

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

KNOWLEDGE SYNTHESIS REPORT

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ACRONYMS

List of leading organizations and their acronyms cited in this review.

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

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

Area	Guidelines
Macro level	
Approaches and Frameworks to Policy Responses	<ul style="list-style-type: none"> ✓ Consider GBV as a public health issue ✓ Integrate gender-responsive programming to COVID-19 responses ✓ Apply critical race, intersectional, human rights, community-based and participatory approaches to emergency health responses and evaluation ✓ Ensure that COVID-19 policy frameworks integrate women’s safety approaches into their multisectoral strategic responses ✓ Provide safety principles (e.g. safe mobility measures) for integration in the responses ✓ Prioritize strengths-based models to promote and enhance community, agency, and resourcefulness
Decision-making	<ul style="list-style-type: none"> ✓ Include diversity of voices and perspectives from Indigenous, Black and Asian communities, and other racialized groups, to ensure equity and comprehensive pandemic and post-pandemic responses ✓ Ensure meaningful participation of women and girls, and that of grassroots and community-based organizations, in decision-making processes - plan development, implementation and monitoring, recovery plans, and longer-term solutions to address GBV during and after COVID-19 ✓ Promote women and girls’ leadership and representation in national, provincial and local/community level COVID-19 policy spaces
Data Collection	<ul style="list-style-type: none"> ✓ Follow the United Nation guiding principles and recommendations for data collection to ensure women and girls’ safety. Principles must be informed by the socio-economic and environmental realities of women and girls. ✓ Produce disaggregated data - race, gender, sex, ethnicity, age, disability, occupation, socioeconomic status, migratory status, geographic location
Funding	<ul style="list-style-type: none"> ✓ Increase dedicated funding for specialized services and supports, including essential social determinants of health - income supports, housing, child-care, food security ✓ Provide additional funding for organizations already serving women and girls experiencing GBV, especially in remote and rural communities, and focused funding for initiatives addressing GBV and empowering women among agencies serving newcomers ✓ Promote substantive equality as a policy objective in government programs and services
Indigenous Communities	<ul style="list-style-type: none"> ✓ Work with Indigenous communities on wellness and emergency COVID-19 responses ✓ Apply a human rights-based approach to COVID-19 plans, with independent oversight and provide additional funding to protect Indigenous people’s health and human rights
Migration Policies	<ul style="list-style-type: none"> ✓ Include protective migration policies to suspend forced deportations and grant permanent resident status to immigrants
Social Protections	<ul style="list-style-type: none"> ✓ Strengthen safety nets and expansion of social protections for marginalized groups – income allowance, stimulus packages, housing subsidies, rent eviction moratoriums, childcare funding, reduce wage gaps ✓ Ensure institutional accountability of the institutions and systems that serve Indigenous, Black and other racialized communities
Meso level	
Service Provision	<ul style="list-style-type: none"> ✓ As per the World Health Organization’s guidelines, ensure services for women and girls are a priority and considered essential in the context of the COVID-19 response

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	<ul style="list-style-type: none"> ✓ Ensure that these services remain open, accessible (e.g. in multiple languages), inclusive, and are well-funded. Eligibility for services should not be determined or impacted by migrants’ status – e.g. with precarious immigration status ✓ Expand access points to mental health services ✓ Apply holistic survivor-centred principles and trauma- and violence-informed supports to service provision ✓ Apply Anti-Racism Anti-Oppression policy to service provision ✓ Adapt and strengthen online supports, helplines, online counselling and technology-based solutions ✓ Apply media safeguards to online supports ✓ Address barriers and the digital divide to access remote services ✓ Promote cultural safety models to service provision ✓ Strength women and girls’ safety nets -health coverage, basic income, housing, childcare
Public Discourses and Messages	<ul style="list-style-type: none"> ✓ Change public discourses and messages in COVID-19 responses to emphasize that GBV survivors’ needs matter, that services are available
Capacity Building	<ul style="list-style-type: none"> ✓ Increase awareness and training on GBV across systems – health, social, education, protection, security, justice ✓ Promote mechanisms to enhance GBV capacities of frontline workers – healthcare providers, law enforcement and court officials, etc. – including online and hybrid education training ✓ Promote capacity building, and training. More inclusion of racialized populations in the health care system
Micro level	
Awareness, Sensitization and Advocacy	<ul style="list-style-type: none"> ✓ Enhance campaigns to raise awareness among service providers – health, justice - and to sensitize the general population. Need a stronger integration of race and intersections with gender, immigration status, income/poverty ✓ Support and fund advocacy efforts from racialized women, grassroots organizations and initiatives, cross-sectoral collaborations in advocacy and campaigns ✓ Engage community “gatekeepers”

INTRODUCTION

An alarming increase in global violence against women and girls during the COVID-19 pandemic has been reported (UN Women, 2020e; WHO, 2020a). The United Nations has referred to this societal problem as the “shadow pandemic” (UN Women, 2020e). Fear, uncertainties and stressors among the population during the pandemic have further exacerbated the prevailing gender-based violence (GBV) by directing anger and aggression against women and female partners (IASC, 2020a). In the year previous to the COVID-19 pandemic, 243 million women and girls across the world (aged 15-49) experienced physical and/or sexual violence (UN Women, 2020e). Gender based violence affects 30–60% of women worldwide, impacting on their physical, mental and sexual health (Dunkle & Decker, 2013). Violence against women results in high rates of mortality and morbidity (Rees et al., 2011), and is also associated with life-long mental health problems including psychological distress, depression, anxiety disorders (post-traumatic stress disorder) and substance use disorders (Gevers & Dartnall, 2014; Tol et al., 2013). Higher rates of attempted suicide (Rees et al., 2011), social exclusion and isolation among women exposed to GBV have also been reported (Tol et al. 2013). Experiences from previous epidemics have shown that women’s physical and psychological burdens increase during health emergencies (IASC, 2020b). These have been linked to government enforced measures to control the spread of the disease, such as social distancing and reduced community interactions, restriction of movement and closure of services. These restrictions have often limited women’s ability to distance themselves from their abusers and to access the supports they need thereby increasing their vulnerability to GBV (IASC, 2020a; WHO, 2020b).

As reported by community-serving agencies in Canada, the most common types of power control tactics perpetrators of GBV use against women are withholding access to information such as radio, news and phones; preventing the victim from communicating with her children and other immediate family members; and withholding soaps, sanitizers and health cards (TVO, 2020). Sex trafficking, also a form of GBV, is strongly related to financial insecurity of the victim. During a pandemic as finances dry up, girls and women with precarious status become even more vulnerable to sex trafficking and are compelled to trade sex for survival. The COVID-19 pandemic has created a disruption in service, funding and delivery, ultimately compromising the care, support (physical, mental) and connections the GBV survivors rely on (UN Women, 2020e). The United Nations Secretary-General has asked for the prevention and rectification of violence against women as a crucial part of all governments’ national response plans for COVID-19 (UN Women, 2020e). Growing evidence indicates that racialized groups have a higher risk of COVID-19 related morbidity and mortality (Eligon, et al, 2020; Keung, 2020; Morrison, 2020). Taken together, racialized women at risk of GBV are a priority group to focus on for immediate mental health support and care during the pandemic.

In this report, we share the findings of our project titled “**COVID-19 pandemic guidelines for mental health support of racialized women at risk of gender-based violence**”. The project was funded under Canadian Institutes of Health Research (CIHR) Operating Grant: Knowledge Synthesis: COVID-19 Rapid Synthesis Funding in Mental Health & Substance Use in 2020. Our project outcomes are available here: <https://cihr-irsc.gc.ca/e/52062.html>. Our project’s overall **goal** was to advance trauma-informed mental health care for racialized women at risk of GBV during the COVID-19 pandemic response and recovery phases. The **CIHR priority populations**

considered in our project were: i) women and girls at risk of domestic or intimate partner violence, and ii) racialized individuals who have less social support and lower economic stability.

Our **objectives** were to: 1) Conduct a rapid review to critically assess the state of knowledge on: a) the racialized and gendered social determinants of mental health among women and girls exposed to GBV during the COVID-19 pandemic, and b) the emerging promising practices for detection, referral, and service provision for equity informed mental health promotion and care; 2) Identify knowledge strengths and gaps, applicability and transferability of findings and emerging public mental health and psychosocial support guidelines; and 3) Engage in gender-specific knowledge exchange and mobilization.

METHODS

Our rapid review follows the Cochrane Rapid Reviews methodology (Cochrane, 2020; Ganann, Ciliska, & Thomas, 2010) which includes six steps:

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

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

Step 3. Searching methods for identification of studies. We included all study designs (qualitative, quantitative, mixed methods). Searches were conducted across 4 electronic databases: 1) Cochrane CENTRAL, 2) Medline, 3) ProQuest (PsycInfo, Sociological Abstracts, Women's Studies International), and 4) EBSCO (CINAHL, Social Services Abstracts, Social Work Abstracts); we also searched and included hand picked peer-reviewed articles. We examined ongoing/unpublished studies through grey literature searching of websites, including electronic news media, Google Scholar, policy documents, and editorials published between the years 2019 to present. Grey literature was sought through searches of electronic database ProQuest. Peer-reviewed research articles published in English and/or French and/or Spanish language were included in the review. For all other sources we included material published only in English. Abstracts of identified articles were reviewed to assess if they met the inclusion and exclusion criteria. For peer-reviewed literature, two reviewers conducted dual screening of abstracts. One team member screened all titles and abstracts for eligibility and a second reviewer checked all excluded records. Full texts were reviewed by one reviewer and a second reviewer checked all excluded studies. The reviewers did not find discrepancies. For grey literature one team member screened all titles and abstracts for eligibility. In the PRISMA diagram (Figure 1) we present the search results and the process of selecting the material for report. Search and keyword strategy were developed by research team members and approved by the study's Principal Investigator (Khanlou) and the health sciences librarian and team member (Mgwigwi) (Table 1). In this *Knowledge Synthesis Report*, we report on 55 selected sources from a total of 286 search results



(see Appendix 1. Description of peer-reviewed selected articles, and Appendix 2. Description of grey literature selected articles).

Figure 1. PRISMA diagram - Rapid Review Search Results

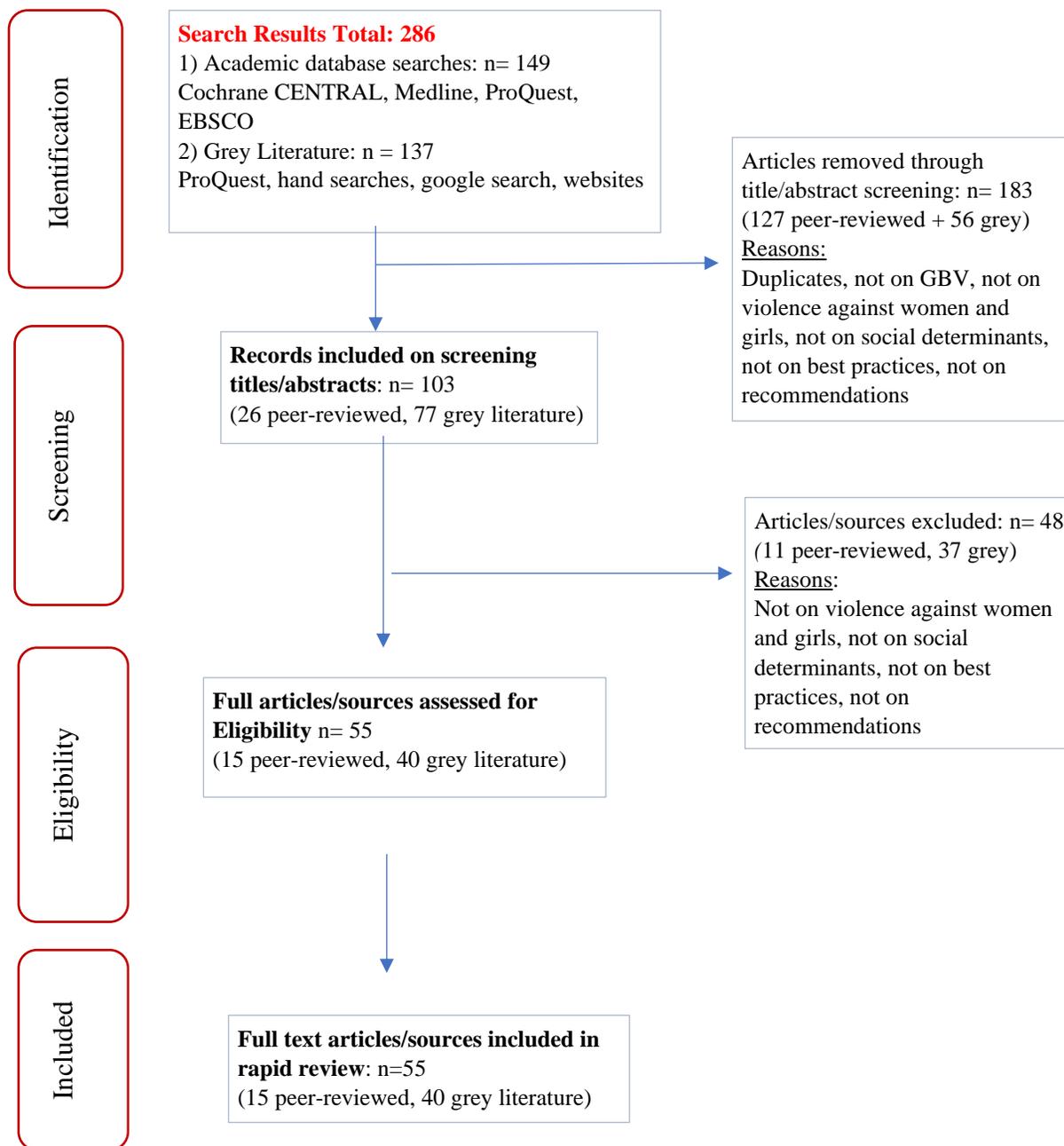


Table 1. Search terms

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

Step 4. Data collection. Full text screening was conducted on standard forms, using an Excel sheet to record key characteristics (e.g., date, study design, participant characteristics).

Step 5. Analysis and Synthesis. Emerging review findings were organized applying a systems approach (Bronfenbrenner ecological systems—micro/ meso/macro) (Bronfenbrenner, 1992), and interpreted through an intersectionality-informed lens of identity markers (Crenshaw, 1989; Hankivsky & Cormier, 2011).

Step 6. Applicability and transferability of findings. We adapted the pyramid of interventions approach (IASC, 2020b), identifying multilevel interventions from the macro (social considerations in basic services and security), meso (strengthening community and family supports) and the micro level (person-to-person, specialized services), and embedding social and cultural considerations, promoting principles related to human rights and equality, building on existing resources, adopting multi-layered interventions and working with integrated support systems (IASC, 2020b). Figure 2 of our report presents the adapted pyramid.

Key Concepts

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

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

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

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

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

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

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

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

Findings

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

We recognize simultaneous pandemics that have long existed, but have come to public attention most recently, the pandemic of systemic racism and the pandemic of gender-based violence that continue to characterize society. The intersection of systemic oppression with the “shadow pandemic” of gender-based violence and the COVID-19 pandemic continue to impact women and girls profoundly. Structural socioeconomic and health inequalities attributed to systemic racism explain the disproportionate impact of the COVID-19 pandemic on racialized populations (Enekwechi, Hardeman, & Powell, 2020).

Women are experiencing the COVID-19 pandemic very differently from men, confirming the historic gender disadvantages women and girls have in society (UNFPA, 2020a). There are multiple social determinants that are placing women and girls at a disadvantage during the current pandemic. The UN recognizes that women are more vulnerable to crises for two interrelated reasons: first, they are more likely than men to work in **informal and precarious jobs**; and second, they carry on most of the **unpaid caregiving** work at home (UNFPA, 2020a). Given their marginalized status in the work and home environment, women will experience the economic downturn disproportionately (IPU, 2020). A key factor determining increasing risks and vulnerability to COVID-19 is that women are frontline providers of services, representing 70% of the health and social care workforce provided around the world (UNICEF, 2020). The literature highlights the racialized and gendered nature of essential frontline workers in grocery stores and pharmacies which puts them at higher risks (IPU, 2020; Rezaee, 2020). Racialized women are at greater risk of COVID-19 because they work in the cleaning sector, as cashiers, social workers, nurses, and as personal support workers (Rezaee, 2020).

Factors associated with where racialized communities live and where they work, place them at higher risk to COVID-19. A recent public health report indicates that COVID-19 rates in Toronto are 10 times higher in racialized neighbourhoods than in the least-impacted areas (Yang et al., 2020 para 7). These racialized neighbourhoods shelter individuals experiencing housing, social services (healthcare) and labour precarity. Racialized members of these communities face greater social and economic disadvantages and have higher levels of economic insecurity, for example lack of affordable housing, overcrowded poor housing conditions, food insecurity, and violence and discrimination (Rezaee, 2020; Yang et al., 2020). As stated by Rezaee (2020), labour market discrimination is highly racialized and gendered. For example, racialized women are most likely to be in low-pay occupations; they earn on average 58 cents for every dollar earned by non-racialized men (Rezaee, 2020, p. 2), and “among women, working poverty is highest for Black women” in the Greater Toronto Area (Ibid.).

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



Girls across the world face increased risks of GBV resulting from COVID-19 related school closures. In past emergency health crisis like the Ebola outbreak in West Africa, an increase in teenage pregnancies was reported. Teenage girls may disproportionately drop out of school due to increased risk of pregnancy and sexual exploitation or to conform to forced marriage (Burzinska & Contreras, 2020). Due to COVID 19, a disproportionate increase in unpaid gendered household work has been reported: girls between 5-14 years are spending 40% more time doing unpaid work at home than boys; this is impacting on the time they have to study and may also cause girls to drop out of school (Burzinska & Contreras, 2020, para 3).

Racism is a fundamental risk factor. Racialized communities bear a disproportionate burden of health inequities. Alarming rates of COVID-19 infections and deaths among Black Americans, and overall disproportionate impacts on people from racialized and ethnic minority backgrounds illustrate existing health inequalities and the consequences of structural racism (Enekwechi et al., 2020). Racialized populations are the hardest hit in this pandemic due to social determinants including poverty, inequitable access to medical care or health advice, inadequate housing, precarious employment, that increase their vulnerability to COVID-19 (Enekwechi, Hardeman et al., 2020). Racism, however, is universal and equally felt in other sectors. Fraser (2020) notes the increased risk of online and offline racial and sexual harassment and targeted sexualised attacks against women of East Asian ancestry. COVID 19 related racism include blaming Chinese Canadian restaurant owners of transmitting the virus and refusal to hire East-Asian looking Uber drivers (Chai, 2020; Gopal & Adesara, 2020). Systemic racism, stigma and discrimination increase the challenges of racialized women to access sexual and reproductive health care (Hall et al., 2020). Research demonstrates the negative impacts of racialized violence against Black individuals in the health system. For example, studies have found that people who have experienced racism and/or who have been mistreated by the police are more likely to have a mistrust of health institutions. Having a mistrust in health institutions leads to delays in COVID-19 screening and other negative outcomes for racialized populations (Enekwechi et al., 2020).

Furthermore, **amplified surveillance** mechanisms due to COVID 19 and the enforcement of social distancing restrictions may disproportionately impact members of racialized and marginalized population (CREVAWC et al., 2020). In Canada, a report illustrates the “massive and extraordinary expansions to police power” to enforce COVID-19 measures which is already disproportionately impacting Black, Indigenous and other marginalized groups (Ho, 2020, para 2).

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

The United Nations (UN) reports that pandemics like COVID-19 exacerbate not only violence within the home, but other forms of violence against women and girls. **Workplace violence** has increased as a result of the pandemic, for example against female healthcare workers in China, Singapore and Italy (Fraser, 2020; UN Women, 2020d). Fraser (2020) reports

that prior to the COVID-19 pandemic, research reported that violence is mainly perpetrated against female nurses in isolated spaces at patients' homes, emergency departments, and in geriatric and psychiatric departments. Xenophobia and racism in the workplace have also been reported in the context of the pandemic. In Manitoba, Canada, a survey conducted with healthcare workers showed that 1 in 5 workers who identified as Asian have experienced racism in the workplace (CREVAWC et al., 2020). Risks of abuse and exploitation increased for marginalized women workers. In the United States for example, Fraser (2020) found reports of increased violence directed at street-based sex workers (Fraser, 2020). Victims of sex trafficking are among the most marginalized groups at risk.

In past humanitarian crises, families have experienced a drastic **reduction in family services**. Previous emergencies show reduced access to services – e.g. abortion, HIV, GBV, mental health – which resulted in “increased rates and sequelae from unintended pregnancies, unsafe abortions, sexually transmitted infections... post-traumatic stress disorder, depression, suicide, intimate partner violence, and maternal and infant mortality” (Hall et al., 2020, p. 1176). The Ebola outbreak in West Africa showed the disproportionate impacts that diversion of funding for essential services have on women and girls; for example, in Sierra Leone more women died of obstetric complications than of the virus itself (IPU, 2020; UNDP, 2020). More broadly disruptions in service provision are felt disproportionately by families who have no or very limited health care insurance and for people on low incomes, locally and globally (Hall et al., 2020; IPU, 2020). UNICEF (2020) notes that support services and life-saving care to GBV survivors including mental health services, clinical management of rape, and psycho-social supports, are disrupted in tertiary level hospitals given that service providers are overburdened with COVID-19 cases. Hall et al. (2020) note that responses to COVID-19 across the globe demonstrate that reproductive and sexual health are not a priority, which further contribute to inequities that impact negatively on the health and wellbeing of women and girls, and marginalized populations in general.

Indigenous communities in Canada

Historical inequalities, racism and discrimination against **Indigenous peoples** in Canada, are among factors that increase the risks of COVID-19, and its deleterious impacts. Indigenous communities are more vulnerable to the pandemic because they are in the midst of experiencing other types of emergencies related to health (e.g. high rates of existing tuberculosis in Northern communities), mental health (e.g. a suicide crisis), underfunding of services (health, mental health) and infrastructure (over-crowded housing, unsafe drinking water), child welfare, and environmental crisis (floods, fires, droughts) (Craft, McGregor, & Hewitt, 2020; Levesque & Thériault, 2020). Therefore, as Craft, McGregor, and Hewitt (2020) state, “Indigenous vulnerability to pandemics must be understood within a broader context of historical and ongoing colonialism, which has disrupted and undermined the health and well-being of Indigenous people” (p. 51).

Indigenous peoples across the world face increased health and mental health risks (Power et al., 2020). **Historic and continuing institutional mistreatment, family separation, racism, discrimination**, police brutality against Indigenous peoples (Human Rights Watch, 2013), and lack of services lead by Indigenous peoples, are among the barriers women and girls seeking services face (CREVAWC et al., 2020). Disparities in health and mental health care availability and access are among the barriers that put women and girls and people at risk (Rezaee, 2020). Other

important issues to consider are the high rates of homicide and suicide among Indigenous communities, which also put women and girls and people from other sexual orientation at higher risk (Rezaee, 2020). Statistics Canada reports that between 2011 and 2016 suicide rates among First Nations were three times higher than among non-Indigenous persons (Kumar & Tjepkema, 2019). Substandard housing, housing shortages, and lack of safe houses and shelters on reserves, increase the risk to violence faced by First Nations children, girls and women (Levesque & Thériault, 2020). Inequities in child welfare services, along with COVID-19 social isolation restrictions, increase the risk faced by First Nations women and girls, who are disproportionately affected by domestic, physical, and sexual and police violence (Human Rights Watch, 2013; Levesque & Thériault, 2020). COVID-19 related challenges emerged in the context of calls for justice to address the recommendations included in the National Inquiry into Murdered and Missing Indigenous Women and Girls' final report – which highlights historical systemic institutional human rights violations against Indigenous women, girls, and 2SLGBTQQIA (Rezaee, 2020). As explained by advocates and researchers, lack of trust in agencies and government institutions providing services also contributes to barriers to accessing services for individuals facing gender-based violence (CREVAWC et al., 2020).

Black and other racialized communities

In the United States, rates of COVID-19 infections and deaths amongst Black Americans, and disproportionate negative effects on racialized people from ethnic groups, illustrate health inequalities (Centers for Disease Control and Prevention, 2020). The death rate among African-Americans is 2.4 times the death rate of White-Americans (The COVID Tracking Project, 2020). In Toronto, the pandemic has had a greater impact on Black and other racialized populations. Together, these groups represent 83 % of reported COVID-19 cases, while representing half of Toronto's total population (City of Toronto, 2020). Other over-represented groups include Arab, Middle Eastern, West Asian, Latin American, Indo-Caribbean, and South Asian. COVID-19's disproportionate impacts bring into light structural historic inequalities (Bowleg, 2020). In the United States for example, the maternal mortality rate among Black women are more than two-and-a-half times higher than white women, and Black infant mortality is twice the rate that of white infants (Wulfhorst, 2020). Researchers and advocates highlight the fact that data shows that “we are not in this together” as emphasized by certain well intentioned “color and class blinding” narratives (Bowleg, 2020). According to service providers “much like COVID-19, intimate partner violence magnifies health inequities” (Maitra & Savage-Borne, 2020, para 3). Recognition of poverty and structural racism help us to understand why and how ethnic and racialized members experience violence differently, shaping women's choices and coping mechanisms.

As noted earlier, structural anti-Asian discrimination has also been overtly visible during the current pandemic. It has given rise to a “secondary contagion of racism” (Chen, Zhang, & Liu, 2020), with increasing numbers of anti-Asian hate incidents in the United States (Lee, Cha, Han, & Tseng, 2020). Researchers recognize the negative effects of racism, as a social determinant of health, on exacerbating health inequalities in these communities (Chen, Zhang, & Liu, 2020; Lee, Cha, Han, & Tseng, 2020). In particular, in regards to marginalized members including low-income, undocumented, elderly, and those with English as their additional language from Asian backgrounds, and “those afraid to seek care because of anti-Asian xenophobia” (Lee, Cha, Han,

& Tseng, 2020, p. 1371). In Canada during the pandemic, more visible minority groups felt unsafe based on their race or ethnicity, and more visible minority women felt unsafe compared with men (Statistics Canada, 2020).

Immigrant and refugee communities

The World Health Organization and other international sectors recognize that women at risk of violence, such as those with precarious migration status, displaced, migrants and refugees, and individuals living in conflict-affected areas, older women, and women with disabilities are likely to be disproportionately affected by violence during COVID-19 (WHO, 2020d). Risk factors and vulnerabilities associated with intimate partner violence in immigrant and refugee communities can trigger unresolved pre-migration trauma (CREVAWC, 2020a). Furthermore, other factors including stress associated with processes of settlement and integration (e.g., changes in family's socioeconomic statuses, gender roles and responsibilities, social networks and supports) are also associated with intimate partner violence (CREVAWC, 2020a). Immigrant and refugee women and girls may face specific barriers to reporting GBV and seeking help, including fear of loss of children due to deportation, fear to engage with the criminal justice system, threats of apprehension, arrest and detention (CREVAWC, 2020b; Rezaee, 2020). Other related barriers may include limited knowledge about their rights or availability of services, discrimination and racism in the service delivery system, language barriers, lack of religious or cultural accommodations and lack of accessible services for women with disabilities (CREVAWC, 2020b). Finally, social isolation, lack of social networks, social stigma and cultural norms related to disclosure of domestic violence add to the factors that shape decisions to report violence (CREVAWC, 2020b).

Efforts that focus on understanding the existing systemic challenges of immigrant health should consider the intersections of migration status, gender and race. Increasingly, Canada's growing immigrant population enters paid work on a temporary or precarious status (precarious work being highly gendered and racialized). Research indicates that existing GBV supports for non-status, refugee and immigrant women should consider the impact of precarious status on an individual's access to services (OCASI, 2020). Migrant women with precarious status and "undocumented" women face a greater risk of violence and abuse. Women in abusive relationships are less likely to report abuse or access support and shelter services if they fear that doing so would put their families' immigration status at risk. Services for women who have experienced violence can only fully protect survivors if information about immigration status remains confidential (OCASI, 2020).

COVID-19 has increased the vulnerability and marginalization of migrant women. For example, women with precarious status are excluded from COVID 19 government relief and assistance programs because access to these programs are dependent on the individuals' legal residency status (Rezaee, 2020). The lack of access to income supports such as Canada Emergency Response Benefits and Canada Child Benefit leaves "behind already-vulnerable people desperate to find shelter, food, and healthcare" (Abji, Pintin-Perez, & Bhuyan, 2020, para 4). The health emergency has intensified pre-pandemic issues such as poor working conditions, low pay, lack of benefits like paid sick leave and other protections for non-status women working on the front-line (Abji et al., 2020). In the context of limited social networks, immigrant women's burden of caregiving has also increased especially with online modes of schooling for children.

Anecdotal reporting of GBV against Non-Status, Refugee and Immigrant (NSRI) women by service providers across Canada has been highlighted at planning meetings, roundtables and webinars focused on the intersectional impacts of COVID-19 on NSRI communities (OCASI, 2020). Across Canada, service providers shared that the persistence of GBV in communities and lack of effective strategies to abate it were exacerbated following the emergency response measures put in place during COVID-19. The social disorientation caused by COVID-19, compounded by the need for agencies to stop serving clients in person, and implement separation and social distancing in place required cross-sectoral collaboration and innovative ways to provide support (wellness checks, adjusting work hours, informal WhatsApp groups, technology, etc.). Organizational leaders, advocates and community members recommend the need to include and centre women's organizations and NSRI survivors of GBV in COVID-19 response efforts suggesting that the issues and unique challenges faced by NSRI women who experience GBV in this context was already a crisis (OCASI, 2020). NSRI women facing economic insecurity "may be forced to engage in riskier behaviour to survive and support their families. They may inadvertently become vectors of the virus and less likely to seek medical support if they fall ill because of immigration concerns" (Rezaee, 2020, p. 5).

In sum, there is a need to address structural determinants that are shaping the health and mental health outcomes of racialized communities during the current pandemic. The experiences of racialized communities highlight the differentiated risks, marginalization, social injustices and inequalities they face, which have been always present, but have become socially visible in the context of the current COVID-19 pandemic. In light of this backdrop, it is not surprising that mental health impacts of COVID-19 have a greater impact on marginalized communities (Jenkins, Gadermann & McAuliffe, 2020).

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

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

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

The integration of ***gender-responsive programming*** into countries' strategic plans for COVID-19 preparedness and response is recommended (John et al., 2020; UNICEF, 2020; UN Women, 2020a). Strategies should take into consideration gendered roles (IPU, 2020; UNICEF, 2020). By integrating a gender lens, we may be able to identify issues such as the burden of care work for women during health emergencies, and the GBV risks, into planning (UNICEF 2020). According to the IPU (2020), by applying a gender lens we are able to oversee governments' responses to the health emergency: ensuring that women and girls have access to protection, shelters and other resources as essential services; controlling the impact of the outbreak on

health-care, police and justice services for survivors; ensuring that strategies to protect women survivors of violence have been adapted in the emergency related plans; establishing codes of conduct to address violence against female health workers and sexual harassment in the social and health sectors; and finally, ensuring measures to protect girls at risk of sexual violence are implemented in the context of schools closures (IPU, 2020, p. 4).

There are also calls to integrate **intersectional, human rights, community-based and critical race approaches** to emergency health responses, in order to address unique and “complex health and social adversities for women, girls and vulnerable populations” (Hall et al 2020, p. 1176). The United Nations highlights the need to ensure that COVID-19 measures “uphold international human rights standards and that civic spaces for civil society, including human rights defenders, are protected” (UNDP, 2020, p. 2). An intersectional approach will ensure policies and interventions focus on women and girls’ specific needs. This is an important step towards the recognition of the differentiated primary and secondary effects of the health emergency on people living in poverty, persons with disabilities, Indigenous people, internally displaced persons, immigrants, refugees, LGBTIQ individuals and others who face intersecting and multiple forms of discrimination (UNFPA, 2020b). An **intersectoral** approach to the COVID-19 response will allow us to identify who “are at heightened risk of different forms of GBV and understand how these may vary across settings” (Fraser, 2020, p. 4) or across other identity markers such as socioeconomic status, race, ethnicity, migration status, among others. Researchers recommend application of critical race analysis to the study and evaluation of public health responses to ensure that the lived experiences of racialized people are taken into consideration during pandemics (Chai, 2020). Finally, researchers highlight the need to apply a sexual and reproductive health and justice framework to the COVID-19 impacts and response so we can monitor and address the inequitable gender, health and social effects of the pandemic in specific sectors of the population (Hall et al, 2020). **These approaches look at the human rights dimensions and recognize the existence of intersecting injustices and power structures across identities.**

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

It is necessary to ensure that COVID-19 policy frameworks integrate women’s safety approaches into their strategic responses. State policies should recognize that lockdown measures increase women’s vulnerabilities, that social distancing at the home may not be a safe place for women and girls (UNFPA, 2020b), therefore, protection of women and girls from the beginning of an emergency crisis should be in place (Onyango, 2020). Violence against women, in all its forms should be seen as a priority and integrated in national and sub-national COVID-19 response plans (EIGE, 2020; UNDP, 2020). Risks of violence against women must be assessed, monitored and addressed as an integral part of the COVID-19 responses (Siangyen, 2020). Examples of this may be to give high priority to incidents of violence against women and girls by police and judicial institutions in the context of the pandemic. **Safety principles** should be integrated, for example, into the process of re-purposing public spaces, such as parks, libraries, parking lots, for health and food security and temporary shelter during the response phase of the pandemic (UN Women, 2020b). At this stage authorities should also ensure women’s **safe mobility measures** include, for example, the provision of accessible, illuminated and safe

alternative routes (UN Women, 2020b). These types of measures will benefit health workers and first responders, the majority of whom are women (UN Women, 2020b). COVID-19 related initiatives also need to be integrated across sectors (Onyango, 2020). Information about COVID-19 prevention and containment should be **inclusive**, ensuring women and girls with disabilities or those who face barriers have accessible information, including in sign language and accessible formats, easy-to-read and plain language, accessible digital technology, relay services, captioning, and text messages (UNFPA, 2020a). Finally, an important long-term recommendation is that local **multisectoral policy frameworks** such as housing, health, local economic development, management of safe public spaces be integrated within budgets and resource allocations to specifically address GBV (UN Women, 2020b).

3) Macro level – Include diversity of perspectives and lived experiences to policies and programming

Advocates highlight the need to incorporate the diversity of voices and lived experiences from community members (e.g., women, Black and Indigenous individuals, members from diverse ethnic communities, refugees and immigrants with precarious status, 2SLGBTQ+) to ensure equity and to build comprehensive pandemic and post-pandemic responses (CREVAWC et al., 2020; Rezaee, 2020). Members of these diverse communities face a range of specifically located risks to the pandemic, as well as differentiated impacts and adapted responses. Therefore, a “one-size-fits-all” approach to the crisis “will likely fail to meet the needs of women and girls, heighten gender-based inequalities, and increase social and economic disparities” among members of the above-mentioned marginalized groups (Rezaee, 2020, p. 2). The Ontario Council of Agencies Serving Immigrants has pointed out that the views and perceptions of women without status have been excluded from mainstream discourse and policy responses (Rezaee, 2020). Calls for leadership building and support is essential, as Senior (2019) highlights, there is a need to include racialized women in government positions to ensure their needs are addressed. Furthermore, along specific needs, future long-term strategies to face health crisis should also take into consideration individuals’ skills and key roles that they and their communities may have to contribute to the crisis response (CREVAWC et al., 2020). COVID-19 strategies should prioritize strengths-based models to advance and promote community, agency, and resourcefulness (CREVAWC et al., 2020). It is recommended that organizations and agencies serving the immigrant and refugee communities should trust and value the expertise of the members of these racialized communities and give them ownership over strategies to address violence (CREVAWC et al., 2020).

4) Macro level – Work with Indigenous communities on wellness and COVID-19 responses

Craft, McGregor, and Hewitt (2020) underscore that COVID-19 Indigenous-led responses in Canada affirm First Nations’ jurisdiction and self-determination. In this context, it is recommended that the federal government work with First Nations on wellness and emergency COVID-19 preparedness (Craft, McGregor, & Hewitt, 2020). However, it is recognized that in order to produce equitable outcomes in relation to the current COVID-19 and in future pandemics, the government of Canada needs to first comprehensively address systemic inequities in its services and programs to First Nations peoples “as required under the *Canadian*

Human Rights Act” (Levesque & Thériault, 2020, p. 382). Furthermore, it is recommended to apply a human **rights-based approach** to COVID-19 responses, “with independent oversight and additional funding to protect Indigenous people’s health and human rights” (Craft, McGregor, & Hewitt, 2020, p. 55).

5) **Macro level – Protective migration policies**

Protections for women and girls with precarious migration status include protective **migration policies**. The suspension of forced deportations during the pandemic by granting immigrants permanent resident status and other social protections including housing, childcare, shelter and food have been recommended by organizations advocating for immigrants’ rights (Rezaee, 2020). Recently, the Migrant Rights Network, the Rights of Non-Status Women Network and other grassroots organizations called for increased funding to address the humanitarian crisis faced by non-status people and migrant women experiencing violence and unsafe working conditions under COVID-19 pandemic (Abji et al., 2020).

6) **Macro level - Women and girls’ participation in program design**

To address the increase of violence against women and girls during COVID-19, UN Women (2020a) considers that it is most essential to prioritize women and girls’ meaningful participation in their organizations decision-making processes, in plan development, implementation and monitoring, recovery plans. In the longer-term women’s roles within communities place them in a position to positively influence program design addressing their unique needs and the barriers they face to meet those needs (Fraser, 2020; John et al., 2020; Siangyen, 2020; UNDP 2020; UNFPA, 2020a). Strengthening women’s leadership and representation in national, provincial, and local and community level COVID-19 policy spaces may ensure that responses are not discriminatory or exclude marginalized populations at risk (UNFPA, 2020a). To promote participation, it is important to engage and support women and girls’ community networks through **in-person and digital platforms**, which are good vehicles in decision-making as well as for sharing key communications, including GBV hotlines and other services and support mechanisms, and to scale program reach (UNICEF, 2020). There are digital platforms that women and girls can use, such as the UNICEF U-report (<https://ureport.in/>), which is described as “a tool to provide dialogue toward joint solutions and insights” (UNICEF, 2020, p. 2).

Furthermore, it is important to ensure support for grassroots women’s rights organizations that provide essential services to remote, hard-to-reach, marginalized populations (UN Women, 2020a). Research shows that women’s groups are “the single most important factor in addressing violence against women and girls” (Onyango, 2020, para 22). It is crucial that organizations participate in development and delivery of services and design of recovery and longer-term solutions of GBV in the context of COVID-19 (UN Women, 2020a). For example, in the United States, culturally specific organizations and programs addressing the needs of marginalized populations, such as Indigenous individuals, has been urged to receive additional funding to support GBV survivors (Cortez, 2020). These organizations provide language-accessible services to hard-to-reach populations to keep victims and their families safe (Cortez, 2020). Fraser (2020) highlights the effectiveness of the “twin track” approach to GBV in her review of lessons we can learn from previous health emergencies like Ebola, cholera and Zika. It

combines support to GBV local and grassroots organizations and the integration of violence against women into sectoral approaches. Therefore, it is recommended that **women's organizations** be considered in recovery plans and long term GBV solutions to address violence during lockdown, slowdown and recovery phases of COVID-19 in urban, rural and online settings (UN Women, 2020b).

7) Macro level - Data collection

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

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

In light of these challenges and risks to women and girl's safety, the United Nations proposes the following **guiding principles for data collection**. First, protecting and supporting women and girls who experience violence should be the priority in crisis situations; even though

robust data is needed, the focus should be on targeting resources for survivors so they can have access to quality services and supports. Second, efforts should be made to use and apply existing data to inform COVID-19 responses; of special relevance is secondary data collected in the contexts of similar crisis. Third, ethical and safety principles for collecting data are preeminent, especially during crisis. Drawing on these principles, the United Nations Women (2020d) provides four recommendations: **1.** Drawing on the principle that states that “doing no harm should be the highest priority”; it is recommended to not proceed with data collection if women and girls’ safety is at risk of violence and distress. **2.** A second relevant recommendation refers to the type of data collection methods and sources chosen – including for example rapid mapping of services, media reports, case reports, participatory approaches, service-based data. Ensuring the safety of women and girls respondents should be the priority when selecting these methods. **3.** The UN Women recommends not to include questions related to violence against women as part of population-based rapid assessment. To protect the safety of women and girls, the recommendation is to include broader questions, instead, related for example to respondents’ feelings of safety in the community or at home, rather than direct questions about their experiences. **4.** Finally, an important recommendation is to promote both advocacy and inclusion in data collection.

Country specific experience should also be incorporated in the interpretation and uptake on these UN guidelines. Furthermore, we also need to consider the expertise of national and local researchers in asking sensitive questions, an experience that needs to be taken into account to address the gap in our knowledge and inform practice and policy in the context of the current COVID-19 pandemic. Advocacy efforts to **promote the rights of marginalized groups** - including adolescent girls, older women, women and girls with disabilities, refugee women, female migrant workers, and racial and ethnic minorities – should be included. As we elaborate below, research should be inclusive of the voices and experiences of women and girls and they also should play a role in research design including fieldwork instruments (UN Women, 2020d).

8) Macro level - Increase dedicated funding

There is a need to increase funding for services to address protection needs for women and girls experiencing violence before and during the COVID-19 pandemic. Support services for GBV survivors are in increased demand during crises, however lessons from past emergencies show that funding for these services is deprioritized and limited (Fraser, 2020). Previous health emergencies show a disruption, diversion and defunding of essential services including, for example, sexual and reproductive health care (Hall et al., 2020) and care and support to GBV survivors (UNICEF, 2020). During the COVID-19 pandemic stakeholders should think creatively to promote coordination and funding across sectors, to aim for community outcome investment and plans applying an **intersectoral lens**, and overall to strengthen social supports (Enekwechi et al., 2020). Furthermore, all protective services should be classified as essential during emergencies (UN Women, 2020a). Therefore, additional resources are needed in response plans (UN Women, 2020a). Advocacy for additional financial resources for essential GBV services is needed (UN Women, 2020a). Finally, and as we discussed previously, economic insecurity is a fundamental barrier for marginalized individuals (van Gelder et al. 2020). Therefore, a key measure is the provision of **cash assistance and in-kind assistance** for GBV survivors (NCLW, et al., 2020). Governments should focus on **substantive equality** as an immediate policy objective to

address historic inequalities experienced by Indigenous communities in Canada (Levesque & Thériault, 2020). A focus on substantive equality recognizes the historical processes – such as colonization - that have put certain communities at disadvantage, and therefore the need to provide more supports to specific groups, in terms of addressing their unique needs.

9) Macro level – Safety nets and Social Protections

Calls for the expansion of gender-sensitive social **safety nets**, including for example healthcare for all people, **universal health coverage**, were found in the review. There is a need to ensure that individuals from any age, nationality, legal status, physical and mental health capacities, socioeconomic background, and sexual orientation have access to GBV services (NCLW et al, 2020). More broadly, **COVID-19 response should ensure that universal health coverage includes marginalised groups** (Enekwechi et al., 2020), and “must designate sexual and reproductive health, family planning, and community health centres as essential health providers, reallocating resources accordingly” (Hall et al, 2020, p. 1177). Other social safety nets of relevance to racialized communities and women with precarious status to face GBV during crisis are, for example, paid sick leave, healthcare insurance, employment insurance, tax relief, child benefits, direct cash, food voucher payments, as well as short-term financial aid, which may guarantee the independence that women need to be able to leave their abusers (NCLW et al, 2020; O'Donnell, Peterman & Potts, 2020; van Gelder et al., 2020). Grassroots community organizations have pointed out that efforts to flatten the COVID-19 curve should include funding for shelter, emergency housing, health care, universal childcare, food, and legal services for non-status women to regularize their migration status (Abji, Pintin-Perez, Bhuyan, 2020).

Recommendations to expand social protections for marginalized groups include ensuring their **economic safety** by implementing stimulus packages, income supports and supplementation among these communities. Basic income allowance for Indigenous women with caregiving responsibilities was recommended by Dr. Pamela Palmater, a Mi'kmaq lawyer, professor, and activist (Rezaee, 2020). In Canada, there is a call to include communities with precarious status in all financial relief measures promoted by the government in the context of COVID 19 (Rezaee, 2020, OCASI, 2020). The need to extend social protections for particular marginalized groups, including protections for people working in the informal sector and contract and subcontract workers who may experience reduced income, termination, or non-renewal for challenging unsafe or exploitative work, is recommended (CREVAWC et al., 2020). **Housing** is a key social protection for Indigenous and racialized immigrant communities. Advocates propose “targeted housing on and off reserves for Indigenous women to keep them off the streets from the virus” (Rezaee, 2020). Specific supports for those with higher needs include the expansion of eligibility for subsidized housing, and other benefits including waiving of application fees, and move-in costs (CREVAWC et al., 2020). **Childcare funding** is an important demand across communities (Rezaee, 2020). Finally, a relevant suggestion pertinent in the current COVID-19 context, is to ensure **accountability** of the institutions and systems that are supposed to help Indigenous, Black and other racialized communities (Senior, 2019).

10) Meso level - Strengthen services for women and girls

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

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

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

b) Bolster violence-related first-response systems to anticipate a surge of violence against women and girls and prepare from the outset of pandemic outbreaks (O'Donnell, Peterman & Potts, 2020).

c) Shelters. Expand their capacity, including re-purposing public and private spaces, such as empty hotels, or education institutions (UN Women, 2020a), and ensure pandemic-safe surge housing for victims of violence (O'Donnell, Peterman & Potts, 2020).

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

e) GBV referral pathways should be updated to reflect service availability, and plans should incorporate strategies to inform communities and service providers about updated pathways needs (UNFPA, 2020a; UN Women, 2020c). Service directories should be updated, and their dissemination among strategic networks should be conducted (UN Women, 2020c). Collaborations between GBV social organizations and the health sector are needed during emergencies, to envision better ways to provide services and to strengthen referral pathways in accordance with COVID-19 mitigation measures (Onyango, 2020). Updates to referral pathways are also instrumental to prevent overwhelming of tertiary hospitals (Fraser, 2020).

f) Mental health access points should be promoted to address mental health gaps in communities at greater risks and with higher disparities (Enekwechi et al., 2020).

g) Online supports need to be guaranteed 24/7. It is important to strengthen the capacity of national hotlines, and to scale-up existing online and virtual platforms for online support networks (O'Donnell, Peterman & Potts, 2020; UNFPA, 2020a). Crisis lines should be accessible in multiple languages (CREVAWC et al., 2020). Innovative approaches to address the women and



girls' needs during the health emergency should be implemented. For example, cellphone apps, WhatsApp, and online channels should be used for filing complaints (Souza et al., 2020). It is necessary to scale-up remote online services including case management, mental health, and psychosocial supports, with trained staff support and following quality of care guidelines (UNFPA, 2020a; UN Women, 2020c).

Internet-based service platforms are considered effective for replacing in-person supports (van Gelder et al 2020). An example is the use of *telemedicine*, which is identified as a good strategy to provide access to services including GBV trauma-informed care, post-traumatic stress disorder, depression, and suicide (Hall et al, 2020). It is recommended that *mobile health* and telemedicine should be explored as potential safe strategic resources for women experiencing violence, especially in humanitarian settings or when women do not have access to mobile phones or internet is limited or inexistent (Roesch et al., 2020). For web-based services and interventions, it is recommended to design **gender-specific** materials (Day & White, 2020). Levels of literacy (e.g., digital) and information that addresses the specific needs of racialized and low socioeconomic status populations are also relevant to consider in designing interventions and materials. Discussion about the digital divide is relevant in the context of online remote supports. The United Nations recommends building partnerships with the private sector to address the needs of disadvantaged populations so they can have access to the supports they need, from education to services (UN Women, 2020b). The media is recognized as a key actor that should provide information and web links to supports – hotlines (van Gelder et al 2020). Social media is also strategic in supporting a “buddy system” and emergency contacts (van Gelder et al 2020).

Recommendations about **media safeguards** when providing online GBV services include safety mechanisms to protect women and girls accessing services and their electronic communications so they do not leave a trail that can be accessed by their abusers – e.g. clear browsing history (for guidelines see Women Services Network, 2020; UN Women, 2020d; van Gelder et al 2020). Other measures, especially for extreme situations, include cellphone protections (Souza et al. 2020). International organizations call for GBV holistic responses including, for example, the integration of mobile justice units, much needed during social-distancing measures, especially to support women and girls in remote areas (UN Women, 2020b). It is also recommended that community organizations explore entry ways for women to access services, such as to supermarkets or pharmacies (Onyango, 2020).

The need to pay attention and **avoid potential sources of exclusion** in gender-based violence and health related service provision, is pointed out as a key recommendation to address inequality and discrimination against marginalized groups (CREVAWC et al., 2020). Recommendations to **promote inclusion** include, for example, strengthening access to referral pathways between diverse community-based services, including services for refugees, immigrants, people with disabilities, and other groups experiencing housing precarity and GBV and health services (CREVAWC et al., 2020).

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

Online supports

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

Innovative service provision

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



The **health and mental health sectors are identified as strategic in mitigating GBV risks**; researchers propose a structural integration of strategies to address violence against women and girls into health systems response (O'Donnell, Peterman & Potts, 2020). The health and mental health care systems can, for example, identify local support services for survivors – shelters, hotlines, counselling, crisis centres – to refer women and girls (Roesch et al., 2020). Along this referral role, it is important to highlight the allied professional capacity that these sectors have on staff (such as psychiatrists, psychologists, nurses, social workers, clinicians, trauma specialists) to mitigate violence against women and girls. Networking to enhance dissemination and communication about services needs to be promoted among existing GBV women's and youth rights organizations. They are essential to promote connectivity and information flow (UNICEF, 2020).

Finally, it is highlighted that **cultural safety models** to healthcare provision need to be incorporated “to mitigate influences of biases and power imbalances that propagate racial disparities” (Gopal & Adesara, 2020, para 6).

11) Meso level – Change the public discourses and messages in COVID-19 responses

Researchers and advocates observe that the current institutional and media discourses and messages around the pandemic have “unintended effects” on women and girls experiencing various forms of violence (CREVAWC et al., 2020). For example, in light of the crisis these women may feel that if they denounce or access GBV services they may become a burden to the health or service systems, that other problems matter more than theirs. Women and girls facing violence may also assume that services for them are not available due to COVID 19 measures. Advocates recommend that **public institutional messages** and media campaigns address these misconceptions and support efforts to disseminate information about services to particular marginalized groups (refugees, women without status) (CREVAWC et al., 2020).

12) Meso Level – Build capacity

Increase in awareness and training on the rising risks of different types of violence against women and girls during the COVID-19 pandemic among frontline workers across sectors such as physicians, nurses, social workers, and settlement workers, and the public in general, is recommended. It is critical that different systems (e.g., health, social, education, child protection, security and justice, social protection) ensure that frontline workers are aware of the **intersections of gender and the COVID-19 outbreak**, and how to address the issue safely and ethically during the emergency crisis (NCLW et al., 2020; UNFPA, 2020a,b; Roesch et al., 2020). Healthcare workers are key in detection, referral and service provision, but they need the training to be able to support victims (Onyango, 2020; Fraser, 2020; van Gelder et al., 2020). Training can be conducted remotely through e-learning, webinars and should be based on **trauma-and-violence** and **survivor centred approaches**, to ensure respect, sympathy and confidentiality and non-judgmental empathetic care (CREVAWC et al., 2020; NCLW et al., 2020; UNFPA, 2020a,b; UN Women, 2020c). Enekwechi et al. (2020) highlight that there is a **need to have more members of racialized communities trained in the health care system, within the healthcare workforce**. Key reasons to promote are that chances are higher that racialized individuals return to their own communities after receiving training. Black and racialized individuals may be able to serve better their communities because they understand better the nuances and specificities of their

communities; they also understand better people's distrust of the medical system. Enekwechi et al. (2020) explain that reasons of this distrust are rooted in the historic racism, where Black people have felt that they have not received treatment for their pain, they feel disrespected as **structural racism** is rooted in medical practices against these communities. Finally, racialized people understand better the health inequities of the population they are serving in their communities. These are key reasons to promote more **medical/healthcare training for individuals from racialized communities** (Enekwechi et al., 2020). Awareness and mechanisms to enhance capacities are also needed in the police and judiciary systems (UN Women, 2020a).

13) Micro level - Strengthen Awareness, sensitization and advocacy

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

Examples of awareness, sensitization, and advocacy efforts

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

The UN (2020) calls for community members to engage in efforts to prevent and address GBV. **Community "gatekeepers"** (Onyango, 2020) may include for example, postal service workers, pharmacists, neighbours, among others, and may play an active role looking out for women and girls who may be at risk of experiencing violence. If possible, they may also be a medium to offer support and information on available resources (UN Women, 2020c). Other important allies in community engagement are religious, faith-based and indigenous spiritual leaders, local women and youth leaders, who can be instrumental as an early warning and alert groups (Onyango, 2020). In addition, **informal social networks** such as neighbours, families, coworkers, and friends are also identified as key actors that can support these efforts (Junker, 2020; Souza et al., 2020); they form part of the "capillary", "primary detection system" for intimate partner violence (van Gelder et al 2020). In emergency times new approaches to tackle the issue are needed; the situation calls for a mass of volunteers to reach out to families, checking in on how things are going, and overall to **support families who are struggling with the COVID-19 pandemic**, to make their needs visible (Bielski, 2020; Astrup, 2020).

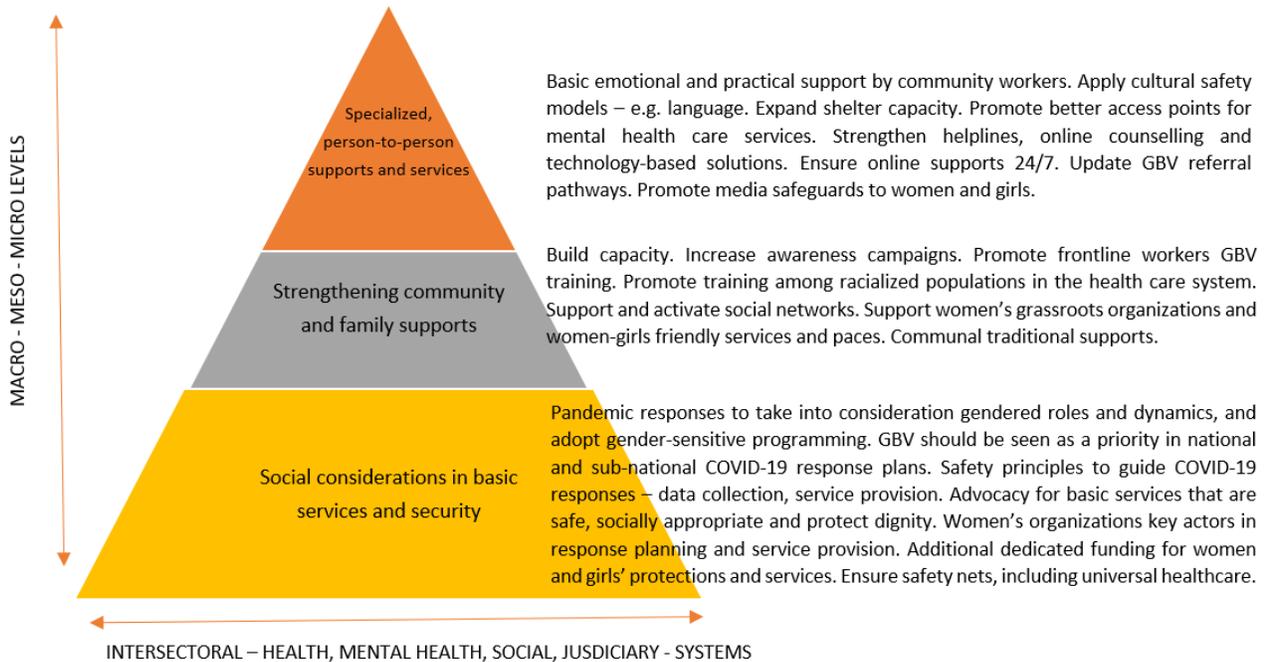
Discussion

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

- i) limited data on how levels of violence change;
- ii) lack of disaggregated data – e.g. sex, race, ethnicity - particularly for marginalized groups such as adolescent girls, women and girls with disabilities, older women, and refugee and migrant women;
- iii) limited research on the pathways of violence against women and girls and health crises; and
- iv) lack of documented evidence of good practices in preventing and responding to violence against women and girls during outbreaks.

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

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



Source: Adapted from Inter-Agency Standing Committee (2020b). Interim Briefing Note. Addressing Mental Health and Psychosocial Aspects of COVID-19 Outbreak. IASC Reference Group on Mental Health and Psychosocial Support in Emergency Settings.

While being cognizant of the current limitations in availability of quality COVID-19 mental health related primary data, interventions highlighted in this pyramid can guide in implementation of upstream practices and policies. Such interventions should take into account that the mental health risk factors of racialized women and girls with GBV experiences during the COVID-19 pandemic are impacted by complex and inter-related social determinants, and require intersectoral collaboration and the involvement of racialized women at all levels of decision making.

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Appendix 1: Description of Peer-Reviewed Selected Articles

Author	Type of document/Title	Focus/purpose/objectives/goal	Findings	Recommendations
Bowleg, 2020	Article. We're Not All in This Together: On COVID-19, Intersectionality, and Structural Inequality	COVID-19 disproportionately affects marginalized communities using intersectionality	The phrase "we are all in this together" fails to acknowledge intersectionality and social inequalities faced by racialized and marginalized communities that have been disproportionately affected by HIV/AIDS, mass incarceration, diabetes, unemployment and presently COVID-19. The impact of COVID-19 follows racial, class and occupational trends with the most impacted being 'essential workers' with low paying jobs (mostly racial minorities, women, and workers with precarious immigrant status).	Intersectionality is an essential lens through which we can examine the effects of COVID-19. It sheds light on how power and inequalities manifest differently across groups. Policymakers, public health officials and allies must rectify the consequences of social inequality as evidenced by the effects of COVID-19 on groups that carry the burden of intersectionality. This can be achieved by addressing their health, economic, and social needs.
Burzynska & Contreras, 2020	Article. Gendered effects of school closures during the COVID-19 pandemic	Vulnerability of girls in the COVID-19 pandemic	UNESCO reported that 90% of all students were sent out of school due to school closures. Girls' education is disproportionately hindered in developing countries because of two primary issues. First, issues related to sexual and reproductive health aspects-teenage girls are disproportionately at risk of dropping out of school because of increased sexual exploitation, forced marriage and/or pregnancy. Second, socioeconomic aspects: girls disproportionately take on more unpaid housework (40% more than boys at 5-14 years of age) resulting in more dropouts than boys as they have less time to study.	Policies should be developed using a gendered perspective, addressing the sexual and reproductive health and socioeconomic issues to facilitate the continued education of girls after measures to contain the COVID-19 pandemic end. Governments are encouraged to collect data on non-paid housework and caregiving responsibilities that are not usually addressed when investigating child labour. Quantifying the effect of these issues assists in assessing the practical significance of these factors to inform and shape interventions toward Sustainable Development Goals.
Chai, 2020	Book chapter	Spread of anti-Asian racism: prevention and critical race analysis in pandemic planning	The racist narratives and attacks on Asian Canadians in the context of the current COVID-19 pandemic illustrates the differentiated risks and vulnerability of racialized and marginalized individuals.	Apply a race-based analysis to analysis and evaluation of public health policy. Health responses may reinforce racist narratives and divert the attention from structural issues marginalized communities are facing, determining risks and vulnerabilities.
Chen, Zhang & Liu, 2020	Article. Potential Impact of COVID-19-Related Racial Discrimination on the Health of Asian Americans	Overview of anti-Asian discrimination in America; examine the conceptual and empirical associations between discrimination and health	Racism has become the 'second contagion' of COVID-19 as anti-Asian discrimination and assault increases. Interpersonal and structural anti-Asian discrimination is evidenced throughout American history. However, the current pandemic highlights the longstanding negative stereotypes associated with this minority group e.g. "Yellow Peril." Social media platforms (e.g., Twitter) revealed increases in Sinophobic slurs from October 2019 to March 2020 and the website Stop AAPI Hate received 1135 reports nationwide within the first two weeks of launching. The lived experience of this hate along with its coverage in the media, may cause significant negative health effects.	US House Representative Grace Meng proposed that COVID-19-related hate crimes should be condemned, documented, and investigated by officials. These incidents may be reported to the 211 hotline or the police. Public health research may examine short- and long-term effects of racial discrimination on health to formulate interventions at multiple levels with cross-racial and interethnic coalitions working together. Research participants should be representative of a range of Asian ethnic groups, paying attention to generation, acculturation using linguistic- and epidemiologically sensitive sampling to increase the generalizability of findings.
Craft, McGregor, & Hewitt, 2020	Book chapter	First Nations' responses to COVID-19	First Nations' responses to the COVID-19 emergency affirm communities' jurisdictions and respond to their unique needs and contexts. The authors argue that First Nations communities are well positioned to make policy and law to respond to the COVID-19 pandemic.	Work with Indigenous communities on wellness and emergency COVID-19 responses.

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<p>Day & White, 2020</p>	<p>Article. Gender-specific online content is important and timely for women receiving treatment for substance use disorders</p>	<p>Gender-specific interventions for women seeking drug and alcohol treatment</p>	<p>Sugarman et al. have found in their study that substance use and relapse are increased during pandemics. Due to curtailing the spread of COVID 19, many drug and alcohol services have decreased their hours of services, online service delivery or through telehealth. According to some studies, telehealth may a weak intervention especially for much marginalized populations. Government issued isolation measures further implicate the risk of family or intimate partner violence. Women with substance use histories are vulnerable to family or IPV. Gender-specific treatment are more effective for women with substance use histories, but due to the constraints of services and resources means women are receiving substance use treatment in a mixed-gender settings.</p>	<p>Web- based gender-specific materials are an efficient alternative for treatment programs to ensure compliance. Differing levels of literacy (including digital literacy) needs to be considered in regard to accessibility and usage. Substance use disorders are more than its psychiatric health history, as there are social determinants that can influence it. Women- only services allow their children to be present while attaining treatment or appointment. They also serve as a form of escape for that experiencing intimate partner violence. Women who have been sexually abused can find working with a male damaging and triggering. Therefore, women-only services will ensure quality of care.</p>
<p>Hall, et al., 2020</p>	<p>Commentary. Centring sexual and reproductive health and justice in the global COVID-19 response</p>	<p>Intersectional approaches and community driven interventions to tackle gendered disparities during COVID 19</p>	<p>The global response to COVID-19 pandemic is inflicting downstream economic and social consequences on women, girls and vulnerable populations. Those who have little protection to their human rights will face exacerbation infringed by the restrictions in place to control the spread of the virus. A reproductive health and justice framework needs to be implemented, it focuses on human rights, intersecting injustices, power structures and unifies various identities. Women make up 70% of the global health and social care workforce and do three times as much unpaid care work at home as men. This heightens the chance of contracting COVID-19 as many women are on the frontlines and providing care to vulnerable populations. Due to the prioritization of resources in controlling COVID-19, there has been a disruption in sexual and reproductive health care services. This in turn can increase the risks of maternal and child morbidity and mortality. In addition, systematic racism, discrimination and stigma perpetuate logistical hurdles in accessing sexual and reproductive healthcare for women and marginalized groups.</p>	<p>Public health responses need to incorporate intersectional, human-rights centred, transdisciplinary science-driven theories and community-driven approaches that will counteract the complexities and social disparities faced by women, girls and marginalized populations. Community driven efforts are crucial especially when it comes to COVID-19 research in which sex disaggregated data on mortality and morbidity should be prioritized. In addition, it is prudent to vocalize the importance of sexual and reproductive health and justice policy as an essential service during COVID-19 response. Due to the lack of in-person health services, telemedicine can be utilized in certain services such as medication abortion, contraception education and trauma-informed care for managing mental health issues such as gender-based violence.</p>
<p>Jenkins, Gaderman n, McAuliffe, 2020</p>	<p>Article. Mental Health Impact of Coronavirus Pandemic Hits Marginalized Groups Hardest.</p>	<p>To add new and concerning nuances to COVID-19 trends, particularly the root causes and differential mental health impact.</p>	<p>There is a growing mental health concern across Canada. According to the Angus Reid Institute, 50% of Canadians expressed that they struggled with mental health during the pandemic, with increasing worry and anxiety. Only 54% of Canadians identified their mental health as “very good” or “excellent” in 2020 (Statistics Canada), unlike the data from 2 years ago with 68%. This was observed pronouncedly in certain groups: those with pre-existing mental health conditions, a disability, or people living in poverty. These findings were paired with a spike in suicidal thoughts or feelings stemming from the pandemic. The social circumstances and stigma experienced by marginalized communities severely impacts their mental health with nearly one in five people experiencing suicidal ideation.</p>	<p>A comprehensive and equity-seeking mental health strategy should not only prevent and treat, but also foster health promoting interventions that use a strengths-based approach to prioritize healthy public policy especially for communities at a greater risk. These communities may also benefit from poverty reduction strategies, e.g. universal basic income, to address the suicide problem and mental health decline associated with job loss and economic hardship. Additionally, trauma- and violence-informed mental health services should work in cooperation with the communities that will access them to provide and develop services that are best suited for them.</p>
<p>John, et al., 2020</p>	<p>Article. Lessons Never Learned: Crisis and gender-based violence</p>	<p>Use experiences from previous emergencies as lessons to</p>	<p>Over 80 countries have exemplified that 1 in 3 women who have been in a relationship have experienced physical and/or sexual violence by an intimate partner at some point in their lives. This is further worsened during global emergency crises such as</p>	<p>Caregivers roles (paid and unpaid) are highly feminized across the public or private sector. This results in a bigger burden during periods of crisis when there are cuts to care services due to financial constraints while there are increasing expectations,</p>

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		address GBV during the COVID-19 pandemic.	pandemics. During the Ebola epidemic, reports of violence were neglected, uncounted and unrecognized. Women and young girls were unable to attend community meetings to receive instructions on how to protect themselves from the disease. Unfortunately, with COVID-19 there has not been any deviation with these issues, with early data stating there is an increase in domestic violence and disruption of gender-based violence and sexual reproductive health services for women and girls.	exposure and susceptibility for women to provide care. There are guidelines in place by UN Women and UNFPA in which governments can utilize a gendered lens when developing policies and solutions in response to COVID 19.
Knaul, et al., 2019	Comment. Countering the pandemic of gender-based violence and maltreatment of young people: The Lancet Commission	Knowledge creation to counter the pandemic. The Lancet Commission of GBV and Maltreatment of Young People intend on producing new tools and data	Over 1/3 of the world's population of women and girls experience IPV or non-partner physical or sexual violence in their lives. Nearly 1/4 of all adults worldwide report physical abuse as children although more frequent for girls which stands at about 20% than boys at almost 10%. GBV decreases global gross domestic product by roughly 2% per year. In some countries, the annual costs of GBV have been estimated at more than 3.5% of GDP, which is double what many governments invest in educating their populations. The continuing, cumulative economic burden in terms of lost income-generation capacity is much higher. The gains of reducing the effects of violence against women and young people are massive since they will catalyse human and economic development in ways that are vital for meeting many of the Sustainable Development Goals.	The Lancet Commission on Gender-based Violence and Maltreatment of Young People will generate new tools and data to empower policy makers and promoters to scale up effective programmes in health, education, income-generation, and gender equality. The work will use the latest analytic frameworks and methods on Gender-based Violence and Maltreatment of Young People which has been grossly under-researched. An inter-sectoral, interdisciplinary approach will engage communities of thought that rarely connect, including public health, health systems, mental health, economics, law, gender, digital health and artificial intelligence, and children's rights.
Le, Cha, Han, & Tseng, 2020	Article. Anti-Asian Xenophobia and Asian American COVID-19 Disparities	Minority health disparities during the COVID-19 pandemic, particularly Asian-American groups	This year, over 1700 anti-Asian hate incidents have been documented in America from March 19- May 19, according to the STOP AAPI Hate campaign. This report is reminiscent of "Yellow Peril," or the fear that Asian immigrants were a threat to American culture. The fear led to the Chinese Exclusion Act (1882) which was the first race-based exclusion law. Ignoring interethnic subgroup data, as well as age, gender, language, and other social factors dismisses significant differences in COVID-19 and associated health risks.	Research needs to look further into COVID-19 data by Asian American subgroups. This will highlight American health disparities and the minority subgroups most impacted by the pandemic. At least seven Asian American ethnic subgroups should be considered (Asian Indian, Chinese, Filipino, Korean, Japanese, Vietnamese, and other Asian groups) for COVID-19 incidence, mortality, testing, and treatment reports.
Levesque & Thériault, 2020	Book chapter	Systemic discrimination in government services on First Nations Peoples in the COVID-19 pandemic context	First Nations peoples at higher risks for COVID-19 as a result of underfunding and discrimination in public services. The author argues that inequities in government services and programs constitute a structural barrier for First Nations communities to prevent and manage health crisis like the current COVID-19 pandemic.	Comprehensively address systemic inequities in government services and programs to First Nations communities. Focus on substantial equality to address the needs of these communities.
Roesch, et al. 2020	Editorial. Violence against women during covid-19 pandemic restrictions	Gendered effects of the COVID-19 pandemic	An average 30% of women are subjected to physical or sexual violence by an intimate partner in their lifetime. This is especially prominent during humanitarian crises, including conflict and natural disasters. However, the gendered impacts of infectious disease epidemics are less understood. For women stuck in abusive relationships, or at risk of abuse, staying in cramped conditions with family and spending more time in close contact with their abuser increases their risk of intimate partner violence. The breakdown of	Violence against women during COVID-19 responses plans should be an integral component of essential services provided by governments. These outlines should provide strategies and make them available for marginalized populations. Local support services such as hotlines, shelters, rape crisis centers and counselling should be allies to health facilities, so that survivors can be directed to such services by health services. Health care providers should be educated and trained

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			social and protective networks may further increase intimate partner violence. Women may have less contact with family, friends, and coworkers who provide support and protection from violence by a partner. Children staying at home during COVID 19 quarantine measures not only put them at risk for exposure to seeing domestic abuse but also being victims of abuse.	to identify risks and consequences of domestic violence against women. Mobile health and telemedicine can serve as an asset during a time of pandemic as it can provide support in a safe and confidential manner.
Power et. al., 2020	Editorial	Contemporary issues raised for Indigenous communities related to the COVID-19 pandemic	Indigenous Peoples are more susceptible to infectious diseases generally, because of social and health inequities that date back to colonization. Indigenous communities face intergenerational and severe poverty, poor physical and mental health, transport and housing challenges, increased rates of domestic violence, shorter life expectancy and limited access to culture-sensitive care. Crises like pandemics are usually associated with a spike in rape, sexual assault, and violence. Indigenous people worldwide are more likely to experience family violence as a by-product of colonization and historical trauma.	Responses to COVID-19 should not be generalized. We should recognize the influence of privilege, wealth, and racism in shaping social inequities, and therefore addressing these issues through culturally sensitive services. To address these issues adequately we need to understand the real impact of COVID-19 on communities through data that can provide evidence of the demand for resources like food and personal protection equipment, allowing services to deconstruct systems that perpetuate these inequities instead of replicating them.
Souza, et al., 2020	Article. Violence against women, children, and adolescents during the COVID-19 pandemic: overview, contributing factors, and mitigating measures	Effects of social distancing on interpersonal relations, such as intimate partners and between parents and children.	The measures recommended by the WHO to fight the pandemic highlight isolation of suspected cases, which entail negative repercussions on economic endeavours at all levels and life and society. And making such measures mandatory has triggered conversations and conflicts between researchers, business, and government officials on public policy to provide economic support for poor communities. One issue that has received little attention from members of the COVID-19 crisis committees involves the repercussions of social distancing on interpersonal interactions, especially between intimate partners and between parents and children. The dynamics of families with young children and adolescents have required greater effort by parents and guardians who need to resolve, housework, and care for the children. At the community level, competition for limited resources, restricted functioning of many services for the protection of children's and adolescents' rights, and the reduction of social networks can increase the risk of violence.	Services for children's rights via person or telephone (WhatsApp or other cell phone apps) should be accessible 24/7. Complaints should be processed quickly to ensure establishing urgent protective measures. Advertising campaigns with a focus of bringing awareness of spousal and child abuse should be more prominent. Support programs for women, children and adolescents in situations of violence should be strengthened. These programs should provide services like social assistance, legal aid and psychological and physical healthcare. Women in situations of violence should practice social isolation in the company with other family members besides the abusive husband and children. Women should have their cellphones secure, as well as the telephone numbers of family members and friends that they can count in emergency situations.
Van Gelder, 2020	Comment. COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence	Effects of the COVID-19 pandemic in the rise of IPV	There are similarities in the measures implemented to control the spread of COVID-19 and tactics used by partners that are abusive. Survivors have characterized these abusive tactics in their relationship as social isolation, functional isolation, surveillance and monitoring of daily activities. Hence, COVID-19 measures can exacerbate the exposures, worsen psychological and economical issues and perpetuate negative coping mechanisms such excessive alcohol consumption. Recent data suggests increasing IPV due to quarantines in Australia, Brazil, China and the United States. Consequently, other nations should expect similar increasing rates and ensure preparedness for such issues.	Health care providers need to be appropriately trained to identify signs of violence and individuals that are at risk. Public awareness on IPV during COVID 19 through means of media and social media will help disseminate information to the general public and provide resources for those who need it. A buddy system and emergency contacts can foster the creation and sustaining of a support network when an IPV victim feels isolated. Websites can replace in person support in which those experiencing IPV can be aware of quickly exiting page and clearing browsing history as their abusers may be monitoring phone and internet use. Services such as shelters and trauma informed counselling for victims should be available for those who need protection. Funding for these services increased.

Appendix 2. Description of Grey Literature Selected Articles

Author/institution	Type of document	Focus/objectives	Findings	Recommendations
Abji, Pintin-Perez, & Bhuyan, 2020	News Article	Impacts of COVID-19 on non-status women	Non-status women are invisible in the COVID-19 public health responses and support programs. Non-status women play an important role, they are frontline key workers - cleaners, domestic workers, personal support workers, and cashiers; therefore, they are at higher risk of the pandemic. Furthermore, they are not considered within the current emergency support programs due to their migration status.	Grassroots community organizations have pointed out that efforts to flatten the COVID-19 curve should include funding for shelter, emergency housing, health care, universal childcare, food, and legal services for non-status women to regularize their migration status.
Astrup, 2020	News Article	Explores the worrying surge in domestic abuse during the Covid-19 lockdown and what is being done to address it	About 76% of domestic abuse services have significantly reduced the amount of services they provide since the pandemic with a third of 119 services report a decrease in staff. More than one out of five of these services are not prepared to accommodate adult victims of violence under pandemic regulations with 42% stating they would not be able to support children.	A team of volunteers working towards increasing the visibility of victims of abuse is essential by making calls and checking in on them. This will alleviate some pressure currently faced by services. Adverts can raise awareness of violence and provide information on available resources. This strategy has been effective on social media through hashtags such as #YouAreNotAlone that remind people that help is still available.
Bielski, 2020	Newspaper article	Provides recommendations to address intimate partner violence during the COVID-19 pandemic	Staff at Interval House Toronto reverted to helping women through emails as several women who had called for assistance were not able to call again for lack of privacy in the home. Most victims of IPV leave when the perpetrator is at work. However, with mass layoffs, the perpetrator is mostly at home with increased economic stress that also limits women's ability to leave as some may be financially dependent on their partner. Additionally, the abusive partner may be financially supporting the entire family, with daycare and school closures, this leaves children vulnerable to violence as well. Therefore, mandated self-isolation is dangerous in enabling perpetrators to actively isolate women from their social network and support.	Educating the public on the warning signs of abusive relationships, how to support victims, building safety plans for leaving, and providing references to resources are strategies that have been implemented at the Western University centre. Neighbours, friends, family members and co-workers should pay special attention to those at risk of domestic violence and are encouraged to provide any assistance. Women who are not able to call centres for assistance may be helped via email. In shelters, a few provincial shelter associations are advocating for prioritized COVID-19 testing for symptomatic women and members of staff.
Centers for Disease Control and Prevention (CDCP), 2020	Report	Outlines some of many social determinants of health that should be considered to achieve health equity across racial and ethnic groups	Social determinants of health put racialized and minority groups at a greater risk of contracting and dying from COVID-19. E.g. 1.) Discrimination: it exists in many systems that are meant to prioritize the well-being of all people including health care, housing, education etc. 2.) Healthcare access: limited by lack of transportation, childcare, days off work, language barriers and cultural differences. Minority groups may also distrust government and healthcare systems. 3.) Occupation: minority groups make up most essential workers in healthcare facilities, factories, grocery stores, and transportation. Consequently, they are more exposed to the virus. 4.) Education and wealth gaps: barriers to quality education can lead to higher school dropout rates and lower college enrollments.	Community organizations, employers, healthcare providers, public health officials, policy makers, play a role in promoting equitable access to health to respond to and prevent the spread of COVID-19. This can be achieved with easily accessible information, affordable testing, medical and mental health services. These services should be shaped by the communities in which racialized, and minority groups reside, learn, work, play, and worship.
City of Toronto, 2020	Report	A daily update of COVID-19 cases among Toronto residents and	Health is influenced by how and where we live, work, and play. Evidence strongly suggests that racialized and low SES groups are more at risk of COVID-19. The reasons for this are uncertain but may include: 1.) Longstanding health disparities associated with social and economic factors. 2.) Stress stemming from racism and other forms of	Toronto Public Health and partner organizations can use this information to reduce the disproportional impact of COVID-19. Furthermore, collaborating with community agencies that work with groups who are over-represented in COVID-19 infection data. This will foster group-specific health promotion

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		outbreaks in Toronto	discrimination. 3.) Barriers to treating or preventing COVID-19, e.g. difficulties in limiting COVID-19 exposure because of work, and the challenged of physical distancing because of overcrowding. 4.) Inequitable access health and social services.	communications and increased focus on testing areas with higher infection rates. The social determinants of health should be a priority in COVID-19 responses. Other levels of government should be incorporated in sustainable planning and advocacy for equitable health and social services.
Cortez, 2020	Congressional Documents and Publications	Letter led by U.S. Senator Bob Casey urging Senate leadership and appropriators to support emergency funding to the Department of Health and Human Services for family and domestic violence programs.	In the USA, the Coronavirus Aid, Relief and Economic Security Act provided funds to address the demands in services and supports for victims of domestic violence. Although it was a great start to addressing the issue, more funding is required to cater to the needs of victims and survivors. Therefore, there is an increased demand in victim service providers across the country, but the providers are not equipped to deal with the novelty and complexity of cases during the pandemic. Rural/remote areas a experiencing the same influx in cases with further limitations as they do not have the resources or capacity to shelter these women and girls. As such, disparities in shelter and resources in American Indian and Alaska Native communities is intensified by the virus as many of these communities already experience overcrowding in homes and compromised sanitation or running water.	Tribal sovereignty should be acknowledged, and resources channeled in response to violence and equity in American Indian and Alaska Native communities. Increasing capacity of shelters and establishing Tribal advocacy programs can increase the safety and well-being of Native women. Relationships should be established between these communities and federal departments as they do not have access to information and responses online. Regarding children at risk of violence, face-to-face visits may be required, in that case, appropriate protective equipped should be provided.
CREVAWC, 2020a	Infographic	Contributing factors to risk and vulnerabilities associated with intimate partner violence in immigrant and refugee communities	Risk factors include unresolved pre-migration trauma, post-migration strain and stigma, stress associated with migration, changes in husband and wife’s socioeconomic statuses, power imbalances between partners, change in social networks and supports, loss of culture, family structures, and community leaders, geographic and social location, economic insecurity resulting from lack of recognition of educational and professional credentials, acculturation level, and changes in gender roles and responsibilities.	The infographic does not include specific recommendations.
CREVAWC, 2020b	Infographic	Identifies the barriers to reporting and disclosing violence and seeking help	Immigrants and refugees face barriers to reporting and disclosing violence and seeking help including fear of loss of children due to apprehension, deportation, or divorce, discrimination and racism within service delivery system, limited knowledge about laws, rights, and domestic violence services, social isolation, fear of deportation due to precarious immigration status, and social stigma surrounding disclosure of domestic violence, among others.	The infographic does not include specific recommendations.
CREVAWC et al., 2020	Publication	Cross-cutting risks and GBV recommendations in Canada, focus on 2SLGBTQ+, Indigenous, Black, and ethnic minority communities	GBV is a side effect of crises. Risk perceptions and changes in social and health services may impact on individuals facing violence. Xenophobia and stigma increase risks for marginalized people. COVID-19 measures (e.g. social distancing) generate the conditions for violence and create barriers for survivors to escape these situations. COVID-19 related prevention strategies reinforce inequalities and expose members of marginalized communities to new forms of exploitation.	Collect data on various indicators to broaden our understanding of multiple impacts and factors that increase vulnerability to violence. Apply an intersectional and gender-informed approach to GBV prevention strategies. Ensure localized services and promote safety nets (housing, income). Incorporate diversity of views and lived-experiences from people from diverse, marginalized, and racialized communities in COVID-19 responses. Integrate GBV into health emergencies plans.
EIGE, 2020	Website	The gendered issue of COVID-19. Makes	The is currently no European Union-wide data on GBV that can be compared but countries such as France and Lithuania have started reporting cases during the lockdown and comparing them to previous	The issue of gender-based violence should be at the front and centre of policy decisions, multiple sectors in society should be involved in a coordinated response to COVID-19 and gender-

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		suggestions to policymakers.	years' cases. This has revealed a significant increase of cases during the pandemic.	based violence, and data collection should be centralized to facilitate an efficient analysis revealing drivers and trends.
Enekwechi, Hardeman, & Powell, W. (2020)	Webinar	Health inequities, social determinants of health in the context of COVID-19 - Black, Indigenous, and racialized population (Latinx, American Indian, Alaskan Native)	In the context of the United States, structural racism is the root cause of health inequities/disparities, and more evident during the COVID-19 pandemic. Disparities exist among Black, Latinx, American Indian, Alaskan Native, and Pacific Islander populations. Disparities are associated to complex and interrelated issues, related to access to health and mental health services, socioeconomic disparities, and the impacts of structural inequities and discrimination.	Promote leadership, and put in place funding, investments, to support marginalized racialized communities. Provide universal health care regardless of employment status. Transform the current health insurance model that runs counter the actual needs of marginalized populations. Ensure everyone has access to housing, and other SDOH. Address issues around the closure of health facilities in rural and African American communities, so to address access issues in the context of the COVID-19 is essential. Promote policy changes at the local level, for example childcare, and other related to SDOH. Address mental health gaps in communities at greater risks and with higher disparities, promote better access points to increase access for vulnerable populations.
Fraser, 2020	Research report	Review of literature. Evidence on the impact of the COVID-19 virus pandemic and other similar epidemics on violence against women and girls	The literature review provides insights about lessons from previous health emergencies. There are gaps in the literature regarding changes in the level of violence and the process through which this occurs, context-specific data on overlapping identities e.g. older women, refugee or migrant women, specific influences of pandemics on violence against women and girls and reliable documentations of effective responses to violence during the pandemic. Impacts of the pandemic on violence against women and girls is most likely to be severe in countries with weak health and justice systems.	Based off previous epidemics, we may benefit from a 'twin track' approach which combines directing organizational support to survivors and incorporating VAWG into responses through health, education, child protection, security and justice, social protection, and financial security. Many other relevant recommendations from around the world are provided.
Gopal & Adesara, 2020	Blog	Addresses racism and health inequalities	Ethnic minorities disproportionately seek intensive care and are among a large portion of COVID-related deaths in the UK. This has also been reflected in the USA. Maternal mortality rates among Asian and Black women are double and five times higher than white British women. Social factors such as increased unemployment, stress, and poverty in combination with disparities in health and life expectancy. Therefore, these vulnerable communities are severely impacted by cuts in funding especially among racialized women. These socio-economic factors have been highlighted during the pandemic.	Healthcare providers should incorporate a cultural safety model or culturally sensitive practices to combat the effects of bias and unevenly distributed power dynamics that perpetuate racial disparities. Politicians should be aware of the harmful effects of budget cuts in public services. A race equality observatory was launched to collect and assess race-based data to reveal disparities in health and healthcare.
Ho, 2020	Newspaper article	Enforcement of COVID-19 measures is disproportionately impacting Black, Indigenous, and marginalized communities	Discussion of a report that highlights that COVID-related fines are disproportionately impacting Black, Indigenous and other marginalized groups, in the provinces of Quebec, Ontario and Nova Scotia, Canada.	Racialize members of the community need social and health supports, not punitive law enforcements.
IPU, 2020	Guidance Note	Provides guidance to parliaments around the world in relation to COVID and gender.	Women make up about three quarters of healthcare workers providing services during the pandemic and play key caring roles in other dimensions of society as heads of households and various essential work. Women also form the majority of refugee and internally displaced communities. Accessing services, in these conditions, is difficult and women are at higher risks of domestic	The COVID- 19 response should be based on gender-related decisions and actions. Resources should not be channeled away from sexual and reproductive health services as this violates the rights of women and girls by jeopardizing their health and agency.



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			violence and exploitation under these circumstances. Most women are marginalized from tax-funded health coverage and other social benefit protections because they work in the informal sector. In the formal sector, they are mostly the first to lose their income in crisis.	
Junker, 2020	News article	Explores the different ways the pandemic may hide domestic violence and probable strategies and responses to help women	Findings appear to be contradictory as some police report an increase in cases and others a decrease in cases. However, those experiencing a decrease in cases report an increase in the severity of the cases. Edmonton Police have encountered a lot of cases such as aggravated assaults and sexual assaults that require specialized investigation by domestic crimes detectives. Domestic violence is characterized by power dynamics and controlling behavior that isolates women from their family and friends. Therefore, with pandemic restrictions, forced isolation may be hard to identify which enables perpetrators to withhold necessities from victims such as hand sanitizer or threaten to cancel insurance.	Responses to counter domestic violence during the pandemic include increased vigilance and preventing forced isolation of women by formulating new means of communication to check in on them. Family, friends and coworkers may also help victims by learning the signs of domestic violence that could be hidden during the pandemic. Women’s shelters are innovative and learning from the pandemic to cater to the indications of domestic violence that are unique to the pandemic. It may be effective to look at an alternative service delivery that addresses the current gaps in service, leading us toward resolve. Incorporating over the phone counselling, support, organizing various arrangements and working with different safety plans that consider the needs of women at the core.
Maitra, & Savage-Borne, 2020	Report	To share the compounded challenges survivors face when intimate abuse intersects with structural violence	Adhering to COVID-19 restrictions, shelters have less beds available and paused lotteries. As such, many survivors of intimate partner violence have no where to go especially considering that the COVID-19 response has been marked with a rise in violence. With strapped resources, some survivors are hard pressed, homeless, and unemployed with many social stressors. Survivors from racial and ethnic minority groups are hesitant about going to shelters because they could experience further harm or targeting because of their cultural identities. Transgender survivors are also at risk of being persecuted at shelters based on their gender. Immigrant survivors’ precarious status deters them from involving the police or the law.	Considering the negative impact of COVID-19 guidelines on intimate partner violence, safety needs to be understood under a broader definition because it is not absolute. It is social, systemic, and structural. Survivors experience great difficulty disclosing abuse, for fear of their partner’s retaliation, judgment by service providers, or pressure to act. We need to empower survivors to shape interventions that cater to their needs, to encourage them to seek help the next time. Otherwise we would be replicating the power dynamics and control embedded in their relationships with the perpetrator within our healthcare service delivery.
NCLW et al., 2020	Issue Alert	Provides updates on gender issues in Lebanon, compiles data to inform programs and offers recommendations to combat gender issues related to GBV	It has been expressed that some forensic doctors were unable or reluctant to officially document physical abuse of survivors at police stations in fear of contracting or spreading COVID-19. The most vulnerable are victims of trafficking who are forced into sexual favours despite the risk of contracting and spreading COVID-19.	Violence against women should be carefully monitored across diverse identities and groups (e.g. immigrants, those with disabilities and elders). Recommendations for the government of Lebanon include making services accessible e.g. making domestic violence hotlines free of charge, equal gender representation in police dealing with GBV, ensuring survivors can attend court proceedings via video conferencing and provide access to life-saving by training responders and healthcare providers in the current conditions.
OCASI, 2020	Report	Environmental Scan – Building Leadership Capacity to Address Gender-Based Violence against Non-Status, Refugee and Immigrant Women Across Canada	Migrant women with precarious status face a greater risk of violence and abuse. Women in abusive relationships are less likely to report abuse or access support and shelter services if they fear that doing so would put their families’ immigration status at risk. Grassroots and community-based interventions are an effective strategy to address GBV but there is a lack of funding to support these strategies. Results from the environmental scan highlight the need to foster a national network among survivors of GBV, their advocates, and frontline	Organizational leaders, advocates and community members recommend the need to include and centre women’s organizations and non-status, refugee and immigrant (NSRI) survivors of GBV in COVID-19 response efforts suggesting that the issues and unique challenges faced by NSRI women who experience GBV in this context was, in fact, already a crisis.

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			service providers using a community-based approaches to address violence.	
O'Donnell, Peterman, & Potts, 2020	Blog	Pathways linking pandemics and violence against women and children	Factors that explain how the context of the current COVID-19 and previous pandemics, interrelates to violence against women and children include poverty, social isolation, increased unpaid caregiving work, reduce and closure of services, increased power control behaviours against victims. racism, discrimination and stigma against Black, Indigenous, Asian, Latino, and other communities.	Reinforce violence-related first-response systems, health systems' responses to pandemics should integrate violence against women and children, expand social and economic safety nets, expand shelters and housing for survivors.
Onyango, 2020	Blog	Draws lessons from Ebola that apply to the COVID-19 pandemic.	COVID-19 disproportionately threatens the health of women and girls because the pandemic safety regulations leave them in vulnerable situations. They experience domestic violence, IPV, child abuse, and various forms of sexual and GBV because a crisis intensifies gender inequities and power hierarchies coupled with economic tensions, stress, and uncertainty. Under these regulations, survivors of abuse do not have the opportunity to distance themselves from their abusers or seek and attain support. This was observed in West Africa during the Ebola crisis of 2013-2015, specifically the response to control the spread of the virus.	Preventative and controlling measures of GBV must be implemented governing bodies in society as well as different sectors to achieve a top-bottom and bottom-up response. Independent women's groups are the single most influential force in addressing GBV. Therefore, women should be involved in the development of responses. Governments should channel resources to organizations that are already involved in addressing issues related to GBV and supporting women and girls. Community leaders should also play a central role in containing the virus and mitigating violence within the community.
Rezaee, 2020	Article	Women, girls and gender-diverse communities' experiences to help formulate a clear understanding of COVID-19 impacts	Data from several federal agencies suggests that women in Canada are more likely to contract and die from COVID-19 than men and have their quality of life or safety threatened by the virus. Racialized women are at higher risk of COVID-19. Women occupy most minimum wage, frontline health, cleaning, and social services jobs, that expose them to the virus. Women make up 90% of Canadian nurses, 75% of respiratory therapists and 90% of personal support workers in long-term care and nursing homes.	An intersectional gender approach should be incorporated in recovery efforts because gender overlaps with class, race, Indigeneity, immigration status, ability, sexuality, gender expression, geography and other attributes that exacerbate inequalities and facilitate marginalization, poverty, and violence. Therefore, being a woman is not a singular experience- a 'one-size-fits-all' approach to COVID-19 will not adequately address the needs of women and girls concerning heighten gender-based inequalities or social and economic disparities.
Roush, 2020	Blog	Critically analyzes the 'invisible' danger of pandemic 'safety' measures	The frequency and intensity of IPV is increased by the uncertainty, stress and unemployment that has developed during the pandemic. This trend also occurred during the 2007-2008 economic recession. However, the pandemic poses a threat to physical and mental health as victims spend more time with their abusive partners and become hypervigilant (increased possibility of post traumatic stress disorder). Furthermore, survivors of IPV may fear contracting the virus at the hospital and may not adequately nurse or treat their injuries. This reduces the possibility of seeking and attaining support as medical practitioners usually refer survivors to mental health and social services.	It is important to proactively communicate with anyone at risk of abuse by not waiting for them to initiate communication. A strategy may be to video call them. Be aware that the abuser may be listening in even in textual communication, but it is important to provide emotional support despite limited freedom to communicate on the side of the victim.
Senior, 2019	Blog	Racialized mothers' specific needs	Racialized, visible minority women, and Indigenous women, earn less than non-visible minority, non-Indigenous women. They are also more likely to be underemployed or unemployed compared with white women.	Promote leadership and participation of racialized women in decision-making positions. Address the structural gender, racial, and socioeconomic inequalities experienced by racialized communities, for example, equitable pay for racialized and Indigenous women. Ensure institutional accountability.
Siangyen, 2020	Blog	Addresses gender inequalities in Asia's	About half of the women and girls in the world are in Asia and in many regions of the continent, they are predominantly disadvantaged due	Non-discriminatory health information and services are a priority. Data on the impacts of COVID-19 should be sorted by

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		response to COVID-19.	to poverty, violence, exclusion, and discrimination. Plan International assessed the circumstances faced by women and girls across six domains: health, education, protection, economic opportunity, representation and laws and policies to assess where countries in the region stand in relation to gender-equity. This showed that, before the pandemic, discriminatory attitudes, and actions marginalized women, limiting their ability to navigate through their own lives and goals.	sex, age, and disability and assessed along those trends, consistently across the world. This is important to facilitate differential responses accord to the context-specific demands of that population.
Statistics Canada, 2020	Infographic	Canadian visible minorities' perceptions of safety during the COVID-19 pandemic	Minority groups are more likely to report feeling unsafe which can negatively affect their health, both physically and mentally. As evidenced by the COVID-19 pandemic 21% of visible minority participants believed that harassment or violent incidents based on race or ethnicity in their neighbourhood occurred twice as much as the proportion among the rest of the population (10%). The rest of the population perceived a 6% increase in the occurrence of harassment or violent incidents based on race, ethnicity, or skin colour. Whereas visible minority participants perceived an increase of triple the percentage (18%). More than 1 in 3 visible minority women, reported feeling unsafe when walking alone at night, compared with 1 in 5 men.	The infographic does not include specific recommendations.
The COVID Tracking Project, 2020	Data report	COVID-19 is affecting people of color the most through up-to-date race and ethnicity data on COVID-19 in the United States	In America, Black people are dying at double the rate of white people (4,797 Black lives at the time). About 20% of COVID-19 deaths have been Black people where race was reported. Race-based data provide a partial understanding of the inequities faced by people of color on a state-level because many states are deeply segregated which means that counties in the same state can have various breakdowns of communities by race and ethnicity.	The data report does not include specific recommendations.
UNDP, 2020	UNDP brief	GBV during COVID	243 million women and girls have been subjected to abuse by their intimate partner (includes sexual and/or physical abuse).	Strategies targeting GBV should be implemented in COVID responses. The brief provides guidelines to approach this issue. Strategies include incorporating women's organizations in COVID response plans, implementations, and assessments by connecting extensive networks and formulating strategies through diverse perspectives (e.g. legal or human rights).
UNICEF, 2020	Technical Note	Recommendations for gender equality in the COVID-19 response.	Tertiary hospitals and frontline service providers may be overwhelmed by COVID-19 cases and momentarily incapable of providing life-saving care and support to GBV survivors. Women and girls disproportionately bare the burden of pandemics because they are the primary caregivers to ill family members and with school closures, they spend more time caring for the children (unpaid care work). School, for girls, provides nutritional benefits and social connection. Most girls do not go back to school after pandemics. This and other factors increase the gender livelihood gap.	The GBV Pocket Guide and app (https://ureport.in/) can teach service providers how to handle GBV disclosures (includes unique approaches for teenage girls) and provides resources at the community level addressing different approaches to and aspects of GBV during the pandemic. Support women's and girls' networks to provide connectivity and information to substitute for conventional social support during social distancing. Provide women with financial tools toward economic empowerment and resilience in severe conditions that may occur again in the future.
UNFPA, 2020a	Interim Technical Brief	To advocate for the rights of women and girls during the COVID-19 pandemic	Epidemics make inequalities between women and men and other vulnerable/marginalized groups worse. They possess less power to influence decisions, rendering issues that directly affect them invisible. Women are more likely to be informally employed or carry out informal work which does not guarantee them financial security in difficult and uncertain times. Responses may benefit from different	Expand service delivery through remote modalities (case management and psychosocial support) with adequate training and support for staff in this new territory. Additionally, clinical, forensic and dignity kits should be available. Programs should ensure the safe and ethical collection and use of gender-based

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			perspectives that will counter for intersecting forms of violence against women and men.	data GBV data which includes reviewing and improving current programs.
UNFPA, 2020b	Technical brief	Providing recommendations for pandemic responses with a specific focus on pandemic effects on women and girls	Gender inequalities increase in extreme conditions like pandemics, which heightens the risk of abuse, affecting the treatment and care women and girls receive. This is because increased tension in the household exposes women and girls to intimate partner or domestic violence and other gender-related abuses such as sexual exploitation. It is important to highlight that social discrimination and inequalities predispose certain groups and individuals to infection, influencing women’s vulnerability to infection, exposure, and treatment, for example.	Services should adapt a survivor-centred approach that equips healthcare workers with the skills and resources to address the instances of gender-based violence, as disclosed to them by the survivor. Service providers are advised to maintain confidentiality and practice empathy and sympathy. An efficient feedback mechanism is critical in keeping details of changing services up to date through out the extensive referral pathway. National partners should be wary of the intersection of gender and pandemic regulations (among multiple overlapping identities such as disability, sexuality) to formulate sensitized responses to the pandemic whilst ensuring that the safety, dignity, and rights of the people are not infringed. This can be achieved by investigating the primary and secondary effects of health emergency on communities and individuals with the protection of women and girls at the centre, preventing the reproduction or perpetuation of gender inequalities.
UN Women, 2020a	Brief	Emerging evidence on the effect of the pandemic on GBV and recommendations	Although Intimate partner violence is the most common violence against women and girls, violence toward women occurs in various contexts at the familial, community and societal level.	Several recommendations are suggested, including treating services for survivors of violence as essential services, providing psychosocial support for these women and girls and repurposing different spaces such as empty hotels to accommodate survivors that would depend on shelters (increases capacity).
UN Women, 2020b	Brief	Reveals a trend in violence against women and children in public spaces, provides recommendations	One out of three women experience sexual harassment in public spaces, in Canada. This continues to occur during the pandemic with other forms of violence in parks, public transport, the streets and online. Social distancing measures have decreased the amount of people on the streets which also decreases the safety of women in these public spaces.	Strategies should reach vulnerable groups such as women experiencing violence and incorporate far-reaching technology-based solutions (SMS, online tools and social networks) with a sensitivity to connectivity and digital literacy. Mobile justice units that adhere to social distancing regulations can be used to reach survivors of violence in remote areas.
UN Women, 2020c	Brief	Trends and implications of providing essential services for survivors	Frontline service providers in the UK have expressed remote technical difficulties (e.g. IT problems) when delivering services online or by phone under the current pandemic regulations. Other challenges are analyzed in the context of the current COVID-19 pandemic.	Interventions and programs should be monitored and evaluated on success or effectiveness to determine their efficiency and efficacy. To address implementational needs, for example, police in other departments can be deployed to address the influx of cases on violence against women and girls.
UN Women, 2020d	Complementary note	Summarizes data collection principles and recommendations	Domestic helplines, police and shelters report an influx of calls since the onset of the COVID pandemic. Others report a significant decrease in calls and use of services since lockdown measures were implemented, decreasing women’s access to these services. Pandemics pose a threat of increasing, not just domestic violence but other forms of violence against women and girls. Some may have intersecting marginalized identities that make them more vulnerable e.g. immigrant women.	Challenges to data collection and storage should be addressed (e.g. remote services may not provide necessary privacy, confidentiality, and protection of sensitive information). If it is not addressed adequately then prevalence data of violence against women that could shape and inform policy and programs will not be attained during the pandemic. Provides recommendations for data collection in the context of the COVID-19 pandemic.
WHO, 2020d	Website	Outlines an informative plan with suggestions of	Violence against women inflicts their human rights. Immediate impacts of violence include mental, sexual, and reproductive health problems such as sexually transmitted infection, HIV and unplanned	The main priority when experiencing violence is to stay safe. Enhancing your support network to family, friends, and neighbours to attain help from a hotline or online survivors of

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		steps to take when experiencing violence at home	pregnancies. In the long term, violence against a woman can impact her quality of life and/or be cause of death. Those who displaced, migrants or refugees and those living in conflict- affected areas, older women and women with disabilities are influenced by determinants that make them much more vulnerable to violence.	violence. Seek help from local services such as shelters or counselling if they are available and open. It is crucial to have a safety plan in place in case the violence escalates. This includes: having a neighbour, friend, relative, colleague or shelter to go to in the event of needing to leave the house immediately for safety.
Women Services Network, 2020	Toolkit	Best practices for frontline workers on service provision for victims of abuse through mobile delivery	Mobile devices allow frontline workers to complete tasks away from their place of work. This makes their services accessible to large geographic and rural areas. Smart devices, laptops and tablets assist frontline workers in communicating with survivor and upload or update paperwork. Regardless of the benefits of mobile devices, frontline workers need to be mindful of the security and safety issues surrounding mobile devices.	Some recommendations include to refrain from using personal devices as a tool for care provision. Confidentiality obligations can be breached when family or friends use the device that contact details of the survivor. Agency mobiles should not be accessed by unauthorised users. It is crucial to have the device operating systems, software and apps updated. This is to ensure that security systems in place are up to date and resolves and security issues. In addition, reviewing security setting not only strengthened it but also help locate and/or remotely delete the device data if it is misplaced or stolen.
Wulfhorst, 2020	Newspaper article	Sentiments of Black women and their experiences as first-time protesters	Recent protests in New York City were marked by smashed windows, looted luxury stores and arson. Four police officers were shot and injured in St. Louis, and one severely injured in Las Vegas. The most recent of many deaths, Floyd’s death, brought attention to the problematic conduct of the police, particularly racial violence against African Americans. George Floyd’s killing was during the COVID-19 pandemic that has disproportionately affected black Americans and created economic instability that has cost them their jobs.	The newspaper article does not include specific recommendations.
Yang et al., 2020	Newspaper article	Public health report on impacts of COVID-19 in Toronto	Racialized neighborhoods are the hardest hit by the COVID-19 pandemic. COVID-19 rates in Toronto are more than 10 times higher in racialized neighbourhoods than in the least-impacted ones areas. These communities face food insecurity, unemployment, lack of affordable and safe housing.	The authors do not provide explicit recommendations, they analyze broader social determinants of health of marginalized communities.

Appendix 3. Project Knowledge Translation Outcomes

INFORMATION SHEET

Khanlou, N., Ssawe, A., Zahraei, S., Connolly, JA., Pashang, S., Bohr, Y., & Vazquez, LM. (2020). **Gender-Based Violence and the COVID-19 Pandemic: Risk Factors and Systemic Challenges.** Information Sheet 16. CIHR Knowledge Synthesis Grant, York University. <https://cihr-irsc.gc.ca/e/52062.html>

INFOGRAPHIC

Gender-Based Violence During COVID-19 Pandemic: Considerations to Promote Mental Health of Racialized Women. CIHR Knowledge Synthesis Grant. York University, South Riverdale Community Health Centre, OCASI. <https://cihr-irsc.gc.ca/e/52062.html>

TOOLKIT

Khanlou, N., Pashang, S., Connolly, JA., Ssawe, A., Bohr, Y., Zahraei, S., & Vazquez, LM. (2020). **Mental Health Supports for Racialized Women at Risk of Gender-based Violence. A Toolkit for Service Providers and Advocates.** CIHR Knowledge Synthesis Grant (2020), York University. <https://cihr-irsc.gc.ca/e/52062.html>

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Khanlou N. (2020). Guest Editorial Special Issue: Health of Frontline Workers during the COVID-19 Pandemic. *Journal of Concurrent Disorders*. <https://concurrentdisorders.ca/current-issue/>

INVITED PRESENTATIONS

Niel U & Khanlou N. (4 August 2020). **Learning from Black mothers of persons with disabilities: Reframing policy and practice during the COVID-19 pandemic.** American Academy of Developmental Medicine and Dentistry. Virtual Grand Rounds. https://www.youtube.com/watch?v=zD2sodSDFPg&feature=emb_logo

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Khanlou, N. (2020). **Media Interview. York University receives funding to advance mental health supports for racialized women during pandemic**. Y-File: York University’s News (10 June 2020). <https://yfile.news.yorku.ca/2020/06/10/york-receives-funding-to-advance-mental-health-supports-for-racialized-women-during-pandemic/>