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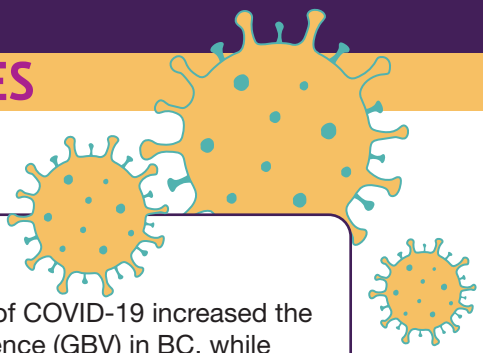
Gender-based Violence

EXAMINING THE SOCIETAL CONSEQUENCES OF THE COVID-19 PANDEMIC



Key Findings:

- The COVID-19 pandemic and response measures to limit the spread of COVID-19 increased the risk, and likely also the prevalence and severity, of gender-based violence (GBV) in BC, while reducing access to related support services.[1,2,3]
- The number of calls to the Battered Women's Support Services crisis line in Vancouver significantly increased during the first month of COVID-19.[4]
- Data gaps make it difficult to accurately understand the prevalence of GBV in the BC population, how often it occurs, and the associated short- and long-term impacts on mental, emotional, physical, and spiritual health and wellness.
- GBV disproportionately affects some populations including gender diverse and non-binary people, those who identify as 2SLGBTQQIA+,[a,5,6] immigrants and refugees, people of colour, Indigenous women and girls,[2,7] individuals living with disabilities, people in rural and remote areas, sex workers, children (especially girls) and youth, pregnant people, and new parents.[8]
- The report *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*[9,10] confirmed that due to structural racism and impacts of colonization, Indigenous women, girls, and Two-Spirit people are at higher risk of violence. The National Inquiry into Missing and Murdered Indigenous Women and Girls issued 231 Calls to Justice that have yet to be fully addressed by either the Government of Canada or the Government of British Columbia.[11]

a 2SLGBTQQIA+ stands for Two-Spirit, lesbian, gay, bisexual, trans, queer, questioning, intersex, and asexual. The plus sign acknowledges the many sexual and gender minority peoples who do not otherwise see themselves reflected in this umbrella acronym.

Situation

The COVID-19 pandemic and measures put in place to protect British Columbians from the spread of COVID-19—specifically those encouraging isolation or sheltering in place early in the pandemic—may have increased overall life stressors (e.g., financial strain, lost jobs, suspension of in-school learning) for some people. In some cases, these measures also put people experiencing, or at risk of, violence into closer and more sustained contact with abusers. The cumulative impacts of these factors likely contributed to increased risk of gender-based violence (GBV) and substantial increases in both the prevalence and the severity of GBV in BC during the pandemic. GBV has become known, in Canada and around the world, as the "shadow pandemic."[1,2,3]

BC Centre for Disease Control
Provincial Health Services Authority

British Columbia | Office of the Provincial Health Officer

If you fear for your immediate safety, have been injured, or are thinking about harming yourself:

- Call 9-1-1 (if available in your community) or your local police station.
- Go to a hospital emergency unit.
- Call or text VictimLinkBC: **1-800-563-0808** toll-free, any time, day or night—for crisis support and information for victims of family violence, sexual violence, and all other crimes.
- Call the Crisis Centre of BC: **1-800-SUICIDE (1-800-784-2433)** toll-free, any time, day or night—for immediate, non-judgmental support and resources.
- Contact the 24/7 crisis line of Battered Women's Support Services at **1-855-687-1868**, or text **604-652-1867**.
- The Hope for Wellness Help Line is available for Indigenous people across Canada, 24/7 at **1-855-242-3310** or via online chat at www.hopeforwellness.ca.
- The Indian Residential School Survivor Society (IRSSS) operates a crisis line for First Nations people in BC that is available 24 hours a day for anyone experiencing pain or distress as a result of their Residential School experience. If you need assistance, please call **1-800-721-0066**.

Find Anti-violence Services, Transition Houses, and Safe Homes in BC

- Ending Violence Association of BC: https://endingviolence.org/need-help/services/
- BC Society of Transition Houses: https://bcsth.ca/get-help-now/

Background

What is Gender-based Violence?

Gender-based violence (GBV) is violence committed against someone based on their sex or gender identity, gender expression, or perceived gender. It can be physical, emotional, psychological, or sexual in nature, and can include any word, action, or attempt to degrade, control, humiliate, intimidate, coerce, deprive, threaten, or harm another person.[8] GBV is an umbrella term that includes, but is not limited to, sexual assault, intimate partner violence, criminal harassment (stalking), and violence against women and girls.[8,12,13]

Intimate partner violence (IPV) describes violence, abuse, or aggression inflicted by one partner against another in a romantic or intimate relationship (i.e., between dating, married, or common-law partners, or spouses). IPV can occur between current or former partners.[2,14] As with GBV, it includes any form of interpersonal violence (e.g., physical, sexual, emotional, financial, psychological, verbal).[15] IPV may also be referred to as *domestic violence*[15] or *spousal violence*.[16]

Violence against women and girls (VAWG) is a subset of GBV. It is important to highlight VAWG because the vast majority of GBV is perpetrated against women and girls.[17] VAWG[b] is a human rights violation,[3] in many cases a crime,[18,19] that can lead to significant short- and long-term effects for survivors and those who are exposed to or witness it. Impacts are varied, but include physical,[14,20,21] emotional,[22] and social harms,[20] as well as economic costs (e.g., labour market withdrawal, costs to the health and justice systems), and may be fatal. In Canada in 2009, the personal and systemic cost of GBV (e.g., costs

b Provincial datasets typically collect sex data (e.g., intersex/female/male) but not gender data (e.g., non-binary/woman/girl/man/boy). In many cases, however, the collection of sex data is conflated with gender by both the data collectors and the residents of BC who submit their data. While this document focuses on gender throughout, the intent is not to further conflate sex and gender.

Indigenous Peoples and Truth and Reconciliation

As the original Peoples of what is now known as Canada, First Nations, Métis, and Inuit have pre-existing rights (commonly referred to as Indigenous or Aboriginal Rights) that are recognized and affirmed by Section 35 of the *Constitution Act*, 1982. First Nations, Métis, and Inuit are distinct Peoples, and each have their own customs, practices, and traditions.

As outlined in *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, Indigenous women, girls, and Two-Spirit people face lasting and deliberate human and Indigenous rights violations and abuses. This has been especially true since the pandemic began, as evidenced by a report by the Native Women's Association of Canada about the impact of COVID-19, which found that Indigenous (First Nations, Métis, and Inuit) women were more concerned about increased gender-based violence than COVID-19. Despite these serious challenges, Indigenous women, girls, and Two-Spirit people remain strong and resilient in the face of adversity, with support from community, family, and dedicated service providers. It remains clear that efforts to address ongoing violence must include Indigenous leadership to determine, plan, and implement the most effective, culturally safe, community or Nation-driven care for Indigenous Peoples.

to the justice system, health care system, and individuals) was estimated at $7.4 billion.[25,26]

Witnessing or experiencing violence in the home, including witnessing GBV and VAWG, is an *adverse childhood experience* (ACE)[23] that can have lasting effects across generations. ACEs have been shown to activate children's physical stress response, cause long-term changes in their immune system, change brain development, increase risk factors for chronic disease in later years, negatively affect mental and emotional health, and increase risk of problematic substance use.[23,24]

VAWG is a longstanding concern in BC and is highlighted as a priority in five of the seven goals[c] in *Promote, Protect, Prevent: Our Health Begins Here—BC's Guiding Framework for Public Health*.[27] It is also included as an area of focus in numerous strategic planning and policy documents across many ministries in BC.[28,29] In 2018, 3.8 million women in Canada (about one in four women age 15 and older) reported facing unwanted sexual behaviours (e.g., unwanted sexual attention, lewd comments) in the preceding 12 months.[30]

How have the COVID-19 pandemic and related response measures affected gender-based violence?

The COVID-19 pandemic and response measures introduced to limit the spread of COVID-19 early in the pandemic changed people's day-to-day lives and resulted in changes to services and programs that may have worsened GBV, either directly or indirectly, in the following ways by:

- Increasing the risk of GBV for survivors who were distancing or self-isolating at home while living with a perpetrator, and may have been unable to flee, safely seek help, or get consent from the perpetrator to leave the home;[2,31,32]
- Reducing capacity at health and social services that could otherwise help a survivor to report, seek help, escape from, and manage outcomes of GBV;[31,33]
- Exacerbating difficulties for people living in rural and remote communities where fewer services are available, who must travel a greater distance to access these services;[34]
- Increasing the stress and related triggers of GBV perpetrators (e.g., financial impacts, unstable housing, food insecurity, lost wages, employment) in addition to potentially increasing their substance use;[31,33,35]
- Decreasing access to community interventions and personal supports for survivors (e.g., family,

c The five relevant goals from the *Guiding Framework for Public Health* are as follows: Healthy Living and Healthy Communities (Goal 1); Maternal, Child, and Family Health (Goal 2); Positive Mental Health and Prevention of Substance Harms (Goal 3); Communicable Disease Prevention (Goal 4); and Injury Prevention (Goal 5).

friends, school, place of worship, workplace, community, transition houses, personal or public transportation, insurance, gas money);[2,31]

- Reducing the ability to safely use virtual health services in the home (e.g., due to not having Internet access or a cell phone, living with a perpetrator who restricts or monitors one's access to services, lack of privacy);[2,32]
- Continuing and increasing experiences of technology-facilitated sexualized violence (e.g., illegally accessing personal information with hateful intent, stalking, malicious distribution of personal materials);[36,37,38,39]
- Increasing reluctance to seek health services because of fear of stigma and discrimination, including fear of child apprehension when disclosing family violence;[2]
- Increasing reluctance to seek support services (e.g., transition houses) due to fears of contracting COVID-19;[32] and
- Increasing reluctance to seek help due to the public messaging to avoid non-urgent visits to emergency departments or other health centres to prevent undue strain on the health system during COVID-19.[40,41]

Equity Considerations

GBV affects BC's diverse population in different ways, resulting in additional risks, related harms, and further marginalization for some groups. Some people are at higher risk of GBV due to various forms of oppression such as sexism, racism, colonialism, homophobia, transphobia, and ableism.[8] GBV is committed disproportionately against women, girls, and 2SLGBTQQIA+ peoples, particularly those who are Indigenous (First Nations, Métis, or Inuit), Black, newcomers to Canada, living in rural and remote communities, and living with disabilities.[8,12] It is important to note that these inequities are unlikely to result from a single, distinct factor.[42] Instead, they are more likely to be the outcome of intersections of different social locations, power relations, and experiences.[42] For example, for Black women, the identities of "Black" and "woman" do not exist independently of each other; people develop and connect these social

The First Nations Health Authority's Statement on the Societal Consequences of BC's COVID-19 Response

COVID-19 and the public health measures taken to respond to it have reinforced existing inequities and discrimination present in BC's health and wellness system. First Nations people in BC have been disproportionately affected by COVID-19. Data shows that First Nations people in BC have tested positive for COVID-19 at a higher rate than other residents, have had lower median ages of hospitalization and have higher rates of admission to intensive care units and death from the virus. The impact of COVID-19 on social determinants such as housing, food security, education and geography has had ripple effects on the health and wellness of First Nations in BC. This is evident in the significant increase in toxic drug deaths during the pandemic and the elevated rates of anxiety, depression and grief experienced by many First Nations people, which is further layered with intergenerational trauma and loss from past pandemics. Despite these challenges, First Nations people in BC have responded to the pandemic with strength and resilience that is grounded in culture and community. Families have found new ways to connect, support their communities and keep each other well. The First Nations Health Authority (FNHA) has worked quickly to expand virtual services, and proudly served as a partner to First Nations communities in BC to advance community priorities and ensure support and services have been available throughout the pandemic. The FNHA's full statement on the societal consequences of BC's COVID-19 response can be found at: https://www.fnha.ca/Documents/FNHA-COVID-19-Statement.pdf.

categorizations to create a complex convergence of discrimination or disadvantage towards Black women.

- **Women:** In Canada, women and girls are more likely to experience IPV than men. In 2018, 44% of women reported having experienced some form of IPV in their lifetime (since age 15).[8]
- **2SLGBTQQIA+ community:** The 2014 General Social Survey on Canadians' Safety (Victimization) showed that individuals identifying as lesbian or gay (142 per 1,000 population) and bisexual (267 per 1,000 population) were much more likely to report being victims of violent crime than heterosexual respondents (69 per 1,000 population).[43] Lesbian, gay, and bisexual individuals face challenges when looking for supports, as many supports are not tailored to their unique needs;[43,44,45] these challenges were even greater when services and supports were limited during the pandemic. In Canada, 59% of transgender and gender diverse people reported having been physically or sexually assaulted at least once since age 15—significantly higher than the 37% of cisgender people who reported the same.[8]
- **Indigenous women, girls, and 2SLGBTQQIA+ people:** Indigenous women, girls, and 2SLGBTQQIA+ people experience higher rates of violence than non-Indigenous women, girls, and 2SLGBTQQIA+ people.[7,9] The final report of the National Inquiry Into Missing and Murdered Indigenous Women and Girls ("the National Inquiry"), *Reclaiming Power and Place*, confirmed that due to structural racism and impacts of colonization, Indigenous women, girls, and Two-Spirit people are at higher risk of violence.[9] The National Inquiry issued 231 Calls to Justice that have yet to be fully addressed by either the Government of Canada or the Government of British Columbia.[11] The report *The Road to Safety: Indigenous Survivors in BC Speak Out Against Intimate Partner Violence During the COVID-19 Pandemic* presents findings from an online survey of Indigenous women and 2SLGBTQQIA+ people conducted in 2021 and 2022, findings from interviews with Indigenous women and gender diverse people who experienced IPV, as well as support workers providing services to this population.[2] Most survey respondents (85%) reported the onset of IPV during the pandemic, and 77% reported an increase in IPV.[2] Support workers shared that the violence experienced by Indigenous survivors had escalated in severity, intensity, and that they observed a shift in the forms of abuse and control perpetrated during the pandemic (e.g., from mental to physical abuse).[2] Furthermore, there were several challenges that prevented Indigenous survivors from seeking services, including housing affordability, lack of services, lack of transportation, racism, discrimination, lack of cultural safety upon receiving help, risk of social services involvement (e.g., child protection services, police, court), family separation, having a disability, and navigating underlying mental health conditions and addictions.[2]
- **People of colour:** Racialized communities already bear a disproportionate burden of stress, illness, and health inequities rooted in the structural racism that often negatively impacts the social determinants of health (e.g., safe housing, income, education, access to health care).[46,47] The existing inequities, impacts of the pandemic, and associated response measures have acted together to increase the risk of violence for racialized peoples, and exacerbated already existing barriers to culturally safe health and social services needed by survivors.[48]
- **Women, girls, and 2SLGBTQQIA+ people in rural and remote communities:** Statistics Canada reported that, in 2019, women living in rural areas across Canadian provinces reported IPV at almost twice the rate of women living in urban areas (860 versus 467 victims per 100,000 population).[8] Similarly, police-reported data from 2017 showed that rates of sexual assault perpetrated against women age 25–89 were twice as high across Northern Canada (provinces and territories) compared to the South (131 versus 57 victims per 100,000 population).[8]
- **Young women and girls:** 2019 police-reported data showed that the rate of family violence against children and youth was significantly higher among girls compared to boys (379 versus 239 victims per 100,000), and more than four times higher for rates of sexual offences

perpetrated by a family member (170 versus 37 victims per 100,000 population).[8] Self-reported data from across Canada in 2018 showed that young women age 15–24 were five times more likely than women 25 and older to have been sexually assaulted in the previous 12 months (5% versus 1%), three times more likely to have been physically assaulted in the previous 12 months (6% versus 2%), and nearly three times more likely to have been emotionally, financially, or psychologically abused in the previous 12 months (28% versus 10%).[8]

- **Transgender youth:** The Canadian Trans Youth Health Survey was launched in October 2013 across all 10 provinces and one territory. It is the first national survey asking transgender youth about experiences influencing their health. This survey showed that 23% of transgender youth (among both the national sample and BC respondents) reported being forced into unwanted sexual encounters.[49] Transgender youth face significant barriers to accessing physical and mental health care; many face rejection, discrimination, and violence at home, at school, in their communities, as well as in the health care system.[49] Furthermore, 2020 data from the Trans PULSE Canada COVID Survey showed that 5.8% of respondents reported an increase in IPV and, due to the pandemic, 7.0% had to live with someone who was unsupportive of their gender.[50]
- **Immigrants and refugees:** Among this population, fears of being reported to immigration authorities, possible deportation, and lack of understanding of their rights in Canada are often reported as key barriers to seeking supports.[51] Immigrants and refugees were especially impacted by travel restrictions during the pandemic, experiencing delays in their immigration process or that of their family members, as well as in citizenship processes.[52,53] Delays by Immigration, Refugee, and Citizenship Canada in processing immigration documentation created a backlog of immigration applications, including immigration document renewal.[54] Expired immigration documents increased fears of deportation and decreased the ability to seek support.[55,56,57] Due to language barriers and differences in cultural norms, immigrants and refugees also faced barriers to finding or using community supports and health services during the COVID-19 pandemic.[58,59,60]
- **People with disabilities:** In Canada in 2014, rates of violence against both women and men with a sensory or physical disability were twice as high as rates of violence against those without disabilities.[61] Rates of violence targeting women and men with a cognitive or mental health-related disability were four times higher than rates for those without a disability.[61] Women with a disability were also nearly twice as likely as women without a disability to report having been sexually assaulted and/or having experienced violent victimization more than once in the preceding year.[61]
- **Sex workers:** This population is already marginalized and stigmatized for their work, which often forces them to work in unsafe conditions and at increased risk of violence. Lack of access to COVID-19 income supports (i.e., Canada Emergency Response Benefit) may have made sex workers more likely to work in unsafe or violent conditions during the pandemic.[62]
- **Pregnant people and new parents:** Pregnant people are more likely to experience IPV, which can be associated with heightened harmful impacts to physical health, mental health, access to care, and ability to access social support networks, for both parent and child.[63,64,65]

Gender-based Violence Data Challenges

There are challenges and gaps in data to accurately describe and monitor GBV, largely because it tends to occur in private settings and frequently goes unreported. Examples of the challenges in collecting accurate data include:

- Survivor's fear of shame or other consequences (e.g., involving Child Protection Services, breaking apart a family[60]) from reporting an incident;[66]
- Survivor's fear of retaliation from their abuser, which could result in further violence or fatal outcomes, the greatest risk for homicide being when a survivor decides to leave their abuser;[16,67]
- Data collected often only include physical violence and not the impact of emotional or financial abuse;[30,68,d]
- Administrative data systems (e.g., health data, police data) are not set up to collect relevant, complete, or timely information on GBV;[69]
- The occurrence of formal charges and meaningful consequences for perpetrators is extremely low: Statistics Canada reports that from 2009–2014, 93,501 incidents of sexual assault were reported to police, of which 43% (40,490 incidents) resulted in charges being laid.[70] Of these charged cases, only half (49%, or 19,806 cases) proceeded to the justice system.[70] Once cases were completed in court, only 8,742 resulted in guilty verdicts,[70] creating fear that the risks of reporting may outweigh the benefits;[30] and
- Those responding to GBV calls (e.g., first responders) are limited to dealing with a specific form of violence (e.g., IPV), and are unable to document the holistic mental, emotional, and physical health needs of victims with the specialized interdisciplinary care they might require.[60]

d In 2019, Statistics Canada pursued data on emotional and financial abuse experienced by Canadians; however, this appears to have been the first instance.

Findings

Increased GBV during COVID-19 has been reported globally.[71] The United Nations has suggested that the pandemic reduced violence prevention and protection efforts, as well as access to social services and care for women and girls.[71] This undermined progress made across the world to end GBV, especially where many women were living with their abusers, unable to leave or access normal support services.[71] In April 2020, the United Nations Development Programme reported that worldwide 243 million women and girls age 15–49 experienced IPV in the previous 12 months.[72] The United Nations Population Fund estimated that if stay-at-home measures continued for six months, an additional 31 million cases of GBV would result.[73]

GBV is known to be substantially underreported.[74] Formal quantitative and qualitative data sources, as well as adequate data collection, management, and reporting, are lacking in BC and in Canada;[74] there is no central, coordinated system to monitor and report on GBV, nor are there standard definitions or measures for reporting. The data referred in this section are understood as representing only a small fraction of GBV experienced in BC and other jurisdictions. While the available data likely underreport GBV, trends over time do provide an indication of whether rates of GBV are increasing or decreasing.

While the COVID-19 pandemic has been a novel public health emergency, the gendered impact and inequitable outcomes are not new. Inequitable outcomes have been observed during previous pandemics, among other emergencies.[75,76,77] At the onset of the pandemic, many research studies were undertaken to better understand these impacts. For further information, please refer to the BC COVID-19 Survey Inventory and BC COVID-19 Research Inventory.

The experiences highlighted in this section likely disproportionately reflect those of heterosexual, cisgender women and girls, and not those of gender diverse and non-binary individuals. The intersectional nature of GBV puts youth, individuals experiencing unstable housing, and people who identify as 2SLGBTQQIA+ at higher risk of being targeted for violence.[78] Also of

considerable concern are the direct short- and long-term impacts of violence on children and youth (survivors of violence themselves, as well as those who witness violence against a parent or other household member), which include a range of emotional, behavioural, and developmental issues, as well as the possibility of post-traumatic stress disorder and intergenerational cycles of abuse.[79] These impacts, although significant, are beyond the scope of this report.

Direct Impacts of the Pandemic and Response Measures on Gender-based Violence and Intimate Partner Violence as Experienced by Survivors and Witnesses

The frequency,[80] prevalence, and severity of abuse appear to have worsened, while the reporting of abuse and the availability of support services decreased.[32] Across North America, risk factors for increased GBV and IPV due to the pandemic and response measures included financial stress, sheltering-in-place, difficulty maintaining social ties (particularly among Canadian women), and symptoms of COVID-19.[81] One study found that stress related to COVID-19 was associated with greater likelihood of sexual coercion among those who lived with a romantic partner.[82] Many have reported that physical distancing and shelter-in-place measures facilitated and reinforced perpetrators' control and abuse,[83] and made it challenging to access services and personal supports. Online supports may not always be accessible due to perpetrator's surveillance of social media accounts.[83] Furthermore, some reported greater reluctance to seek help during the initial months of the pandemic due to concerns of being exposed to COVID-19 at shelters.[32]

Two Statistics Canada studies show the impact of physical distancing measures. The first study dated March 29 to April 3, 2020, found that 33.4% of Canadians reported being "very" or "extremely" concerned about family stress from confinement.[84] 9.9% of female respondents were "very" or "extremely" concerned about violence in the home, compared to only 6.0% of men.[84] The second study dated April 3 to 9, 2020, showed that, overall and across each age category, women were more likely than men to be "very" or "extremely" anxious about violence in the home during early phases of the COVID-19 pandemic; young women age 15–24 (12%) were significantly more likely to report this level of concern compared to men (8%).[85] Several other sources report survivors experiencing moderate to severe depressive symptoms, as well as self-harm, suicidal ideation, post-traumatic stress disorder, eating disorders, anxiety, and substance use during the pandemic.[81,86,87]

Survivors have been more likely to stay longer with an abuser due to uncertainty experienced through the pandemic (e.g., difficulty with planning ahead, concern about losing housing if they were to leave their abuser).[32,88] These effects may continue well past the pandemic. For example, research in Canada and the United States found that GBV survivors reported continued long-term impacts following a crisis (e.g., Hurricane Katrina), ranging from six months to two years after the event.[89,90,91,92]

In Canada, women and girls are killed by violence every 2.5 days.[93] During the first year of the pandemic, there was a 9.6% increase in the number of women and girls killed, from 146 in 2019 to 160 in 2020, with the highest monthly counts in March (17), April (26), and July (23); of these killings, 80% were committed by men and 22.5% by known intimate partners.[94] Women age 25–34, 35–44, 45–54, and 55–64 were over-represented as victims of femicide compared to the general population in 2020; in 2019, only women age 55–64 were over-represented.[94] Among the victims killed in incidents involving a male perpetrator, 68 were known to have left behind children; it is estimated that at least 157 children in Canada have lost a mother in 2020 due to femicide.[94]

Femicide is defined as the intentional killing of a girl or woman because of their sex or gender, often rooted in an explicit hatred toward women and girls.[94] Importantly, the statistics above are likely to be an underestimate given known challenges with documenting femicide: accessibility, availability of data (especially in cases with ongoing criminal investigations), timeliness of data (i.e., counts increasing years after the actual time of death as investigations, court verdicts, and other information sources are made public), publicly available data not identifying whether an act was

specifically gender-based or a form of femicide, deaths not being countable as femicides if not formally deemed homicides, and lack of concerted measures to collect information on femicide prevention initiatives.[94] Many of the data used to report these values come from media coverage and publicly available court documents, making it difficult to obtain an accurate count or work towards meaningful prevention efforts.

British Columbians had the opportunity to share their experiences of how the pandemic and response measures impacted them through the BC COVID-19 Survey on Population Experiences, Action and Knowledge. The second iteration of the survey, conducted from April–May 2021, assessed whether household conflict had increased since the pandemic. The findings are as follows:[95]

- Overall, 43.9% of respondents reported an increase in household conflict.
- Of those who reported an increase in household conflict, 59.4% lived with children in the household, as compared to 37.8% who lived in households without children.
- Increased household conflict was reported among younger respondents: 51.5% among individuals age 18–29, 50.3% among individuals age 30–39, and 52.5% among individuals age 40–49.
- Increased household conflict was reported more frequently among respondents who identified as West Asian/Arab (52.1%), South Asian (49.6%), and Latin American/Hispanic (48.3%).

Demand for Health, Policing, and Social Services

Use of Crisis Lines

In the first year of the pandemic, there was a significant increase in both the frequency and severity of calls for help reported in BC and across Canada.[32] The crisis line of the Vancouver-based Battered Women's Support Services typically receives 18,000 calls annually;[4] in the early months of the pandemic, there was a 300% increase in calls, including over 32,000 requests for support.[96] Similarly, Canada's Assaulted Women's Helpline received 51,299 calls from April 1 to September 30, 2020, compared to 24,010 calls during the same period in 2019.[97] An additional 20,334 calls were received between October 1 and December 31, 2020, compared to 12,352 over the same period in the previous year.[97] Information was not available on whether services were able to meet this increased demand.

Access and Use of Shelters and Transition Homes

To better understand the impact of the pandemic on survivors of violence, Women's Shelters Canada published findings from a special iteration of a national survey, Shelter Voices 2020,[32] which surveyed 266 shelters and 251 shelter and transition home organizations across Canada[e] during two time periods: Phase 1 (March–May 2020), when restrictions were most strict, and Phase 2 (June–October 2020), when restrictions were initially relaxed.[f] Their findings include:

- **Frequency of calls**: 59% of respondents reported a decrease in calls during Phase 1, while 61% reported an increase during Phase 2.
- **Requests for admittance to shelters**: 65% of respondents reported a decrease in requests during Phase 1, while 54% reported an increase during Phase 2.
- **Difficulty seeking support:** Survivors may have faced difficulties in seeking support or fleeing their environments during the early months of the pandemic. Many of the narratives captured in the survey reflect what is already known: inability to make calls due to perpetrators controlling phones, devices, and movements; fear of potential homelessness; and fear of outbreaks in shelters.

e The response rate was 52%, and there was representation from every province and territory, as well as urban and rural areas, and Indigenous shelters/transition homes.

f The report does not specify the pre-pandemic time period that survey respondents were asked to compare with when answering questions, so while the results below indicate changes over time, the time period being examined is not clear.

- **Reduced capacity**: 71% of respondents' sites had to reduce capacity to meet public health recommendations (e.g., due to need for isolation unit on-site, limiting shared rooms and bathrooms, limiting use of communal areas). The impact of this reduced capacity on the services' ability to meet demand is not known.
- **Change in severity of violence experienced by survivors coming into the shelter**: 52% of respondents reported either "much more" or "somewhat more" severe violence, compared to 48% reporting "about the same." Respondents also reported admitting women with worse outcomes on danger risk assessments, showing higher indicators of lethality.
- **Use of pandemic as a means of control by abusers**: There was an increase of coercive control used by perpetrators, such as threats to intentionally transmit COVID-19 to survivors and children, delaying of court dates, and violations of child custody arrangements.
- **Ability to provide services**: 28% of respondents indicated that the pandemic "greatly" impacted their ability to provide services, and 39% reported being "moderately" impacted.

It should be noted that access to, and availability of, transition homes and similar safe houses was already limited prior to the pandemic. In November 2019, an average of 620 women and children were turned away from shelters for survivors of domestic violence across Canada per day, with over 80% being turned away because the shelter was full.[98] This is noteworthy as November typically sees lower numbers than other months due to reluctance to flee in advance of the winter holiday season.[98] From 2014 to 2018, the average number of women and children being turned away from shelters each day has increased 69%, from 539 (2014) to 911 (2018).[98]

Emergency Department Visits

Emergency Department (ED) visits for sexual and physical assault reflect the more extreme incidents that require immediate emergency care, and only represent cases where GBV was clearly specified as the cause. Therefore, less severe but ongoing violence, or violence where the cause is not disclosed, is not reflected in data on ED visits. Published ED data for sexual assault during the pandemic are also very limited, although one study from Ottawa reported a 54.55% reduction in the weekly counts of assault victims presenting at the ED-based Sexual Assault and Domestic Violence Program from March 4 to May 5, 2020, with a decrease of 53.49% in sexual assault cases and a 48.45% reduction in physical assault cases weekly.[99] In BC, there was a reduction of approximately 40% in age-standardized rates for all causes of ED visits from March to April 2020,[100] as well as a 50% reduction nationally.[101] Further investigation is needed to understand how ED visits for sexual assault and other forms of violence may have fluctuated in comparison to pre-pandemic times across BC. Acknowledging the significant increased frequency in calls to crisis lines and requests for safe housing, the decrease in ED visits is likely linked to an inability or reluctance to access health care services during the early months of the pandemic, and not reflective of a reduction in the need for those services.

Police-reported Sexual Assaults

Finally, Statistics Canada reported a 26.6% decline in total police-reported[g] sexual assaults and an 11.4% decline in total police-reported assaults from March to June 2020, as compared to the same period in 2019 across Canada. In contrast, domestic disturbances increased by 11.6% during this same period.[102] Similarly, 54% of Canadian victim services providers reported an increase in the number of victims served from mid-March to early July 2020.[103]

Obtaining and understanding the reporting statistics for Indigenous women is much more complicated due to systemic racism, which creates barriers that can prevent Indigenous women from seeking help following violent or traumatic experiences. Examples of these barriers include inaccessibility of supports and services, as well as mistrust in the police, criminal justice system, health system, and institutions intended to protect people from

g The survey responses included voluntarily reported data from 17 police services across Canada, which together serve approximately 59% of the overall Canadian population. The survey responses from the Royal Canadian Mounted Police (RCMP) were limited and only captured experiences of those serving 32% of the Canadian population.

harm.[34] Specifically, many Indigenous women have reported that they are afraid to contact the police.[104] There are both historic and contemporary reasons for this, including instances of police violence against Indigenous people, and the role police play in perpetuating colonial violence in their interactions with Indigenous IPV survivors.[2] For example, some Indigenous IPV survivors report that police have frequently dealt with situations of violence inappropriately, favouring male perpetrators of violence and reporting to Child Protection Services for the purposes of child apprehension.[2] Both law enforcement and the justice system often retraumatize Indigenous IPV survivors seeking help.[2]

Increased Need for Resources to Better Address Intimate Partner Violence

The stories of survivors and service providers clearly indicate an increased need for resources through the pandemic and long after it wanes. The physical distancing and shelter-in-place measures required a considerable shift in how services are organized and provided in BC and elsewhere:

- Existing transition houses and other safe spaces underwent physical renovations to ensure the safety and well-being of clients and adhere to public health orders.[32]
- In March 2020, Battered Women's Support Services pivoted to provide 24/7 support adding texting services, email options, and callouts for more volunteers to support the increased demand.[96]
- Many service providers implemented virtual services and new technologies (e.g., PROMiSE, an IPV safety planning tool developed for use during public health emergencies and launched in December 2020 throughout the Greater Toronto Area[105]) to continue providing services when in-person services were not an option (e.g., video/phone conferencing, online chat, email, text messaging).[103]
- Many service providers implemented innovative new ways for survivors to report violence (e.g., "Signal of Help," a simple hand gesture a survivor can make to convey a need for help without leaving any indication that help was sought),[106] or relay important messages to survivors (e.g., "Bruised Fruit" campaign providing a call-in number for support),[107] in common community settings that survivors might still have had access to during the pandemic (e.g., pharmacies, grocery stores).
- Additional training was initiated to support health care professionals (e.g., physicians,[108] nurses,[109] midwives[110]) to ask about potential violence, to understand longer term patterns in patients presenting repeatedly with symptoms of violence, and to strengthen the ability to develop safety plans with clients.
- Many service providers had to hire and train more staff to meet the growing needs of survivors and their affected families.[96]

In addition to the items above, more ways to recognize and respond to coercive control—which often precedes violence—are needed. On October 5, 2020, BC Member of Parliament Randall Garrison introduced a private member's bill, Bill C-247, an *Act to amend the Criminal Code (controlling or coercive conduct)*, that, if it became law, would create an offence of engaging in "controlling or coercive conduct," i.e., conduct resulting in significant impact on the targeted individual(s), as evidenced by a fear of violence, a decline in physical or mental health, or substantial adverse effects on their daily activities.[111] This proposed legislation was intended to criminalize the behaviour patterns and worsening conduct of abusers, and create the legal framework for police to be able to act on abusive, threatening, or controlling behaviour in the absence of physical violence. However, this bill did not become law.[112,113] Coercive control is one of several considerations for making a protection order listed in BC's *Family Law Act*.[114]

Considerations for Further Action

While GBV is difficult to address due to the complexities and sensitivities involved, actions can be taken to help prevent it from happening, to better monitor frequency and severity when it happens, and to better respond to it in BC. This section provides considerations for action based on the findings of this report. These are not formal recommendations, but rather ideas to consider when shaping recommendations and actions related to this topic.

1. Implement province-wide violence prevention initiatives that increase awareness and understanding of GBV as an issue, with particular focus on equity-seeking groups disproportionately impacted by GBV (e.g., 2SLGBTQQIA+), and highlight attention to perpetrator prevention (e.g., targeted early education involving boys and youth on the role of gender in violence and the root causes of violence, involving men and boys in initiatives to prevent GBV)[115,116] and broader structural prevention efforts (e.g., gender equity, female empowerment, stable housing and income)[117] rather than victim prevention approaches that put the onus on potential victims to avoid violence.
2. Integrate efforts to assess and respond to GBV in BC across all government ministries and other partners to ensure a comprehensive understanding of the issue, focusing on improved data collection and analysis methods, and the most coordinated, efficient, and effective response, with optimal outcomes for survivors and their families.
3. Improve measurement and understanding of GBV while upholding victims' confidentiality and safety. Until better data are available on GBV in BC, all other response efforts will be limited in their ability to understand, assess, and respond effectively and strategically to GBV. Better data could also be used to evaluate efforts to prevent and respond to GBV.
4. Increase communication and awareness of GBV and its impacts across all ministries and all pandemic-related activities, and actively work to implement a Gender-based Analysis Plus[h,118] and trauma- and violence-informed care[i,119,120] lens broadly across any emergency response.[121,122]
5. Support interdisciplinary programs that focus on the impacts of GBV on children (e.g., the Adverse Childhood Experiences (ACEs) Working Group of the Child and Youth Mental Health and Substance Use Community of Practice).[23,123,124]
6. Support efforts to strengthen health professionals' clinical skills in recognizing and asking clients about GBV and its direct and indirect impacts, in addition to knowing the appropriate next steps.

h Gender-based Analysis Plus (GBA+) is an analytical tool used to understand and evaluate how diverse groups of women, men, and gender diverse people may experience policies, programs, and initiatives. The "+" acknowledges that analyses go beyond biological (sex) and socio-cultural (gender) differences.

i Trauma- and violence-informed care is a strengths-based framework grounded in acknowledgement of, and response to, the impact of traumatic life events (historic and persistent). It can reduce barriers to accessing health and social services, and promote more caring, compassionate, person-centred, and non-judgmental care.

Appendix A: Data methodology notes

1. **BC COVID-19 Survey on Population Experiences, Action and Knowledge (SPEAK) Data:** The BC COVID-10 SPEAK was funded by the BCCDC Foundation for Public Health. SPEAK data are publicly accessible here: http://www.bccdc.ca/health-professionals/data-reports/bc-covid-19-speak-dashboard.

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