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"There's no amount of tea in the world that is going to fix the patriarchy right now": The gendered impacts of the COVID-19 pandemic for women in the gender-based violence sector

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1. Introduction

As of June 2022, there had been over 246 million cases of COVID-19 worldwide, and countless public health restrictions enacted to slow disease spread (World Health Organization, 2021b). Women and vulnerable populations, such as individuals experiencing gender-based violence (GBV), have borne the brunt of the unintended consequences associated with these public health restrictions, with the United Nations (2022) identifying three key areas where COVID-19 and public health responses have contributed to gender inequity: increased job and income loss, unpaid care work, and violence against women and girls.

COVID-19 resulted in unprecedented disruptions to global economies. Income loss has been attributed to a reduction in work hours, a trend observed across all genders during COVID-19 (Carli, 2020; Collins et al., 2021). However, this reduction was not experienced equally across genders, as women reported a decrease in work hours 4 to 5 times greater than men (Collins et al., 2021). Beyond reduced hours and the associated income loss, preliminary studies on the early effects of COVID-19 indicated there were no gender differences among those who temporarily lost their jobs (Dang & Nguyen, 2021). However, differences emerged when lay-offs ended and workers were to return to work; specifically, due to increased unpaid caregiving demands including childcare and elder care, women were at higher risk of permanently losing their jobs than men and disproportionately left the workforce voluntarily or reduced their work hours (Carli, 2020; Petts et al., 2021). This was due, in part, to public health restrictions that closed childcare centers and schools, a step deemed necessary to help reduce community transmission, but enacted at a significant cost to families, especially women. While in two-parent heterosexual families both parents reported exhaustion and reduced capacity for paid employment, this was worse for mothers (Bender et al., 2022; Lyttelton et al., 2021). The impact of income and job loss experienced by all genders has left families vulnerable, and the disparities in income and job losses for women has further widened the gender pay gap by an estimated 20–40% (Collins et al., 2021).

The intersection of familial, financial, and pandemic-related stress heightened the risk of experiencing violence, a trend previously observed during times of crisis (United Nations, 2022). GBV can be understood as any harmful act directed at an individual based on their gender and is rooted in gender inequality, the abuse of power, and harmful norms (Heise, Ellsberg, & Gottmoeller, 2002). GBV is a serious threat to the wellbeing of survivors, with health consequences such as physical injury, anxiety, depression, post-traumatic stress disorder, and fear as well as financial consequences such as decreased access to health care and transportation (Canadian Medical Association, 2021; Cotter, 2021; World Health Organization, 2021a). Emerging evidence indicated both the incidence and prevalence of GBV increased during the COVID-19 pandemic with one in two women reporting that they or a woman they know experienced violence during the pandemic (Peterman et al., 2020; Roesch et al., 2020; United Nations, 2022). Specifically, in Canada, there was a reported 20–30% increase in violence, with domestic violence calls in Ontario increasing by 22% in the first year of the COVID-19 pandemic (Illingsworth & Ferrera, 2020).

The GBV and COVID-19 pandemics both resulted in significant health and social consequences independently; however, when these pandemics intersect, a 'syndemic' occurs where effects are further amplified (Khanlou et al., 2020). A 'syndemic' describes how diseases are provoked by socioeconomic, political, or environmental contexts, all of which interact and lead to synergistic vulnerability for equity-deserving

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populations, intensifying social and structural inequities (Willen et al., 2017). The increased vulnerability of experiencing GBV during a pandemic was magnified by disruptions to GBV services due to public health restrictions, including substantial decreases in maximum shelter occupancy and staffing shortages (Lyons & Brewer, 2021; Trudell & Whitmore, 2020). This 'syndemic' also put additional pressures on the GBV sector. These pressures should be considered in the context of a decade or more of austerity measures enacted by funders in many high-income countries, including Canada, and the expanding scope of practice many shelters faced as they tried to bridge gaps in service (e.g. system navigation support, permanent housing, safe substance use, etc.) provision for the most vulnerable members of their communities (Khanlou et al., 2020; Samardzic & Morton, 2020). Staff and leaders working in the GBV sector in Canada were, even prior to COVID-19, at high risk of burnout and secondary trauma due to the nature of the work, and the moral distress of trying to provide sufficient services in an over-stretched, under-funded and fragmented sector (Dworkin et al., 2016; Kulkarni et al., 2013).

While most sectors were impacted by the volatility of COVID-19 and the associated public health responses (Lemieux et al., 2020), certain sectors faced significantly more disruption, especially those that: provide emergency and/or congregate accommodations; are a social service; have primarily younger workers who are paid hourly; and are non-unionized (Dang & Nguyen, 2021; Lemieux et al., 2020). Furthermore, having a predominantly female workforce including female leaders, workers, and clients in this sector amplified the impact of COVID-19 as women who continued to work during the pandemic reported heightened job insecurity and poorer mental health compared to men (Nordhues et al., 2021), and were less likely to be designated essential workers in comparable settings (Mantler et al., 2021; Wood et al., 2020). The GBV sector is therefore unique because of these characteristics, leading to disproportionately negative impacts from COVID-19 and related public health directives. This study, using purposive and snowball sampling, focused specifically on the experiences of leaders, staff, and women clients of GBV services in Ontario to answer the research question of how the COVID-19 pandemic made gendered experiences more visible at the service, organizational, and structural levels in the GBV sector..

2. Methods

2.1. Design

This qualitative interpretive description study (Thorne, 2016; Thorne et al., 2004) used an integrated knowledge mobilization (KMb) approach (Kothari and Wathen, 2013, 2017). Interpretive description was selected as it aligned with the pragmatic orientation (Morgan, 2014) of aiming to generate real-time disciplinary knowledge for the GBV sector, in which mainly social workers, but also counselors and peer support staff provide a range of supports to women, during the COVID-19 pandemic, a need identified by leaders in the GBV sector. This is consistent with our integrated KMb approach, i.e., partnering with community organizations and leaders to collaboratively engage in mutually beneficial research. Additional methods detail is available in Mantler et al. (2021).

2.2. Conceptual and theoretical framing

A critical feminist intersectional framework was used in this study. This framework employs a unique lens for understanding how various forms of inequality interact and/or overlap to exacerbate inequitable structural processes that disadvantage some and privilege others (Crenshaw, 1989, pp. 139–167; Nash, 2008). The choices and circumstances individuals have available to them are influenced by structural conditions and power dynamics both across systems and in the research process. In acknowledging the impact of structural processes that have real consequences for people occupying different social locations, our use of intersectionality is intentional to highlight multiple vantage points and perspectives by including different groups (i.e., GBV service leaders, staff, and clients) and, within these groups, participants had varying life experiences that added nuance to our findings.

2.3. Context

In Ontario, there are over 160 women's shelters providing supports to women and families who have experienced GBV, including 24-h emergency shelter, counselling, community outreach programs, and system navigation (Women's Shelters Canada, 2020). Women's shelters are primarily funded through the Ministry of Children, Community and Social Services, however, many shelters receive additional program-specific funds from other government ministries and municipalities, and seek out grants or use fundraising to meet the needs of service users. Five women's shelters from across Ontario, Canada were partners in this research project, selected primarily through pre-existing relationships with the research team, and to represent rural, urban and remote/Northern parts of the province.

2.4. Sampling and recruitment

We used stratified purposive and snowball sampling with our five partner Executive Directors (ED; those who participated in the conceptualization of this study) recruiting shelter clients, staff, their ED colleagues, and GBV system advocates in both urban and rural regions in Ontario. We were specifically seeking individuals with first-hand experiences of what shelter services were like during the COVID-19 pandemic and included participants from three groups to obtain a variety of perspectives: shelter clients using residential services, staff working at women's shelters, and EDs from women's shelters and other social service organizations that serve women who have experienced violence. Participants were initially recruited via posters and by invitations for direct service staff to participate in the research sent via major GBV sector email list-servs in Ontario. Subsequently, to expand our sample size, we asked ED participants to share our study with other EDs in local organizations that provide services to those experiencing violence. Interested individuals were asked to email the research team.

2.5. Procedures

Ethics approval was obtained from The Universit of Western Ontario Non-Medical Research Ethics Board (Protocol 115865) and data collection, both individual interviews and focus groups, occurred between June 2020 and December 2021. All interviews and focus groups were audio-recorded and transcribed verbatim by a professional transcription service. Each transcript was anonymized prior to analysis. The data collection and analysis process were guided by Lincoln and Guba (1986) and Thorne and colleagues' (1997) principles of auditability, fit, dependence, and transferability. To reduce barriers to participation shelter clients and shelter staff received a gift card in recognition of their time. EDs and the system advocate were not provided with remuneration.

2.6. Data generation

Individual interviews were conducted with shelter staff ($n = 26$), shelter clients ($n = 8$), and a system advocate ($n = 1$); interviews were selected for these groups to gather more detailed feedback on individual experiences of the changes to GBV services during the COVID-19 pandemic. All interviews were video/telephone-based, lasted about 60 min each, and occurred between June 2020 and December 2021. Interviews focused more generally on how COVID-19 pandemic guidelines and changes to GBV services were experienced by participants, with some variations in questions asked for the different groups (see Table 1 below).

Participation for EDs consisted of one 2-h video-based focus group (5

Table 1
Interview and focus group questions by cohort.

Cohort	Questions
Interview with Shelter Clients	• How have things been for you (and your kids, if any) here at [shelter]? • We're especially interested in how things have changed at the shelter since the pandemic was declared: - Can you talk about the changes you've seen or heard about in how things are done? - How have these changes impacted you (and your kids, if any)? - Are your needs being met the same, better, worse, differently? • How are you (and your kids, if any) coping with COVID-19 related rules and other issues? • Has the pandemic impacted how you're thinking about next steps for you and your family? • If you were giving advice to [shelter] on what to do for a future crisis or a time when everything is changing really fast, what would it be? • Do you have any advice for other services or anyone else (government, media, members of the public)? • Is there anything else you'd like to share?
Interview with Shelter Staff	• Tell me about the last few months – how have things been at the agency? • What changed for you the most in your everyday work practice as a result of COVID-19? • How was the timeline from when the pandemic started, to now? • If you were giving your ED, or other shelters, advice right now about what changes to keep and what to get rid of, what would you say? • How have these changes impacted your clients? • Are there new stresses in your work, due to COVID-19 or other factors, that make it harder to care for your clients or yourself?
Focus Group with Executive Directors	• How are things going for you in your shelter/service? • What have the big changes been? • What lessons have you learned from COVID-19?

sessions, 4 to 6 EDs per group, $n = 24$) between June and October 2020 and a follow up one-and-a-half-hour focus group with the same participants in the initial focus groups (5 sessions, 1 to 4 EDs per group, $n = 15$) between September and November 2021. Focus groups were selected to allow interaction and discussion among EDs with the goal of exploring commonalities and differences in the experience of leading a GBV organization during the COVID-19 pandemic. Focus groups focused on changes in the shelter due to COVID-19 as well as perspectives on emerging policies and provincial mandates (see Table 1 below).

2.7. Data analysis

Transcripts from both interviews and focus groups were organized using Quirkos qualitative analysis software (Quirkos, 2020). Interpretive description following Thorne's approach guided the analysis for this study (Thorne, 2016; Thorne et al., 2004). The 37 transcripts were each independently coded by two of the seven researchers involved. Initially, those who conducted the interviews/focus groups and the principal investigator who has extensive knowledge in the field met and created a preliminary coding structure with definitions based on field notes and what was known from the literature that had guided the interview questions. Each coding dyad was initially assigned two transcripts to analyze using open and line-by-line coding. Dyads met to discuss the applicability of the coding structure and code definitions, with refinements to the coding structure and definitions made, as needed. This process was repeated three times and was informed by extant practice literature - a fundamental principle of interpretive description - and the coding team was confident that the coding structure sufficiently covered the data. Next, all interview and focus group transcripts were assigned to two people for coding. Once all transcripts were coded, Quirkos files were merged across coders. Next, key term searches (i.e., "gender", "mother", "parenting", "caregiving", etc.) and queries were run to provide reports related to the concept of the gendered impact of the pandemic. The coding team then met to theorize the relationships withing, and structure of, the data and extract meaning (Thorne et al., 2004). Findings were then presented to our ED research partners during two half-day sessions to provide them with the opportunity to help contextualize our findings in their ongoing experience with service provision during the pandemic, and to shape recommendations arising from the findings (Thorne et al., 2004).

3. Results

3.1. Demographics

All eight shelter clients were female-identified, the majority (63%) were under the age of 30 (63%) and had at least one child with them in the shelter (63%). Participating staff and EDs worked in communities ranging from 4700 to 1,500,000 people and represented 24 different agencies across Ontario, in both urban and rural areas.. Ten EDs and eight staff worked in rural locations; two EDs were from Indigenous organizations. Participating staff had a wide range in their length of employment with their current employer, ranging from less than a year to more than 30 years, with the majority in full-time positions (65%). Twenty of the EDs and the system advocate identified as female, and four identified as male. The majority of EDs and the system advocate had a bachelor's degree and were an average of 48 years old ($SD = 9.53$). For complete demographics see Table 2.

> … It's the group of women that we work with that get it done, ultimately. And we care for ourselves, and we care for our families, and we care for the people that are in our lives professionally … But this is how we made it through the pandemic … It was decisions made and care given by women (Focus Group [FG] ID 201, Time [T] 1).

Table 2
Demographics.

Characteristic	*n*(%)
Women receiving services (N = 8)	
Ethnicity (Caucasian)	8 (100)
Born in Canada	7 (87.5)
Canadian citizen	8 (100)
Employed	4 (50)
Children living with them	5 (62.5)
At least high school education	4 (50)
Direct service staff (N = 26)	
Years in field (10 +)	15 (58)
Years at current organization (10 +)	9 (35)
Gender (female)	26 (100)
Role at women's shelter or sexual assault center	
Residential counselling	21 (81)
Outreach (includes housing support, court, public education)	3 (12)
Support Services (administrative, custodial, dietary)	2 (8)
Employment status (full-time)	18 (69)
Worked remotely during pandemic	6 (23)
Location (urban)	22 (85)
Executive Directors (N = 24)	
Ethnicity (Indigenous)	3 (12.5)
Born in Canada	21 (87.5)
Gender (female)	20 (83.3)
Education	12 (50)
Master's degree	10 (42)
Bachelor's degree	12 (50)
College	1 (4)
Highschool	1 (4)
Type of organization (women's shelter)[a]	14 (58)
Indigenous shelter/organization	2 (8.3)
Rural shelter/organization	10 (41.6)

[a] Other organization types included: homeless shelters, counselling services, child/youth agencies, etc.

Our findings emphasized that the gendered impacts of the pandemic were felt in a variety of ways at the service level for women, the organizational level for staff and EDs, and at the structural level across agencies, leaders, and relevant funding and public health systems. One ED pointedly stated, "… one of the things that we know about COVID is that women-identified folks are disproportionately impacted by [the pandemic] …" (FG203, T1). Given our sample consisted of mostly female-identified people, and this reflects the make-up of primarily female-identified clients and workers in this field (Bandali, 2019; Nordhues et al., 2021), the narratives below represent the experiences of women (shelter clients, frontline service providers, and EDs) during the pandemic, though men's perspectives are included where available.

3.2. Service level

3.2.1. Mothering while accessing GBV services

Women shared their perceptions of how the pandemic and related public health guidelines impacted their ability to parent, cope, and navigate or access services. Shelter clients found it difficult to juggle their children's needs and childcare while navigating how to adequately receive service. One staff member (S102) shared their perception that reaching women who had children was more difficult during the pandemic,

> "It's been a lot of calling [clients] and not getting a response … Or just a lot of times I would go to phone a mom, and she'd be like 'Yeah, I'm hanging out with my kids, so can I phone you when she's asleep?' and you know that she's whispering because the kid's beside her in the bed sleeping."

In shelter, being the primary caregiver and/or a single parent while isolating in their room with limited access to programs and restrictions on community outings left mothers feeling the weight of parenting responsibilities with no respite, as one mom (W122) said, "I love [my children] dearly, but being locked in a room with two toddlers for a week was a little bit intense." Staff identified isolation requirements as adding stress for shelter clients, particularly mothers, who were already navigating a major transition in their lives by coming to a shelter. These isolation requirements also restricted childcare normally available in shelters, including limitations on staff being able to provide childcare, limitations on daycare access, and restrictions on allowing children to spend time with family members outside of shelter:

> "As my role as the child support counselor, I'm [usually] meeting with kids physically, [providing] support to them, planning activities and groups … [offering] childcare if mommy needs a break or is meeting with another staff or has a meeting or counseling … So, when COVID hit, a lot of that stopped, in March, when families were basically quarantined to their rooms … So that's one way that my role very much shifted." (S119)

While many GBV organizations used innovative solutions to manage public health guidelines while continuing to provide quality care, the pressures of caregiving had very real implications for shelter clients. One mother (W127) staying in a shelter and receiving counselling by phone shared her experience with a lack of childcare,

> When I do my counselling sessions on the phone … being stuck in one room I feel like I wasn't able to talk about a lot of past trauma just [because] I don't want my kids hearing it. So, I haven't been able to work through that very much. And it would have been pretty cool to be able to have assistance with childcare for that.

Mothers also felt they had to put their goals for schooling or work on hold due to lack of childcare in the shelter and an overall lack of programming for children during the pandemic.

Isolation requirements and pandemic guidelines in shelter changed the way shelter clients could effectively parent, such as not being able to take their children outside, having to find activities they could do in their rooms, and keeping a close eye on their children when interacting with other families, as this staff member (S125) identified,

> "So, [the guidelines were] extremely difficult [for one mom] with five children in the house, and mom having to entertain them in a limited space. And when you have small children that just want to run around, we had to change a lot on how we did that and let one family out [in the yard] at a time, sanitizing after they were done."

All the new rules left some shelter clients feeling like their parenting abilities were under surveillance by other moms in the shelter, other agencies, and sometimes staff. Some mothers reported being 'mom-shamed,' feeling, for example, judged about decisions to take children to in-person school and scrutinized for their ability to manage the stress of being cooped up in a room with their children all day. One mother (W121) shared her experience,

> … the school, I mean, there were moms telling me, like, 'oh, well, you should be doing this with your child.' And it's like, you know what, you take care of your child the way you want to take care of your child, and I'll do what's right for me.

Like many other parents across the province, our participants also had to navigate the switch to virtual school, something that was particularly difficult while living in a shelter. In some cases, shelter protocols required children to do virtual schooling, even when in-person was an option, to decrease the chance that children would bring the virus into the shelter, as one ED (FG206, T2),

> "At one point we had to say, "No, your child is homeschooled while you're residing at the shelter … So every resident who has children, the children would need to have virtual schooling, remote schooling and our children's [counsellor] will provide some supports around getting things in place, getting them the tools to make that happen."

Staff tried to support mothers and children with schooling by providing worksheets and over-the-phone support, but this was not the same as in-person support. One mother (W121) shared feeling like the pandemic, and particularly not being able to do in-person schooling, was taking a major toll on her children,

> … they've been acting totally different. I don't know if it's maybe the COVID that's making them act like this mentally. Because I know that before the [pandemic], they were at school, seeing their friends, they were happy, they could go to parks and do whatever.

3.2.2. Obligatory gratitude

Shelter clients, whether in shelter or remotely, consistently reported that they needed, or were expected, to be grateful for the service they were receiving, even though they and staff/EDs felt services were inadequate and insufficient due to pandemic guidelines. One shelter client (W128) who accessed shelter shared, "… and I'm grateful for the spot, the space, but I mean I can only do so much here like this …" indicating she felt that pandemic restrictions altered her ability to effectively engage in a plan with staff. Some staff reported feeling as though their outreach clients were continually apologetic for having to miss or reschedule phone appointments or having to tend to their children's needs during their sessions. Shelter clients reported overall that they were truly grateful for the services they received despite limitations and restrictions due to the pandemic, as one shelter client (W123) shared her experience at the shelter, "I love [the staff], they're awesome … they're so in tuned with everybody, they're so nice, they're so willing to help." However, because shelter clients felt a need to be grateful for receiving any kind of service during a pandemic, some feared seeming ungrateful for the support, and also felt they did not have the opportunity to provide feedback regarding aspects of the services that were not working for them and their children. One shelter client (W122) shared her thoughts

on how shelters could improve their communication about service changes and involve clients more in the process,

> "I think perhaps maybe the manner restrictions are delivered in could be considered, that would be helpful … where staff can maybe let [clients] know what needs to happen and restrictions that need to be put in for people's safety … But also then have the resident in to say, okay, well, this is happening."

3.3. Organizational level

3.3.1. Caregiving and emotional labour at work and home

Many EDs and staff reported that the pandemic and related guidelines led to a change in how their jobs could be done. Staff indicated that because shelter clients and children were generally isolated in their rooms and were unable to attend services in-person, more emotional labour had to be expended in creative ways to meet the needs of shelter clients and children. For example, one staff member (S107) said, "I was supporting [a client] through email and it's so weird. How do you develop a rapport or relationship with somebody through email, right? So that was an added dimension to our work." However, some staff also felt that the extra effort they needed to put into their work due to the pandemic was worth it to continue providing support to their clients, as one (S104) said,

> There are definitely some hard parts to [working during a pandemic]. It's a lot … everybody trying to work together to create the best possible environment … We haven't dealt with something like this before … you've got women coming and going and we're trying to find housing and everything like that … But I think we've been doing really well to maintain everything that we have built to accomplish … But it has been a struggle, for sure.

EDs overall felt pressure from being both a female leader in a feminist organization and an employer, which weighed heavily on them and altered their work roles. One ED noted that women in leadership roles in the GBV sector have always been seen as "warriors" (FG208, T2), with expectations of strength and perseverance in the face of challenges. Specifically, the predominantly female role of *caring* was identified by leaders as a dominant subtext in their roles as ED, one which some EDs were not comfortable with:

> Yeah, and feeling like you're constantly having to care for everybody … that's very common for women in caregiving professions but … I'm not a social worker, [I] deliberately chose to not have a career where I'm client facing. That's not me, I don't want that job. And now I feel like I am experiencing all of those things that frontline workers experience because I'm having to do that for all the staff that work for me" (FG210, T2).

Leaders were also often left with the difficult job of figuring out how best to support staff (i.e., those working from home or taking a leave of absence, etc.) while maintaining coverage and support on-site. One ED (FG202, T1) noted,

> I'm actually hiring a brand-new position …. So, their job is to be on site full time, no work from home … because that's the only way that we're going to be able to continue running the organization and not keep ourselves being burnt out. So, you know, that's a pretty big expense and it's a new expense and this is because … in our COVID response collectively, working parents and especially women, their needs are not being considered and they're not being properly addressed.

Several EDs and staff felt that the changes to their job spilled into their home lives, where they tended to take on most of the caregiving responsibilities. While a common experience for women in general, this was particularly prominent for single mothers or those who had limited child support from spouses or family members. One ED (FG202, T1) said,

> … so myself and all of our directors – we're all parents of school-age kids. So, we've been running the organization all as parents with kids at home … So, our entire infrastructure is being run and managed by women and the reality throughout this entire thing is childcare and the responsibility of parents has just been such a low priority and we're now bearing the burden of that.

Many staff and EDs reported feeling like they had exhausted their empathy and care at work and had nothing left for their families when they got home. One ED (FG202, T1) talked about the impact this had on her child, "… I literally fake empathy and my 12-year-old has started calling me on it. She's like, 'You know, Mom, when you talk to me like that it feels like you don't even really care.'"

Much like their shelter clients, staff and EDs also struggled with the transition to virtual schooling and/or decisions to send their children to school amidst risks of contracting COVID-19. One ED (FG202, T1) who sent her child back to in-person school shared her experience, "Someone actually just said to me yesterday, 'Oh, you're a brave mom sending your daughter to school.' It's a good thing that they couldn't see my face [laughs]. … 'I am a working mom with absolutely no choice … '" The reality was that women leaders in the GBV sector felt that policy decisions, particularly those that influenced their ability to work while caregiving, were not sensitive to gendered work and family imperatives. One ED (FG202, T1) noted,

> … in our COVID response collectively, working parents and especially women, their needs are not being considered and then [in] the sector, it's very common for women to have children and like for a whole management team to have children who are at home and really not to have other options. And I found sort of not feeling like I have the answers for the staff team and then also not feeling like I have the answers just to take care of my kid properly. That's been a gendered stressor for sure.

3.3.2. Self-care

Staff and EDs struggled with navigating changes in their jobs, increases in emotional labour for clients and colleagues/staff, and providing different types of care without increased or adequate support or self-care strategies. One ED (FG210, T2) discussed how the self-care strategies suggested by a trauma counsellor felt unhelpful,

> … [the trauma counsellor was] like, 'You should do more self-care, go for walks, have some tea' and I really just reacted very strongly and was like, 'No I'm sorry there's no amount of tea in the world that is going to fix the patriarchy right now.' … I'm like if one more person tells me to self-care or pour a cup of tea I literally was going to explode.

A few EDs also shared that there were 'tips' for professionals navigating a pandemic (e.g., for working from home, working with your children, etc.) that were circulating on social media that felt misguided:

> I was constantly getting these tips and if you look at them none talk about gender. Like none of them are realistic. They're incredibly classist … I just felt like all of these tips that were supposed to help us actually caused a lot more damage (FG202, T1).

3.4. Gendered expectations of leaders

Some comments highlighted differences in the expectations of female versus male leaders. Some EDs felt that female EDs were expected to maintain a friendly or positive attitude while also successfully navigating the pandemic, an expectation that was seen as being gendered in nature and not applying to male leaders. One female ED (FG202, T1) noted,

> … it's mostly about not feeling like I'm being very supportive of the team … [giving] them the answers they need and also [showing] up every day with a smile and treating everyone as I would like to be treated and being friendly and all the things that I think we see female EDs bring forward that we maybe don't expect from men in these roles.

These gender norms also influenced male EDs, as they felt pressure to conform to what might be considered traditionally male traits, including putting on a brave face and avoiding showing emotion in front of staff. One male ED (FG203, T1) described "I go dead inside usually when we lose a client because it's just like, you can't cry in front of your staff. I usually save that for driving home."

3.5. Structural level

3.5.1. GBV sector losing ground, and the road to recovery for women

There was overwhelming consensus from EDs that aspects of the GBV sector and society in general were already broken, that this brokenness was both revealed and exacerbated during the pandemic, and that many gains made in the feminist and GBV movements over the last twenty years were lost. First, EDs pointed to increases in both the frequency and severity of violence against women, increased calls to police, and compounding issues like mental illness and substance use that suggested a need for more comprehensive services during the pandemic; one ED (FG201, T1) said, "… [we] are seeing women sexually abused in ways … that [are] so heightened and so abhorrent and so close to ending women's lives, and no one wants to talk about that." Yet, the closure and delay of social services created additional barriers in already taxed systems and created a sense of hopelessness for EDs. One ED (FG208, T2) described how COVID-19 policies resulted in police releasing offenders pre-trial rather than keeping them in jails where viral transmission could occur,

> We're back in the '80s; we have nothing for women right now. We have no access to justice, the police … Nobody's keeping the perpetrators and they're continuing to abuse, harass, kill the women in [location]. And I don't know how we get that back.

EDs also felt that additional funding for the GBV sector during the pandemic was useful, but insufficient to address the impact of changes, with some feeling like this female-dominated sector continues to be under-valued and under-resourced. Moreover, some EDs viewed the regression as broader than the GBV sector, impacting the very place of women in society. One said,

> I think we have taken a step back in this movement – a significant step back. When we look at the economic impact of the pandemic on women. When we look at the social impact of the pandemic on women. We've seen violence rates increase exponentially. We've seen wages and income decrease exponentially. We have seen primary caregiving go right back to women. It seems like inroads that we've made in the last 20 years have just – we're five steps behind now. (FG207, T2)

EDs discussed the increased advocacy during the pandemic with other agencies, such as police, government and social service ministries, public health, and court systems, to center and support the experiences of women and children. Advocacy was enacted against racist and sexist policing practices and against changes in courts that delayed trials and charges against violent abusers and/or allowed them to re-enter communities while closing community spaces that were meant to support the most vulnerable. These leaders noted a continued need for agencies, organizations, and key actors to make space to discuss difficult, gendered issues as they relate to the pandemic, something that was not frequently done:

> I think something coming up is when we don't have time or space to dialogue, there's a cost that translates into service or this unconscious evolution of our work. And we just convened as shelter EDs at our 'Let's Talk' and we touched on [vaccination policies and Feminism] … and the air went out of the room … I think we're afraid to talk about this and the lack of dialogue is going to have a cost on women. (FG207, T2)

Some respondents felt that politicians and bureaucrats were paying what they termed 'lip service' to GBV services and other female-dominated jobs (e.g., teachers, nurses) by acknowledging them as essential and/or providing some additional funding:

> … the city and the province and the [federal government] were all saying you guys are important, this role is important … they're really quick to go out publicly and talk about how important everything is but then, you know, the press conference that they do the next day is [where] they're using us as pawns in their economic gain. (FG202, T1)

However, respondents also felt that these officials did not fully understand the weight of the work that women do in the GBV sector, and that this acknowledgment and additional funding was not enough to address the disproportionate impact of the COVID-19 pandemic on GBV services, experiences of violence, and staff needs. As one ED (FG202, T1) said, "I mean I think that one of the [areas] where gender plays into the context of our organization is [that] everyone's work is still undervalued. It is [mostly] women who do the work and [are] underpaid." EDs were clear that a gendered lens needed to be applied to the pandemic and any pandemic recovery plans for GBV as this could help acknowledge the pandemic's impact on women and mothers receiving service and experiencing abuse and improve the recognition of the work that women, and mothers, do in this sector. However, there was little hope that a feminist-inspired recovery plan for COVID-19 would be on the table, "I'm just assuming that there is – that gender is not being considered in any kind of economic recovery" (FG202, T1).

Despite these views that a gendered lens has been absent from services both pre- and post-pandemic, and discussions of the implications of this, some respondents shared feelings of hope that the severity of the pandemic and the attention to women's issues would bring about change. Several ED participants discussed a desire for future generations to look back on this pandemic and understand the work that women (leaders, staff, all women) were doing to support those experiencing abuse, with one (FG201, T1) noting,

> I hope that my children, when they look back on this moment, will have seen the bravery of myself and my sisters and will see a different world that we are willing to fight for and that we will no longer capitulate, compromise for incremental change, that this will be a turning point that is taught in mainstream history classes.

4. Discussion

Our findings foreground the gendered impacts of the pandemic for women and mothers who were either working or accessing services in the GBV sector. It is important to note that the GBV sector faced challenges and barriers pre-pandemic that had clear gendered impacts, such as chronic under-funding and under-valuing of jobs and services that primarily serve and are served by women, in tandem with high levels of burnout and stress for a traditionally female dominated workforce (Dworkin et al., 2016; Kulkarni et al., 2013). However, our research clearly outlines that these gendered impacts continued, and in some cases were exacerbated in the GBV sector during the pandemic. First, we found that the pandemic re-entrenched the gendered, often de-valued, roles that women occupy in society. This was shown in the expectations that women, staff, and leaders articulated when it came to parenting and caregiving in the home, as well as navigating virtual school with their children. These expectations disproportionately fell on the shoulders of women, especially single mothers, those who had little to no informal

support, or those who were unable to access childcare services. It has been clearly demonstrated that women tend to take on more of the parenting and caregiving responsibilities in the home due to gender stereotypes and norms that situate women as nurturing, caring, and self-sacrificing (Bandali, 2019; Moyser & Burlock, 2018) and that this trend continued during the pandemic when parenting and caregiving responsibilities were more complex (Gladu, 2021; Hazarika & Das, 2020).

Mothers living in residential shelters felt the impact of taking on all or most parenting responsibilities in the context of shelter and pandemic protocols. Isolation requirements that restricted families to smaller spaces, and shelter policies that encouraged or required children to remain in shelter (e.g., virtual over in-person school, etc.) increased stress levels for mothers in shelters. There appears to be no research to date that has demonstrated these findings in the context of the COVID-19 pandemic, though a separate analysis from our research documents the impact of pandemic protocols and rules in shelter for women, staff, and EDs (Wathen et al., 2022). These circumstances challenged parenting approaches in shelters and increased experiences of 'mom shaming' (Abetz & Moore, 2018), both within and external to the shelter. However, these experiences likely did not entirely result from the pandemic, as previous literature has demonstrated that women living in shelters feel that their parenting skills are under scrutiny from staff, other women, and other agencies (i.e., the child welfare system) (Cosgrove & Flynn, 2005; Fauci & Goodman, 2019; Gengler, 2011). Nonetheless, the pandemic and associated protocols did hinder autonomy and decision-making for mothers. Yet, shelter clients, whether mothers or not, felt obligated to be grateful for any services received, regardless of whether services met their needs. This finding is novel, though there is evidence of a gratitude narrative for other vulnerable groups outside of the context of a global pandemic, such as refugees entering a new country and feeling obligated to be grateful for services, even when their needs are not being met (Thiruselvam, 2019).

For staff and leaders working at GBV agencies, the expectation to continue being the primary caregiver at home, coupled with the increased pressure and stress of working during a pandemic, led to hardships in balancing family life and work. Research has shown that mothers disproportionately felt the impact of increased childcare demands and disruptions to their work due to home responsibilities (Carli, 2020). Much like the mothers in our study, women in Bender and colleagues' (2022) study shared feelings of decreased capacity for parenting due to exacerbated stress and emotional labour at work. In line with recent research (Lyttelton et al., 2021), staff in our study who worked from home had difficulty balancing their work and their children's needs and used strategies such as working irregular hours and longer days. This balancing act took a significant mental and physical toll on women, with many reporting exhaustion and mental anguish of knowing neither role was done well. Additionally, our research did not demonstrate women experiencing income loss or job insecurity during the pandemic due to increased unpaid labour in the home (Carli, 2020; Collins et al., 2021; Petts et al., 2021). Although staff in our sample were assured job security and well supported in their efforts to balance home and work life, many did experience insufficient hazard or pandemic pay and loss of income due to provincial orders restricting employment at multiple congregate care settings. The impact of these orders, particularly for relief and part-time workers, has not yet been thoroughly explored in the literature. However, some research has shown that positions traditionally held by women were likely to be designated as essential (Raile et al., 2021) and our own research highlights a delay in identifying GBV workers as essential in Ontario (Mantler et al., 2021).

Self-care strategies, along with organizational supports, are crucial for workers in the GBV sector, and even more so during the COVID-19 pandemic (Mantler et al., 2021; Carrington et al., 2020; Nnawulezi & Hacskaylo, 2021; Wood et al., 2020). However, EDs and staff in our study felt that suggested self-care strategies during the pandemic lacked attention to gender, sometimes trivialized their experiences, and/or did not adequately reduce the experience of vicarious trauma that is often experienced in the GBV sector. Pre-pandemic research has shown that self-care and self-help discourses have traditionally targeted women (Riley et al., 2019), often encouraging individual behaviours like self-love, rather than structural or organizational change and support (Bandali, 2019; Riley et al., 2019). Preliminary research in the United Kingdom on the gendered nature of self-care during the COVID-19 pandemic is consistent with this (Gill & Orgad, 2021). For our participants, self-care directives increased feelings of frustration in staff and EDs and highlighted the lack of understanding of what they were going through during the pandemic. There is a need to seriously examine and revise the self-care discourse—self-care itself is not a solution for the collective trauma experienced in the past few years. Rather, comprehensive plans that address moral distress and its structural causes and remedies must be prioritized (Varcoe et al., 2012).

Our research also found gendered role expectations for female leaders of organizations, in comparison to men. Female leaders in our study felt that society expected them to adhere to traditionally feminine traits such as maintaining a positive attitude, smiling all the time, and constantly providing support to staff, shelter clients, and their own families, despite experiencing an immense amount of stress and pressure to lead a GBV agency through a pandemic. These expectations were not found for (the admittedly few) male EDs in our study when it came to parenting and remaining positive, but there was evidence that male EDs felt pressure to adhere to traditionally masculine traits, namely putting on a brave face and showing little emotion. Our findings align with previous, pre-pandemic research that demonstrates the expectations for female leaders related to positivity, teamwork/collectivism, and being relationship-oriented while also juggling family care in the home (Cheung & Halpern, 2010). Further research has highlighted the expectation for female leaders in all sectors to adhere to traditionally feminine norms to not appear too 'masculine' while also being perceived as an effective leader (Bierema, 2016). Clearly, there are structural-level problems when it comes to the gendered expectations of female leaders, and these were keenly felt by EDs during the pandemic.

Finally, our research highlights the absence of a gendered lens for systems and organizations that are established to support issues that affect women, such as GBV. Staff and EDs in our study identified that the closures and restrictions on women's (and other vulnerable group's) services during the pandemic led workers to question whether the GBV sector, their agencies, and their work were valued by government and policy officials. For these participants, the pandemic revealed systems simply not set up to adequately or effectively respond to complex issues, like GBV, that impact women every day. This is consistent with research on the chronic under-funding and under-valuing of the GBV sector (Samardzic & Morton, 2020) within a system of fragmented services (Yakubovich & Maki, 2021), problems that were amplified during the COVID-19 pandemic (Khanlou et al., 2020). However, our research also highlights how women working in this sector continued to support shelter clients and children and advocate for more equitable and anti-oppressive practices in society. While the narrative of GBV sector workers as 'warriors' is common and was present in our data, as with the "hero" narratives in health care during the pandemic (Mohammed et al., 2021), we recognize that this narrative is harmful as it places additional pressure on their ability to work through the pandemic and to self-sacrifice so that they can to continue supporting shelter clients and children.

4.1. Recommendations

Our findings demonstrated some of the gendered impacts of the COVID-19 pandemic for women working or using services in the GBV sector, as well as some structural considerations for the gendered impact of the pandemic. Other analyses from this research have focused on the need to address unintended consequences of public health guidelines for women experiencing GBV and using shelter services during a pandemic

(Authors et al., 2022), as such we will not repeat these here. However, there are structural considerations that intersect with gender that require reform.

First, traditional gender norms need to continue to be challenged both in terms of expectations on mothers as well as women in leadership roles as these norms and expectations were exacerbated during the COVID-19 pandemic, adding additional stress and work/emotional labour in a tumultuous time of uncertainty. These norms and roles include unrealistic mothering narratives, juggling of multiple roles (e.g., mothers, educators, employees/employers), expectations of leaders, and caregiving/emotional labour, all in the face of the ongoing trauma and uncertainty of the COVID-19 pandemic.

Second, there is a need to alter the self-care discourse, particularly for staff and EDs in the GBV sector, something that likely needed revision prior to the pandemic but was worsened during the pandemic with misdirected self-care discourses targeting primarily female workers and leaders in the GBV sector. Traditional discourses of self-care (e.g., positivity, individual transformation) are often invoked in this sector but do not adequately address the scope of stress and vicarious trauma that is experienced and even more with the added stresses and difficulties of the pandemic. Organizations and governments should prioritize and support more comprehensive support plans for shelter clients, staff and EDs (i.e., expanded counselling sessions, opportunities to debrief, comprehensive plans to combat vicarious trauma, etc.) that incorporate a gendered, and pandemic, lens.

Third, pandemic recovery for COVID-19, and proactive planning for any future pandemics, must incorporate a feminist lens to attend the disproportionate, and negative, impacts of the pandemic on women.

4.2. Limitations and future research

Participants in this study mostly identified as women, which while representative of the GBV sector, still merits caution in the interpretation of the results, particularly the findings related to gender differences. Most of men's views in this study were from leaders in services that serve women experiencing violence but are not women's shelters. While this approach to sampling was used to provide a more robust understanding of the experiences of the broader GBV sector in the context of COVID-19, there could be nuanced differences in these men's specific areas of work that are not accounted for in our analysis. Moreover, experiences of mothering and changes in employment and income were not specifically included in demographic data, and as such only those who described these impacts during interviews/focus groups were included in our analysis. Follow-up studies examining the intersection with mothering, employment, and income would help us understand how these factors are influenced by gender both during the pandemic, and the post-pandemic recovery.

5. Conclusions

Taking a critical feminist intersectional approach to looking at the experience of the COVID-19 pandemic in the context of GBV services, prevailing gender norms and roles influenced both those using, and those delivering, services. Our data show women and mothers quickly adapted to the dual full-time roles required during the many iterations of the pandemic's public health restrictions and lockdowns. However, the unintended consequences of widening various gender gaps and reinforcing damaging narratives encouraging women to continue to carry the weight of caregiving and economies cannot be ignored. Staff and leaders in GBV services in Ontario played a critical role in supporting women experiencing violence throughout the pandemic, despite the unintended consequences of public health restrictions, and the significant gendered impact of those restrictions, which was often overlooked by decision-makers. The general public, policymakers, and funders need to not only acknowledge the critical work done in the GBV sector but also attend to the implications of policy decisions particularly for women. We must collectively continue to challenge gender norms and roles and fully support GBV workers by providing them the necessary tools to support their health and wellbeing during post-pandemic recovery.

Declarations of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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