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“Boiling water but there's no pop-off valve”: Health care professionals’ perceptions of the effects
of COVID-19 on Intimate Partner Violence

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Abstract

“Boiling water but there’s no pop-off valve”: Health care professionals’ perceptions of the effects of COVID-19 on Intimate Partner Violence

By Ellen L. Hendrix

Introduction: Anecdotal evidence suggests an increase in intimate partner violence (IPV) during the COVID-19 pandemic yet little is known about the impacts of movement-related restrictions on experiences of IPV; even less is known about health providers’ perceptions of these same issues. The purpose of this study was to understand the impacts of COVID-19 on IPV from the perspective of health care professionals (HCPs).

Methods: From November 2020 to January 2021 semi-structured interviews were conducted with eight HCPs at a large public hospital in Atlanta, Georgia. Participants included emergency medicine physicians (n=4), trauma surgeons (n=3), and a social worker (n=1). A thematic analysis with both deductive and inductive codes was conducted to identify themes.

Results: Six themes emerged from the eight interviews with HCPs providing insight into their perceptions and observations of COVID-19 movement-related restrictions on IPV. These themes include: (1) COVID-19 movement-related restrictions likely exacerbated IPV; (2) IPV increased (spiked) two times during COVID-19; (3) HCPs encountered many barriers and few facilitators to IPV care provision during COVID-19; (4) IPV patients expressed fears in seeking care but did not delay treatment during the pandemic; (5) relative to the pre-pandemic period HCPs perceived no changes in IPV case presentation or severity; and (6) HCPs suggested specific internal and external improvements for IPV response. Navigating the safe discharge of patients was a primary barrier discussed by HCPs which they attributed to: a lack of community resources for people experiencing IPV; changing policies on testing requirements; fewer admissions into support facilities to observe social distancing; and the closing of a women’s shelter at the start of 2020.

Conclusions: This study deepens the understanding of the impacts of COVID-19 movement-related restrictions on IPV. Findings along with suggestions from HCPs for prevention and response to IPV during pandemics can be used to inform future pandemic preparedness.

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Acronym List

C3s	Clinical Care Coordinators
CDC	United States Centers for Disease Control and Prevention
COVID-19	Coronavirus Disease 2019
DV	Domestic Violence
ED	Emergency Department
EM	Emergency Medicine
EVD	Ebola Virus Disease
GBV	Gender-Based Violence
GDPH	Georgia Department of Public Health
HCP	Health Care Professional
IDI	In-Depth Interview
IPV	Intimate Partner Violence
MARTA	Metropolitan Atlanta Rapid Transit Authority
PTSD	Post-Traumatic Stress Disorder
SARS	Severe Acute Respiratory Syndrome
SOPs	Standardized Operating Procedures
VAW	Violence Against Women
WHO	World Health Organization

Chapter 1: Introduction

Intimate partner violence (IPV), defined as physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner, is a significant public health threat in the United States (U.S.) (National Center for Injury Prevention and Control, 2020). Nearly 20 people per minute, equating to 10 million people per year, experience physical abuse by an intimate partner in the U.S. (Black, 2011). During their lifetime, one in four women and one in ten men experience sexual violence, physical violence, and/or stalking by an intimate partner and report a related impact such as an injury or missing days of work or school (Smith, 2018). The economic impact of IPV increases the magnitude of this public health issue; each year, the costs of rape, physical assault, and stalking by an intimate partner exceed \$5.8 billion, a majority going towards medical and mental health care (National Center for Injury Prevention and Control, 2003). In the state of Georgia, 35.1% of women experience physical violence, sexual violence and/or stalking from an intimate partner underscoring the substantial public health threat of IPV even before the coronavirus disease 2019 (COVID-19) pandemic (CDC, 2014).

On March 2, 2020, the Georgia Department of Public Health (GDPH) (2020) confirmed the first cases of COVID-19 in the state. Three weeks later on March 24, 2020, Atlanta Mayor Keisha Lance Bottoms issued a citywide shelter-in-place order ("Atl. Exec. Order No. 2020-21," 2020) and on April 3, 2020, Georgia Governor Brian Kemp enacted a statewide shelter-in-place order ("Ga. Exec. Order No. 04.02.20.01," 2020). Under these orders, residents were directed to stay in their homes unless conducting essential business and were encouraged to practice social distancing. While these and other movement-related restrictions and infection control techniques

such as isolation and quarantine orders have been successful in slowing the spread of COVID-19, their effects on IPV are largely unknown (D. P. Evans, 2020).

At the start of the pandemic, media reports and other sources of anecdotal evidence suggested a global rise in IPV occurrence and in IPV support resource utilization (Allen-Ebrahimian, 2020; Azcona, 2020; Barbara et al., 2020; Daya, 2020; D. P. Evans, 2020; D. P. Evans, Hawk, S.R., and Ripkey, C.E.; Taub, 2020). Like Georgia and other U.S. states, many countries enacted movement-related restrictions to reduce the spread of COVID-19 in the early stages of the pandemic. Increased IPV reporting coupled with widespread movement-related restrictions fueled fears that these restrictions may exacerbate new and existing violence in relationships (D. P. Evans, Hawk, S.R., and Ripkey, C.E.). Throughout the pandemic, more research has emerged in support of these concerns. In a study comparing 2018-2020 crime data from the Atlanta Police Department, researchers discovered a rise of cumulative counts of domestic crimes during 2020 compared with the previous two years, suggesting an increase in DV occurrence (D. P. Evans, Hawk, S.R., and Ripkey, C.E.). However, the full effects of COVID-19 and movement-related restrictions on IPV are still largely unknown. Furthermore, knowledge of health care professionals' (HCP) perspectives of these effects is lacking; no study to date has examined the impacts of COVID-19 from the perspective of HCPs who frequently serve survivors of these types of relationship violence. To fill this gap in knowledge, a study is needed focusing on the perspectives of HCPs.

As of April 18, 2021, GDPH has reported nearly 870,000 cases, over 17,200 deaths, and nearly 60,500 hospitalizations in the state of Georgia (Georgia Department of Public Health, 2021). Due

to the significant toll endured by Georgia's health care system during COVID-19, a large metropolitan hospital in Atlanta, GA provides an ideal context in which to study the effects of this pandemic on IPV from the perspective of HCPs.

Problem Statement

Before the COVID-19 pandemic, IPV posed a significant public health threat in the United States, as nearly 20 people per minute experience physical abuse by an intimate partner (Black, 2011). Within the state of Georgia, 35.1% of women experience physical violence, sexual violence and/or stalking from an intimate partner (CDC, 2014). Due to these alarmingly high occurrences of IPV, the impacts of the COVID-19 pandemic on this type of violence are of public health concern. Yet, these impacts remain largely unknown. While anecdotal evidence suggests an exacerbation of IPV during COVID-19, few empirical studies exist to offer understanding towards this exacerbation, including within the context of Atlanta, GA (Allen-Ebrahimian, 2020; Azcona, 2020; Daya, 2020; D. P. Evans, 2020; Taub, 2020). Furthermore, existing literature does not address the impacts that movement-related restrictions enacted to reduce the spread of COVID-19, such as shelter-in-place, quarantine, and isolation orders, have had on experiences of IPV, nor does the literature address the strategies or interventions that can be used to prevent and respond to IPV during this and future pandemics. Finally, information on the perceptions of health care professionals who frequently provide direct care to survivors of IPV in hospital settings is lacking.

Purpose Statement

The purpose of this study was to understand the impacts of COVID-19, including the impacts of movement-related restrictions such as shelter-in-place, quarantine, and isolation orders, on experiences of IPV from the perspective of health care professionals. Exploring this perspective provides much-needed context to the available anecdotal evidence.

Research Objective and Aims

The objective of this study is to understand the impacts of the COVID-19 pandemic on intimate partner violence from the perspective of health care professionals in Atlanta, GA.

The aims of this study were the following:

- Aim 1: Understand the effects of COVID-19 movement-related restrictions on experiences of IPV from providers' perspectives;
- Aim 2: Explain providers' perceptions of IPV patient health care seeking behaviors during the COVID-19 pandemic;
- Aim 3: Identify barriers and facilitators in providing care to patients experiencing IPV during the COVID-19 pandemic;
- Aim 4: Understand changes in IPV case presentation during the COVID-19 pandemic compared to before the pandemic; and
- Aim 5: Identify strategies and interventions to prevent and/or better respond to IPV during pandemics.

Significance Statement

Information is lacking on the effects of COVID-19 movement-related restrictions on experiences of IPV and on health care professionals' perceptions of these effects. As the COVID-19 pandemic continues its global threat on public health and safety, the findings of this study can be used to inform the current response to IPV during this public health emergency. They can also be used to inform future pandemic preparedness within public health facilities/agencies in Atlanta, Georgia to improve the response to IPV during pandemics. The methodology used in this study could be adapted for future research conducted in other regions of Georgia or other U.S. states regarding experiences of IPV during COVID-19 and the perceptions of HCPs, social service providers, and survivors of IPV.

It is important to examine how HCPs perceive experiences of IPV during COVID-19 as these frontline workers have provided medical and supportive care to survivors of this type of violence in hospital settings before and during the pandemic. Understanding HCPs' observations and perceptions provides a means to understand the complex relationship between COVID-19 and IPV, which in turn may improve IPV prevention and response measures taken during COVID-19 and future pandemics.

Definition of Terms

Domestic violence: refers to intimate partner violence but can also encompass child or elder abuse, or abuse by any member of a household

Intimate partner violence: physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (Breiding MJ, 2015)

Isolation: the practice of separating someone with confirmed or suspected COVID-19 infection to prevent their contact with others to reduce the risk of transmission (CDC, 2021)

Movement-related restrictions: limiting movement of an individual or group to prevent the transmission of a communicable disease

Pandemic: an epidemic occurring worldwide, or over a very wide area, crossing international boundaries and usually affecting a large number of people

Quarantine: the practice of separating individuals who have had close contact with someone with COVID-19 to determine whether they develop symptoms or test positive for the disease (CDC, 2021)

Shelter-in-place: an official order, issued during an emergency, that directs people to stay in the indoor place or building that they already occupy and not to leave unless absolutely necessary

Social distancing: the practice of increasing the space between individuals and decreasing their frequency of contact to reduce the risk of spreading COVID-19 (ideally to maintain at least 6 feet between all individuals, even those who are asymptomatic) (CDC, 2021)

Chapter 2: Literature Review

To understand HCPs' perceptions of the effects of COVID-19 and movement-related restrictions on IPV, it is necessary to explore the impacts of other emergencies such as natural disasters, humanitarian crises, and pandemics on IPV. It is also useful to explore the social, economic, and interpersonal pathways which contribute to IPV during times of disaster or global health emergency.

Intimate Partner Violence

IPV is a global public health threat as it is experienced by people in all settings across all demographic, socioeconomic, cultural, and religious groups (World Health Organization, 2012). While IPV is a global issue, the majority of people who experience IPV are women. A World Health Organization (WHO) (2021) systematic review using studies from over 150 countries found that over one in four women (27%) aged 15-49 years have experienced physical and/or sexual IPV during their lifetime and 13% have experienced these forms of violence in the past 12 months. Experiences of IPV remain high as they are seen globally to be private affairs “beyond the reach of policy-makers, health-care, and other service providers ”(World Health Organization on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data, 2021). However, this evidence makes it clear that violence against women (VAW), including in the form of IPV, is a “concern of pandemic proportions” (World Health Organization on behalf of the United Nations Inter-Agency Working Group on Violence Against Women Estimation and Data, 2021).

In the United States, nearly 20 people per minute experience physical abuse by an intimate partner (Black, 2011). While this rate is high, IPV tends to be underreported for a multitude of reasons including fear of retaliation, economic dependency, imbalanced power relations between men and women, and pervasive victim blaming attitudes (Gracia, 2004). Underreporting of physical IPV is also evident in U.S. emergency departments (ED). Although studies suggest that 1–7% of female patients present to the ED with IPV-related physical injuries, a recent study found that only 0.06% of visits by women to U.S. EDs were designated with a code relating to physical IPV (Beydoun, 2017). IPV underreporting to police and in EDs may be exacerbated by COVID-19 movement-related restrictions due to decreased access to reporting resources. Thus, HCPs offer a useful perspective in understanding how movement-related restrictions enacted to curb the spread of COVID-19 may impact IPV survivors and their ability to seek medical care for IPV-related injuries.

Consequences of IPV

As one of the most frequent human rights violations, IPV can have severe consequences on survivors' physical health including fatal outcomes of homicide or suicide and interpersonal injury. These types of violence can also lead to mental health issues such as depression, anxiety, sleep disorders, and post-traumatic stress disorders (PTSD) and can limit survivors' control over their sexual and reproductive health including contraception decisions (World Health Organization, 2013). In addition to these devastating personal effects, IPV carries a high cost to society. A recent study modeled that among U.S. adults with a history of IPV, the lifetime economic burden was \$3.6 trillion (Peterson et al., 2018).

IPV during emergencies or in emergency settings

Several studies suggest that VAW including IPV increases in prevalence and severity during times of emergency (F. P. Buttell, Carney, M.M., 2009; Clemens, Hietala, Rytter, Schmidt, & Reese, 1999; Enarson, Fothergill, & Peek, 2018; Lauve-Moon & Ferreira, 2017; Parkinson, 2019). Research into the scope of VAW during natural disasters such as Hurricane Katrina in the United States in 2005, humanitarian emergencies, and pandemics such as the 2014 Ebola Virus Disease outbreak in Liberia, Guinea, and Sierra Leone warrants concern over increased experiences of IPV during the COVID-19 pandemic (F. P. Buttell, Carney, M.M., 2009; Onyango, Resnick, Davis, & Shah, 2019; Vu et al., 2014).

IPV and natural disasters

Following Hurricane Katrina in 2005, rates of VAW in affected areas rose from 4.6 cases per 100,000 per day to over 16 cases per 100,000 per day (Bell & Folkerth, 2016). Additional findings of increased DV calls to New Orleans police post-hurricane were also reported (F. P. Buttell, Carney, M.M., 2009). Evidence from the 2010 earthquake in Haiti suggests that a disaster's impact on experiences of IPV can extend long after the initial disaster. Two years after the earthquake, women living in areas of greater earthquake devastation had higher rates of physical and sexual IPV than women living in less impacted areas. Probable contributing factors include changes in family economics and changes in women's access to social support (Weitzman, 2016). Following the Deepwater Horizon Oil Spill in 2010 in the Gulf of Mexico, Lauve-Moon and Ferreira (2017) found that people directly impacted by the oil spill were about twice as likely to experience both physical and emotional IPV compared to those not impacted

by the disaster. Furthermore, access to support services was poor for those who experienced both physical and emotional IPV (Lauve-Moon & Ferreira, 2017).

Several factors are suggested to drive the increased prevalence and severity of IPV following natural disasters including new strains and conflicts on interpersonal relationships and limited access to social services and support systems (Lauve-Moon & Ferreira, 2017). Social and medical services such as mental health counseling or temporary shelter as well as connection to family and friends may be compromised during times of disaster (Jenkins & Phillips, 2008). Thus, those experiencing IPV who normally turn to these services and systems have fewer options for support (Dutton, 2007). While HCPs in post-disaster settings may be aware of an increased need of DV or IPV resources, these workers may not be adequately trained to respond to IPV-related needs due to limited resources allocated towards those efforts (Lauve-Moon & Ferreira, 2017; Yun, Lurie, & Hyde, 2010).

IPV and humanitarian settings

A systematic review of the magnitude of gender-based violence (GBV) in emergency settings found higher rates of IPV compared to rates of rape or sexual violence perpetrated by those outside of the home (Stark & Ager, 2011). In addition, forms of GBV, including IPV, are intensified during humanitarian emergencies (Inter-Agency Standing Committee, 2015). A 2014 meta-analysis found that across 19 studies, over one in five female refugees or displaced women experienced sexual violence. Authors noted that this figure is likely underreported due to the barriers which prevent disclosure of experienced violence (Vu et al., 2014).

IPV and pandemics

To understand the impacts of the COVID-19 pandemic on experiences of IPV, it is helpful to explore how the 2014-2016 Ebola Virus Disease (EVD) pandemic in Guinea, Liberia, and Sierra Leone led to increased violence against and exploitation of women. GBV service centers in Sierra Leone reported a 19% increase in women accessing their counselling and case management services compared to several months before the outbreak (John, Casey, Carino, & McGovern, 2020). In 2015, Save the Children conducted focus groups with over 1,000 children in Sierra Leone who reported increased incidence of sexual violence against girls across the country (Risso-Gill, 2015). Another study which combined a data review with qualitative methods found that recorded cases of DV in Sierra Leone were higher in 2014 than the previous five years, indicating that EVD contributed to these increases (UNDP, 2015).

Peterman (2020) identifies core contributors of IPV during pandemics to include economic insecurity, movement-related restrictions such as quarantine and isolation, disaster-related unrest, increased exposure to abusive partners, and decreased access to health services. An exploration of available literature finds that these factors were present during the EVD pandemic. As restrictions on movement tightened including quarantines, curfews, and school closures to control the spread of EVD, economic security was disrupted for many women, leading to increased poverty and increased risk of sexual exploitation and violence (International Rescue Committee, 2015; Onyango et al., 2019). The outbreak also directly obstructed IPV survivors' ability to seek medical, legal, and social services as resources were diverted to the EVD response (John et al., 2020; UNDP, 2015). Separation from family members and lack of communication

with support systems compounded the increased risk of IPV among women (Onyango et al., 2019).

IPV during the COVID-19 pandemic

Empirical evidence on the impacts of the COVID-19 pandemic on IPV is scarce. However, most of the available literature in the form of anecdotal evidence, rapid reviews, and commentaries suggest that VAW in the form of DV and IPV has intensified since the onset of the COVID-19 pandemic (D. P. Evans, 2020). The Executive Director of United Nations Women has described this phenomenon as a “shadow pandemic” that must be addressed concurrently with the COVID-19 response (UN Women, 2020a).

Media Reports

Early in the COVID-19 pandemic, media sources reported an increased use of domestic and intimate partner violence resources across the globe in countries such as Argentina, Cyprus, France, Singapore, Spain, China, and Canada (Allen-Ebrahimian, 2020; Azcona, 2020; Daya, 2020; Taub, 2020). *The New York Times* reported an 18% increase in the number of emergency DV calls made in Spain during the first two weeks of lockdown compared to the same period a month earlier (Taub, 2020). A surge in calls to DV helplines also occurred in China in early February, a period of city-wide lockdowns, and a 30% surge in DV reports was experienced by the French police in early April, about two weeks after France announced its lockdowns (Taub, 2020). In Canada, calls to a DV support service increased by 300% between mid-March and early April (Daya, 2020). In the United Kingdom, IPV homicides between March 23 and April 12 were nearly three times greater than rates during the same time period over the previous

decade (Azcona, 2020). Increased IPV homicides were also experienced in Brazil which saw a 22% increase in femicide during the first two months of their movement restrictions, and in Argentina where femicides reached a 10-year high under COVID-19 lockdowns, with over 50 femicides in less than two months (Bastos, 2020; Lopez, 2020).

Rapid Data Reviews

Rapid data reviews point to similar trends of increased DV and IPV resource utilization during the pandemic (Aguero, 2021; F. Buttell, and Ferreira, R.J., 2020; Gosangi et al., 2020; Matoori et al., 2020). IPV rates in Wuhan, China in February 2020 were three times higher than rates in February 2019 (F. Buttell, and Ferreira, R.J., 2020). In Peru, calls to a DV hotline increased 48% between April and July 2020 following nationwide stay at home orders in mid-March (Aguero, 2021). Police departments in cities across the United States such as Seattle, Chicago, and Boston reported increased rates of DV reports in periods following lockdowns compared to the same periods in 2019 (Matoori et al., 2020). Increases in DV occurrence are not isolated to periods after lockdowns were implemented. Communications from police departments in Philadelphia reveal a seven percent increase in the rate of DV reports the month before lockdowns began (Matoori et al., 2020). Fears of COVID-19 mixed with greater power and control of perpetrators over their partners may explain this increase in IPV before periods of lockdown. Finally, a systematic review of 18 studies by Piquero, Jennings, Jemison, Kaukinen, and Knaul (2021) found a 7.86% average increase in reports of domestic violence following the implementation of COVID-19 movement-related restrictions. Studies included in their review were geographically diverse, representing cities across the U.S. and countries across the globe such as Argentina, Italy, and India.

Empirical Evidence

Studies with more robust data collection methods corroborate evidence from anecdotal reports, media reports, and commentaries. Leslie and Wilson (2020) used difference-in-difference methods to compare DV calls in 14 U.S. cities before and after social distancing orders began relative to similar periods in 2019. They found that COVID-19 led to a 7.5% increase in calls for DV service during March, April, and May 2020 with the largest increase occurring during the first five weeks after widespread social distancing began (Leslie & Wilson, 2020). Furthermore, social distancing was attributed to an uptick in DV service calls in areas without a recent history of DV calls (Leslie & Wilson, 2020). When examining data from the Dallas Police Department in Texas, Piquero et al. (2020) found an increase in domestic violence in the two weeks after Dallas' citywide shelter-in-place order took effect. Also using police department data, researchers in Atlanta, Georgia discovered a rise of cumulative counts of domestic crimes during 2020 compared with the previous two years, suggesting an increase in DV occurrence (D. P. Evans, Hawk, S.R., and Ripkey, C.E.).

A community-based study in Ethiopia found the prevalence of IPV (22.4%) among married women during COVID-19 movement-related restrictions to be comparable to the pre-pandemic figure (Tadesse, Tarekegn, Wagaw, Muluneh, & Kassa, 2020). While this study does not indicate an increase of IPV during COVID-19 restrictions, it indicates that IPV remained a significant threat to public health and safety during the pandemic. A cross-sectional analysis aimed at describing IPV severity and victimization during the early stages of the pandemic found that sexual and physical violence was exacerbated, with the risk of IPV worsening among those experiencing physical IPV to be 4.38 times higher compared to those not experiencing physical

IPV (Jetelina, Knell, & Molsberry, 2020). Finally, early evidence from a qualitative study in the United Kingdom using semi-structured interviews with IPV survivors and health care practitioners suggests that stalker victimization has increased during the COVID-19 pandemic. Participants discussed increases in cyber abuse and online stalking. Social distancing measures and movement-related restrictions have increased survivors' reliance on the Internet for working, banking, and accessing support services. This in turn may increase exposure to stalking perpetrators (Bracewell, Hargreaves, & Stanley, 2020).

Reports of decreased IPV resource use

Despite the growing body of evidence suggesting increased rates of IPV and IPV service utilization during COVID-19, several countries report downturns in use of certain IPV-related resources. During the first six weeks of lockdowns in the United Kingdom, referrals for forensic examinations by national sexual assault referral centers were halved (Johnson et al., 2020). In Italy, while IPV-related requests from phone counseling services increased over 2.5 times during the first two weeks of April compared to the same period in 2019, the number of women seeking in-person emergency medical and mental health care was halved (Barbara et al., 2020).

However, these reports may not accurately describe the situation of IPV during COVID-19. Importantly, these reports describe reduced use of in-person services. As previously described, with movement-related restrictions in place, the ability for survivors to leave their home to connect with in-person support services may be compromised. Fears of contracting COVID-19 may also limit survivors' use of in-person services.

Pathways between COVID-19 and increased IPV

Several pathways between COVID-19 and increased IPV include similar factors to those experienced in other pandemics such as limited access among survivors to support services and networks and increased exposure to abusive partners (Azcona, 2020; World Health Organization, 2020). Perpetrators may also leverage the fear associated with COVID-19 to exert greater control over partners they are abusing (Azcona, 2020).

There are multiple established risk factors of IPV including low socioeconomic status, unemployment, low educational attainment, and previous history or exposure to violence. Unemployment and previous experience of violence are also risk factors for perpetrating IPV along with economic stress and psychological disorders such as depression, PTSD, and alcohol and substance abuse. Interpersonal risk factors also predispose relationships to IPV including those characterized by conflict and those which operate within rigid gender roles (Moreira & Pinto da Costa, 2020). COVID-19 is a potential trigger for new or worsening IPV due to its influence on IPV risk factors. Employment opportunities and schooling strategies have shifted dramatically during the COVID-19 pandemic. In the United States, tens of millions lost jobs or worked fewer hours, about 35% of jobs shifted to remote work, and public schools nationwide adopted remote learning strategies (Leslie & Wilson, 2020). Household financial strain, housing instability, a shift in parenting responsibilities, restricted access to medical and sexual and reproductive health services, and restricted access to legal systems and protection orders are likely to increase IPV risk (Bracewell et al., 2020; F. Buttell, and Ferreira, R.J., 2020; Jarnecke & Flanagan, 2020; Sanchez, Vale, Rodrigues, & Surita, 2020).

Health impacts of movement-related restrictions

Movement-related restrictions are common tools used to limit the spread of infectious diseases during outbreaks and pandemics. Quarantine (the separation of those exposed to a contagious disease to determine whether they develop symptoms or test positive) and isolation (the separation of those with confirmed or suspected infection with a contagious disease) have been utilized in the past to curb the spread of outbreaks such as the severe acute respiratory syndrome (SARS) outbreak in 2003 and Ebola Virus Disease pandemic in 2014 (Brooks et al., 2020). Quarantine and isolation are also being used to fight the COVID-19 pandemic. While movement-related restrictions are effective tools in halting transmission, there are other consequences that must be acknowledged.

Multiple studies report negative psychological impacts of quarantine including PTSD, sleep disorders, and anger issues (Brooks et al., 2020). The length of quarantine can also impact psychological outcomes, with longer quarantines being associated with poorer mental health outcomes (Brooks et al., 2020). Similar impacts were observed with the statewide shelter-in-place orders in California which took effect on March 20, 2020 (Raj, Johns, Barker, & Silverman, 2020). A cross-sectional analysis of California state-representative data collected two weeks after the shelter-in-place began found higher than normal symptoms of depression and anxiety. An elevated risk for negative psychological outcomes was also observed among individuals with a history of IPV (Raj et al., 2020). Shelter-in-place orders also “mimic common forms of partner abuse such as forcing isolation from friends and family...and generally controlling the victim’s associations, movements, activities,” and access to health care (Piquero et al., 2020).

Additional movement-related restrictions such as quarantine, isolation, and social distancing are likely to exacerbate these negative psychological health impacts. The WHO has cautioned that movement-related restrictions ordered to control the spread of COVID-19 may also work to “exacerbate the risk of violence against women” (Barbara et al., 2020). Research into the relationship between movement-related restrictions and IPV occurrence is thus needed to inform the pandemic response and meet the needs of those experiencing these types of violence.

Role of health care professionals

This study focuses on perceptions of HCPs as frontline workers are often highly aware of the need for IPV services during and after times of disaster. This is due to the fact that HCPs provide direct care to people experiencing IPV during these emergencies (Enarson et al., 2018). Doctors, nurses, and social workers in health care settings provide referrals to people experiencing IPV for social services and offer support in safety planning (M. L. Evans, Lindauer, & Farrell, 2020). Despite the critical support offered by these providers, barriers may exist which limit their ability to provide these referrals or even identify cases of IPV. Such barriers include limited time and resources, insufficient training, and limited consistency with IPV screening (Sprague et al., 2012; Tower, 2006; Zero & Geary, 2020). IPV screening inconsistencies may be exacerbated with the reliance on telemedicine during the pandemic, and IPV-related injuries may be misinterpreted or go unnoticed if health care providers are overwhelmed by the number of COVID-19 patients in the emergency department (M. L. Evans et al., 2020; Gosangi et al., 2020). Due to the strains COVID-19 has placed on health care systems’ resources, it is crucial to learn from HCPs about their perspectives on support available to people experiencing IPV during COVID-19.

Conclusion and added value

As the COVID-19 pandemic progresses, its full effects on IPV remain unknown. While anecdotal reports, rapid data reviews, and the limited empirical studies point to increases in IPV prevalence and severity, little is known about the impacts of COVID-19 movement-related restrictions on experiences of IPV. Therefore, more research is needed to inform our response in a way that addresses not only the health and economic burdens of COVID-19 but also the less visible impacts on IPV. To date, no study has evaluated the perceptions of COVID-19 movement-related restrictions such as shelter-in-place, quarantine, and isolation orders and their effects on IPV from the perspective of HCPs. This is the gap in literature this study aims to fill.

Chapter 3: Methods

Design

To explore this topic, a cross-sectional mixed methods study was conducted. Due to the limited existing knowledge of the effects of COVID-19 movement-related restrictions on IPV, this study design allowed us to gain a robust understanding of the topic from the perspective of HCPs who frequently work with survivors of such violence in hospital and ED settings. IPV is a sensitive issue which also lends itself well to the use of qualitative methods where researchers build rapport with participants during data collection. In-depth interviews (IDI) were chosen as this method of data collection is conducive to identifying personal experiences and gaining rich information on HCPs' perceptions and experiences.

Instrument

An original IDI guide was created and began with a short survey on participant demographics (Appendix I). Qualitative questions followed to explore three domains with participants: (1) COVID-19 health impacts, (2) COVID-19 movement-related restrictions and violence, and (3) health seeking behaviors. Quantitative questions were asked at the start of the second and third qualitative domains to gauge participants' knowledge of movement-related restrictions and their experience working directly with patients experiencing IPV before beginning a deeper conversation on these topics.

The primary interviewer conducted three practice interviews with members of the study team. Feedback from these practice interviews informed changes to the IDI guide including the addition of probes to gain more in-depth responses. Following practice interviews with the study

team, the primary interviewer pilot tested the guide with two HCPs purposively selected to provide rich data that was eligible for analysis. Iterative changes to the IDI guide were also made during pilot testing including deletion of a question that was less relevant to the research objective.

Participants

To be eligible to participate in this study, HCPs had to work at the study site, a large metropolitan hospital in Atlanta, GA, during both the pre-COVID period (January- June 2019) and the COVID period (January-June 2020). Participants were recruited from pre-selected fields (Social Work, Advanced Practice Providers, and Medicine) from the Departments of Emergency Medicine (EM) and Surgery based on these Departments proximity to IPV case management. A master list of employees from these fields was obtained from Co-Investigators who work at the study site (N=113). To ensure a diversity of sample across fields, the master sample list was divided into the following four categories of providers: (1) advanced practice providers, (2) full-time social workers, (3) EM physicians, and (4) trauma surgeons. The two study Co-Investigators were excluded from these sub frames. Microsoft Excel was used to generate a random number for each individual in the sample and the random selection function in Excel was used to identify three providers from each subframe to be recruited in the study. Two participants selected from the surgeon subframe were ineligible, so two other participants were randomly selected to replace them.

Participants were recruited for the study via a series of emails, the first of which introduced the study purpose. If there was no reply, follow up emails were sent up to three times every three

days. After a reply, we sent three subsequent emails to confirm eligibility and schedule a date and time for an interview through Calendly, confirm the date and time of the interview, and remind participants of their interview 24 hours in advance.

Data Collection

Data collection occurred from November 2020 – January 2021 and although data was only collected at one time point, this study was able to examine HCPs' perceptions and experiences before and during the COVID-19 pandemic due to the study's inclusion criteria. The concern of recall bias was mitigated in the IDI guide by offering time frames for participants to focus their reflection and responses. Following pilot interviews, the primary interviewer conducted eight in-depth interviews with HCPs (two with pilots and six with study participants). Interviews lasted between 45 and 75 minutes and were conducted and recorded remotely via Zoom. Each interview was transcribed verbatim using Happy Scribe, and transcripts were fidelity checked for accuracy using the Zoom audio recording.

Data Analysis

Data analysis occurred concurrently with data collection. A thematic analysis of the qualitative data was conducted using MAXQDA to identify core concepts, patterns, and themes across participants. To begin, the research team collectively created a codebook of deductive codes identified using the IDI guide. Next, the primary interviewer conducted several close reads of the data and applied memos to the data. Using the preliminary deductive codebook, the primary interviewer coded one transcript. From this transcript, deductive codes and definitions were

revised, and inductive codes which emerged from the data were added to the codebook. This updated codebook was used to recode the first transcript and subsequent seven transcripts.

Descriptive statistics were run on the quantitative data using Qualtrics and Excel. For the question on number of patients encountered during a typical shift who experience violence in their relationships, participants provided a range. In calculating mean and standard deviation, the lower value of the range was used. Therefore, the data presented for this question is a conservative estimate of the true value.

Ethical Considerations

Consent forms were emailed to participants twice in advance of the interview and read aloud to participants before the interview. Verbal consent was given by each participant before data collection began and documented by the research team. This research was approved by Emory University's Institutional Review Board (Study ID 00000432).

Chapter 4: Results

Six themes emerged from the eight IDIs with HCPs providing insight into their perceptions and observations of COVID-19 movement-related restrictions on IPV. These themes include: (1) COVID-19 movement-related restrictions likely exacerbated IPV; (2) IPV increased (spiked) two times during COVID-19; (3) HCPs encountered many barriers and few facilitators to IPV care provision during COVID-19; (4) IPV patients expressed fears in seeking care but did not delay treatment during the pandemic; (5) relative to the pre-pandemic period HCPs perceived no changes in IPV case presentation or severity; and (6) HCPs suggested specific internal and external improvements for IPV response.

Participant Demographics

Participants interviewed included EM physicians (n=4), trauma surgeons (n=3), and a social worker (n=1). All were aware of city-wide, Atlanta-specific, COVID-19 movement-related restrictions; however, only three participants could recall statewide movement restrictions. The majority of participants (n=6) did not have any training on responding to IPV or relationship violence; only two participants reported having specialized training in this area. Participants reported encountering an average of 1.8 patients experiencing relationship violence during a typical shift which range per provider type between eight and 12 hours (Table 1).

Table 1. Demographic information for HCPs

Characteristics	Overall N=8
Age in years, mean (SD)	41.1 (8.6)
Gender, n (%)	
Female	3 (37.5)
Male	5 (62.5)
Race, n (%)	
White	3 (37.5)
Black or African American	4 (50.0)
Asian/Pacific Islander	1 (12.5)
Marital Status, n (%)	
Never married	2 (25.0)
Married	5 (62.5)
Divorced	1 (12.5)
Highest Education, n (%)	
Master's degree	1 (12.5)
Professional degree	7 (87.5)
Profession, n (%)	
Emergency medicine physician	4 (50.0)
Trauma surgeon	3 (37.5)
Social worker	1 (12.5)
Length in years in current position, mean (SD)	4.8 (5.3)
Length in years in health care field, mean (SD)	13.9 (6.9)
Knowledge of Atlanta movement-related restrictions, n (%)	
Yes	8 (100.0)
No	0 (0.0)
Knowledge of Georgia movement-related restrictions, n (%)	
Yes	3 (37.5)
No	5 (62.5)
Special training, n (%)	
Yes	2 (25.0)
No	6 (75.0)
# patients experiencing violence in relationships per shift, mean (SD)	1.8 (1.6)

COVID-19 movement-related restrictions likely exacerbated IPV

When asked about the effects of movement-related restrictions on patients experiencing IPV, the majority of HCPs felt these restrictions could exacerbate IPV. Participants likened the impact of shelter-in-place orders and violent relationships to "powder kegs" and a tank of "boiling water but there's no popoff valve"; such circumstances were described as volatile situations on the

precipice of exploding. HCPs noted that movement-related restrictions might contribute to increased stress and mental trauma, magnifying feelings of loneliness and isolation. They saw these situations as reducing the ability among perpetrators to "modulate their emotional state or [use their] coping mechanisms." Participants believed such stress alongside sheltering in place with an abuser was a potential risk factor for increased violence.

Participants speculated that movement-related restrictions reduced the number of "outlets" people experiencing IPV had for support. They believed that reduced ability to connect to support systems such as family and friends likely contributed to feelings of isolation. Nearly half of participants shared fears that movement-related restrictions may limit a person's ability to escape a violent situation. One EM physician explained these and other challenges that survivors of IPV may have faced under movement-related restrictions:

We know that perpetrators want to isolate you. And so now we've given them a gift of isolation... Victims or survivors are now compelled to and have to be isolated with their abuser. I can't imagine the trauma that might incur. And even if you want to call out to somebody or try to go visit, if the phone is all you have, but you're in imminent danger, you know, what does that mean in terms of thinking about taking your children, if you have them, along with you in an environment where you might be exposed, or not exposed? Do you have masks to be able to go where you need to go? Are people going to accept you in without perhaps a COVID negative test? I mean, it is just unbelievable the number of what ifs, if you will, that people are thinking about.

Participants also believed that the loss of support structures could lead people who weren't normally violent to "lose control."

Half of participants (n=4) believed that confinement to the home in observation of movement-related restrictions could have contributed to their perception that IPV increased at the beginning of the pandemic. HCPs speculated on potential explanations for this phenomenon including a lack of ability to distance oneself from the violence; several speculated that movement-related

restrictions may have increased violence or tension in relationships due to being "stuck in the house." One EM physician recounted hearing about an increase in the number of calls made to the Georgia Coalition Against Domestic Violence, noting that "there was an uptick in intimate partner violence for people who had to shelter-in-place with their abuser." While the effects of movement-related restrictions on the severity of IPV were largely unknown to these participants, one EM physician felt that some less severe IPV altercations observed during the pandemic could have been prevented if more social support options had been available to perpetrators of violence.

Most participants were unable to comment on how movement-related restrictions have impacted violence perpetrators and the control they exerted over their partners; however, three speculated that movement-related restrictions have "increased the amount of dominance the partner has over" their victim. One EM physician speculated that if someone experiencing violence tested positive (for COVID-19), and they were actually able to isolate, the isolation orders may have reduced exposure to their abuser. However, several participants shared that it was difficult to properly isolate and quarantine, particularly for smaller households and those in which people had to continue to work to provide for their family. Two HCPs speculated an increased risk of abuser control due to movement-related restrictions, as abusers may have a "heightened awareness of power" and the knowledge that their partner may not have options for leaving the relationship under shelter-in-place or quarantine orders.

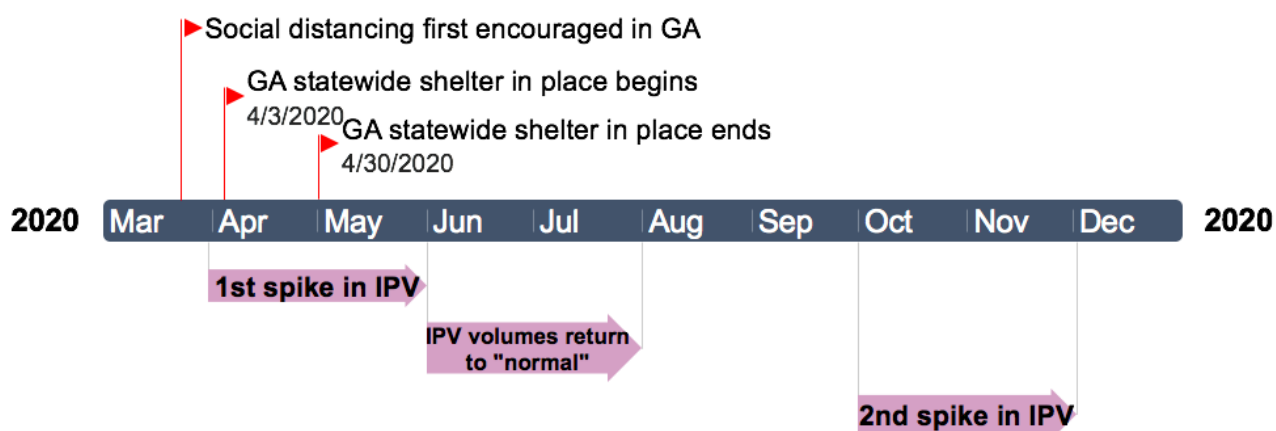
Finally, participants discussed the social issues exacerbated by COVID-19 among their patients, which put them at greater risk for both the infection and IPV. Social issues included

homelessness, food insecurity, unstable transportation, unstable employment, and health insurance insecurity. One EM physician commented that shelter-in-place orders may have contributed to job loss, and one social worker commented that when MARTA (the public transport operator in Atlanta) severely limited its routes at the beginning of the pandemic, patients experiencing IPV had transportation issues.

IPV increased (spiked) two times during COVID-19

Participants perceived two spikes in IPV cases between March and December 2020 (Figure 1). Half of participants expressed that at the start of the pandemic in April and May 2020, there was a spike in IPV. While this was based largely on perceptions of hospital censuses, one surgeon expressed that “every single day, you'd hear another story” about IPV. The most common explanations given for this spike was “confinement to an environment” with an abusive partner and few other outlets for support. Another contributor offered by one EM physician was that the closing of domestic violence shelters in Atlanta made the task of safely discharging patients experiencing IPV after hospital-based treatment more challenging.

Figure 1. Timeline of IPV frequency perceived by HCPs during 2020



During the months of June and July 2020, participants perceived that the volume of IPV patients returned to “normal” levels. Despite this perceived return to normal for IPV cases, many participants shared that the number of violent traumas (e.g. shootings and stabbings) increased during this time. While increases in violent trauma during summer months are typical, one EM physician explained that several factors may have contributed to a particularly high level of violent traumas including “COVID fatigue” in which people became more comfortable leaving their homes, expiring shelter-in-place orders, and racial justice protests in Atlanta. Another EM physician described this interaction between the pandemic, police brutality, protests, politics, and public health as the “peril of the p’s.”

A second spike in IPV was observed by one EM physician in October and November 2020 with these patients experiencing more concurrent psychological, substance abuse, and chronic homelessness issues. These concurrent issues were less frequently observed in the first spike. However, it is possible they were present then but became more visible to HCPs during the second spike, particularly when in-hospital admissions for IPV patients extended to multiple days in the search for discharge support. When discussing IPV patients with multiple social issues during the second spike, this physician shared the following:

Maybe there's more of them or maybe because the resources in the city are so limited, we become more aware of them because they're having to stay a couple of days. And sometimes the psychologic issues are unmasked as they stay for a day or two, that all of a sudden, the story of what happened starts to devolve a little bit.

HCPs encountered many barriers and few facilitators in IPV care provision during COVID-19

Major patterns emerged in the barriers to providing care and support for IPV patients during the COVID-19 pandemic. Those include personal, community-level and practice-oriented barriers. Two facilitators emerged related to the study site's visitor policy and a social support "fixer." A commonly shared personal barrier was in making connections to patients through COVID-19 personal protective equipment (PPE). One EM physician commented that while using PPE – including multiple masks, goggles, and gowns – "you look more like an object than a person."

The most salient community-level barrier to providing care to IPV patients during the COVID-19 pandemic was a lack of community resources, including shelters, in Atlanta which predated the pandemic. At many points in the pandemic, the few options available for safe discharge were at full capacity. A social worker felt that this lack of resources was due to "not enough time and attention put into the need." This social worker also shared that some facilities reduced their daily intakes, with social distancing requirements being a potential contributing factor. Many facilities required a negative COVID-19 test before admission or repeatedly changed their testing protocol, which further delayed safe discharge of patients experiencing IPV. Safe discharge to a patient's or friend's home also posed a challenge to one surgeon as some family and friends were hesitant to accept patients out of fear of contracting COVID-19. Navigating safe discharge for patients without family or friends to stay with was further complicated by the closing of a women's shelter at the beginning of 2020 before the pandemic hit. Once COVID-19 hit Atlanta, the shelter never reopened. One EM physician described the precarious nature of discharging

patients to hotels during the pandemic; even when survivors were appropriately placed in hotels, there were instances where their perpetrator tracked them down and reinjured them.

The lack of community resources in Atlanta was particularly challenging on the weekends. With shelters largely unavailable in Atlanta, HCPs had to “cast [their] net wider and find shelters in other cities. Some as far away as Stockbridge or Valdosta.” Given the distance to these alternate sites (>200 miles in some cases) transportation remained an important issue. One EM physician shared a case encapsulating this challenge.

We had one lady who presented on a Friday night and it was clear that we were not going to be able to get her any transportation until Monday. So, she wound up staying in the emergency department all weekend... We even looked through our social services and our social worker was trying to get approval from his manager to spend money on a Lyft, which would have been, I think, over \$400... Which is funny because I think, you know, the hospital probably spent more than \$400 keeping this person there for three days. You know, but it's just differential budgets. And nobody puts those two things together. And it's hard, because then you get the next person. It's like, well, what do you do with that?

Another EM physician echoed this challenge, adding that they had to get creative with how to provide social support, especially when religious institutions in Atlanta temporarily closed due to COVID-19. A third EM physician shared a struggle in figuring out how to connect patients to counseling resources as support became virtual through telehealth, saying that “a lot of telemedicine assumes that people have a certain level of privilege to have a TV or phone.” Lack of this privilege presented its own barriers to care.

The most common practice-oriented challenges centered on the pace of work in the hospital and the fragmented nature of work in the IPV field which may limit "consistency around making sure people have the accurate information delivered, followed up on, and close looped in terms of communication." A trauma surgeon commented that providers are so busy that they don't have

time to sit with IPV patients and let them “decompress” their trauma experiences. Interactions were viewed as being routine —asking the necessary questions before quickly moving on to the next patient. The lack of time and resources to provide emotional support to patients experiencing IPV, an existing problem, was exacerbated during COVID-19 as the study site ran “lean” during the pandemic to “minimize the number of people in-house” in the effort to prevent COVID-19 infection. For one EM physician, the pace challenge overlapped with lack of community resources:

How can you keep pace with the response and how can you keep pace with the services that might be needed for survivors/victims, right? Because if you are trying to move somebody into a place of safety, where are you moving them to? If there are struggles and challenges with access, right? So, it is tough.

Another practice-oriented barrier was general staffing and bed capacity issues at the study site.

This hospital was “chronically full” due to on-going flooding issues making rooms unusable, long lasting nursing and bed shortages, and patients being boarded longer during the pandemic.

A final practice-oriented barrier was low compliance with the hospital’s current violence screening tool which was attributed by one surgeon to high nursing turnover and high trauma volumes. The tool is also not specific to IPV, but rather screens for multiple forms of interpersonal and community violence. An EM physician also aware of low IPV screening compliance shared this possible explanation: “People are afraid to ask [about IPV], and I suspect because then what do you do with it? You know, if resources are scarce.”

The study site’s COVID-19 visitor policy and a liaison from the Women’s Resource Center to End Domestic Violence facilitated IPV screening and care provision during the pandemic. HCPs noted that since companions and visitors were not allowed in the hospital, except for exceptional circumstances, patients were seen alone and without a potential abuser, therefore, it was easier to

ask a patient about violence experiences in their intimate relationship. A second facilitator established in spring 2020 was the Women's Resource Center liaison who helped HCPs marshal resources for social support. In addition, the liaison was a "fixer" when HCPs reached roadblocks in the support they could provide, having the ability to authorize transportation, clothing distribution, and hotel stays. Hotel stays were particularly hard to obtain as hotels were reluctant to offer vouchers to someone who needed to stay more than one or two nights. One EM physician shared the following success story from this new collaboration:

We did have a case a couple of weeks ago where we successfully got somebody a plane ticket to New Orleans. So, we kind of repatriated them back in New Orleans where they had a place where they could go. So, I'm not sure how we came about the funds for the plane ticket, but we were able to do that.

IPV patients expressed fears in seeking care but did not delay treatment during the pandemic

IPV patients expressed pandemic-related fears, but HCPs did not observe a delay in health care seeking among these patients due to these fears. A social worker shared that IPV patients worried about the availability of IPV support resources, especially with “everything being shut down.”

When asked about concerns IPV patients shared regarding care seeking during the pandemic, one trauma surgeon shared:

It's the fear of catching COVID. The whole thing around it, you know, being in the hospital is, again, you're going to catch it in the hospital. The hospital gives it to you. The nose swab gives it to you. It doesn't really exist and there's absolutely no way that you're testing me for COVID. I refuse it. You know, all this kind of stuff.

To explain a lack of delay in care despite pandemic-related fears, a trauma surgeon shared that patients experiencing IPV who present to the EM typically have significant injuries, so there isn't always a personal choice in whether or not to seek care. This was echoed by an EM physician who shared that patients with significant IPV-related injuries were probably “judging

that to be more important than a theoretical risk of contracting COVID while they're at the hospital." In contrast, HCPs observed that patients in the general population delayed accessing health care due to fears of contracting COVID-19. One EM physician explained that some delayed care for serious medical conditions such as heart attacks, strokes, and brain bleeds out of fear of the virus.

An important consideration described by HCPs is that it is hard for providers to know if patients experiencing IPV delayed care unless they specifically probed on this question. An EM physician believed that isolation and quarantine orders may have increased fear or abuse among IPV patients which could have impacted whether or not they sought care. A social worker shared that some people experiencing IPV "probably just don't come forward because either they tried to before and they know that there aren't a lot of resources or because they don't know that they'll be able to get the help that they need."

Relative to pre-pandemic period, HCPs perceived no changes in IPV case presentation or severity

HCPs did not describe any changes to IPV patient profiles in terms of race, age, or gender. While some men presented with IPV-related injuries, most patients experiencing IPV remained the same as before COVID-19, typically young women. One interesting observation about case presentation noted by two participants was that during the pandemic, there were more instances of mutual violence rather single perpetrator situations with "one person clearly being the victim." A trauma surgeon shared the following cases:

The husband beat up the wife, and so the wife threw a knife into his back as he was walking out the door. Or the wife ran over the husband but when you look further into it, it's because the husband was beating up the wife with a hammer.

In these altercations, it seemed to one EM physician as if both partners, “came to their senses at some point in the thing and decided not to kill each other.” Another change related to the types of weapons used in IPV cases, with a shift towards more household objects. An EM physician discussed the change in this way:

There's a lot less guns and more like fist-found objects like frying pans, stuff like that. And it felt like there were people who weren't initially violent or didn't have access to weapons like lost it. So, like that was my going into the summer takeaway. It wasn't as much guns and knives as much as it was frying pans, video game controllers, stuff like that

The physician went on to describe a case where a woman was beaten severely with a frying pan by her partner who “didn’t have anything else to use as a weapon”; the physician could not recall the last time they had that type of weapon used in an IPV case during their 18 years of medical practice.

Participants disagreed if severity of IPV had worsened during the pandemic. Half of participants expressed that there were no observed changes in IPV severity, while two participants speculated that severity of IPV injuries seemed worse. One EM physician described the following complex case:

I remember maybe one case with a resident way back, where it was more trauma in the sense that the patient's partner was just really inebriated and just out of work. And because he was out of work, took the stressors out on her. But it's not to say whether COVID was the cause of that. I just think he was out of work and he was isolated and she was isolated. And perhaps that would have brought her in a little bit more

However, this physician did not feel this one incident was indicative of an overall rise in severity of IPV, as physicians at this hospital routinely see large volumes of severe cases.

HCPs suggested specific internal and external improvements for IPV response

HCPs offered suggestions on methods to prevent or better respond to IPV during pandemics.

Suggestions discussed involved: improving communication about IPV support resources; engaging with community organizations to improve availability of IPV support resources; improving IPV screening and follow up for patients experiencing IPV; and establishing an office at the study site to coordinate community response needs of IPV patients.

Several participants suggested the need for early communication of support available to people experiencing IPV during a pandemic. They said that such communications could and should be shared on social media platforms at the state or even national level and include information on hotlines, online support groups for those experiencing violence in their relationships, and awareness of the stressors one can experience during a pandemic, such as the social issues of financial strain, homelessness, and food insecurity observed during the COVID-19 pandemic. An EM physician emphasized that if movement-related restrictions are enacted in the future, messaging should be disseminated that encourages those whose homes are not safe to seek alternate shelter at safe places.

Another subtheme related to engagement with community organizations. To provide alternative safe places during movement-related restrictions for people experiencing IPV during pandemics, participants believed that work can be done now to standardize shelters' protocols for admission, including who needs to have a negative test of the contagion before admission. This would address the delays to discharging patients due to changing admission protocols at shelters, such as those experienced during the COVID-19 pandemic. To encourage people experiencing

violence in their relationships to come forward and seek support during a future pandemic, a social worker suggested establishing a “facility available specifically for patients who are experiencing IPV to be able to go to.”

Participants viewed screening and follow up care as an important area of improvement in IPV-related care during pandemics. One trauma surgeon discussed the need to put in place a “very stringent way to screen for” IPV where everybody who engages health care in any setting is screened. According to one surgeon, this suggestion is being acted upon. The trauma center at the study site is working to enact screening for IPV in a more standardized way based on best practice guidelines from the American College of Surgeons. The goal is to develop a nursing-driven protocol where a four-question validated tool is used to assess for potential IPV. The trauma center started this process before COVID-19 but got sidetracked for about six months by the pandemic. Work has recently resumed on this process of bringing their screening up to best practices.

Multiple providers discussed the possibility of cases of IPV that went unrecognized in the health system during COVID-19 and the need for follow up; cases during the COVID-19 pandemic where follow up was absent were also mentioned. One surgeon shared “a case where somebody came in after being beat up by their significant other and then came back two weeks later and they got missed completely.” A similar case during the COVID-19 pandemic was shared by another surgeon.

“We had a guy who got beat up by his partner because he didn't want to have sex with them. He got a brain bleed from it. He was in the hospital. We sent him home. And then like a week later, he came back, because his partner beat him up again and killed him.”

When asked whether this person was referred to social services, this surgeon explained “I think he declined...but no one ever did the follow up for him.” Two participants proposed a robust and active follow up system for IPV patients including home visits to ensure patients know how to isolate and have an environment where they can actually isolate. This would "probably deter more violence." However, these participants also stressed that if these home visits were employed during a pandemic response, they would need to be conducted according to any necessary social distancing protocols.

One EM physician discussed the option of establishing a Domestic Violence Coordinating Office at the study site which could coordinate all community response needs including legal, housing, and follow up. The study site already uses clinical care coordinators, known as C3s, to consult with medical staff regarding patient statuses, bed placement, and resource utilization. This physician saw potential for using C3s in the IPV sphere to improve follow up. Another EM physician proposed the following coordinating structure:

I had actually brought up with our, kind of Chief of Public Relations, I was like, is there a way to either develop a GoFundMe or, you know, through the board or through some of our fundraising to have a fund for rides to shelters for patients? You know, if our rate limiting step is a \$400 Lyft ride, then let's figure out a way to provide that service sustainably where you'd have a fund for that. But I think some of that is going to be looking outside of the traditional operating budget.

This suggestion could ameliorate challenges related to transportation when HCPs are discharging patients to shelters or other facilities that are farther away

Chapter 5: Discussion

Providers identified several key themes observed during their practice highlighting the complex relationship between COVID-19 and IPV, specifically related to the impact of movement-related restrictions on increasing IPV. Providers suggested that confinement to environments with an abusive partner coupled with a reduced ability to connect to social networks likely contributed to perceived spikes in IPV. Further, providers described navigating the safe discharge of patients experiencing IPV as a major barrier due to limited community resources. Finally, HCPs provided suggestions to prevent and better respond to IPV during pandemics including improving communication on the availability of IPV support resources, improving IPV screening and follow up for patients experiencing IPV, and establishing an office at the study site to coordinate community response needs of patients experiencing IPV.

HCPs perceived two increases (spikes) of IPV during 2020 in April and May and October and November. Compared to the pre-pandemic period, there were no perceived changes to IPV patient profile; patients experiencing IPV during the COVID-19 pandemic were, for the most part, young women. These findings support the numerous studies which point to increased violence against women during times of emergency (F. P. Buttell, Carney, M.M., 2009; Clemens et al., 1999; Enarson et al., 2018; Lauve-Moon & Ferreira, 2017; Parkinson, 2019). Furthermore, our findings support the anecdotal evidence that IPV has intensified globally since the onset of the COVID-19 pandemic, a phenomenon described by UN Women as a “shadow pandemic” (Azcona, 2020; Bastos, 2020; Daya, 2020; Taub, 2020; UN Women, 2020a). Although our study is not generalizable to perceptions of HCPs outside of our study site due to the research methods used, its significance lies in that it adds to the body of work which supports the “shadow

pandemic” and supports calls for improved response to the concurrent public health threats of COVID-19 and intimate partner violence.

The stress related to sheltering in place and other movement-related restrictions was highlighted as a risk factor in the uptick of IPV observed by HCPs in this study. HCPs also shared that movement-related restrictions may have induced feelings of loneliness and isolation and may have reduced the coping mechanisms of perpetrators of violence. These findings support reports of negative psychological impacts of quarantine and shelter-in-place orders (Brooks et al., 2020; Raj et al., 2020) and the findings of Peterman (2020) who identified movement-related restrictions as a core contributor of IPV during pandemics. During the Ebola Virus Disease outbreak in West Africa from 2014-2016, lack of communication with support systems compounded the increased risk of IPV among women (Onyango et al., 2019). Findings from our study suggest that COVID-19 movement-related restrictions played a similar role in reducing the number of social "outlets" people experiencing IPV had for support by reducing the ability to connect to support systems such as family and friends; this was true for both potential survivors as well as perpetrators.

Our findings of reduced social support and negative psychological outcomes arising from movement-related restrictions during a pandemic are supported by existing literature of this and previous pandemics. Therefore, we suggest that the interaction between IPV, pandemic movement-related restrictions, and negative psychological effects is not unique to the COVID-19 pandemic, but rather an enduring relationship that must garner serious consideration when movement-related restrictions are enacted during future pandemic response. As movement-

related restrictions are a critical step in the prevention of the spread of a pandemic, their implementation in future pandemic responses must be accompanied by the acknowledgment that not every home environment is safe. To respond to this need for alternative safe environments for those experiencing violence in relationships during pandemics, governments and public health agencies can build resources for these support services into their response plans for future pandemics.

One of the primary barriers to providing support to patients experiencing IPV identified by HCPs was the lack of availability of community resources in Atlanta. This was particularly challenging in relation to the safe discharge of patients experiencing IPV without other safe housing options. The perceived spikes in IPV with “normal” levels of IPV cases in the periods in between suggest a sustained need for IPV support services in Atlanta during the COVID-19 pandemic. Yet, findings from this study suggest that the demand for IPV community support outweighs the supply of resources. Thus, advocacy in favor of increasing the amount of support services and facilities for people experiencing IPV in Atlanta is a potential strategy to help improve HCPs’ ability to connect patients to support services. Increasing the amount of housing facilities for patients experiencing IPV is likely a time-consuming process. Therefore, immediate action and allocation of resources by governments and public health agencies may be necessary to meet the demand during a future pandemic or other public health emergency.

Navigating the safe discharge of IPV patients was also complicated by frequent protocol changes from shelters and housing facilities. In the context of COVID-19, changing protocols were likely inevitable due to the evolving knowledge of the virus and its associated risks. Guidelines were

provided by the U.S. Centers for Disease Control and Prevention (CDC) for shared and congregate housing including DV and homeless shelters to prevent the spread of COVID-19 as early as April 25, 2020 (CDC, 2020). These guidelines evolved as the pandemic progressed, and shelters made decisions on how to manage their admissions safely based on the resources available to them, which likely contributed to changes in admissions protocols. Now with the experience of operating through a pandemic, shelters and housing facilities have the opportunity to standardize operating procedures (SOPs) of admission during times of emergency. This standardization could include circumstances under which clients can be admitted, such as those based on testing requirements or levels of community spread. Admissions standards during pandemics and other states of emergency would not solve the challenges with safe discharge of hospital patients experienced by these HCPs, yet they could improve transparency on the availability of resources for IPV patients. SOPs developed now could also easily be re-instituted in the future when necessary.

There is high feasibility to apply the findings from this study to clinical settings, particularly the suggestions provided by HCPs. While certain suggestions such as the establishment of a domestic violence coordinating office might be more specific to the study site, others, particularly regarding improved public health communications have implications and transferability for statewide or even national implementation. The experience of IPV is not bound to Atlanta, but rather is a global issue which threatens public health and safety. Therefore, statewide or even nationwide messaging to improve awareness of the stressors and social issues that accompany a pandemic along with information on support services available to people experiencing IPV could improve the response to IPV during pandemics. Further messaging that

identifies safe locations for people experiencing IPV, even if public health and government officials are encouraging people to stay at home, could help prevent incidences of violence in relationships.

Another suggestion with clinical application is the establishment of a GoFundMe or other fund to pay the transportation costs of IPV patients who find shelter in distant facilities. This fund could also be adopted in other clinical settings which face similar issues in securing transportation for patients experiencing IPV. As costs to the health system incurred by IPV patients extending their hospital stay in the search for safe discharge may exceed the transportation costs to a distant housing facility, this transportation fund may have cost savings benefits to the implementing hospital. However, due to loss of hospital funds during COVID-19, it may not be feasible for the study site to accommodate this fund with their budget. If this fund cannot be financed by existing budgets and external funds are needed, such as the case would be with a GoFundMe, the sustainability of this fund may be limited. Questions also arise as to who would manage these funds and how they would be allocated equitably.

The suggestion to implement a more stringent IPV screening process at the study site is highly feasible given that proponents have already begun work on this task. If enacted, this change could reduce the number of patients experiencing violence in their relationship who go undetected in the health system. It could also have implications in overcoming low compliance on the current IPV screening tool, one of the barriers to care shared by HCPs. In further discussion of low IPV screening compliance, participants shared that high nursing turnover, high trauma volumes, and lack of time to spend with patients were potential contributing factors.

These factors mirror those discussed in a systematic review, which found that time and resource constraints, limited consistency, and lack of knowledge were the most commonly reported barriers to IPV screening among health care providers (Sprague et al., 2012). As barriers to IPV screening in our study align with those found in a systematic review nearly a decade ago, it is possible these barriers are enduring and exist in areas outside of metro-Atlanta.

Limitations

There are several limitations to this study. In addition to the two pilot interviews included in analysis, the study aimed to recruit 12 providers, three from each of four professions (social workers, EM physicians, trauma surgeons, and advanced practice providers). However, we were only able to recruit one social worker, three EM physicians, two surgeons, and no advanced practice providers. This was due to time constraints from providers actively fighting the COVID-19 pandemic. Therefore, we are missing perspectives from advanced care providers and social workers. While the deductive codebook was created collaboratively across the research team, only one researcher coded the data for analysis. Another limitation of this study is the potential for a clinical sample bias; we only interviewed HCPs who interact with survivors of IPV who seek emergency health services. Therefore, the experiences of survivors of IPV who did not seek emergency medical care during the COVID-19 pandemic following a violent incident were not known to participants. Due to this limitation, we cannot solely rely on data from health care utilization such as reviews of medical admissions and qualitative interviews with social service and health care professionals to understand the complex relationship between COVID-19 and IPV. It is necessary to complement the data collected during the study by expanding data

collection efforts to learn directly from people experiencing IPV. This provides an opportunity for future research.

Chapter 6: Conclusions and Recommendations

Conclusions

The findings of this study provide context from the perspective of HCPs on the anecdotal evidence of an increase in IPV during the COVID-19 pandemic. Findings also provide a deeper understanding of the perceptions of HCPs on the impacts of COVID-19 on IPV, including the impacts of movement-related restrictions and the barriers HCPs faced in providing care to their IPV patients during the pandemic. This section summarizes how findings from this study can be applied in clinical and educational settings and how they can be used to inform future pandemic preparedness and public health policy. Recommendations for future research are also presented.

Concurrent response to IPV and COVID-19

HCPs in Atlanta perceived two increases or spikes in IPV during 2020, one in April and May and another in October and November. This supports the anecdotal evidence that IPV intensified worldwide following the onset of the COVID-19 pandemic. It also adds evidence to validate the phenomenon known as the “shadow pandemic.” As the COVID-19 pandemic continues its global threat on public health, findings from this study support calls from advocates that the “shadow pandemic” must be addressed concurrently with the COVID-19 response. Immediate public health action can be taken by public health departments and officials to integrate messaging about IPV into their existing communications strategy. While an overload of information may reduce the effectiveness of this communication approach, it is a low-cost method to inform the public about the issue of IPV during the pandemic. This messaging should also include information on available IPV support services, including those that can be accessed remotely. As IPV support has traditionally been in person, those experiencing IPV may not be

aware of the level of support that is available to them during the pandemic. Thus, it is important to include in this mass messaging the availability of IPV support services that are virtual, such as online support groups, hotlines, and counseling services.

Build IPV support into future pandemic preparedness

A public health policy implication of this study is the need to build a response to intimate partner violence into future hospital and government-based pandemic preparedness plans. Findings from this study suggest that movement-related restrictions have negative impacts on the mental health of those experiencing IPV and are a contributing factor to an increase in IPV during pandemics. Thus, as movement-related restrictions are built into pandemic response plans, resources need to be allocated towards securing safe environments for people experiencing violence in their relationships. If needs assessments are conducted now to assess the availability of IPV support services, appropriate funds can be allocated to expand services to meet the need. Furthermore, by developing SOPs now, IPV support agencies can activate these procedures as needed to meet the demand for services during times of emergency. Due to competing needs for resource allocation in pandemic preparedness, advocacy is likely needed to ensure support for those experiencing IPV is built into these preparedness plans and SOPs. Finally, hospital emergency preparedness plans would benefit from provisions ensuring the continuation of IPV screening throughout emergencies. During the COVID-19 pandemic, IPV screening processes were stopped. Although the intensification of IPV during pandemics may be known by HCPs, it is difficult to respond effectively to problems that are not measured. Thus, it is critical that IPV screening, as a standard level of care, continues during times of emergency.

Integrating IPV into health care professionals' education

Findings from this study have implications beyond public health policy, with application in educational settings. HCPs in Atlanta identified low compliance with IPV screening and the fragmented nature of IPV work as barriers to providing support to patients experiencing IPV during the COVID-19 pandemic. Improving the integration of IPV into the training of HCPs could better connect IPV into the daily routines of providers and strengthen compliance with IPV screening. This integration could occur at the start of these providers' education with greater adoption of IPV into medical and other health professional school curricula. IPV could also be integrated into the teachings that HCPs receive during periods of internship and residency. If IPV becomes more engrained in HCP learning, alert among HCPs to screen for IPV could increase, possibly making IPV screening an automatic component of the standard of care to all patients and thus bringing the shadow pandemic into the light.

Recommendations for future research

The findings of this study prompt recommendations for future research to address the key results in other contexts in Atlanta, other cities in Georgia, or in other U.S. states. The capacity of each state to provide support services to those experiencing IPV during the pandemic likely differs. While this study suggests a dearth of resources in Atlanta, these results are not generalizable and may not reflect the situation in other cities in Georgia or in other U.S. states. Thus, additional data collection on IPV during COVID-19 is needed to help understand the availability of support services including housing facilities, counseling services, and legal support in contexts and cities outside a large public hospital in Atlanta, GA. When studying availability of support services in future data collection, approaches such as those used in this study can be adopted to avoid harm

to those experiencing IPV. These approaches include interviewing community and hospital-based service providers and using secondary sources such as record reviews.

Although HCPs provide an important clinical perspective on the impacts of COVID-19 on IPV, they lack a personal perspective into the experiences of IPV during the pandemic. We only interviewed HCPs who interacted with survivors of IPV who sought emergency care following a violent incident before and during the COVID-19 pandemic. Therefore, the experiences of survivors of IPV who did not seek emergency medical care were unknown to participants. Due to this limitation, we cannot solely rely on data from health care utilization such as medical admissions reviews or interviews with HCPs to fully understand the complex relationship between COVID-19 and IPV. Interviewing survivors of IPV can add context to the impacts of COVID-19 and movement-related restrictions on their experiences of IPV during the pandemic. Expanding data collection to this population also has the potential to capture the perspective of survivors who did not seek emergency medical care following a violent incident with their partner. While interviewing survivors of IPV could provide valuable insight, there are ethical considerations which must be respected, including minimizing harm to these participants. Remote data collection with IPV survivors during the COVID-19 pandemic poses challenges to participant safety and confidentiality (UN Women, 2020b). This is particularly true for survivors of IPV who are housed with their abuser under movement-related restrictions. Thus, strategies should be implemented in advance to reduce any distress caused by the data collection. Such strategies include ensuring interviewers are trained in ethical data collection methods, offering support resources to participants who need them, and putting in place safety measures for participants such as passwords for communication.

Due to the limited sample size of this study, comparisons could not be made across profession types interviewed (social worker, trauma surgeon, and emergency medicine physician).

Experiences and perceptions may differ across profession type, even if these providers are working at the same hospital. Additional interviews among HCPs at the study site within each of these professions, including advance practice providers, would allow for a comparative analysis that could add context to the results presented in this study or yield novel results.

Furthermore, changes reported by participants on the quantity and severity of IPV cases presenting at the ED of our study site before and during the COVID-19 pandemic were based on perceptions of hospital censuses and observations of trends in patient intake. A quantitative review of hospital records from the study site during the same time periods as the inclusion criteria for this study, January – June of 2019 and 2020, could provide an objective perspective on any changes in volume of IPV cases.

Results from this study suggest that movement-related restrictions likely contributed to the spike in IPV observed in Atlanta, Georgia at the start of the pandemic in April and May 2020.

However, the enactment of movement-related restrictions differed by state. Due to this decentralized response to the COVID-19 pandemic in the U.S., the timing and existence of spikes in IPV may also differ by state. Therefore, similar studies with health care providers in other U.S. states that followed different timelines for movement restriction enactment than Atlanta, GA may yield differing results. While participants in this study did not report any observable changes in IPV case presentation or patient profile, conducting similar studies in

other U.S. cities or states may illuminate important changes in IPV case presentation or patient profile in those new contexts.

The findings of this study are meant to provide context to the anecdotal evidence of an increase in IPV during the COVID-19 pandemic and describe health care professionals' experiences working with patients experiencing IPV during the COVID-19 pandemic in Atlanta, Georgia. The results and conclusions presented achieve both of these objectives. If these findings are applied in clinical and governmental settings to inform future pandemic preparedness and policy and are incorporated into future research, they could bolster the response to intimate partner violence in Atlanta, Georgia during pandemics.

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Appendix I: In-Depth Interview Guide

Good morning/afternoon and thank you for agreeing to speak with me today. My name is _____ and I am part of a research team from Emory University. I'd also like to introduce _____ who will be taking notes during our conversation. Is it ok if they stay on the call to take notes? Before we get started, I'd like to confirm that you meet the inclusion criteria for our study.

1. Did you work at [name of study site] between January-June 2019? <Y/N> **If No, exclude from study.**
2. Did you work at [name of study site] between January-June 2020? <Y/N> **If No, exclude from study.**

I e-mailed you a verbal consent form and I'd like to review it with you now while I introduce the study. **<Share screen of verbal consent version 11.17.20>** We are conducting research to examine the potential impacts of COVID-19 on Domestic Violence or Intimate Partner Violence which is defined as physical, psychological or sexual violence inflicted upon someone by a past or current intimate partner. Because health care professionals at [name of hospital] directly serve survivors of this kind of violence, we believe it is important to hear from providers about their experiences and perceptions. Our goal in speaking to providers is to gather information about domestic violence during the COVID period and to inform future pandemic preparedness.

During our conversation, we will be talking about your perceptions of COVID-19 on Domestic or Intimate Partner Violence. I am particularly interested in hearing about your personal experiences and perspectives as a provider, so please feel free to share openly. I have a set of topics I would like to discuss, but you are welcome to bring up other relevant topics. Your participation today is completely voluntary, and you may withdraw your participation at any time. If you do not feel comfortable answering any question, just let me know and we can skip it. Since your responses are so valuable to our research, I would like to record our conversation to ensure I capture everything we discussed. Only the research team and I will listen to the recording, and your responses will only be used for this project. As with any study, there are a few risks including the potential for a breach of confidentiality. However, we will manage this risk by removing your name and other identifying information from the transcript. Is it okay if I record our conversation? Now that we've gone through the verbal consent, do you have any questions with this consent form?

Our interview will last about one hour. Do you have any questions before we get started? May I begin recording?

I'd like to start by asking some brief questions about you.

Opening Questions and Quantitative Survey

< Screen share the Qualtrics survey for HCPs. Read each question aloud and enter the response selected by each participant. If open-ended type in their response verbatim.>

Demographics

1. What is your gender <open-ended>?
2. What is your age? <## years>
3. What is your race? <checklist-choose all that apply>
 White
 Black or African American
 American Indian or Alaska Native
 Asian/Pacific Islander
 Other Race: _____ <Open-ended>
4. What is your marital or relationship status? <choose one>
 Never married
 Married
 Widowed
 Divorced
 Separated
 Member of an unmarried couple
5. What is the highest level of education you have achieved?
 Did not complete high school
 High school graduate, diploma or the equivalent (for example: GED)
 Some college credit, no degree
 Trade/technical/vocational training
 Associate degree
 Bachelor's degree
 Master's degree
 Professional degree
 Doctorate degree

Employment

Now I'm going to ask a few questions about your role at [name of hospital].

6. What is your current job title? <Open-ended>
7. How long have you worked in your current position? <##> years. **If less than one year enter 0.**
8. How long have you worked in the health care field? <##> years. **If less than one year enter 0.**
<Turn off screen share>

COVID Health Impacts

Now, I would like to turn to questions about COVID-19 and your work at [name of hospital].

9. Since the onset of the COVID-19 pandemic in February/March of this year, what differences in presentation or health have you seen among your patients?

- a. Did you notice increases in respiratory illness? **<if not a clinician do not probe this>**
- b. Increase in depression, anxiety, or stress/disorders?
- c. Other
- d. How does this differ from before?

10. What kinds of changes have you observed related to injury at [name of hospital] during the COVID period

- a. Increases or decreases in injury?
 - i. Intentional injuries (*Non-accidental*)?
 - ii. Unintentional injury (*Accidental*)?
- b. How does this differ from before?

11. What kinds of social issues have you seen among your patients during the COVID period?

- a. Probes: Unemployed, Kids out of school, Forced to be at home (shelter-in-place), Coerced into being home as a matter of partner control, Threats of COVID infection, Unstable housing or transportation, Effect of police violence during this time; if relevant at all
- b. Have you seen anything among your patients related to unemployment? (kids out of school, threats of COVID infection, unstable housing or transportation, police violence)
- c. If participant starts talking generally about social issues in the world, ask, Is this happening in your Emergency Room?
- d. How does this differ from before?

COVID-19 Movement Restrictions and Violence

Next, I'm going to ask a few questions about COVID-19 related movement restrictions.

< Screen share the Qualtrics survey for HCPs. >

12. Are you aware of any COVID-19 related movement restrictions enacted in Atlanta? <Y/N>

<enter in Qualtrics during interview>

- a. If yes, what restrictions? <Open-ended>

13. Are you aware of any COVID-19 related movement restrictions enacted in Georgia? <Y/N>

<enter in Qualtrics during interview>

- a. If yes, what restrictions? <Open-ended>

<Turn off screen share>

Thank you. As a result of COVID-19, there were a number of movement-related restrictions and infection control techniques put in place. These include a statewide shelter-in-place order which started on April 3 and ended April 30, isolation orders for confirmed cases, and quarantine orders for close contacts of cases. The infection control technique of social distancing has been encouraged in Georgia since late March and remains a recommendation. Now I'd like to focus on your perceptions of these restrictions.

14. How do you think the shelter-in-place orders (city, county, and/or state) affected the patients you see if at all?

- a. Specifically when thinking about patients experiencing domestic or intimate partner violence, how do you think these orders affected them?

15. How do you think social distancing recommendations have affected the patients you see if at all?

- a. Specifically patients experiencing domestic or intimate partner violence

16. How do you think isolation orders for confirmed COVID-19 cases and quarantine orders for contacts of COVID-19 cases have affected the patients you see if at all?

- a. Specifically patients experiencing domestic or intimate partner violence

Health Seeking Behaviors

Now I would like to focus specifically on cases of domestic or intimate partner violence you may have seen at [name of hospital] during the COVID period. < Screen share the Qualtrics survey for HCPs.>

17. Do you work directly with patients experiencing violence in their relationships? <Y/N>
<enter in Qualtrics during interview>

18. Do you have any special training working with patients experiencing violence in their relationships? <Y/N> <enter in Qualtrics during interview>

- a. If yes, what training? <Open-ended>

19. In a typical shift at [name of hospital], how many patients do you encounter who are experiencing violence in their relationships? <##> cases <enter in Qualtrics during interview>
<Turn off screen share>

20. Have you noticed that domestic or intimate partner violence cases have presented differently during the COVID period, and if so in what ways?

- a. Probe: Attempted killing, types or severity of injury, changes to victim profile (ie gender, age)
- b. Have you noticed differences in other health issues specifically among patients experiencing domestic or intimate partner violence?
- c. How does this differ from before?

21. What kinds of social issues have you seen among your domestic violence patients during the COVID period?

- a. Probes: Unemployed, Kids out of school, Forced to be at home (shelter-in-place), Coerced into being home as a matter of partner control, Threats of COVID infection, unstable housing or transportation, Effect of police violence during this time; if relevant at all

- b. If they ask to clarify: Some people have reported things like unemployment or schools being closed as affecting their lives during the COVID period. Have you seen these or other types of social issues?
 - c. How does this differ from before?
22. What have patients experiencing domestic or intimate partner violence shared with you about their decisions and concerns about seeking health care during the COVID period?
23. What kinds of support do you typically provide to your patients experiencing domestic or intimate partner violence?
- a. How has this changed if at all during COVID?
 - b. Please describe any new methods of support that emerged out of COVID related changes?
 - c. What additional resources do you need to support patients experiencing domestic violence during COVID?
24. What barriers, if any, do you face in providing support due to COVID?
- a) What institutional barriers do you face in providing support to these patients due to COVID?
 - b) What practice-related barriers do you face in providing support to these patients due to COVID?
 - c) What personal barriers do you face in providing support to these patients due to COVID?
25. What would you suggest to prevent or better respond to domestic or intimate partner violence during pandemics?
- a. Specifically at [name of hospital]
26. Is there anything else that we have not yet covered that you feel is important? **<Make sure to be quiet for at least 30 seconds>.**

Thank you for your time. **<Don't turn off recorder until they really stop talking. This is usually when informants give good info!>**