grant-type funding streams had very few reporting requirements. Funds were diverted into purchasing provisions, PPE, and other items needed to comply with public health mandates: “…if we needed to isolate a woman, we could buy them little fridges. They would get us take out menus, take-out food, like everything was covered. So that was very helpful” (Erin). Morgan echoes this experience, “we had a HEPA filter sent to us from the government for our offices, [and] masks” (Morgan). Non-governmental organizations also made grants available for non-for-profits to apply and receive funding for PPE and help them navigate the pandemic, “so, when it came to like PPE, that kind of stuff, [they] did have funding to help [them] better transition” (Morgan).

Changes in governmental administration of these services and the way they are funded had beneficial impacts for IPV organizations. Although participants did not delve into this topic, it was mentioned that this change may have impacted their funding for the better. Morgan noted that they were funded “...in the beginning of the pandemic, and for the last 20 years, by the Governor General of Canada, and during the pandemic, and just recently [they] were transferred to the Ministry of Social Services of Ontario”. However, service providers are conscious that the increases in

funding are temporary and expressed fears as they face an uncertain economic future: “we feel that for the next couple of years, we're going to be financially okay. But we're also preparing for all of this funding to come to an end because it will” (Erin).

The increases in funding brought on significant benefits to service providers as they were able to come out of “poverty levels” (Erin) and divert their efforts into increasing the range of services. However, the pandemic also brought on a spike in IPV cases that service providers were not prepared to assist. Due to the precarious working conditions prior to the pandemic, service providers had to play catch-up in order to address new trends in IPV. The section below explores service providers’ experiences with new IPV trends.

4.3 Trends in IPV from Service Provider Perspectives During and Post COVID-19

This section explores six trends that service providers witnessed over the pandemic and its aftermath: 1) the use of coercive control by perpetrators; 2) strangulation as one of the most reported injuries to service providers; 3) concerning increases in sexual assaults as pandemic quarantine measures started to lift; 4) the exacerbation of mental health concerns and substance abuse; 5) increased IPV cases among youth; and 6) a significant dip in in-person service access and follow-up from clients.

4.3.1 Coercive Control

A trend that stood out to service providers was the increase in coercive control that was fuelled by the inherent fear of the pandemic and quarantine protocols. Erin explains: “the whole coercive control, psychological control, misinformation, all of that thing, it just became this very specialized form of abuse” (Erin). Several clients

reported the “withdrawal of things such as forbidding them to have vaccines, or giving them misinformation about COVID and creating additional fears that was beyond the typical news” (Erin) as a way to control their actions.

4.3.2 Strangulation

Service providers reported that the severity of violence in IPV cases has also increased. Concerningly, cases involving “more strangulation, like more non-fatal strangulation and just more physical injuries” (Taylor), which is a risk factor for intimate partner homicide (IPH), increased. This trend was reported province-wide:

> We've been talking about this with our provincial organization…we're seeing a lot more strangulation and that is one of the highest risk factors for death. So, when a woman discloses strangulation, we take that very seriously. (Erin)

However, due to recent changes in legislation, strangulation is no longer grouped in with assault charges but rather it is penalized separately. Therefore, it is unclear whether the spike in reported rates has been caused by documentation or if this specific type of violence is related to the pandemic in any way. Erin explains: “I don't know if there's more awareness now of it being seen as a unique factor and a risk factor. We don't understand, it’s kind of that chicken or the egg” (Erin).

4.3.3 Sexual Assault

An increase in sexual violence was also reported. As Taylor noted “when school started, we did see an increase again in child sexual abuse disclosures. So that spiked a little bit again”. Spikes in violence over certain seasons were reported to be expected by service providers. Interestingly, over the pandemic, Taylor witnessed an increase in violence and sexual assault during periods of good weather when people are more

likely to leave their homes. They explain further: “I have no idea what the correlation is, but our numbers seem to really spike, when the sun's out and people are going places” (Taylor). Erin raises the same point about the spike in sexual assault rates and whether it is a real trend or whether there’s simply more awareness about this or “the violence [is] actually increasing or is it just the awareness of the increased violence? We're not sure” (Erin).

Lastly, Morgan raised the point of sexual assault among intimate partners often being under reported. They explained how women do not tend to recognize certain behaviours around sexual intimacy as violent: “there's a huge component of sexual violence, control, things like that” (Morga) in domestic violence cases. During conversations with victims of domestic violence their clients will state “I'm only here for this”, but when [they] start to open up and talk about the case, [many will say] “oh my God, I'm experiencing sexual violence”” (Morgan).

4.3.4 Mental Health and Substance Abuse

Service providers agreed that the mental health of their clients had significantly deteriorated during COVID-19 “especially at the one-year mark during the pandemic, anyone that already struggled with any type of mental health issue or concern…a lot of people experienced quite an exacerbation in their mental health symptoms” (Taylor). Addressing these mental health concerns became a bigger part of service providers’ client assessments and action plans, on top of addressing the particular assault:

> Before [pre-pandemic] we would address it [mental health], but, typically unless there was an acute psychiatric issue going on, I would not typically spend that amount of time for the most part because the assault information and assault

> assessment stuff was outweighing it, but it was like, wow, I'm spending a lot of time doing all this other mental health stuff right now. (Taylor)

4.3.5 Youth

Although not within the scope of this research, it is important to mention that service providers reported an increase in sexual violence among a younger population. Erin explains: “we're hearing in our community lots of stuff that's happening with the youth. We're seeing a lot of violence with the youth and a lot of sexual violence with the youth as well” (Erin). Taylor echoes this experience as sexual violence reports among their client pool increased significantly once schools reopened, as previously mentioned.

4.3.6 Dip in In-person Access to Services and Follow-up

Service providers noticed a “dip in follow-up and maybe a little bit in the acute numbers, but not a ton” (Taylor). In addition, most participants agreed that the fear of COVID-19 infection was a big deterrent for persons seeking services: “when our city was on outbreak, people were definitely nervous to come in, and people would tell me that they were nervous to come to the hospital. They didn't want to come in if they didn't have to” (Taylor). As previously mentioned, quarantine restrictions and isolation measures were also cited as being deterrents for access to service, especially for persons seeking shelter: “I know women struggle with it [quarantine] when they're told, because it really is difficult, I can't imagine…being stuck in a room” (Jordan).

To add to this point, Taylor noted that their clients, especially younger individuals who were in online school during the pandemic, were not interested in accessing services online because “[they] do all this other stuff on the internet. [They]

would rather see someone in person, and they just weren't really interested [in online counselling]" (Taylor). Finally, service providers added that, due to safety concerns, accessing online services, such as counselling over Zoom, was not a possibility for some "people for safety too, they were just like, yeah, that's just not going to happen" (Taylor).

4.4 Broader Systematic Changes to the Service Provider Context of Northwestern Ontario

4.4.1 Changes in Available Community Services (libraries, doctor's office etc.)

The closure of public buildings and services during the pandemic meant that "the places that women used to call from, if they didn't have their own cell phone that they could have open access to, they would go to the library and use their phones and use their internet…they would go to so many different places. They [public places] were all shut down. There was nowhere to go" (Erin). In addition, according to providers, IPV survivors quarantining with their abusers were unable to find the time and space to seek help safely:

> They didn't have safe phones, they couldn't even use the excuse of "I'm just going to the store to pick up a few groceries" anymore because that was done once a week. Right? Like all of the things that used to be able to allow them access to the outside world, that's gone. (Erin)

Service providers expressed their concerns over the situation:

> Most services shut down…there was no in-person counselling. It was really hard to get an in-person doctor's appointment or to get the police here, to talk to

> them [IPV survivors]. All of those things, just everything changed, and the violence continued to increase, the woman's isolation continued too. (Erin)

4.4.2 The Insufficiencies of the Justice System

Service providers all agreed that the pandemic exposed "the complete horrific dysfunction of the judicial system that had such a horrific impact on the women" (Erin). Service providers raised concerns over police not removing perpetrators from homes or communities, which meant IPV survivors were unable to reintegrate into the community safely. Alex explains their experience: "a lot of the times when OPP [Police] is called…when we're trying to get women back into the community, they're never removing the male, right? The male is always there. He's still in the community" (Alex). This was particularly challenging for IPV survivors living in Indigenous reserves as strict no travel restrictions were implemented early on with community members having to ask for Chief council permission to leave. This posed a wide array of issues; Alex recounts some instances in which perpetrators were related to the Chief council members and "the woman is either not believed or she's kind of bullied out of the community" (Alex).

In addition, Erin explains how perpetrators were released from custody "when they had the outbreaks [COVID-19] within the jails, people just got out" (Erin). This increased the risks to IPV survivors as "...[jails] were releasing very violent perpetrators, they were not holding them. They were getting out on bail. They were only being held maybe overnight with conditions" (Erin). Traditionally, survivors are notified before their abuser is released. Pre-pandemic this system had some drawbacks and was inconsistent, from service provider perspectives, but it was useful enough. However, "with the pandemic, it didn't work" (Erin).

Accessing legal aid was made even more challenging in small rural and remote communities across NWO. Although smaller communities were accustomed to attending court hearings via online court, these processes were delayed further as court services in Thunder Bay, the largest urban centre, continued to collapse under the wake of the pandemic. For instance, traditionally detained perpetrators would have two options depending on the severity of the assault; “they're either released on the spot that night with conditions or they're held in [town] jail overnight, and they do video bail the next day” (Erin). Then, “they were transported to Thunder Bay jail, where they would have a bail hearing in a couple of days to kind of develop that bail plan” (Erin). However, during the pandemic, travel restrictions and the risk of overcrowding jails and potential COVID-19 outbreaks impeded the transfer of perpetrators to Thunder Bay. This system was compromised and there was no follow through from authorities on these procedures, in turn compromising survivors’ safety:

> It didn't matter what you had done [or] the severity of the violence…it seemed most likely you were not going to be sent to Thunder Bay and held for a couple of days. So, that of course really increased the women's risk, because now he [perpetrator] didn't have a couple of days to calm down and process things, they would be released immediately, and they'd be angry, angry, angry! (Erin)

The court system became extremely delayed as all in-person operations halted due to work-from-home mandates. Consequently, it became difficult to access legal services such as “family court, so, if a woman needed temporary custody, it was just very difficult to get a hold of anyone in the judicial system” (Erin). Taylor echoes this experience as navigating the legal system with their clients became increasingly difficult:

> Our court and justice situation was a mess, like really difficult! Women that I was trying to get support to even try to file a peace bond or something like you couldn't do anything. You call the police, “no call the courthouse”, “no call this person”, but like lots of back and forth, really difficult to access. (Taylor)

They emphasize the “big gaps in how things are running, how confusing it is, how inconsistent” (Taylor) navigating the judicial system can be, especially during the pandemic. From their experience:

> It depends on the day, depends on the person, you get different answers…I found that throughout the pandemic, especially for women who really needed to access court services, you know, sitting in my office being like, “I literally don't know what to say. I have called every single person that I could. I've called this person. I've called that person. I've called this person back. I don't know what to tell you. I don't have answers. They just aren't doing it. (Taylor)

Concerningly, the cases that were filed were sometimes dismissed “because the people that needed to be in court just couldn't get the information together enough” (Taylor). This level of dead-end bureaucracy demoralized IPV service providers and the survivors they serve from trying to access legal aid: “having to try to support someone in making a second report or trying to reach somebody and then being like, well, nothing happened the last time. So why would I do it now? It just makes things really difficult and more high risk in my eyes” (Taylor).

The exacerbation of barriers to IPV service provision and access, coupled with the collapse of the justice system during the pandemic, greatly contributed to the rise in intimate partner violence. The following section outlines service providers’ perspectives on what is needed in order to prevent this phenomenon and mitigate the consequences of inequitable emergency policies.

4.5 Service Providers' Perspectives on What is Needed to Improve IPV Service Provision and Access in NWO and Develop Equitable Emergency Policy.

4.5.1 Emergency Policy that Fits the Needs of IPV Organizations

Emergency shelters for survivors of IPV fall under "congregate care" (Erin), which includes group homes, correctional facilities, and children and youth residential settings (Public Health Ontario, n.d.). This meant that pandemic protocols were very strict and restrictive over the entirety of the pandemic. Erin explains that even two years into the pandemic when restrictions had lifted, and public health mandates were easing up, for shelters "it's changed very little because we're [shelters] considered congregate care, so we have to follow the same rules as the long-term care homes" (Erin). Jordan echoes the same experience with their staff "having to do the rapid testing three times a week prior to coming into work", even after COVID-19 health mandates had been lifted for the rest of the population. Although shelters are shared living spaces and, consequently, are vulnerable to the spread of infection and "need extra protection" (Erin), these policies were not designed for the special needs of IPV survivors accessing these services. As previously mentioned, the strict enforcement of congregate care health and quarantine protocols in shelters acted as a significant deterrent for survivors in need of safe living accommodations. Jordan "noticed a decrease in people accessing the shelter after they learned about the isolation", noting that these protocols were a "deterrent for mothers with children" (Jordan) and clients would often "call, but if they could find a different place to stay where they didn't have to self-isolate and didn't have to mask, then they would" (Jordan). In Erin's words: "by putting us in the same lump as the congregate care long-term care homes, they were putting policy into place that wasn't relevant" (Erin).

In addition, because governmental policies are sent out to organizations within one category, in this case congregate care, rules and regulations are not catered to the specific needs of that specific environment. Service providers end up having to search through lengthy documents to find policies relevant to their practice. Erin emphasizes that they really needed “a document for shelters for people that work with violence. This is what you have. These are the rules and the guides that you have to follow. That is a huge piece of what was missing through all of this” (Erin).

The last “pandemic”, SARS, was the basis for the pandemic policy that most organizations were working with at the beginning of the COVID-19 pandemic. However, due to the extenuating circumstances and the restrictive protocols to halt the spread of COVID-19, these policies “became irrelevant. It wasn't enough” (Erin). Service providers “used thousands and thousands of hours” (Erin) to create their own emergency policy from scratch and implement accordingly. This posed several challenges as they grappled with questions like “What needs to be included? What is the bare minimum? What is the bare minimum of guidelines to follow?” (Erin). Erin opined that these policies should be “created [by the government] and sent [to shelters in] an email with everything that [they] need. It just would make so much more sense”. They went on to suggest the possibility of having a “fill in the blank” policy document that can be adjusted “specific to each individual shelter” (Erin).

4.5.2 Increased Intersectoral Collaboration and Communication across Governmental Agencies and Service Providers

Morgan, Erin, and Taylor pointed out the inherent challenges with a siloed system especially during times of crisis, with “many different levels, the health unit, public health, our ministry, health ministry, just all these different people giving you

directives" (Erin). They emphasized the need for consistency and improved communication and collaboration within and among governmental entities and suggested that "social services [could] come up with one method of getting the information correctly. One set of directives correctly. So, people aren't spending so much of their valuable time chasing answers in documents" (Erin).

Providers also emphasized the importance of fostering improved communication and collaborative partnerships among service providers across sectors to establish a stronger network of services available to clients. Taylor emphasized the advantages of strengthening inter-organizational partnerships:

> I'm a big believer in "you need this service, I know a person at this place who can do that for you, let's call them together". I know the person at the end of the phone, and I trust them versus before the pandemic, I think we knew about things, but I think now there's so many more players coming to the table".

Other service providers echoed this sentiment, stating the need to continue strengthening these newly formed partnerships. This is especially important for organizations serving ethnic and language minority groups. For instance, in relation to language minorities, Morgan underscored the challenges they have encountered: "you can't offer service in French if [service providers] have [only] a basic understanding of the French language". If a client needs "counselling services in French, they're not going to be able to have service" (Morgan). They emphasized the need to create collaborative networks where agencies can refer language minorities – such as Francophones – to organizations that have the appropriate resources to provide the assistance they need.

4.5.3 Prioritize IPV Services Through Adequate Funding

Service providers expressed the need for shelters and IPV-related organizations to be prioritized and well-funded, so they do not have to go back to "survival mode":

> What needs to happen in this time is they need to take a look at our funding again to take us out of that basic survival rate of funding to a space that we can actually stop putting so much time and energy to figuring out where our groceries and our hydro are coming from. (Erin)

4.5.4 Investment in Telecommunications Infrastructure and Transportation

Erin, Alex, Taylor, and Jordan emphasized the fact that "connectivity is really poor in these communities" (Jordan). They alluded to the need for governments to prioritize "getting a better internet, high fiber or whatever they call it in there. That might help because then you could do even more Zoom [appointments]" (Jordan). Jordan also noted that "some [communities] are fine because they're not so far off the main highway" and emphasized that enhanced connectivity is particularly important for remote and northern communities.

As mentioned in previous sections, the need for increased funding for transportation, and improved transportation infrastructure was cited by all service providers, especially in rural, remote, and northern communities across NWO.

4.5.5 Improvements to the Justice System and Prioritization of IPV Cases

As thoroughly discussed in section 4.4.2 The Insufficiencies of the Justice System, all service providers agreed that "the most glaringly obvious gap in our community [NWO] right now is still what's going on with [the] justice [system] and court" (Taylor). Providers highlighted the inconsistencies and dead ends within the justice system as major barriers to service provision:

> The VAW [Violence Against Women] committees… in our community have worked really well in trying to engage that sector [Justice System], some has been successful, some has not been successful. I can make a phone call to someone and find something out really easily about almost anything else except when it comes to court stuff. I come up at a dead end, where there's like people trying to find the same answer and we're just unsuccessful. (Taylor)

Furthermore, service providers underscored the importance of enhanced accessibility to protective services for IPV survivors. This includes prompt and efficient emergency management, such as “removing the man from the house or the community, so that she has her own safe space”, as well as facilitating legal procedures like “filing a peace bond” (Taylor). Providers alluded to the urgent need for major improvements to the inconsistent and overly bureaucratic judicial system. Specifically, there is a need for improved communication with the public regarding the necessary protocols that IPV survivors need to follow in order to get the help they require. Additionally, providers stressed the importance of standardized, easy-to-follow protocols, readily accessible to anyone in need of legal aid.

These findings reflect the perspectives of IPV service providers in NWO, highlighting the challenges they faced during the COVID-19 pandemic, the barriers to access their clients encountered, the unexpected benefits brought on by policy changes, and their perceived needs in the face of an emergency. The following section will discuss these themes in-depth, drawing from existing literature and current events.

Chapter 5: Discussion

5.1 Summary of Findings

The aim of this inquiry was to capture the perspectives and experiences on the rise in Intimate Partner Violence (IPV) and the lived experiences of IPV service providers in Northwestern Ontario (NWO) during the COVID-19 pandemic. The research was guided by the following question: What challenges have IPV service providers and survivors (from service providers' perspectives) encountered during the COVID-19 pandemic due to the implementation of COVID emergency protocols in rural, remote, and northern areas of Northwestern Ontario? With this objective, the conducted interviews sought to address: 1) the factors contributing to a troubling surge in IPV during and after the COVID-19 pandemic in the context of Northwestern Ontario; 2) how organizations adapted to the pandemic and its subsequent emergency protocols implemented to manage it's spread and impact; 3) the impact of the pandemic on service provision and access for IPV survivors in the region; and 4) the necessary supports to prevent/mitigate the rise of IPV in future largescale emergencies and enhance IPV service provision in Northwestern Ontario.

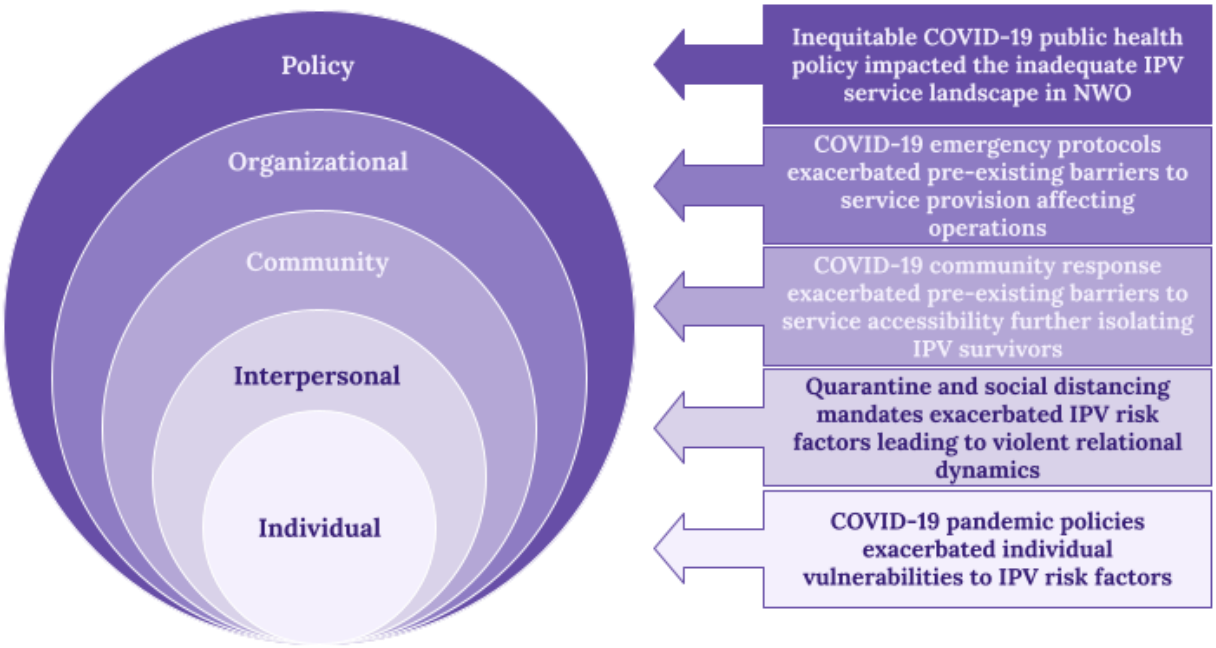
Five IPV service providers situated in various communities across Northwestern Ontario were interviewed. The organizations they represented included women's shelters, healthcare facilities, social services, and counselling services, all focused on offering assistance to IPV survivors in the region. The participants had varied professional backgrounds, providing a wide range of perspectives and reflecting the diversity of services available in NWO. The target populations served by these organizations were diverse, influenced significantly by the location of each organization. Nevertheless, the majority of service providers noted that they primarily

worked with Indigenous and Euro-Canadian women, with a smaller but growing immigrant client base.

Data analysis and interpretation followed the social-ecological determinants of health theory, accentuating the impact of pandemic emergency and health policies on intersecting IPV risk factors on five levels: individual, interpersonal, community, organizational, and policy. Specifically, this discussion draws parallels to the existing literature, stemming from other geographical areas, and sheds light on the unique challenges to IPV service provision experienced by providers in the context of Northwestern Ontario during the COVID-19 pandemic. Moreover, the findings are interpreted through a feminist lens, emphasizing gender-based violence (GBV) and the need for organizational and policy changes to address the systemic factors that underpin this phenomenon. Figure 6 depicts the social-ecological framework that constitutes the basis for the discussion section.

Figure 6

The Social-Ecological Model of Intimate Partner Violence in the context of NWO.



Note: Adapted from *Applying the Social-Ecological Model of Health to Loneliness*, by K. Killam, 2020 (https://kasleykillam.medium.com/the-inspiration-behind-community-microgrants-5bdedff5e48a). Copyright 2020 by Medium.

In contrast to the literature review, in the discussion chapter, I will follow the order outlined above in Figure 6 and below in Table 1, commencing with the ecological realm and subsequently addressing the social realm within this social-ecological model. I have chosen to invert this order with the aim to highlight how the public health policies of the COVID-19 pandemic filtered down, impacting each level of this framework, exacerbating IPV risk factors while limiting service provision and access in Northwestern Ontario.

Hence, I start the discussion delving into the three levels of the ecological realm; first, I examine the inequitable health policies implemented in an effort to halt the spread of COVID-19. Second, I analyze how emergency protocols shaped the operational response to the increase in IPV at the organizational level. Third, I discuss how the COVID-19 community response exacerbated pre-existing barriers to service accessibility, further isolating IPV survivors. Shifting focus to the social realm, I explore how quarantine and social distancing measures impacted interpersonal dynamics leading to a surge in violence within the home. Then, I delve into the individual level IPV risk factors and how the pandemic exacerbated these pre-existing vulnerabilities. Each section discusses key findings, followed by a "what is needed?" section, highlighting recommendations based on existing literature and initiatives. Following this discussion, I critically assess the strengths and limitations inherent to the methodology and reach of this study. Finally, the chapter ends with a short brief on the knowledge dissemination strategy.

Table 1

Summary of Main Findings and Recommendations

Social Ecological Frame-work	Main Findings			WHAT IS NEEDED?
	Pre-existing barriers to service provision & access	**IPV trends & systematic changes due to covid-19**	**Unexpected benefits of the covid-19 pandemic**	
Policy Level	**1.** Siloed systems	**1.** Inequitable health policy developed without consulting IPV organizations and/or IPV survivors. o Siloed system meant no communication among gov. ministries/departments. o Contradictory directives from different governmental entities.	NA	**1.** Strong partnerships among government entities and IPV service providers: o Spaces or tables where direct communication between gov. and organizations is encouraged.
	1a. Bureaucracy and the overburdened justice system	***1a.*** Pandemic highlighted the broken bureaucracy and insufficiencies of the justice system. o Remote work and court closures meant decreased access to legal aid.	NA	***1a.*** Justice systems that prioritize protection measures for IPV survivors: o Multilevel programming from law enforcement to judges. o IPV training to all personnel. o Enhanced notification systems for IPV survivors.
	1b. Funding does not prioritize IPV services. o Funding based on per capita, does not consider rural/remote needs.	***1b.*** Funding redirected towards pandemic efforts.	***1b.*** Increased funding to IPV organizations after surge in IPV rates. o Crisis relief funds quickly available with little requirements benefited IPV organizations.	***1b.*** Prioritization of IPV services through secure and consistent funding: o Additional Qualitative research to understand the real needs of IPV service providers and survivors in NWO and where to divest funds. o Looming economic crisis ahead? Mitigation strategies needed.

Organizational Level	**2.** Limited funding and resources available to IPV service providers. o Inconsistent income based on fundraising and grant applications. o Providers in survival mode.	**2.** Health policy demanded organizations meet certain standards they were not ready or able to afford.	**2.** Funding diverted towards IPV organizations for COVID-19 purposes and in response to a spike in IPV rates. o Funding from feds and provincial gov. o Crisis relief funds available with little requirements.	**2.** Rethink funding formulas for IPV services: o Recognize IPV services and core social services. o Secure and consistent annual funding instead of grants based. o Remoteness quotient as basis for calculating funding needs. o Remove unnecessary reporting obligations.
	2a. Limited capacity at emergency women's shelters. o Shelters often exceeded capacity.	***2a.*** Shelters considered congregate care poses challenges: o Capacity reduced by social distancing measures. o Networks of care disrupted.	***2a.*** Resources allocated towards health policy implementation and alternative shelter options for IPV survivors.	***2a.*** Emergency women's shelters should be considered their own category with policy based on their unique needs: o Need for gendered perspective when developing emergency policy.
	2b. Organizations in NWO used to operating in a "paper world".	***2b.*** Digitalization of services posed challenges to organizations transitioning from a "paper world". o Connectivity challenges.	***2b.*** Organizations got an upgrade. o Funding for devices and internet. o Expansion of online services.	***2b.*** Continuous funding reflecting the demands of an increasingly digitalized world.
	2c. High turnaround rates in the field. o Women overrepresented in social work and frontline positions.	***2c.*** Majority of frontline workers are women. o More vulnerable to infection o Dual burden of care work in the home and in the workplace.	***2c.*** Alternative work models. o Hybrid/remote. o Condensed 4-day week also adopted by some organizations.	***2c.*** Advocating for the continuation of these new work models as a way to alleviate the disproportionate impact of emergency crises on women, who often bear the brunt of care work: o Consideration of unique needs of staff working remotely (e.g., mental health supports).

Community Level	**3.** NWO Geography o Rural, remote, northern (RRN) communities	**3.** Increased isolation from services and support systems.	**3.** Innovation in service provision models. o Expansion of online services able to reach clients where they are (theoretically).	**3.** Research and investment in innovative IPV service provision catering to rural, remote, and northern community needs.
	3a. Limited transportation options in RRN communities.	***3a.*** Travel restrictions exacerbated barriers to IPV service access in isolated communities.	NA	***3a.*** Funding formulas must take into account the needs of RRN communities: o Allocate increased funds for transportation costs. o Partner with local public and private transport to increase access to free transport for IPV survivors.
	3b. Poor telecommunications connectivity.	***3b.*** Community resources and access points no longer available to community members. o Closures of public spaces that acted as resource centres for IPV survivors seeking help.	***3b.*** Increase in text and online chat options from different organizations.	***3b.*** Advocacy & investment to increase telecommunications infrastructure in RRN communities: o Digital/tele-health initiatives that take into account the connectivity limitations of RRN communities. o Increase local access to IPV services.
	3c. Indigenous reserves have unique service accessibility challenges.	***3c.*** Navigating COVID-19 community guidelines in Indigenous reserves poses challenges for service providers and survivors. o Strict travel bans within reserves. o Navigating tight-knit communities and the potential for social scrutiny.	NA	***3c.*** Increasing availability of IPV resources within Indigenous reserves: o Increased availability of confidential IPV resources. o Funding towards IPV response training. o Reinforce existing partnerships with IPV organizations.

Interpersonal Level	**4.** Mental health concerns and substance abuse.	**4.** Exacerbation of mental health concerns and substance abuse. o Service providers allocated more time and resources towards addressing mental health symptoms and concerns compared to assault.	NA	**4.** Investment in Mental Health programming and resources for IPV survivors and perpetrators: o Revamp of existing programming directed at perpetrators (i.e., PAR program etc.).
	4a. Relational dynamics and intergenerational trauma.	***4a.*** Systematic confinement of survivors with abusers. o Survivors unable to access services safely. o Coercive control and psychological manipulation. o Increase in frequency and severity of physical abuse.	NA	***4a.*** Gendered view on emergency policy: o Investment in educational programming focusing on healthy relational dynamics directed at perpetrators. o Enhancement and implementation of IPV topics in school curriculums.
Individual Level	**5.** Social location related to IPV vulnerability.	**5.** Pandemic exacerbated individual risk factors for IPV and diminished individuals' ability to access supports.	NA	**5.** Grants programs available to IPV survivors trying to leave an abusive relationship.
	5a. Minority groups face increased access barriers.	***5a.*** Indigenous individuals unable to navigate IPV due to increased barriers. o Strict in-reserve COVID-19 community guidelines.	NA	***5a.*** Direct funding towards vulnerable populations: o Investment in linguistically and culturally competent programming.
	5b. Socio-economic status. o Individuals of low SES overrepresented in IPV rates.	***5b.*** Worsening of precarious circumstances for individuals of low SES. o Increased vulnerability to IPV o Increased barriers to service access.	NA	***5b.*** Direct funding towards vulnerable populations: o Investment in services that address basic needs (e.g., shelters, food banks).

5.2 Ecological Realm

This discussion begins in the ecological context, examining how the health policies meant to safeguard the population from COVID-19 contagion trickled down each social-ecological level, exacerbating IPV risk factors, increasing barriers to access, and leading to an IPV "shadow pandemic" (Viero et al., 2021). First, I examine the pandemic health policies that led to major shifts in the IPV service landscape in Northwestern Ontario, intensifying systemic insufficiencies within governmental and legal entities. Next, I investigate how service providers navigated policy changes and adapted to the unique challenges presented by the COVID-19 pandemic, underlining the resilience and flexibility required by organizations in the face of unprecedented circumstances. Additionally, I delve into the unexpected benefits of pandemic crisis relief funds for IPV organizations. Lastly, I explore the community level factors contributing to the unique barriers to IPV service provision and access in NWO, highlighting how quarantine and travel restrictions aggravated these barriers, especially in Indigenous communities.

5.2.1 Policy Level

Pandemic Response and Inequities in Policy Development.

The action-oriented nature of these policies and their quick implementation highlighted the impact that governmental institutions as well as global organizations can have on an outcome when health issues are prioritized. However, these rapid changes also revealed shortcomings in our current system. Light was shed on the inefficiencies of our siloed system characterized by the compartmentalization of social issues into different Ministries and departments.

Over the pandemic, the lack of communication among governmental entities was reflected in the way information regarding the pandemic, the COVID-19 virus, and public health mandates reached IPV service providers. This inefficient way of information dissemination hindered service providers' ability to provide needed services while adapting to health mandates, creating frustration among staff. To address this issue, Norris et al. delineate four key "adaptive capacities" crucial for community recovery post-crisis or disaster (Norris et al., 2008). In this framework, these capacities encompass economic development, social capital, information and communication, and community competence (Norris et al., 2008). In particular, the authors highlight the importance of accurate and timely communications regarding potential dangers and available behavioral choices in the face of an emergency crisis (Norris et al., 2008). While their study focuses on effective ways to inform the public at large, these methods can also be applied to cross-organizational communication. Interviewed participants alluded to the fact that governmental directives were confusing and untrustworthy as they received contradictory and ever-changing information from various governmental entities in the form of lengthy and confusing documents. This framework underscores the need for the communicator to be trusted, and the importance of employing local sources of information to communicate governmental directives (Longstaff & Yang, 2008; Norris et al., 2008). In the context of Ontario at large, enhanced collaboration and communication among siloed governmental entities (e.g., Ministries and departments) could improve the accuracy and clarity of directives in times of crisis. This, in turn, could bolster trust in the sender (i.e., governmental institutions). Utilizing local Health Units as a centralized information hub may also be a viable way to more efficiently disseminate information to local service providers. In the context of NWO, interviewed providers disclosed

partnerships with their Health Units, leveraging these existing connections could improve trust in governmental directives and foster adherence to recommendations (Norris et al., 2008).

In addition, interviewed providers commented on the fact that government-mandated health policies and the "safe at home" public health messaging failed to reflect the needs and realities of IPV organizations and survivors during COVID-19, this was also documented in the literature (Kaukinen, 2020; Kofman et al., 2020; Naveed et al., 2022). The blatant disregard for IPV survivors' realities and needs in times of crises was also documented during the 2009 Black Saturday bushfires in Australia, where the predominant public messaging was focused on honouring men as heroes as they fought bushfires in the community, forcing individuals experiencing heightened rates of IPV at the hands of their male partners to keep silent about their abuse (Parkinson & Zara, 2013).

What is Needed?

When asked what they thought was needed in order to develop more equitable public health policies, service providers emphasized two key points: First and foremost, IPV services need to be regarded as essential social services, tailoring policy to organizational and survivor needs. To add to this, Wood et al. suggest classifying IPV and SA workers as first responders, placing them on par with firefighters, paramedics, and nurses. This recognition would help address their occupational needs effectively, acknowledging their frontline roles in emergency crises (Wood et al., 2020). Second, providers alluded to the need for fostering well-founded collaborative partnerships between IPV service providers and governmental entities. They reflected on the need for designated spaces or "tables" where direct communication was made

possible, allowing IPV organizations and advocates to voice concerns and needs to governmental representatives. The “adaptive capacities” framework outlined earlier, reflects provider perspectives, suggesting the enhancement of inter-organizational, reciprocal, supportive, and cooperative networks as a way to build community capacity in the face of largescale emergencies (Norris et al., 2008). Most importantly, providers and existing literature underscored the importance of equitable policy and public messaging that reflects the unique realities of IPV service provision and access in rural, remote, and northern communities (Moffitt et al., 2022).

Bureaucracy and the Insufficiencies of the Judicial System.

One of the most prevalent themes in both the data collected and existing IPV related literature was the utter collapse of the justice system during the pandemic and the disastrous implications for IPV survivors (Koshan et al., 2020). Interviewed providers unanimously highlighted the longstanding insufficiencies of the justice system, particularly when it comes to IPV legal matters. Critiques among providers on the excessively bureaucratic procedures that IPV survivors must navigate when seeking legal protection against a perpetrator were rampant and filled with frustration. According to service providers, IPV cases are often dismissed due to incomplete documentation or failure to submit paperwork by a predetermined date, court dates are often delayed, and the absence of follow-up with IPV perpetrators allows them the opportunity for retaliation.

These inadequacies were gravely exacerbated during COVID-19 as echoed in the literature (Koshan et al., 2020; Piquero, 2021). The pandemic greatly impacted the already overburdened judicial system, remote work mandates and court closures disrupted existing cases and claims, delaying proper assessment and legal action in

IPV cases (Moffitt et al., 2022). In the context of Northwestern Ontario, COVID-19 protocols implemented by police and detention facilities failed to account for the dangers to IPV survivors (Moffitt et al., 2022). Risk to IPV survivors is often heightened after a reported assault (Moffitt et al., 2022). Providers affirmed these risks were compounded by the decision to release potentially dangerous perpetrators due to outbreaks in detention facilities, also reflected in the literature (Moffitt et al., 2022). In many cases, authorities failed to notify IPV survivors that their abuser had been freed, increasing the risk of retaliation. Moreover, traditionally, perpetrators in small rural towns in NWO are taken to Thunder Bay facilities waiting for hearing procedures, this allows survivors ample time to seek necessary services. Providers explained this was no longer the case during the pandemic; due to travel restrictions, perpetrators were released on bail into the community without giving the survivor a chance to access IPV services including safe shelter, safety planning, counselling, and/or legal aid.

The lack of adequate protective measures available to IPV survivors is an issue that can result in detrimental consequences, impacting not only the survivor but our communities at large. Most recently, the disheartening case of intimate partner homicide, which took the lives of three children, on October 23rd in Sault Ste. Marie is an example of the absence of clear and proactive protection measures against perpetrators, leading to innocent lives lost (CBC News, 2023a). This case is not an outlier; the Annual Femicide List published every year by the Ontario Association of Interval & Transition Houses (AITH), reported 52 femicides province-wide from November 2021 to 2022 (Ontario Association of Interval & Transition Houses, 2022). Of these 52 femicides, 20 are categorized as intimate partner femicides (Ontario Association of Interval & Transition Houses, 2022). The Renfrew County femicides in 2015, where a man shot and killed three women with whom he had previous romantic

relationships, led to a month-long inquest in 2021, yielding 86 recommendations to end IPV (Office of the Chief Coroner, 2022). The common denominator in these cases is that victims sought help from police or legal services, with two of the victims in the Renfrew County case taking legal action against the perpetrator (Hayes, 2022). In the latter, the perpetrator failed to attend a program meant to treat intimate partner abusers repeatedly with no follow-up or consequence from authorities (Hayes, 2022). He then proceeded to defy probation orders and murder these three women (Hayes, 2022). A peer-reviewed study exploring the link between domestic violence and mass shootings found that in nearly 70%, or two-thirds, of all mass shootings recorded in the United States from 2014 to 2019, perpetrators either shot or killed a partner or family member or had a history of domestic violence (Geller et al., 2021). This study underscores the fact that the rise in IPV is a public health and security issue, demanding a level of commitment comparable to the COVID-19 pandemic response.

What is Needed?

These cases have prompted over 40 municipalities across the province of Ontario to declare an IPV epidemic and demand the province follow (with no luck so far) as IPV rates and severity have skyrocketed (Weir, 2023). Labelling the rise in IPV as an epidemic is crucial in the fight to end gender-based violence. Shifting the perspective of IPV as being a threat to individuals behind closed doors to recognizing it as a broader community threat is essential in driving the prioritization of the IPV portfolio on a provincial and national level.

Built on the premise that gender-based violence constitutes a violation of human rights and is criminalized under Canadian jurisdiction, The National Action Plan to End Gender-Based Violence in Canada outlines five actionable pillars, one being

the need for a responsive justice system (Women and Gender Equality Canada, 2022). It is imperative to examine and address the insufficiencies within the legal system at all levels, starting with law enforcement, prosecutors, judges, and victim service providers, through multilevel programming (Women and Gender Equality Canada, 2022). To start, IPV training available to all personnel involved in the justice system is necessary in order to address the lack of urgency that IPV cases are afforded (Office of the Chief Coroner, 2022). The Renfrew Inquest recommends the provision of specialized training to police officers with the aim of establishing an IPV specialist in each police detachment (recommendation 30) (Office of the Chief Coroner, 2022). Substantial changes to legal procedures in IPV cases, specifically giving precedence to protection measures for survivors, are crucial in preventing intimate partner femicides (Office of the Chief Coroner, 2022). Investing in efficient notification systems is necessary, especially for those living in small tight-knit rural communities (Moffitt et al., 2022; Office of the Chief Coroner, 2022). The Renfrew Inquest suggests the implementation of an IPV Registry for repeat offenders similar to the Sex Offender Information Registry (Office of the Chief Coroner, 2022). Finally, implementing new or enhancing existing programs to treat perpetrators, coupled with stricter follow-up procedures for perpetrators on probation is necessary in addressing gender-based violence, including intimate partner violence, comprehensively (Office of the Chief Coroner, 2022).

5.2.2 Organizational level

Moving onto the organizational level, this section discusses the challenges encountered by service providers over the pandemic, how public health mandates impacted their operations, their resilience in adapting to ever-changing directives, and

the unexpected benefits that the pandemic brought to historically underfunded IPV organizations.

Funding.

IPV organizations have historically been underfunded and deprioritized, this is well-documented in the literature and my data (Khan, 2023; Laverock, 2023; Wood et al., 2020). Service providers confirm that they collect their monetary and material resources through fundraising, community donation drives, and grants offered by governmental entities or global organizations (e.g., WHO). In Ontario, governmental funding is determined through a "funding formula" based on population per capita (FAO, 2021). Once funding is made available, service providers must adhere to strict guidelines for the allocation of funds, providing continuous reports on how these funds are being used (Moffitt et al., 2022; Wood et al., 2020). Although the population served by organizations in NWO is significantly smaller compared to the populations in urban hubs such as Toronto, these regulations overlook the unique needs of IPV organizations and women's shelters specific to RRN areas generally and in Northwestern Ontario specifically (Moffitt et al., 2022). The high cost of transportation, especially in rural, remote, and fly-in communities poses significant challenges to service provision, solvable only with increased resources (Moffitt et al., 2022). Moreover, they fail to recognize the countless hours of work invested into applying for grants and fulfilling reporting obligations, which divert human resources from assisting IPV survivors (Wood et al., 2020).

Health policy demanded organizations meet certain standards they were not ready or able to afford. However, the need to implement quarantine and social distancing policies, and work-from-home mandates prompted federal and provincial

governments to offer several unrestricted funding opportunities and crisis relief funds for IPV organizations. This emergency policy unexpectedly provided IPV organizations with the much-needed funding they have always sought. While these measures were a part of the pandemic containment efforts, the additional influx of financial support afforded providers the means to rethink services and transition towards new and innovative methods of service delivery.

Most recently, the province of Ontario announced it is investing $4 million to support survivors of IPV, DV, human trafficking, and child exploitation (Ontario, 2023). These funds are being allocated to service providers supporting these causes through the Victim Support Grant (VSG) program, as a part of Ontario's Guns, Gangs and Violence Reduction Strategy (Ontario, 2023). Of relevance, the following programs supporting IPV survivors in NWO are recipients of this grant: (1) Footprints North West, Dryden will invest the funds in operations supporting IPV survivors, and education programming; (2) Project CAP, Kenora will direct these funds towards addressing physical and mental health issues, poverty, and homelessness faced by IPV survivors; (3) IPV Awareness, Rainy River will use the funds to support current, relevant, and culturally appropriate IPV training to children, youth, and teachers in the region; (4) IPV Collaboration, Red Lake will invest this funding in supporting women's shelters operations and programming; (5) IPV Project, Sioux Lookout will invest the grant funds in supporting IPV initiatives regionally based on community needs; and (6) Post Incident Victim Support Worker, Thunder Bay Police Service is partnering up with Faye Peterson House to provide victim-centred and trauma-informed programming to IPV survivors; the funds will help in hiring a specialized worker (Ontario, 2023). Notably, in addition to supporting existing IPV services and programming, organizations will be investing funds into IPV educational programming directed at

youth, increasing awareness among a younger population and potentially mitigating future IPV victimization and perpetration in the community.

Emergency Women's Shelters.

Social distancing measures forced women's shelters in NWO to further reduce their capacity, greatly diminishing their ability to address the rising IPV rates. This was echoed in the results of a large-scale qualitative study performed across 24 states in the United States. Battered women's shelters experienced a reduction in service provision capacity due to state-mandated COVID-19 protocols that resulted in a significant decrease in available shelter beds coupled with an increase in demand (Wood et al., 2020). In Canada, however, increased funding streams allowed shelters to implement alternative emergency housing options for IPV survivors. Providers in NWO were now able to find external accommodations for their clients, for instance, in hotel rooms. Nevertheless, this also posed challenges requiring providers to develop new protocols for service delivery such as supplying food for women lodged in external facilities, offering online counselling, and implementing safety measures.

Once individuals were able to leave their violent households to access shelter or in-person services, they encountered several other barriers. Service providers noted that individuals accessing their services were often hesitant to follow-up with their appointments due to the fear of contracting COVID-19. Other providers affirmed that IPV survivors seeking temporary housing options or emergency shelter were discouraged by the mandatory quarantine measures they were asked to follow, especially when they had to stay in a single room with their children. Service providers recalled a few cases where clients reached their facilities via phone to specifically ask whether quarantine mandates were in effect with no follow through. The literature

touches upon the fear of COVID-19 infection as a deterrent to access services (Moffitt et al., 2022). However, studies have not delved further into forced quarantine at shelters as a major deterrent for individuals in precarious circumstances. It is important to understand the major toll that quarantining, especially alongside their children, had on women-identifying individuals seeking shelter due to IPV and why it deterred them to the point of opting out of support seeking.

Similarly, the mandatory quarantine and vaccine requirements completely changed the dynamics among shelter staff and clients. It is important to highlight the familiar, nurturing, and safe care that women's shelters, especially in rural and remote communities, provide to their clients. Service providers affirmed that the sense of community that was formed among shelter clients and staff was greatly impacted by COVID-19 measures. It is not necessary to further dive into the importance of quarantine measures at the beginning of the pandemic. Nevertheless, it is important to now look at the many layers of impact on IPV services associated with these measures.

During the pandemic, "networks of care" within the shelter were erased due to government mandated social distancing. These spaces that once cultivated a sense of safety and community among women became isolating in times when women needed supportive and engaging environments after having escaped traumatizing situations (Goodman & Smyth, 2011). Within formal structures, women can engage in informal networks of care established through shared meals and recreational activities, according to providers. Past studies point at the importance of strong social networks for women navigating violence within their relationships, citing strong bonds with family and friends as essential in their process (Goodman & Smyth, 2011; Krenkel & Moré, 2022). However, there is a lack in literature examining the importance of creating social networks within formal structures, such as shelters. We did not take into

account that social distancing would have an effect on how women seeking support would be isolated within a structure that was supposed to provide community. This reflects the implementation of inequitable social and health policy that does not reflect the needs of IPV service providers and survivors. The need for these safe spaces specifically established with the needs of IPV survivors in mind is reflected in the 12 recommendations that form the basis for Canada's National Action Plan to End Gender-Based Violence (Yakubovich et al., 2023).

The Digitalization of IPV Services.

NWO service providers still largely operate in a predominantly paper-based system, particularly in smaller rural communities. This is partly due to connectivity challenges across the territory and primarily because of insufficient funding for the digitalization of services. Consequently, the sudden transition to remote work and online service delivery proved challenging. A qualitative study on the occupational experiences of the IPV/SA workforce highlighted the fact that over half of all workers switched to video conferencing platforms as a means of service delivery during the COVID-19 pandemic (Wood et al., 2020). Among prevalent challenges encountered by staff members was their fear and anxiety over clients' safety during safety planning or therapy in a digital space, due to potential surveillance from the abuser (Wood et al., 2020). Most service providers in NWO said their main means of contacting clients was via phone or text message, which was cited by advocates as being preferable to video conferencing options due to safety concerns (Wood et al., 2020). Fortunately, the augmented funding played a pivotal role in allowing organizations to procure devices and phone plans for staff mandated to work remotely and expand online text options for IPV survivors seeking help. Unfortunately, providers expressed uncertainty and fear

for the future, recognizing that these upgrades may not be sustainable in the long term as COVID-related funding comes to an end.

In addition, advocates highlighted the difficulties of conducting emotionally challenging and inherently private work from their own homes, emphasizing the importance of separating a staff member's personal and family space from their stressful work environment (Wood et al., 2020). Increased research should be directed at understanding how agencies can support remote work arrangements in the future to prevent secondary traumatic stress (STS) and burnout among IPV service providers (Wood et al., 2020).

The Burden of Care Work.

The final sub-theme within the organizational level centres on the disproportionate burden of care carried by women (Power, 2020). It is important to highlight that all interviewed service providers identified as women. This aligns with the broader societal trend of women predominantly bearing the responsibilities of care work (Power, 2020). Professions such as social work, nursing, and childcare see a higher representation of women, placing them on the frontlines of emergency crises. The emotionally and mentally demanding nature of social work, including IPV service provision, contributes to high turnover rates. The pandemic magnified these trends, resulting in heightened burnout and mental health strains among this population (Power, 2020). In addition, women are the main contributors to the unpaid and often invisible “care economy” (Power, 2020), bearing the responsibilities of a “second shift”, a term coined by sociologist Arlie Hochschild, referring to the dual workload in both their professions and at home (Hochschild & Machung, 2012). Most recently feminist literature points at a “third shift” as women take on the emotional labour in their

households, a prevalent trend over the pandemic (Chung, 2020). To add another layer, women took on the role of informal educators as quarantine measures forced children into online schooling, blurring the lines between educational structures and the home (Power, 2020) . The increased layers of unpaid care work borne by women reflected gender-regressive emergency policies disproportionately affecting this demographic over the pandemic (Power, 2020).

Executive directors and managers emphasized the profound impact of the pandemic's uncertainty on their staff's mental health as daily operations became potentially hazardous to their health. To address the escalating burden on frontline workers, improve mental health, and prevent burnout, some organizations adopted a four-day work week (4DWW) and a flexible hybrid work model. According to one organization, this model significantly benefited their staff and substantially increased productivity. The benefits of a 4DWW have been making headlines since the pandemic allowed for a re-evaluation of work models, with Belgium officially implementing this model country-wide in 2022 (De Jongh, 2023). A systematic review of 31 academic articles points at favourable impacts on workers, including increased morale, job satisfaction, and reduced turnover rates (T. T. Campbell, 2023). However, they warn of potential negatives including intensified performance monitoring and measures, scheduling conflicts, and concern that the aforementioned advantages may fade over time (T. T. Campbell, 2023).

What is Needed?

As previously stated, prioritization of IPV services is necessary in order to address funding needs and, in turn, improve service provision. My findings reflect and support the Renfrew Inquest recommendations on IPV funding needs in Ontario (Office

of the Chief Coroner, 2022). In particular, recommendation 20 asserts the need to "realign the approach to public funding provided to IPV service providers with a view to removing unnecessary reporting obligations with a focus on service" (Office of the Chief Coroner, 2022). This includes recognizing IPV services as core social services (Wood et al., 2020), providing annualized public funding, and consideration of the remoteness quotient used to calculate funding in other social services as a model for properly funding service providers in rural, remote, and northern regions (Office of the Chief Coroner, 2022). Continuous income can help these organizations keep up with the demands of an increasingly digitalized world and upgrade service delivery methods to include online services that can reach a wider audience (Emezue, 2020; Jeyaraman & Chandan, 2020). Finally, in terms of emergency policy, it is imperative that emergency women's shelters be considered their own category instead of grouping them under "congregate care" services. This emphasizes the need for a gendered perspective when developing social services policy, considering women's shelters have unique needs (Meinhart et al., 2021). The prompt implementation of these recommendations would significantly enhance service delivery and accessibility for IPV survivors in Northwestern Ontario.

While the pandemic prompted the exploration of alternative work options for administrative and office-bound staff, frontline workers were not afforded the same options due to the nature of their roles. A condensed 4DWW model may help in counteracting some of the strain felt by these workers. Importantly, advocates warn that these measures have the potential to be counterproductive if employers opt for a 4DWW with a salary reduction (T. T. Campbell, 2023). Harper (2019) warns that women, especially parents, may opt for this option, greatly impacting their long-term earning potential and driving a bigger gap in income inequality. Consequently, this

may be a beneficial option only when employers offer full salaries along with the condensed 4DWW (Harper, 2019).

Recognizing the burnout affecting workers in the social and healthcare sectors, particularly the disproportionate burden on women, is a crucial step toward establishing gender-based, equitable work policies, and emergency protocols that account for the imbalanced care responsibilities borne by women. Advocating for new work models, including condensed four-day weeks and hybrid schedules - with full pay - is essential to mitigate the disproportionate impact of emergency crises on women (T. T. Campbell, 2023; Harper, 2019).

Just as organizations experienced rippling effects from COVID-19 emergency policies, so did the communities within which they operate. I now shift focus to the community level, exploring the challenges communities encountered in the face of unprecedented circumstances and concluding with recommendations based on service provider perspectives and existing literature.

5.2.3 Community Level

As noted in section *1.1.3 Study Setting and Population Background*, Northwestern Ontario is characterized by vast natural landscapes hosting a diverse population composed of a majority Euro-Canadian settlers, a large Indigenous population, and a growing population of immigrants encouraged by northern immigration initiatives (OACAS, n.d.). The largest urban hub, Thunder Bay, hosts the majority of the population in the region (123,258 as of 2021) (Northwestern Ontario Municipal Association, n.d.; TBRHSC, n.d.-b). The rest of the population lives in smaller communities along Highway 17 and the Trans-Canada highway, as well as rural and remote townships dotted along secondary roads. There are 88 Indigenous reserves in

the region (Ontario, n.d.). This dispersion of the population across an expansive territory creates a unique backdrop for IPV service provision with inherent accessibility barriers within communities.

Challenges Inherent to NWO's Geography and Demographic Composition.

The logistical obstacles to IPV service delivery and access in rural communities are widely acknowledged by service providers and the existing literature (Hansen & Lory, 2020; Jeffrey et al., 2019; Moffitt et al., 2022). In addition to common barriers to accessing support (e.g. limited financial means to leave the relationship, concern for children, fear of partner, stigma), IPV survivors living in rural communities face increased social isolation and limited access to informal support from family and friends and formal support from health and social services (Moffitt et al., 2022).

Transportation and Connectivity Barriers.

Providers identified barriers primarily rooted in transportation and connectivity inherent to the RRN landscape. Based on my own tabulations of the catchment areas disclosed by service providers, organizations cover an average of 250 Km, with IPV survivors needing to travel over an hour and a half to reach services in rural NWO and even more for those in remote areas. If specific services are only available in Thunder Bay, IPV survivors are forced to take on day trips, often travelling over 8 hours to reach this urban hub. This is consistent with existing literature, citing long distances as a common barrier in RRN regions across Canada (Moffitt et al., 2022). These geographical challenges are also accompanied by extreme weather conditions with harsh winters making travel a lot harder - sometimes impossible due to road closures - and unsafe for IPV survivors (Moffitt et al., 2022). Consequently, leaving an abusive

relationship requires extensive planning and resources, especially for survivors living in RRN.

According to interviewed providers, there are only two women's shelters serving fly-in communities and with the necessary resources to accommodate the costly travel logistics needed to get IPV survivors to safety. These already precarious circumstances were exacerbated by mandated quarantine and travel restriction over the pandemic, confining IPV survivors to their homes (Kofman et al., 2020; Moffitt et al., 2022). Concerningly, police response was also greatly impacted by the pandemic, increasing barriers to reporting or receiving assistance in escalated conflicts (Moffitt et al., 2022). In many reported cases, due to the risk of infection, dispatchers opted to “resolve” matters via phone instead of attending in-person call requests (Moffitt et al., 2022; Roszell, 2020). These COVID-19 protocols further isolated survivors from emergency services, often discouraging them from seeking assistance (Moffitt et al., 2022). Gaining access to internet services as well as devices was also cited as being a significant barrier for IPV service providers and their clients. As previously mentioned in the section titled *The Digitalization of IPV Services*, providers, especially those in smaller towns, still operate in a “paper world”. The pandemic pushed organizations to upgrade their operations as most of their staff switched to remote work. Services that could be performed virtually or over the phone, for instance counselling and safety planning, were now mostly available via those means. Additionally, some providers explained that due to increased funding they were able to expand their online services. Although all services were still available through virtual means, providers cited this as a barrier to survivors over the pandemic due to the inherent challenges in connectivity in NWO. Existing literature reflects these findings, pointing at the limited availability of

telecommunications providers and high-speed internet in rural regions of Canada compared to urban centres, limiting the reach of services in RRN (Moffitt et al., 2022).

The Importance of Public Spaces.

The partial or complete closure of community resources including libraries, walk-in clinics, and other public spaces was detrimental to survivors seeking support over the pandemic. Traditionally, public spaces are a first point of contact for IPV survivors seeking help. Providers noted that their clients often find easy access to telephones, internet, and digital devices at these places, enabling them to connect with emergency services, shelters, counselling services, and legal aid in situations in which they lack safe access to these resources at home. Quarantine restrictions and closures of public spaces systematically erased these access points for survivors (Jarnecke et al., 2020). The need for these public resources available to all patrons of the community is well documented in the literature (Jarnecke et al., 2020). Several authors documented community initiatives in partnership with IPV organizations aiming to counteract these changes. For instance, in an effort to aid survivors in seeking support over the pandemic, France designated pharmacies and grocery stores as contact points where women were able to use code words to alert staff of their abuse, in which case emergency services would be called immediately (Kottasova, 2020).

In the context of Northwestern Ontario, the need for public spaces is anecdotally documented by service providers. However, interventions geared towards women in rural and remote areas still need investment. Online services were expanded over the pandemic in an effort to reach clients across long distances (theoretically). Nevertheless, connectivity is still not reliably available across Northwestern Ontario, especially in rural and remote areas, not to mention the safety concerns over the

pandemic as survivors were confined to the same spaces as their abusers (Emezue, 2020). Access to digital devices is equally challenging for some individuals, rendering virtual initiatives accessible mostly to women in higher income brackets, especially over the pandemic. These existing social inequities were severely exacerbated during the pandemic as "stay-at-home" orders disproportionately affected marginalized and impoverished communities on several fronts (Evans et al., 2020; Hansen & Lory, 2020).

Tight-knit Communities and Indigenous Reserves.

The tight-knit nature and familiarity of RRN communities add another barrier to reporting. Familiarity among service providers and clients is often common in these communities. Unfortunately, the lack of provider-client anonymity and confidentiality can lead to fear of social scrutiny discouraging survivors from taking steps in leaving their abusive relationships (Moffitt et al., 2022). Similarly, due to this familiarity among the community, women who come forward with abuse claims are often met with disbelief by their peers and/or local service providers who may also have connections with the perpetrator (Moffitt et al., 2022). Interviewed providers alluded to these dynamics, especially in Indigenous reserves, as abusers often have familial ties with Chiefs and/or leaders in the community. This posed significant barriers to access during the COVID-19 pandemic due to the implementation of community closures and travel restrictions in Indigenous reserves with the aim to prevent the spread of COVID-19. Community members generally required authorization from the Chief's office to leave their community; these negotiations and requests were mediated by IPV service providers. Consequently, navigating these COVID-19 community guidelines proved challenging for service providers trying to get IPV survivors the help they needed. Providers also mentioned the fact that these guidelines looked different in every First

Nations community and reserve, hence, providers had to put extensive research and effort into navigating the distinct guidelines on an individual basis, often delaying the transfer of IPV survivors to safety.

What is needed?

Ending violence against women needs a comprehensive community approach. Partnerships between public and private spaces in the community and IPV organizations are needed to increase access to services and create strong support networks for IPV survivors. The Renfrew Inquests recommends the establishment of grassroots "Safe Space" programs in collaboration with businesses where survivors can feel safe and ask for information in local businesses (recommendation 49) (Office of the Chief Coroner, 2022). This would require community awareness of the issue as well as adequate training on IPV indicators and conflict de-escalation for participating businesses and their staff.

It is crucial to address RRN connectivity challenges in order to effectively expand Tele-Health and online services in NWO. The first step in broadening the availability of such services involves advocating for investment and expansion of telecommunications infrastructure across NWO, especially in rural, remote, and northern regions (Moffitt et al., 2022; Office of the Chief Coroner, 2022). Further, exploring the possibility to partner with telecommunications companies to implement programs like the "Phones for a Fresh Start" initiative offered by SaskTel, where community members are able to donate old phones to be refurbished and donated to persons fleeing domestic abuse as a way to secure access to devices for IPV survivors (SaskTel, n.d.). In addition, partnering with local public and private transportation providers to provide free access to transportation for IPV survivors in emergencies can

facilitate their journey towards safety and support. To address the gap in available transportation in small rural towns, fundings for shelter-owned vehicles could be a way of securing safe transfer of survivors within range. Drawing inspiration from Designated Driver services, these vehicles could be operated by hired staff or community members that can sign up to be a “safe driver” and get IPV survivors to safety.

Additionally, there is a need to expand confidential IPV resources within Indigenous reserves and allocate funds for IPV response training. Most importantly, in order to accomplish any lasting change, there needs to be federal and provincial investment in IPV services, tailoring funding formulas to the needs of rural and remote communities, with a specific focus on increased funds for transportation and connectivity costs (Office of the Chief Coroner, 2022).

Having examined the impacts of COVID-19 on the ecological realm, I now pivot the discussion towards the changes in the social fabric that led to increased rates of IPV. While the ecological lens shed light on the rippling effects of public emergency policy on the broader institutional, organizational, and community level structures, delving into the social realm allows us to explore the intricacies of social structures within the home. The next section examines the compounding effects of COVID-19 quarantine and social distancing measures on relational dynamics leading to increased violence in the home, and the intersections between social location and vulnerability to IPV.

5.3 Social Realm

The social plane within social-ecological theory pertains to the intersections between individual and interpersonal risk factors leading to intimate partner violence

(Eriksson et al., 2018; Goh et al., 2020). In the context of this work the social level helps to explain the individual and relational behavioural changes brought on by the COVID-19 pandemic. These societal changes culminated in a concerning spike in IPV cases reported worldwide and in Northwestern Ontario. In this section, I explore how quarantine and social distancing policies impacted the day-to-day lives of service providers and their clients. I also unravel some of the trends in IPV reported by providers in their practice over the pandemic and its aftermath, shedding light on the challenges faced by frontline workers and individuals seeking support, from provider perspectives, in the context of NWO. I start this exploration delving into the interpersonal level factors, which include the exacerbation of mental health concerns among IPV survivors and perpetrators, and the effects of quarantine and social distancing on relational dynamics. The discussion ends with the individual level factors, examining the intersection of social location and vulnerability to IPV during the COVID-19 pandemic.

5.3.1 Interpersonal Level

Trend: Quarantine, Social Distancing and Coercive Control.

Quarantine and social distancing measures exacerbated stressors in the home as families faced the inherent fears and uncertainties that come with unprecedented circumstances. This coupled with loss of employment, increased isolation, and the exacerbation of mental health symptoms and unhealthy coping mechanisms created volatile environments leading to spikes in IPV rates worldwide (Bouillon-Minois et al., 2020; Leslie & Wilson, 2020; Silva et al., 2020; Usher et al., 2020). This phenomenon

was also experienced by IPV service providers in Northwestern Ontario who witnessed concerning trends as the pandemic developed.

All interviewed providers reported that the first trend they noticed, as quarantine measures came into effect, was a boom in call volume coupled with a notable decline in in-person clientele. This trend was also reported by several news outlets as advocates against GBV warned that the forced confinement and isolation of survivors with their abusers due to quarantine measures may hinder their ability to seek help (Usher et al., 2020; Weller et al., 2021). Interviewed providers concurred, explaining that, in their opinion, the forced isolation in close quarters with abusers prevented at-risk individuals from reaching services as well as social support networks. Bradbury-Jones & Isham (2020) echo this sentiment affirming "safe-at-home" did not apply to everyone, especially those individuals living in violence prone environments.

Glowacz et al. (2020) highlight the fact that most of the media's focus during the pandemic and aftermath has been on the more physical and extreme cases of IPV, and more hidden forms of abuse are often not discussed. From service providers' anecdotal accounts, due to the mandated stay-at-home rules, survivors did not have "valid" excuses to leave their homes, making them easy targets of coercive control and psychological manipulation. This was discussed by service providers as a prevalent trend that their clients reported over the pandemic. Sociologist and Professor Evan Stark writes on the topic of coercive control, affirming the trend as rooted in patriarchal views, perpetuating sexual discrimination and women's socially constructed "default" domesticity (Stark, 2007). He categorizes this form of abuse as frequent, often minor assaults with the aim to "intimidate, isolate, humiliate, exploit, regulate, and micromanage women's enactment" (Stark, 2007) of everyday life.

Pandemic protocols created confined environments where this type of intimate partner abuse was prominent (Glowacz et al., 2022). Provider's clients reported that their abusers used misinformation about COVID-19 to instill fear of leaving and discouraged them from getting vaccinated. Abusers reportedly used IPV survivors' fears over the pandemic as a way to exert control over their behaviours. This type of pandemic fuelled psychological abuse was abundantly present in the literature, with authors citing this behaviour as a way for perpetrators to further isolate their partner from support systems and services (Jarnecke et al., 2020; Lyons & Brewer, 2021; Ragavan et al., 2022).

What is Needed?

Eradicating intimate partner violence necessitates a cultural shift on abusive relational dynamics rooted in patriarchal views within the home (De Coster & Heimer, 2021; George & Stith, 2014). In order to tackle risk factors at the interpersonal level and create lasting change, we must first educate on acceptable behaviours in relationships (Office of the Chief Coroner, 2022). Raising awareness about less visible forms of IPV, including coercive control, is crucial in comprehensively addressing these dynamics before they escalate into more extreme forms of IPV (CTVNews, 2023). Prioritizing new or existing educational programming on healthy relational dynamics, appropriate behaviours in dating, and conflict resolution in middle and high school curricula is essential in preventing all forms of IPV and ending generational violence that may have begun at home (Roseboom, 2020).

Programming directed at perpetrators is lacking, perhaps due to the nature of our punitive justice system (Cismaru & Lavack, 2011). There's also a gap in literature regarding strategies to engage perpetrators in treatment programming. Nevertheless,

this type of programming is necessary in order to address IPV comprehensively and effectively diminish GBV. Some organizations across the province offer the court-mandated Partner Assault Response (PAR) program (PAR Services of Toronto, n.d.). This group-facilitated program targets men who perpetrate IPV on their female partners and is based on the Duluth Model for treating domestic violence which has been found effective in reducing recidivism of violent offences but only deemed "promising" in reducing victimization (National Institute of Justice, 2013). However, availability is scarce, especially in NWO, with only a handful of organizations offering similar programming (NorthWesthealthline, n.d.). Further, although the program implements a comprehensive curriculum, it is only 12 sessions long, which may not be enough, especially for repeat offenders, and it is usually court-mandated meaning it is offered once perpetrators have already inflicted condemnable violent acts on their partners. Hence, programming that targets perpetrators before they escalate violence to the point of being convicted needs to be considered.

The *Family Violence Is Not Ok* campaign from New Zealand and the *Freedom From Fear, Campaign Against Domestic Violence* from Australia, are regarded as successful and effective in their goal to address this social issue holistically (Cismaru & Lavack, 2011). These primarily social media campaigns offered messaging and programming for IPV survivors and perpetrators, tackling the issue on all fronts. Both campaigns offered programming for "IPV perpetrators in the precontemplation, contemplation, preparation, and action stages, focusing on reasons to improve domestic relationships and actions to take" (Cismaru & Lavack, 2011). The latter publicized a helpline for perpetrators which received 6,000 calls in the first 21 months and about half (53%) of men who called voluntarily signed up to be referred to a men's behaviour change program (Cismaru & Lavack, 2011). This type of programming could

be beneficial in RRN communities where services directed at IPV survivors are hard to reach, especially in times of crisis when relational dynamics are further affected by outside stressors.

Trend: Reports of Strangulation Cases during the Pandemic.

Interviewed organizations highlighted a surge in IPV-related physical violence, notably an increase in reported cases of non-fatal strangulation. This aligns with existing literature, with several studies highlighting a significant rise in the frequency and severity of IPV-related physical injuries during the COVID-19 pandemic (Hansen & Lory, 2020; Jetelina et al., 2021; Roseboom, 2020; Sharma & Borah, 2020). Such injuries tend to be perpetrated on the upper body (Abbate Ford et al., 2021; Boserup et al., 2020; Coulthard et al., 2020; Matoori et al., 2021). Specifically, studies have documented a considerable increase in brain injuries attributable to intimate partner violence during the COVID-19 pandemic (Bugeja et al., 2022; Colantonio & Valera, 2022; Saleem et al., 2021).

Data indicates that the prevalence of IPV-related acquired brain injuries, worldwide, was high even before the COVID-19 pandemic (Saleem et al., 2021). A study on injury outcomes in women living with IPV showed that they are seven times more likely to sustain a head injury with loss of consciousness compared to women living without IPV (J. C. Anderson et al., 2015). Another study reported that about three out of four women in abusive relationships suffer from at least one brain injury, including strangulation, and nearly half suffer from repetitive acquired brain injuries (Valera & Berenbaum, 2003). Victims of non-fatal strangulation most commonly report neck pain, headaches as well as signs of more severe injury such as loss of consciousness, dysphagia (i.e., difficulty swallowing), and dysphonia (i.e., disorders of the voice)

(Bugeja et al., 2022; Colantonio & Valera, 2022; Saleem et al., 2021). Alarmingly, a history of strangulation-related injuries has been known to lead to alterations in consciousness and working memory, long-term memory, depression, and posttraumatic stress disorder (Colantonio & Valera, 2022). Although this issue has been reported by service providers and violence against women (VAW) advocates, there is a huge gap in the media, data, and the literature addressing the urgent matter of increased cases of non-fatal strangulation and its health risks (Bugeja et al., 2022; Mason et al., 2020; Saleem et al., 2021).

What is needed?

The existing literature clearly indicates a need for enhanced IPV training for healthcare providers and the implementation of trauma-informed protocols for the detection of IPV in patients (Abbate Ford et al., 2021; Bugeja et al., 2022; Coulthard et al., 2020). It is imperative for practitioners to recognize signs of IPV in patients presenting with head trauma (Bugeja et al., 2022). Providers must be aware that traumatic brain injury (TBI) mechanisms may differ in patients with a history of IPV compared to those with sports or military-related injuries (Colantonio & Valera, 2022; Valera & Berenbaum, 2003). For instance, brain injuries from a blunt trauma to the head may have different outcomes compared to an injury resulting from blocking of oxygen in strangulation incidents (Colantonio & Valera, 2022). Therefore, thorough research on the distinct symptom profiles of IPV-related head trauma is necessary to inform best practices for identifying IPV survivors in healthcare settings (Dams-O'Connor et al., 2023; Fares-Otero, 2020).

Moreover, first responders and healthcare providers should receive training to promptly offer appropriate resources/referrals to IPV survivors (Bugeja et al., 2022). A

multidisciplinary approach to managing IPV-related head injuries should involve a team of professionals, including psychiatrists, occupational and/or physical therapists, social workers, and IPV advocates, with expertise on IPV management (Bugeja et al., 2022). Additionally, during emergencies such as pandemics, IPV survivors should be prioritized for receiving appropriate vaccines and/or medications (e.g., COVID-19 vaccines) (Colantonio & Valera, 2022). This could reduce their fear of contracting the disease and encourage them to seek help safely.

Finally, community-based education strategies addressing IPV-related head trauma may assist survivors in protecting themselves from physical violence. These campaigns should focus on educating survivors on safeguarding the head, neck, and face from beatings, while also providing information on available resources and services near them (Colantonio & Valera, 2022). Education strategies may also help survivors in recognizing that an escape from abuse is still possible, even during an emergency crisis (Colantonio & Valera, 2022).

5.3.2 Individual Level

The following section discusses the intersection between social location and heightened risk of IPV. Based on the main themes distilled from study findings, I explore the association between socioeconomic status, geographic location, and belonging to a minority group with heightened risk of IPV. Lastly, I discuss two concerning trends reported by service providers - the exacerbation of mental health and the spike in sexual assault reports among youth. Finally, I finish this discussion with a segment on “what is needed?” stating the interventions that are needed to address the individual level IPV risk factors.

Socioeconomic Status and IPV Risk.

At the individual level, women seeking IPV services encounter different structural barriers depending on their social location. It is important to mention that IPV is present across all social classes and should not be stereotyped as an issue inherent to low-income households. This can lead to stigma and social scrutiny that can be isolating for women (Moffitt et al., 2022). Nevertheless, women of low SES are at increased risk of experiencing IPV due to the association of income with other risk factors (Moreira & Pinto da Costa, 2020).

Interestingly, a notable theme that came up in the findings is the fact that the nature of certain services attracts women of diverse socio-economic backgrounds. To explain further, organizations offering emergency shelter for IPV survivors typically serve clients of lower SES, whereas counselling agencies have higher income clients. Service providers explain that shelters are a last resort option for economically disadvantaged IPV survivors who often lack the supports needed to leave violent situations. On the other hand, more affluent women often have the means to access other support networks and find alternative ways to leave their abusive relationships. Even though the literature did not allude to this trend specifically, it does underscore the fact that women's shelters tend to serve a population of lower SES (Jonker et al., 2012). Further research into the association between income and service utilization is crucial in creating programming that considers the realities of IPV survivors across social classes and how to address their distinct needs when navigating the end of an abusive relationship.

Moreover, IPV perpetration among people from lower SES is linked to more severe forms of violence against an intimate partner (Moreira & Pinto da Costa, 2020). This trend may be explained by the intersecting effects of stress due to employment

instability leading to deterioration of mental health and unhealthy coping mechanisms such as substance abuse and, finally, the escalation of intrafamilial altercations that can result in IPV perpetration (Moreira & Pinto da Costa, 2020). Unfortunately, these dynamics were compounded by the COVID-19 pandemic as workplace closures coupled with confinement left many families without a stable income and increased familial tensions (Usher et al., 2020; Yahya et al., 2020). Providers confirmed some of these trends, mentioning some of the factors that led perpetrators to act violently against their partners. However, due to the survivor-focused nature of their work, interviewed providers did not mention supports available to IPV perpetrators. This may indicate a lack of availability and perhaps normalization of the unavailability of these programs in the region.

Geographical Location.

Geographical location poses increased barriers to access, as previously discussed through this research. The geography of NWO poses several barriers to IPV service delivery and access, all of which were discussed in-depth in section *5.2.3 Community Level*. Geographical location is addressed in this section because it is a part of the intersecting individual level factors that affect IPV survivors' ability to seek help. According to the literature, women in RRN are subject to higher rates of IPV, with higher frequency and severity compared to women residing in urban hubs (Hansen & Lory, 2020; Moffitt et al., 2020). These trends are further compounded by the heightened vulnerability to IPV of women with low SES, as they often lack the means to leave dangerous situations and access services in regions where availability is limited. This is reflected in service providers' large catchment areas in RRN areas of NWO, with a major concentration of IPV specialized services in Thunder Bay, the largest urban

centre in the region. Increased service availability in RRN has been identified as a priority by providers and existing literature. This is especially relevant in NWO given that about 40% (percentage was calculated from population counts) of the population lives in rural areas, according to 2016 census data (Statistics Canada, 2016).

Indigenous Women and Minorities.

Research indicates that belonging to a minority is not inherently tied to the increased risk of IPV but rather belonging to a minority in an oppressive social context (Moreira & Pinto da Costa, 2020). This reflects the disheartening realities of Indigenous women in NWO and Canada overall, where they face the highest rates of gender-based violence, especially IPV, compared to their non-Indigenous counterparts (Ficklin et al., 2022; Royal Canadian Mounted Police, 2015). These trends are echoed by the accounts of interviewed service providers who reported high averages (40-60%) of Indigenous women and their children represented in the client pool seeking safe shelter from violent homes. These rates are significant considering Indigenous women represent only (4%) of the overall female population in Canada (Ontario, 2022). However, these rates can also be skewed by the fact that NWO service provider catchment areas include numerous Indigenous reserves. Further, Indigenous women experience higher rates of more severe forms of intimate partner violence including physical abuse, sexual assault, and intimate partner homicide (Boyce, 2016; Moreau et al., 2020). Statistics Canada reports that six in ten (63%) Indigenous women and girls gender-based homicides were perpetrated by an intimate partner, with beating being the most common method (40%) (Statistics Canada, 2023). This issue is historical and rooted in colonial oppressive policies that systematized violence against Indigenous women at all social and structural levels - from the interpersonal to the institutional (Demkiw,

2023; Ficklin et al., 2022). Similarly, COVID-19 emergency policies systematically confined IPV survivors to violent environments. This was especially the case for Indigenous women living on-reserve due to the strict COVID-19 guidelines and travel restrictions implemented by Indigenous communities across NWO, increasing barriers to access. Finally, Moffit et al. (2020) raise the point that for Indigenous women living on-reserve, leaving a violent relationship sometimes also means deciding to leave their communities along with their families, friends, as well as culture and language, making it a very difficult decision.

Although the primary focus of this thesis has been on IPV in heterosexual relationships, it is crucial to acknowledge that IPV is also prevalent among same-sex and gender-diverse couples (Pistella et al., 2022). Interviewed providers reported cis-gendered heterosexual women as being the predominant demographic they serve. However, three out of the five providers reported serving gender-diverse and sexual minorities. One service provider attributed the underrepresentation of LGBTQ+ IPV survivors in their practice to the low disclosure rate in the LGBTQ+ community, despite being subject to comparable and sometimes higher rates of IPV. This is consistent with existing literature and is thought to be the result of the historical heteronormativity of IPV services, coupled with the pervasive stigmatization of LGBTQ+ identities and relationships, and a significant shortage of available IPV services for this population (Pistella et al., 2022; Williams & Mann, 2017). While interviewed providers claimed their services were inclusive of the LGBTQ+ community, a closer examination of their online resources revealed otherwise. The visuals and language used in these resources seem exclusionary, representing primarily cis-gendered heterosexual white women. Although this may be a reflection of the population reported by service providers—a majority being cis-gendered women victimized by male partners—it's essential to consider that

the lack of representation included in these resources may be contributing to the lack of awareness of IPV in LGBTQ+ relationships, in turn discouraging LGBTQ+ IPV survivors from seeking the help they need.

Trend: The Exacerbation of Mental Health Symptoms and Concerns.

The mental health burden of the pandemic was seen across the population with reports of mental health symptoms intensifying due to increased isolation, stress, and uncertainty (Glowacz et al., 2022). Nevertheless, the magnitude of the mental health burden is still hidden as we start to fully grasp the far-reaching repercussions of the pandemic on mental health.

The exacerbation of mental health symptoms among IPV survivors was a recurring theme across all interviews with service providers. Participants attested to a significant deterioration in their clients' mental health. Some declared that their workload had shifted towards addressing mental health symptoms and finding appropriate supports, to the detriment of addressing the actual assault incidents during their consultations with IPV survivors. The detrimental effects of the pandemic on the mental health of the population, especially those with prior diagnosis, was thoroughly echoed in the literature (Glowacz et al., 2022; Michaelsen et al., 2022). A similar Canada-wide qualitative study emphasized how the convergence of various factors - the fear and risk of contagion, diminished access to formal and informal supports, financial instability, and escalating abuse - amplified pre-existing trauma, heightened stress, and exacerbated the mental health challenges face by survivors (Michaelsen et al., 2022). Concerningly, heightened anxiety and depression may further hinder a survivor's ability to seek support from family and friends, access necessary

services, or maintain employment, in turn, increasing reliance on their abuser, both emotionally and financially (Michaelsen et al., 2022).

Although this research's scope only allows for coverage of IPV survivor experiences and needs through service providers' perspectives, it is equally important to comprehensively address the risk factors for IPV (Bhavsar et al., 2021). A study from 2018 established significant correlations between IPV perpetration and mental health disorders (Glowacz et al., 2022). Researchers cited issues such as anger management, anxiety, depression, personality disorders, alcoholism, or problem gambling as being risk factors for IPV perpetration (Glowacz et al., 2022). The inherent stresses associated with confinement during COVID-19 exacerbated these psychopathological problems, further triggering violent episodes (Glowacz et al., 2022). Hence, investment in mental health programming and resources is crucial in addressing underlying stressors that can lead to conflict in the home (Bhavsar et al., 2021). Mental health resources should be available for both IPV survivors and perpetrators (Bhavsar et al., 2021; Glowacz et al., 2022).

What is Needed?

Effectively managing IPV rates amid crises, requires a comprehensive approach spanning social, medical, and legal dimensions (Michaelsen et al., 2022). Investment in mental health social programming is imperative in addressing the underlying risk factors for IPV (Glowacz et al., 2022). Health professionals should be vigilant about their patients' mental stability, intervening to address co-morbidities and aggravated psychiatric disorder symptoms, assessing the potential for violence risks (Bhavsar et al., 2021; Gulati & Kelly, 2020). Notably, it is crucial to develop protocols and train frontline professionals in mental health to assess and address IPV risk factors (Gulati &

Kelly, 2020). Public education campaigns on IPV should encompass men's perspectives, encouraging them to seek help for abusive behaviors and fostering conversations about concerning behaviors (Cismaru & Lavack, 2011). Efforts should also target minimizing destabilizing factors for perpetrators, considering aspects such as financial instability, housing insecurity, mental health issues, and rural contexts (Glowacz et al., 2022).

As previously stated, investment in mental health programming and resources is crucial in addressing underlying stressors that can lead to conflict in the home (Bhavsar et al., 2021). Mental health resources should be available for both IPV survivors and perpetrators (Bhavsar et al., 2021; Glowacz et al., 2022). Programs should be culturally appropriate and tailored to the unique needs of rural, remote, and northern regions (Moffitt et al., 2022). Adopting a social-ecological view on IPV service access barriers can help stakeholders understand what is truly needed within their local communities, creating effective initiatives that are realistically accessible within existing social and cultural structures (Moffitt et al., 2022).

5.4 Strengths and Limitations

First, although research rigour has been at the forefront of the study design, due to the nature of the interpretivist framework guiding the methodology, transferability may be an issue (Tolley et al., 2016). The study methodology and design’s objective were to collect narrative data on the lived experiences of a specified population of IPV service providers in Northwestern Ontario. Therefore, transferability to other populations in differing geographical locations may not be feasible. However, this methodology also allows for the in-depth exploration of a phenomenon affecting a marginalized and underrepresented group leading to advancements in knowledge and

the bridging of a significant gap in literature. In order to counteract the transferability concerns, the study design has followed qualitative research standards, and a detailed description of the procedures has been outlined.

This project constitutes the first qualitative study, to our knowledge, on the perspectives and lived experiences of IPV service providers focusing solely on Northwestern Ontario. The regional focus allows for a comprehensive understanding of IPV trends unique to the context of rural, remote, and northern communities in NWO. Literature addressing IPV specifically in NWO is still limited, however, an updated literature review yielded a growing number of articles addressing IPV risk factors unique to rural, remote, and northern regions of Canada as a whole or Ontario as a whole (Jeffrey et al., 2019; Moffitt et al., 2022).

Secondly, although most interviewed service providers serve a wide population, Indigenous populations are not primarily represented in the study population. Indigenous organizations were not interviewed, primarily because there was no interest from staff. Therefore, risk factors and barriers specific to Indigenous populations may not be fully accounted for throughout this research. Some Indigenous specific themes did come up and they are discussed, however data cannot be generalized, and the results may not fully reflect the realities of IPV service providers and IPV survivors in Indigenous communities. Additionally, I narrowed down the scope of this thesis to the experiences of cis-gendered women navigating heterosexual relationships, primarily based on the fact that it is a gendered issue. Service providers' accounts reflected this as they reported mainly serving cis-gendered women with male partners. Therefore, increased research on the unique barriers that LGBTQ+ IPV survivors face is crucial in adapting services to this population.

Lastly, I focused my research scope on IPV in rural and remote regions because (1) it reflects the geographic composition of NWO; and (2) there is a clear gap in literature on IPV service provision in these regions. Therefore, with my research I am able to contribute to increased awareness of the unique challenges that IPV service providers and survivors face in rural and remote regions. However, it is important to acknowledge that this focus may also perpetuate stereotypes on rurality and rural inhabitants (Sandberg, 2013).

5.5 Knowledge Dissemination Strategy

The dissemination of findings has taken various forms in order to target different audiences. First, I participated in the COVID-19 & Public Health Forum organized by the Canadian Public Health Association in 2020. My poster presentation aimed to engage stakeholders, public health professionals and the public and raise awareness on the topic as well as present the findings of my literature review. Second, I presented my preliminary findings to the Thunder Bay & District Coordinating Committee to End Woman Abuse (TBDCCEWA) in October of 2023 in an effort to contribute to the discussion following the declaration of an IPV epidemic in Thunder Bay. A short report highlighting my main findings was sent to committee members. In addition, the final thesis will be published and available in academic institutions for the purpose of knowledge dissemination and further study. Subsequently, I aim to publish an academic journal article of my main findings in an effort to bridge the gap in IPV literature in the context of Northwestern Ontario. Finally, as the knowledge dissemination process is ongoing, I aim to reach stakeholders in the public sector by presenting my findings at academic and community conferences and writing a policy brief with the purpose of raising awareness on the current issue and informing policy

and/or programming. These stakeholders include Patty Hajdu, Minister of Indigenous Services of Canada; Sylvia Jones, Ontario Minister of Health; and Marci Ien, Minister for Women and Gender Equality and Youth of Canada.

Chapter 6: Conclusion

In conclusion, the COVID-19 pandemic greatly exacerbated existing barriers to IPV service provision and access across Northwestern Ontario, especially in rural and remote communities. Social distancing and travel restrictions posed serious dangers to IPV survivors navigating the stresses of a pandemic coupled with increased violence in their homes. Simultaneously, these restrictions posed serious challenges to providers. However, governmental intervention through the release of crisis recovery funds, greatly increased IPV service providers' capacity to serve survivors amidst unprecedented circumstances. These unexpected benefits from the COVID-19 pandemic underscored the need for these organizations to be prioritized, recognized as essential social services, and properly funded taking into account regional needs. Most importantly, the provincial government should address the surge in IPV rates post-pandemic by declaring this issue an epidemic and actioning the Renfrew Inquiry recommendations.

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Appendices

A - Definition of Terms

Northwestern Ontario	Economic region of Northern Ontario composed of three districts: Thunder Bay district, Rainy River district, Kenora district.
Rural	A community or geographic location with a population less than 10,000 (Bollman 2016; Statistics Canada 2020).
Remote	A community or geographic location that is not accessible by road year-round (Ontario Ministry of Health and Long-Term Care 2011).
Northern	A community or geographic location that is designated by the provincial government as being the northern part of the province (Northern Ontario Heritage Fund Corporation, 2018).
Urban Centre/Hub	An urban centre is defined as a geographic location with a population of at least 50,000 inhabitants overall (OECD, 2022)
Individual/community made vulnerable	This term is used to refer to groups of people (e.g., children, pregnant women, elderly, people, migrants and refugees, people who uses drugs, people of low socioeconomic status, people who are ill etc.) who, due to disparities in economic, social, physical, and health status, have increased susceptibility to negative social and health outcomes, compared to the dominant population (Rukmana, 2014). The terms “vulnerable groups” and “disadvantaged groups” are often used interchangeably (European Institute for Gender Equality, n.d.). However, the term “vulnerable groups” is not recommended due to the stereotyped misconception that ‘vulnerability’ is an inherent characteristic of individuals and not a result of the structural barriers that put some individuals at a social disadvantage (European Institute for Gender Equality, n.d.). In the context of this study, the term vulnerable will be used as it is dominant in the literature. The research refers to individuals/communities made vulnerable when referring to their heightened risk of experiencing/perpetrating intimate partner violence due to a combination of risk factors exacerbated by the COVID-19 pandemic.
Marginalized individual/community:	The term is used for groups that often experience discrimination or social, political, and/or economic exclusion due to unequal power dynamics across economic, political, social, and cultural levels (National Collaborating Centre for Determinants of Health, n.d.). In the context of this study, the historical and structural marginalization of certain communities increases their risk of experiencing and/or perpetrating IPV.

B - List of IPV Service Providers in Northwestern Ontario

Table 2

List of IPV Service Providers in NWO by District

Thunder Bay District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
City of Thunder Bay Domestic Violence Unit	Emergency services	1200 Balmoral St, Thunder Bay, ON P7B 5Z5	807-684-1200
Thunder Bay Police Services Thunder Bay Victim Assistance Unit	Emergency services	1200 Balmoral Street Thunder Bay, Ontario P7B 5Z5	807-626-7000 807-684-1200
Thunder Bay and Area Victim Services Victim Crisis Assistance and Referral Services	Emergency services	317 Victoria Avenue East, Suite 9, Thunder Bay, ON P7C 1A4	807-684-1051
Faye Peterson House Thunder Bay Women's Shelter	Women's shelters	Thunder Bay, ON P7B 6T7	1-800-465-6971
Shelter House	Women's shelters	420 George St, Thunder Bay, P7E 5Y8	807-623-8182
Marjorie House	Women's shelters	Marathon, ON P0T 2E0	807-229-2223
Geraldton Family Resource Centre Women's Shelter	Women’s shelter	Greenstone, ON	807-854-1529
Urban Abbey Women’s Shelter	Women’s shelters	308 Red River Road, Thunder Bay, P7B 1B1	807-768-8923 tbayabbey@gmail.com
Thunder Bay Regional Health Sciences Centre Sexual Assault and Domestic Violence Treatment Centre	Health Services	980 Oliver Rd, Thunder Bay, ON P7B 6V4	807-684-6751
Elevate NOW	Health Services	106 Cumberland St N, Suite 102, Thunder Bay, ON P7A 4M2	807-345-1516 info@elevatenwo.org
NorWest Community Health Centre	Health Services	525 Simpson Street, Thunder Bay, ON P7C 3J6	807-622-8235 1-866-357-5454
North Wind Counselling Services	Counselling	141 May St S, Thunder Bay, ON P7E 1A9	807-622-5790

Thunder Bay Counselling Violence Against Women Program	Counselling	544 Winnipeg Ave, Thunder Bay, ON P7B 3S7	807-684-1880
Centr'Elles Geraldton Sexual Assault and Rape Crisis Centre	Counselling	204 Main St, Greenstone, ON P0T 1M0	1-888-415-4156
Catholic Family Development Centre Abuse Related Support Group	Counselling	1121 Barton St, Thunder Bay, ON P7B5N3	807-345-7323
Salvation Army Singles Parent Program	Counselling	545 Cumberland St N, Thunder Bay, ON P7A 4S2	807-345-7319
Sexual Abuse Counselling Centre Thunder Bay	Counselling	385 Mooney St, Thunder Bay, ON P7B 5L5	807-345-0894
Thunder Bay and Area Victim Services Victim Crisis Assistance and Referral Services	Counselling	317 Victoria Ave E Suite 9, Thunder Bay, ON P7C 1A4	807-684-1051
Thunder Bay Courthouse Victim/Witness Assistance Program	Emergency crisis	125 Brodie St N, Suite 5200 Thunder Bay, ON, P7C 0A3	807-626-7120 1-800-394-6930
Ontario. Ministry of the Attorney General Northern Region - Thunder Bay District - Independent Legal Advice for Sexual Assault Survivors Program	Advocacy / Legal Aid	Thunder Bay, ON	1-855-226-3904
Northwestern Ontario Women's Centre	Advocacy / Legal Aid	73 Cumberland St N Suite 101, Thunder Bay, ON P7A 4L8	807-345-7802
Ontario Ministry of the Attorney General Northern Region Bail Safety Program	Advocacy / Legal Aid	125 Brodie St N Suite 5200 Thunder Bay, ON P7C 0A3	807-626-7110
Mediation North Family Law Information Centre (FLIC)	Advocacy / Legal Aid	Northern Ontario	1-800-935-5455 807-475-3500 TBay flic.mediationnorth@gmail.com
Legal Aid Ontario Thunder Bay Duty Counsel (Criminal)	Advocacy / Legal Aid	125 Brodie St. N. Thunder Bay, P7C0A3	(807) 623-1920
Thunder Bay and District Coordinating Committee to End Woman Abuse Woman Abuse Prevention Committee	Advocacy / Legal Aid	Thunder Bay, ON	807-345-0450

Thunder Bay Christian Community Centre	Immigrant / Multicultural / Religious Affiliations	132 Dease Street Thunder Bay, ON P7C 2H6	807-623-8184
Thunder Bay Multicultural Association	Immigrant / Multicultural / Religious Affiliations	17 N. Court Street Thunder Bay, ON, P7A 4T4	807-345-0551 1-866-831-1141
St. Andrew's Dew Drop Inn Soup Kitchen	Food Security Resources	292 Red River Road Thunder Bay, ON P7B 1A8	(807) 346-0809
Regional Food Distribution Association of Northwestern Ontario	Food Security Resources	570 South Syndicate Ave, Thunder Bay, ON P7E 1E7	807-622-7440
Rainy River District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
Rainy River District Women's Shelter of Hope	Women's Shelter	Atikokan, ON P0T 1C0	807-597-2868
Kenora Rainy River District Child and Family Services	Family services Child protection services	820 Lakeview Dr, Kenora, ON P9N 3P7	807-467-5437 1-800-465-1100
Atikokan General Hospital Atikokan Community Counselling	Health services Counselling	123 Marks St, Atikokan, ON P0T 1C0	807-597-2724
Northwest Community Legal Clinic	Legal aid	206 Scott Street Fort Frances, ON P9A 1G7	807-274-5327 1-800-799-2485
Kenora District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
Hoshizaki House Dryden District Crisis Shelter Emergency Women's Shelter	Women's shelter	Dryden, ON P8N 3E3	807-223-7311
First Step Women's Shelter Nahnahda-Wee-ee-Waywin Emergency Shelter	Women's shelter	15 Fair St, Sioux Lookout, ON P8T 1B8	807-737-4848
Women's Shelter Saakaate House Kendall House Young Moms Program	Women's shelter	Kenora, ON P9N 3X1	807-468-1889
Women's Shelter Saakaate House	Women's shelter		
Dryden Regional Health Centre Sexual Assault and Domestic Violence Care and Treatment Program	Counselling Medical services	58 Goodall St, Dryden, ON P8N 2Z6	807-223-7427
Lake of The Woods District Hospital	Medical services	21 Sylvan St W, Kenora, ON P9N 3W7	807-468-9861

Kenora Sexual Assault Centre	Counselling Advocacy	101 Chipman St, Kenora, ON P9N 1V7	807-468-7958
The Other Ways Now Program	PAR Program for IPV perpetrators	1422 Hwy 17 E Unit 2, Kenora, ON P9N 3X1	807-468-4703
Kenora Coalition to End Human Trafficking	Research and advocacy	Kenora, ON	1-800-900-1010

Helplines and Online Resources			
Organization	**Services Offered**	**Location**	**Contact**
Talk4Healing - Telephone Helpline	Helplines	Thunder Bay, ON	1-855-554-4325
Assaulted Women's Helpline	Helplines		416-863-0511
Fem'aide	Helplines		Tel: 877-336-2433 SMS: 1-877-336-2433 femaide.ca/clavardage
Kids Help Phone	Helplines		1-800-668-6868
Faye Peterson House	Online resources	Thunder Bay, ON P7B 6T7	1-800-465-6971
NeedHelpNow.ca	Online resources		https://needhelpnow.ca/en/contact/

C - List of Indigenous IPV Service Providers in Northwestern Ontario

Table 3

List of Indigenous IPV Service Providers in NWO by District

Thunder Bay District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
Beendigen	Counselling	100 Anemki Dr Suite 103, Fort William First Nation, ON P7J 1J4	807-622-1121
Biinjitiwaabik Zaaging Anishinaabek - Rocky Bay Child and Family Services Main Office - Family Support Worker	Emergency services	119B MacDonald Ave Rocky Bay Reserve, Biinjitiwaabik Zaaging Anishinaabek First Nation, ON P0T 2B0	807-885-1697
Eabametoong First Nation Nursing Station - Crisis Intervention	Emergency services	Kevin S C Sagutcheway Nursing Station, , Eabametoong First Nation, ON P0T 1L0	807-242-1151
Ginoogaming First Nation - New Ginoogaming Health Centre Crisis Intervention	Emergency services	203 Balsam Rd, Ginoogaming First Nation, ON P0T 2A0	807-876-2732
Indige-Spheres to Empowerment - Research and Anti-Human Trafficking Programs	Research and advocacy	226 Heath St Unit 9, Thunder Bay, ON P7E 2P9	705-305-8349
NAN Hope	24/7 crisis counselling	Thunder Bay, ON	1-844-626-4673
Neskantaga First Nation	Emergency services	Band Office, Neskantaga First Nation, ON P0T 1Z0	807-479-2570
Nibinamik First Nation	Emergency services	Nibinamik Health Centre, Nibinamik First Nation, ON P0T 3B0	807-593-2211
Nokiiwin Tribal Council	Legal Advice	384 Fort William Rd, Thunder Bay, ON P7B 2Z3	807-474-4230
Pays Plat First Nation - Pays Plat Health Centre - Family Violence Initiative	Social services	10 Pow Wow Dr Business Centre, Unit C, Thunder Bay Unorganized, ON P0T 3C0	807-824-1112
Thunder Bay Indigenous Friendship Centre Indigenous Healing and Wellness Program	Social services, cultural services	401 Cumberland St N, Thunder Bay, ON P7A 4P7	807-345-5840
Thunderbird Friendship Centre Healing and Wellness Coordinator Program	Crisis intervention Healing circles Peer counselling	301 Beamish Ave W, Greenstone, ON P0T 1M0	807-854-1060

Kinna Aweya Legal Clinic	Advocacy/Legal aid	86 S. Cumberland St. Thunder Bay, ON P7B 2V3 404 Main Street, Unit A, P.O. Box 1090 Geraldton, ON P0T 1M0 #101 – 52 Peninsula Square P.O. Box 658, Marathon, ON P0T 2E0	
Rainy River District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
Atikokan Native Friendship Centre	Emergency services	309 Main St W, Atikokan, ON P0T 1C0	807-597-1213
Giishkaandago'Ikwe Health Services Anti-Human Trafficking Services	Counselling Harm reduction services	601 King's Hwy, Fort Frances, ON P9A 3M9	807-274-2042
Lac La Croix First Nation	Emergency services	140 Main St, Lac La Croix First Nation, ON P9A 3N9	807-485-2541
United Native Friendship Centre Crisis Intervention	Emergency services	427 Mowat Ave, Fort Frances, ON P9A 3N1	807-274-8541
Weechi It Te Win Family Services Crisis Intervention	Emergency services	Nanicost Building, 1455 Idylwild Dr, Fort Frances, ON P9A 3N1	1-800-465-2911
Kenora District IPV Resources			
Organization	**Services Offered**	**Location**	**Contact**
Deer Lake First Nation – Deer Lake Health Centre - Crisis Intervention	Emergency services	Deer Lake Health Centre, Deer Lake First Nation, ON P0V 1N0	807-775-2226
Grassy Narrows First Nation - Grassy Narrows Medical Centre - Crisis Intervention	Emergency services	Upper Core, Asubpeeschoseewagong Netum Anishinabek First Nation, ON P0X 1B0	807-925-2652
Kasabonika Lake First Nation	Emergency services	Kasabonika Band Office, Kasabonika Lake First Nation, ON P0V 1Y0	807-535-2547
Keewaywin First Nation	Emergency services	202 Band Office Rd, Keewaywin First Nation, ON P0V 3G0	807-771-1210
Kenora Chiefs Advisory	Counselling	240 Veterans Dr Third Floor, Suite 301, Kenora, ON P9N 3X4	807-467-8144
Kitchenuhmaykoosib Inninuwug	Emergency women's shelter	Equay Wuk Women's Shelter, Kitchenuhmaykoosib Inninuwug/Big Trout Lake First Nation, ON P0V 1G0	807-537-2267

Muskrat Dam First Nation	Emergency services	Nellie Fiddler Memorial Health Centre, Muskrat Dam First Nation, ON P0V 3B0	807-471-2608
Naotkamegwanning First Nation	Provides a 24-hour crisis line Emergency shelter	Naotkamegwanning/Whitefish Bay First Nation, ON P0X 1L0	807-226-2605
Nishnawbe Gamik Friendship Centre	PAR program IPV survivor support Counselling	52 King St, Sioux Lookout, ON P8T 1B8	807-737-1903
Nishnawbe-Aski Legal Services Corporation	Legal advice	308 Second St S Suite 14, Kenora, ON P9N 1G4	807-737-7981
Ontario Native Women's Association	Cultural supports Emergency support	136 Main St S, Kenora, ON P9N 1S9	1-800-667-0816
Pikangikum First Nation - Walmart Health Building	Emergency services	Walmart Health Building, , Pikangikum First Nation, ON P0V 2L0	807-773-5550
Sachigo Lake First Nation - Sachigo Lake Business Centre Complex - Crisis Intervention	Emergency services	Sachigo Lake Business Centre 48 Airport Rd, Sachigo Lake First Nation, ON P0V 2P0	807-595-2577
Sioux Lookout First Nations Health Authority - Crisis Response	Emergency services	54 Queen St, Sioux Lookout, ON P8T 1B8	807-737-4011
Sioux Lookout Meno Ya Win Health Centre - Assault Care and Treatment Program	Advocacy Access to reproductive health	1 Meno Ya Win Way, Sioux Lookout, ON P8T 1B4	807-737-6565
Waasegiizhig Nanaandawe'iyewigamig - Youth Healing Lodge - Traditional Aboriginal Healing	Shelter Counselling Cultural programming	Health Centre Rd Obashkaandagaang First Nation, Keewatin, ON P0X 1C0	807-543-1065
Wapekeka First Nation - Nursing Station Crisis Intervention	Emergency services	PO Box 1 c/o Nursing Station, Wapekeka, ON P0V 1B0	807-537-2320
Webequie First Nation - Nursing Station Crisis Intervention	Emergency services	PO Box 90 c/o Nursing Station, Webequie, ON P0T 3A0	807-353-7241
Wunnumin Lake First Nation - Band Office Crisis Prevention	Emergency services	Band Office Main Rd, Wunnumin Lake First Nation, ON P0V 2Z0	807-442-2559

D - Recruitment Email Template

Recruitment E-mail Template

Subject Line: Research study: Perspectives on the rise in IPV from IPV providers

Body Copy:

Hello,

I am a Master of Public Health student at Lakehead University, Thunder Bay, currently in the process of completing my master's thesis on the rise in intimate partner violence (IPV) during the COVID-19 pandemic.

My research thesis entitled "Northwestern Ontario service providers' perspectives on the rise in intimate partner violence cases during the COVID-19 pandemic" aims to:

(1) explore the challenges that service providers and IPV survivors have faced during the COVID-19 pandemic due to the implementation of emergency protocols in rural and northern areas of Northwestern Ontario.
(2) identify ways in which public policy could support IPV related organizations and the individuals that access these services in times of crisis from the perspective and based on the experiences of IPV service providers.

Who can participate?

- IPV-related service providers servicing rural, remote, and northern areas in Northwestern Ontario (e.g., shelters, social service providers, non-profit organizations, counselling services etc.).
- the organization must offer services to survivors of IPV in any aspect whether financially, emergency services, counselling services and other.
- the organization was open during most of the pandemic.
- the organization services individuals in rural and remote communities in the regions of Northwestern Ontario.

For further information regarding this research study please refer to the attached Information Letter and Informed Consent form. Participation in the study is completely voluntary and confidential.

If your organization is interested in participating or would like to further discuss or clarify the objectives and logistics of the study, please reply to this email before (date) stating your intent to participate and your availability for an interview or discussion session.

Thank you,
Oriana Rodriguez
Master of Public Health student
Principal Investigator
Lakehead University
955 Oliver Rd, Thunder Bay,
Ontario, P7B 5E1, Canada
+1 647-863-1762

E - Follow-up Email Template

Follow-up E-mail Template

Subject: Research Study Interview: "Service Provider Perspectives on IPV during COVID-19"

Dear (name),

Thank you for agreeing to be a part of my study titled "Northwestern Ontario service providers' perspectives on the rise in intimate partner violence cases during the COVID-19 pandemic". I am looking forward to meeting for an interview.

I would like to confirm your availability for the (date) at (time) via Zoom. Please find the Zoom link and calendar invitation below.

(Zoom invitation)

Prior to our meeting, please review and fill out the consent form attached to this email. Participation is completely voluntary. If you have any questions about the study, please do not hesitate to contact me at any time, I will be glad to clarify any questions or concerns.

Thank you,

Oriana Rodriguez

Master of Public Health student

Investigator

Lakehead University
955 Oliver Rd, Thunder Bay,
Ontario, P7B 5E1, Canada
+1 647-863-1762

F - Cold Call Script

Cold Call Script Template

Hello,

Have I reached (name of organization)?

My name is Oriana Rodriguez, I am a Master of Public Health student at Lakehead University and am currently in the process of completing my master's thesis that seeks to study the rise of intimate partner violence during the COVID-19 pandemic from service providers' perspectives. I am in the process of recruiting participants for an interview based qualitative study. Would you be interested in participating in the study? I would be happy to provide more information at this time or book an appointment with one of your staff to further discuss what the study entails.

You can contact me at +1 647-863-1762 or via e-mail at orodrig1@lakeheadu.ca.

Thank you and have a great day!

G - Information Letter

Information Letter

Dear Potential Participant:

As someone who provides IPV-related services to survivors in Northwestern Ontario, you are invited to participate in a research study entitled "Northwestern Ontario service providers' perspectives on the rise in IPV cases during the COVID-19 pandemic". This study is interview based and will consist of a series of open-ended questions related to intimate partner violence (IPV) and the impact of the COVID-19 pandemic.

This form explains the purpose of the study, what your role as a participant will entail, and what the risks and benefits of the study are. Taking part in this study is voluntary. Before you decide whether or not you would like to take part in this study, please read this letter carefully to understand what is involved. After you have read the letter, please ask any questions you may have.

PURPOSE

From the perspectives of service providers, this study aims to uncover the experiences that IPV service providers and survivors in rural, remote, and northern regions of Northwestern Ontario have had and continue to have during the ongoing COVID-19 pandemic. The goal of the research is twofold: (1) to explore and subsequently raise awareness about IPV and the impacts crisis like pandemics may have on access to services for survivors and opportunity to provide services for providers, and (2) to inform future health policy and program development, especially in times of crisis.

WHAT INFORMATION WILL BE COLLECTED?

This study will collect two types of information. First, data collected through interviews which include audio or video recordings of virtual interviews, and field notes taken by the researcher over the course of the interview process as well as contact information for the interviewee. The following questions guide my inquiry into this subject:

(1) What are the unique challenges that service providers and intimate partner violence survivors in Northwestern Ontario have faced due to the implementation of emergency protocols during the COVID-19 pandemic?

(2) What are the ways in which public policy could support IPV related organizations and the individuals that access these services in times of crisis?

(3) What is necessary in the development of inclusive, gendered, and equitable health policy and emergency protocols in times of crises?

WHAT IS REQUESTED OF ME AS A PARTICIPANT?

The study will take the form of a 45-minute one-on-one interview over phone, or the virtual platform Zoom. The interviews will consist of open-ended questions related to the organization's experiences regarding a rise in IPV cases over the course of the COVID-19 pandemic, the challenges, and barriers to service provision you have faced, and how your organization has overcome these trends.

WHAT ARE MY RIGHTS AS A PARTICIPANT?

This study abides by the Respect for Persons principles of the TCPS2 of the Panel on Research Ethics of Canada. Therefore, as a participant in this study you:

- are under no obligation to participate, and are free to withdraw at any time during the interview process and up to one month after you receive a full transcript of your interview, without consequence;
- your decision to participate will not affect your academic status/employment;
- will be given, in a timely manner throughout the course of the research project, information that is relevant to your decision to continue or withdraw from participation;
- will be given information on the participant's right to request the withdrawal of data before the aforementioned deadline.

WHAT ARE THE RISKS AND BENEFITS?

This study poses a minimal level of risk to participants as interview questions pertain to their organization's experiences and touches upon subject matter that relates to their daily lives. However, due to the nature and sensitivity of the subject matter, there is the possibility that some participants encounter questions during the interview that may trigger emotional responses.

HOW WILL MY CONFIDENTIALITY BE MAINTAINED?

Privacy and confidentiality throughout the research study will be assured to the highest extent possible. Information collected will be saved under codes to ensure the lowest degree of identifiability. Personal information and identifiers linked to other information provided by participants (e.g., employment position, educational records) will not be reported in the dissemination materials unless full consent to do so is obtained. Participants' personal information will be kept in a masterlist in a separate password protected file and will only be accessible to the principal investigator. Raw data (i.e., interview voice/video recordings) will also be kept in a separate password protected file not linked to the final transcripts and results/dissemination materials. Collected data will be kept in the researcher's password protected computer and a Lakehead University VPN shared file accessible only to the principal researcher and thesis supervisor for the duration of the study. Following the completion of the study, all data (including raw data) will be kept in an offline storage space (external hard drive) in a locked room for a minimum of five years as per Lakehead University policy. Organization data will be kept confidential at all times following the same procedures. Finally, participant/organization data will not be shared with third parties, unless permission to do so has been explicitly granted. Data identifying participants/organizations will not be included in the dissemination process.

WHAT WILL MY DATA BE USED FOR?

The data collected in this study is a part of the principal researcher's master's thesis. Results will be published narratively in the form of a research report. Findings will be used as the basis for a list of recommendations to inform health and emergency policy and programming improvements. Further, findings will potentially be disseminated through conference presentations and/or academic journal articles.

WHERE WILL MY DATA BE STORED?

Data files will be stored in the principal researcher's password protected computer and Lakehead University VPN shared file that will only be accessed by the researchers listed on this information letter. Video and voice recordings will be collected for transcription purposes. Videos and/or pictures of participants will not be included in data dissemination materials. Lastly, all data, including raw data

(video/voice recordings) will be securely kept in an offline storage space (external hard drive) in a locked room for a minimum of five years as per Lakehead University policy.

HOW CAN I RECEIVE A COPY OF THE RESEARCH RESULTS?

In order to validate the findings of this study, participants will be sent a copy of the interview transcript for review prior to data analysis. Further, the researcher will invite participants to a final presentation where the researcher will share findings via a PowerPoint presentation. Finally, results will be published in the form of a master's thesis. Participants will have access to the publication of the final thesis upon request.

WHAT IF I WANT TO WITHDRAW FROM THE STUDY?

Participation withdrawal can be requested at any time throughout the data collection process (interview) and up to one month after receipt of the interview transcript. This includes withdrawal of all types of data previously collected, including personal information and data collected during the interview process. Withdrawal from the study can be requested by contacting the interviewer Oriana Rodriguez, student researcher and principal investigator, via e-mail at orodrig1@lakeheadu.ca or phone at +1 647-863-1762, up to one month after receiving a copy of your interview transcript. If you have any questions or concerns regarding the withdrawal process, please do not hesitate to contact the investigators listed below.

RESEARCHER CONTACT INFORMATION:

Student researcher, **Affiliation and contact information**	**Thesis supervisor,** **Affiliation and contact information**
Oriana Rodriguez, Student researcher/Interviewer Faculty of Health Sciences Lakehead University 955 Oliver Rd, Thunder Bay, Ontario, P7B 5E1, Canada **Email:** orodrig1@lakeheadu.ca **Tel:** +1 647-863-1762	Helle Moeller, Thesis supervisor Faculty of Health Sciences Lakehead University 955 Oliver Rd, Thunder Bay, Ontario, P7B 5E1, Canada **Email:** hmoeller@lakeheadu.ca

Research findings are not intended for commercialization purposes. There are no real, potential, or perceived conflicts of interest on the part of the researchers or their institution(s). The student researcher will undertake all aspects of the research process which includes interviewing participants, data analysis and interpretation processes.

RESEARCH ETHICS BOARD REVIEW AND APPROVAL:

This research study has been reviewed and approved by the Lakehead University Research Ethics Board. If you have any questions related to the ethics of the research and would like to speak to someone outside of the research team, please contact Sue Wright at the Research Ethics Board at 807-343-8283 or research@lakeheadu.ca.

H - Consent Form

Consent Form

MY CONSENT:

I agree to the following:

- ✓ I have read and understand the information contained in the Information Letter;
- ✓ I agree to participate voluntarily;
- ✓ I understand the risks and benefits to the study;
- ✓ I may choose not to answer any question and/or withdraw from the study up until **one month** after receiving my interview transcript;
- ✓ that the data will be securely stored in an offline storage space (external hard drive) in a locked room for a minimum period of 5 years following completion of the research project;
- ✓ I understand that the research findings will be made available to me upon request;
- ✓ My identity will remain confidential;
- ✓ All of my questions have been answered.

By consenting to participate, I have not waived any rights to legal recourse in the event of research-related harm.

Participant name (printed) *Signature and Date*

I agree to have my interview audio or video recorded over Zoom? YES/NO

I prefer that my organization stay anonymous? YES/NO

To request a copy of the research results please contact Oriana Rodriguez (main investigator) at orodria1@lakeheadu.ca.

I - Interview Guide

Initial Interview Guide

Break the ice questions

"Would you start by telling me a bit about yourself, your organization, the work that you do, and why you agreed to participate in this study?"

Prompt questions:

1. What services does your organization provide to survivors of IPV?
2. What region(s) do you serve?
3. What is the demographic profile of IPV survivors that you service?

Questions about COVID-19 and emergency protocols

"What have been your and your organization's experiences with COVID-19? How did COVID-19 impact your organization's operations and staff worklife?"

Prompt questions:

1. How was your specific work impacted by COVID-19?
2. What was the COVID-19 transition like for the organization?
3. Did most of your staff transition to work from home mandates?
4. Did your organization offer in-person services throughout the pandemic or during lockdown? What services?
5. Did your organization have previous emergency protocols in place? What was the transition like?
6. How was service provision affected by the COVID-19 pandemic and the emergency protocols (e.g., lockdown, social distancing, remote work etc.)

Questions about IPV survivors and COVID-19

"From your perspective and experience, in what ways did COVID-19 most affect IPV survivors?"

Prompt questions:

1. What changes have survivors accessing your services experienced during the COVID-19 pandemic?
2. What changes brought on by the COVID-19 pandemic and emergency protocols most impact IPV survivors' well-being?

Questions about IPV during the COVID-19 pandemic

"From your perspective and experience, how did COVID-19 and emergency protocols impact IPV, and IPV rates and trends?"

Prompt questions:

1. What was your organization's experience with IPV cases during lockdown?
2. What trends have you observed during the COVID-19 pandemic?

J - Lakehead University REB Approval

Lakehead UNIVERSITY

Research Ethics Board
t: (807) 343-8283
research@lakeheadu.ca

January 26, 2022

Principal Investigator: Dr. Helle Moeller
Student: Oriana Rodriquez
Health and Behavioural Sciences\Health Sciences
Lakehead University
955 Oliver Road
Thunder Bay, ON P7B 5E1

Dear Dr. Helle Moeller and Oriana:

Re: Romeo File No: 1469055

On behalf of the Research Ethics Board, I am pleased to grant ethical approval to your research project titled, "Northwestern Ontario service providers' perspectives on the rise in IPV cases during the COVID-19 pandemic".

Ethics approval is valid until January 26, 2023. Please submit a Request for Renewal to the Office of Research Services via the Romeo Research Portal by December 26, 2022, if your research involving human participants will continue for longer than one year. A Final Report must be submitted promptly upon completion of the project. Access the Romeo Research Portal by logging into myInfo at:

https://erpwp.lakeheadu.ca/

During the course of the study, any modifications to the protocol or forms must not be initiated without prior written approval from the REB. You must promptly notify the REB of any adverse events that may occur.

Best wishes for a successful research project.

Sincerely,

Dr. Kristin Burnett
Chair, Research Ethics Board

/sa