THE INTERSECTION OF COVID-19 & DOMESTIC VIOLENCE

A Rapid Analysis of Current Literature

ABSTRACT

H.P. Lovecraft, a 20th Century American pioneer in supernatural literature, wrote, "the oldest and strongest emotion of mankind is fear, and the oldest and strongest kind of fear is fear of the unknown." Declaration of the COVID-19 pandemic elicited such a fear, but in the context of modern science and technology. When science could not allay public worry about contagion, containment, and treatment, uncertainty and distrust of leadership set in, laying the groundwork for fear of the unknown. In the nine months since COVID-19 was first diagnosed in the U.S., little more has been learned about virus transmission, immunity, and vaccination. According to the literature, fear, nurtured through mass and social media, has become the greatest negative outcome of COVID-19 on the physical and mental health of the American people. This fear spawned what UN Women dubs the 'Shadow Pandemic'.

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Summary of Key Findings

Two issues:

1. The increased incidence of domestic/intimate partner violence during the pandemic
2. The insurgence of dis-information, misinformation, and divisive rhetoric

Primary themes at the intersection of domestic violence and COVID-19:

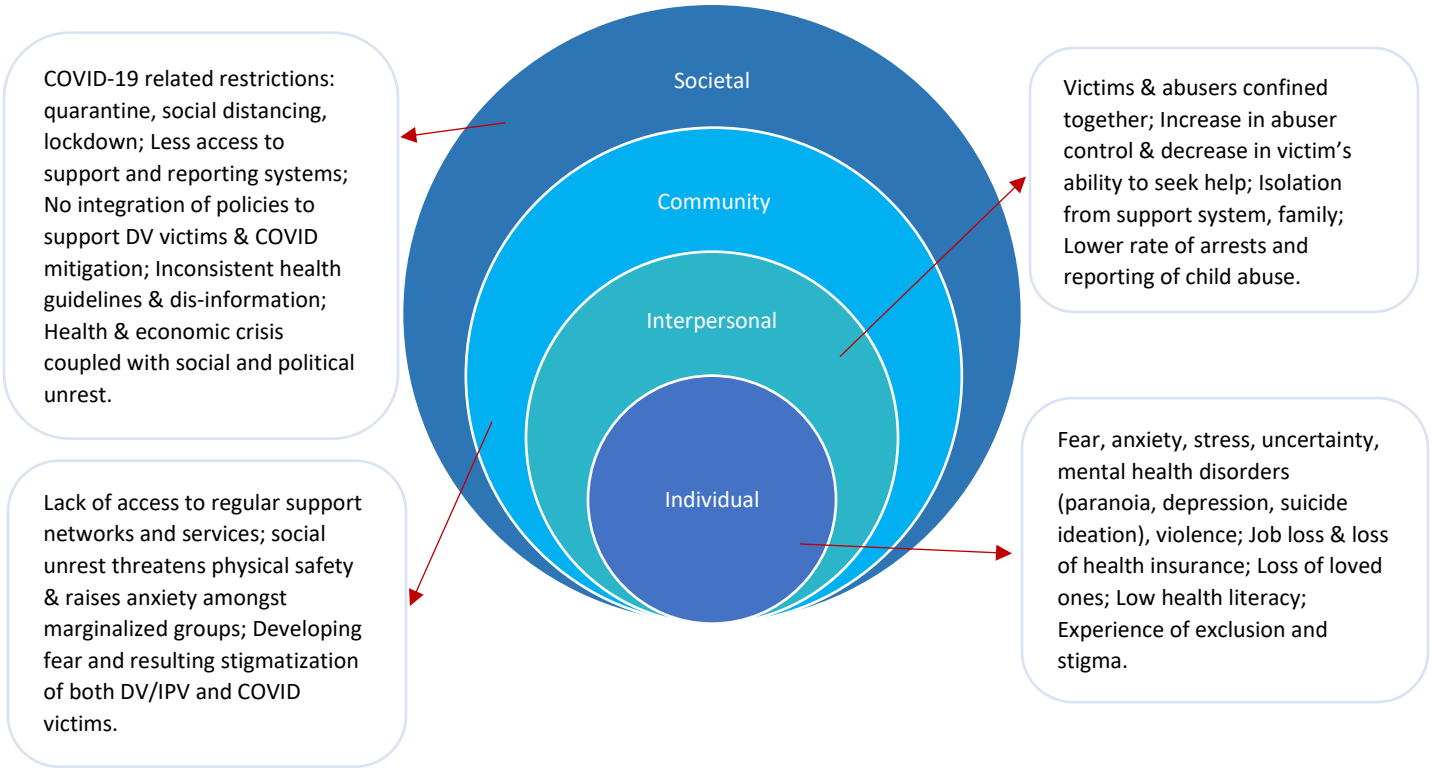
1. Fear
2. Safety

'…empathy in communication is critical for managing public anxiety' (Mheidly, 2020)

Evidence-based solutions:

1. Use **mass media strategies** to grow awareness and educate the public about the 'issues' to change ideologies e.g. social norms that perpetrate violence
2. Build **advocacy and support networks** for victims isolated under COVID-related restrictions
3. Build upon an **inclusive framework of social norms** that supports efforts to control the spread of COVID-19
4. Focus on **safety planning and implementation** using web-based platforms (MyPlan, iSafe) and low-tech reporting methods (code words, neighbor-watch)
5. Create **access to services** needed by victims of chronic intimate-partner and family violence
6. Improve **surveillance** of domestic violence (this could be an outcome of #5)

FIGURE 1: Socio-Ecological Framework for understanding domestic violence during a pandemic. (*adapted from Sanchez, et al., 2020*)



Background

Intimate Partner Violence (IPV) is the most common form of gender-based brutality and manipulation. IPV involves four types of behavior: physical violence, sexual violence, stalking and psychological aggression (CDC, 2020). An estimated 30% of women aged 15 or older experience physical and/or sexual violence by an intimate partner in their lifetime worldwide (CDC, 2020; Hall, 2020; WHO, 2020). In the U.S. one in five women and one in seven men have experienced ***severe*** physical violence from an intimate partner in their lifetime (CDC, 2020). IPV can manifest in physical and social comorbidities throughout an IPV survivor's lifetime. Negative health outcomes include chronic illness and physical disabilities, depression, post-traumatic-stress disorder, and higher risk for substance abuse and perpetration of violence (Fares-Otero, 2020; Vora, 2020).

SARS-CoV-2 or COVID-19 was first detected in Wuhan China at the end of December 2019. By March 11, 2020 the World Health Organization described the rapid spread of the virus as an '*outbreak*'. By April 2020 the virus had spread to 210 countries and territories, prompting the WHO to categorize the situation as a pandemic. In response to the growing number of diagnoses and related deaths, countries like Italy, Spain, New Zealand and China quickly instituted quarantine measures to slow the infection rate. These measures ranged from citywide lockdowns to border closures (Olcer et al., 2020; UNICEF, 2020). In the past six months, infection rates have fluctuated in response to varying levels of virus-mitigating measures, killing at least one-fifth of the five million infected worldwide (WHO, 2020).

The Literature Review

The AIM of this Review is to analyze published data concerning the intersection of domestic violence and COVID-19 worldwide to inform the development of a culturally appropriate Toolkit of resources, and Dissemination Plan for the Toolkit, to help service providers and advocates address domestic violence in the context of a pandemic.

The following is not a systematic review. COVID-19 is described by experts as a '*fluid situation'*, a pandemic experienced in real time (Pratt et al., 2020, DaSilva, et al., 2020, Kofman & Garfin, 2020). The number of articles and status of COVID-related statistics is in constant flux. Consequently, the approach is an iterative rapid review of articles, commentaries, website content, etc. that discuss research and evidence-based findings indicating a correlation between COVID-19 and domestic violence.

The data was collected through a targeted search of electronic databases of peer reviewed literature including PubMed, the PubMed COVID-platform, CINAHL, WHO Index, and Google Scholar. This iterative process was applied to websites and publication listings of leading organizations in the field, as well as a cross reference of article bibliographies. The search produced 7,000 articles, abstracts, and other resources using the following key search words: domestic violence, intimate partner violence, coronavirus, COVID-19, pandemic, social media, social distancing, isolation, safety. Resource titles were reviewed for relevance to the Aim, narrowing the results to 122 items.

Selected resources were published in English and met these criteria: (1) published between Jan-Sept 30, 2020; (2) reported info relevant to the Aim; (3) is a review or experimental study, however commentaries and Letters to the Editors of peer-reviewed journals were also included if they were cited by other peer-reviewed publications. Resources were excluded if irrelevant, constituted prospective

non-implemented studies, or if the author(s) cited conflict of interest. Of the 122 sources selected, 23 examine the dynamics of domestic violence in the context of pandemic situations, 39 provide information for proposed Toolkit content and frameworks for communication through mass media, and 43 provide tools that may be adapted and disseminated. To support the theoretical foundation of the proposed dissemination plan, six articles examine evidence-based frameworks and 11 provide strategic approaches for dissemination. To achieve the Aim, four objectives guide the qualitative synthesis of information.

Table 1. Review Objectives

OBJECTIVES	GUIDING QUESTIONS
1. Understand the experience and impact of pandemic situations on gender-based, intimate partner and family violence.	How have COVID-related issues impacted DV/GBV/IPV in the world? what is the gendered impact of COVID on women, and what gendered burdens are experienced?
2. Understand the experience and impact of mass media on survivors of violence during pandemic situations.	What types of mainstream messages and modes effectively frame virus-mitigating behavior? What are effective modes of communication with victims of DV during pandemic induced isolation and lockdown?
3. Understand the impact on the operations of organizations and individuals serving survivors of violence during a pandemic.	How do organizations continue providing services during pandemic-related restrictions on movement and interpersonal communication?
4. Develop recommendations and a toolkit of resources informed by Aims 1 – 3 and a plan to disseminate these products to survivors of DV, DV service providers, and the general public.	what evidence supports development of effective information dissemination in a population similar to AS?

Objective 1: An Established Link Between Domestic Violence and the COVID-19 Pandemic

COVID-19 is one pandemic in the recent history of biological outbreaks which includes H1N1, Ebola, Measles and Dengue Fever. Unlike past outbreaks, COVID-19 has spread quickly across the globe, impacting every country and territory. While few facts are available about the spread and risk factors for infection, domestic violence has emerged as a growing worldwide outcome of the main actions taken to mitigate the spread of COVID-19, specifically quarantine measures, social distancing, lockdowns and sheltering-in-place. These types of isolating measures may worsen vulnerabilities to domestic violence due to inaccessibility to social support systems and disconnection from environments in which reporting of violence is mandatory, i.e. schools and hospitals (Abel et al., 2020; Boserup, et al., 2020, Bradbury-Jones, et al., 2020).

The most common theoretical framework used in the literature to explain domestic violence in the context of a pandemic is the socioecological model (Moone, et al. 2007, WHO, 2020, World Bank, 2015). The approach used by public health professionals is to improve health and safety by addressing underlying risk factors that increase the likelihood that an individual will be come a victim or perpetrators of violence (Chandan, et al., 2020, Violence Prevention Alliance, 2011). The socioecological model views interpersonal violence as the outcome of interaction between many factors found in four

levels: individual, relationships (interpersonal), community and society (Figure 1). At the societal level – government, mass media, international health and economic authorities – create a pandemic environment through media messages and mandates. Society's response trickles down to the community level – business closures, restricted movement, quarantine and isolation. These decrease social cohesion and access to public services for victims and their children. In personal environments shelter-in-place orders confine victims with their abusers, reduce victim access to social support networks and mediators. At the individual level the impact of COVID-related mitigation measures can aggravate violence – increased stress, depression, consumption of alcohol and drugs. School and job closures jeopardize mandatory reporting, surveillance, and help seeking behaviors. At each socioecological level, public health interventions can support factors that decrease violence and increase safety.

Researchers have found that **stress is a manifestation of the socioecological impacts of COVID-19** including job loss, perceived and actual fear of the disease itself, uncertainty of the future, reduced access to coping resources like therapies and group support (da Silva, et al., 2020; Hall, et al., 2020). The American Psychology Association's website cites ***'stress and social isolation'*** **as risks for DV** (Abramson, 2020). One narrative review identified three empirical categories of precipitating COVID-related factors to DV: economic instability, alcohol and drug use, weaker women's support networks (da Silva, 2020). In a U.S. study (n=2045), job loss/economic stress was the COVID-related factor most associated with DV (Davis, et al., 2020). Job loss preceded financial hardship, loss of health insurance and confinement in a stressful home environment.

Xavier-Hall and colleagues (2020) introduce the Syndemic Framework which suggests that social comorbidities, two or more conditions, can manifest in clusters of health issues that commonly happen under conditions of poverty, inequality, stigma and stress. In their small study (n=28) researchers found that socioecological factors coupled with trauma resulting from direct or indirect violence leads to enhanced depression and mental instability. Women, especially those who have children, elderly or disabled family members in the home, are experiencing additional burdens during COVID-19. Globally, women comprise 70% of the world's health workforce (UN Women, 2020), and in the U.S. one in three women is an 'essential worker' (NY Times, 2020). As they continue to work outside the home, their responsibilities at home are compounded by closed schools, day care, and support services. Additionally, the lack of childcare and school closures forced some women to quit their jobs or, if asked to work from home, do so without the benefit of 'breaks' and time for activities that sustain wellness like co-worker support, organizational team building, and simply time to focus on oneself.

Mental health experts find that domestic violence *is* an '*environmental stressor'* and that people exposed to DV while confined in their homes with their abusers will more likely develop neurocognitive impairment (Fares-Otero, et al, 2020; Fatke, et al., 2020). A cross-sectional analysis of data from an online survey conducted in California (n=2081) two weeks after the state shelter-in-place order revealed that moderate to severe mental health symptoms were experienced by 20% of respondents. Depression and anxiety were the primary health outcomes, and the amount of time spent sheltering in place was significantly associated with greater mental health symptom severity and DV (McLay, MM, 2020; Peterman, et al., 2020; Raj, et al., 2020; Roesch, et al., 2020). A narrative review of DV risk factors found that having a previous history of exposure or experience of violence is the most significant link to neuropsychiatric disorders reported by DV victims, describing '*stress and frustration'* as '*standard fuel for violence*' (Moreira, et al., 2020). The U.S. Centers for Disease Control links symptoms of anxiety

disorder and depressive disorder to the morbidity and mortality caused by COVID-19 and related mitigation measures (Czeisler, et al., 2020): representative panel surveys of adults age 18 and older across the U.S. during June 24-30, 2020 reported high rates of mental health disorders (41%), trauma related disorder (26%) and suicide ideation (11%).

Between March and May 2020 experts documented a 7.5% increase in domestic violence related calls to police in the U.S. with the largest uptick to 9.5% occurring during the first five weeks (Leslie, et al., 2020). Notably, the COVID-related social distancing mandates led to significant increases in calls from city blocks with *no* recent history of domestic violence calls. Unfortunately, the number of at-home violence cases rose by 22% while the number of arrests declined by 3% indicating that response to calls for help may often be diffused by first-responders as opposed to removing perpetrators from the home.

As financial assistance from the U.S. government expires, the resulting **economic crisis may be the most significant contributor to the surge in domestic violence** (Sharma, et al., 2020). Household stress, disruption of livelihoods, disruption of social and protective networks, limited access to support services and redirected health resources to support COVID-related healthcare will exacerbate this crisis which has earned a new name, the '***Shadow Pandemic'*** (UN Women, 2020).

Objective 2: The Role of Mass Media on COVID-related Outcomes for DV/IPV Victims

Media is an essential mediator for health communication and plays an important role in changing attitudes and intentions and influencing health behavior. Its effectiveness in health communication lies in strong written, verbal and visual communication strategies that can impact public views and perceptions. Media has the power to influence mindsets, behaviors, and the emotions of entire populations. Its fundamental role is to ensure accurate information is transmitted efficiently and the masses are kept well-informed (Vora, et al., 2020). In fact, a key strategic objective of the World Health Organization to manage COVID-19 is to *'communicate critical information to all communities and prevent the spread of misinformation*' (Dutta, et al., 2020).

During the early phases of the pandemic, January – March 2020, facts were more accurately referred to as 'BETs' or best evidence at the time (Eysenbach, 2020). Little was known, and little is known today, about the virus compared to the 'infodemic' of COVID-related publications on social and mass media. An infodemic is an '*overabundance of news mixing facts and fiction'* and is a key driver of social stigma, anxiety, and fear during a pandemic (Sotgiu, et al., 2020). Public response is closely correlated to the amount of media coverage present (Bruns, et al., 2020). As of June 2020, over 26,000 COVID-19 articles were indexed in PubMed, implying an adoption of protocols to fast-track articles to print. As of September 30, 2020, a Google search for the term COVID-19 produced over five million results. The volume of contradictory news, misinformation and manipulated data on social media is a global public health threat (Shorey, et al., 2020; Weinberger-Litman, et al., 2020). In fact, the WHO refers to **COVID-19 as a '*communication crisis*'** (2020).

According to WHO Executive Director Dr. Winnie Byanyima, '*misinformation is perpetuating stigma and discrimination*' across the globe (2020). In response, on February 15, 2020 the World Health Organization convened a virtual 'crowdsourcing' event to develop a framework for infodemic management (Tangcharoensathien, et al., 2020). 50 proposed actions were developed into **six Policy Implications:**

1. Information must be **science based**
2. Information must be translated into **actionable behavior change** messages
3. Messages must **be inclusive**
4. Messages must be amplified through **partnerships**
5. Messages must be monitored and **evaluated**
6. Messages should support preparedness and response to inform **risk mitigation**

An early pioneer of infodemic theory, G. Eysenbach (2020) proposed **Four Pillars of Infodemic Management**:

1. Information monitoring or **info-veillance**
2. **Building eHealth Literacy** and Science Literacy capacity
3. **Fact checking** and peer review
4. Accurate and timely **knowledge translation**

Eysenbach also advises that evidence be integrated with economic and political considerations and may be subject to cultural variations and influences. He considers eHealth Literacy an '*essential skill*' as 72% of the U.S. population accesses the internet for news and information (Pew Research Center, Feb. 2019). Compounding the issue of volume is the '**disinfodemic**': *misinformation* entwined with half-truths that fuel pandemic related stress (UN-ICFJ Research, 2020). False media or fake news have shaped U.S. public perspective and opinion on everything from COVID, to politics and social unrest including virus symptoms, treatments, misleading statistics, discrediting of legitimate facts, content driven by financial gain, celebrity-focused dis-information. UN-ICFJ Research '*identifies quality journalism as a major force for identifying and exposing disinformation*' (2020).

Media plays a fundamental role in the public response to a pandemic – input that people collect as 'receivers' of media shape their actions and reactions to the pandemic (Mheidly, 2020)

Disinformation, or '*sensationalized half-truths*' affect individual decision making by inciting fear and uncertainty (Aslam, et al., 2020). Media cues can trigger stigmatizing perceptions and beliefs, especially during a pandemic (McCauley, et al., 2020). The literature points to a need for science-based approaches to identifying, synthesizing, and interpreting information, suggesting that a '*collective framework of social norms*' that support efforts to control spread of COVID could also champion safety and support for victims of violence (Aslam, et al. 2020, Baines, et al., 2020, Bhanot, et al., 2020).

Mass media, the original mode of information, now competes with interactive **social media** platforms. Information is shared and received more quickly than ever before, prompting a 'viral phenomenon' – *how thoughts, trends and information move through the masses* similar to how viruses propagate (Wikipedia, 2020). Studies show that, unfortunately, through social media people share falsehoods more often than evidence-based info. A two-day analysis of 1000 tweets circulated on Twitter from Feb 6-7, 2020 revealed false pandemic information was Tweeted more than science-based evidence of fact checking tweets, and independent users were responsible for 75% of misleading content on YouTube (Mheidly, et al., 2020).

73% of U.S. adults surveyed in February 2019 reported that they had used YouTube ever during the prior 12 months compared to 69% using Facebook, and 37% (the next closest category) using Instagram (Pew

Research, 2019). An analysis of YouTube videos produced in six languages including English found that reliable sources of information such as government and health organizations did not effectively disseminate information on this most popular web-based platform in the U.S. (Dutta, et al., 2020).

As an alternative to mass and social media, one community in quarantine relied on local organizations for information and support. A Modern Orthodox Jewish sector in New York City was the first geographically based group to be quarantined for COVID in America. Between March 15-17, 2020, researchers recruited 303 adults in this community to complete surveys measuring distress and anxiety levels, experience of stigma, and trust in information sources (Weinberger-Litman, et al., 2020). The levels of distress and anxiety reported were directly associated with the '*inadequate health related information received'*, and 50% were concerned about future stigma related to their quarantine as described in the mass media. They found that 80% of participants trusted community organizations more than any other source of COVID related information.

To understand the correlation between media and emotional wellbeing, F. Aslam and colleagues extracted and classified sentiments and emotions from 141,208 COVID related headlines published between January 15 and June 3, 2020 by 25 global English news sources (Aslam, et al., 2020). **Fear was the most frequently documented emotion.** They found that the connotation of news headlines elicited high emotion scores with negative polarity, creating an environment that supports anxiety, xenophobia and stigma. A study in the Czech Republic (n=1000) found that '*pessimistic communication used by the Czech mass media contributed to intensifying traumatic feelings and fear in the general public during the initial COVID-19 breakout* (Trnka, et al., 2020).

UN-ICFJ Researchers found that the disinfodemic is an underlying cause of *'individual rejection of public health recommendations leading to fear which leads to stigma'* (Policy Brief, 2020). One study explored why people ignore shelter-in-place orders and social distancing recommendations with the aim of identifying how media messages could change behaviors to decrease the risk of spreading COVID-19 (Olcer, et al., 2020). Using qualitative document analysis, they examined media posts from Reddit, Twitter and YouTube. The main take-away from this effort was that the government, based on user posts, could not produce a '*shared sense of inclusion concerning protective measures because it could not build **public trust** and take concrete economic steps to satisfy them.'* Also, people who did not possess the health literacy skills to effectively digest media content or feel comfortable in the knowledge they did have perceived government recommendations as 'attacks' on their personal freedoms. Several academic commentaries and 'Letters to the Editor' echoed this sentiment, advising that *'accurate information leading to understanding is the key to enabling appropriate decision making*' (Tandon, R. 2020; Olcer, et al., 2020, Cori, et al., 2020).

'It is important to understand the psychological influences that affect the individual efforts in following guidelines and seeking the right information.' (Mheidly, 2020)

Another perspective introduced in the literature is the theory of ***'loose' versus 'tight' cultures*** and the impact on how media influences behavior. The U.S. is described as a 'loose' culture wherein citizens are unfamiliar with tightly coordinated, government directed social action towards a common goal such as halting the spread of a virus, and are ambivalent about sacrificing their freedom for strict rules that constrain their choices (Gelfand, M. 2020). This has resulted in a disorganized and inconsistent response to COVID-19 by U.S. national and local governments, leaving room for non-scientists to flood media channels with disinformation and decisive rhetoric. The authors

compare this to COVID mitigation in China and Singapore who possess decidedly 'tight' cultures grounded in conforming regulations, and who experienced less negative impact from COVID. In these countries, fear of the virus drove people towards a '*tightening in the face of threat'* to survive (Bhanot, 2020). Analysis of Chinese media found that a unique combination of strong governance, strict regulation, strong community vigilance, citizen participation and wise use of big data and digital tech were key factors in China's efforts to combat COVID (Mheidly, 2020).

Fear and worry are concentrated in places where the largest number of confirmed COVID-19 cases are diagnosed (Fitzpatrick, 2020). Sensationalistic media headlines of death, economic doom, and social unrest can elicit fear and cause people to oscillate between denial and phobia (Soraci, 2020). UN-ICFJ researchers identified **four main formats of COVID-19 disinformation** leading to public fear and anxiety:

- emotive narrative constructs and memes,
- fraudulently altered, fabricated or decontextualized images and videos,
- disinformation infiltrators and orchestrated campaigns,
- fabricated websites and authoritative identities.

In countries like China, Japan, and Singapore higher *'situational strength'* was significantly related to long-term adherence to virus mitigating behavior i.e. higher cautiousness, higher dutifulness to country, greater self-regulation strength, and higher self-monitoring (Gelfand, 2020). Unlike the U.S., mass and social media messaging in 'tighter' cultures is cohesive among authoritative sources, consistent, sensitive to health literacy levels, and inclusive.

2a. Messaging to Frame the Intersection of COVID-19 and Domestic Violence

The aim of pandemic messaging is to effectively (e.g. transparent, relevant, culturally appropriate, consistent, understandable) frame beneficial information and disseminate it in ways that influence individuals to adopt protective measures. In the case of those experiencing domestic violence, this includes developing safety plans, ways to diffuse violent situations, and help-seeking behaviors.

The literature provides little in the way of empirical support for effective pandemic-related messaging for victims of domestic violence other than pointing to the need for a deeper understanding of cultural differences in this domain. A review of organizational and government websites focused on domestic violence produced a list of consistent content attributes:

- clickable quick-exit tabs to secure privacy
- a focus on safety during quarantine/lockdown isolation with abusers including strategies to diffuse escalating violence, physically protect oneself against the act of violence, and negotiate time away from the home (to shop, pick up prescriptions, etc.)
- lists of online support resources, 'Tip Sheets', 'Pocket Guides'

A notable change in the website narratives is the approach to dealing with violence without options to leave or escape the abuse. Stress and social isolation raise the risk for domestic violence (Abramson, 2020). Very little is mentioned on the websites about coping with these stressors as a family unit, with a partner, or strategies to mitigate the impact after violence occurs.

A few studies have *examined the role of individual differences in emotional and personality-based variables in predicting virus-mitigating behaviors* (Harper, et al., 2020). S. Bhanot (2020) provides some

insight with research that proposes that people in cultures like the U.S. that champion personal freedom as a virtue, may be predisposed to reactance behavior during a pandemic. Jack Brehm (1966) pioneered the concept of **reactance behavior**: *when individual freedoms are reduced or threatened*, such as the choice to wear a mask or not, *people tend to be motivationally aroused to regain those freedoms* (Steindl, et al., 2020). In other words, Americans are more ambivalent about sacrificing personal freedoms for strict rules that constrain individual choices, even in the face of uncertainty, or perhaps, in spite of it. As they grow more antipathetic towards 'expertise and science' the spread of misinformation and public dissonance grows. **The task is to determine how best to frame adherence to directives from experts as a social norm worthwhile to follow**.

While COVID-free as of this writing, American Samoa initially took major steps towards limiting movement in the community before closing its borders. While the overwhelming public reaction to church service closure and limiting attendance at gatherings was compliance, reflecting the 'social tightness' of the culture, within a short time public behavior reflected a different reality. Public health messaging emphasized hand washing and staying 6-feet apart but spoke less to the importance of social distancing. Family gatherings, fa'alavelave, and even smaller church group services continued. These 'reactions' to the mandate were not so much defiance as they were demonstrations of how much people value family and church over rules for individual behavior. Messages emphasizing contagious spread of the virus and risk for families and the community as a whole may be more effective than a focus on individual behavior i.e. the 'do your part' campaign.

Supporting literature for this framing approach include studies that implemented the Fear of Coronavirus Questionnaire, developed March 2020 and validated in 11 countries to date (Ahorsu, et al. 2020). 439 respondents from 28 countries completed the online questionnaire (70% from the Netherlands). The strongest predictor of fear of COVID was the risk of infection for loved ones (Mertens, et al., 2020). This outcome mirrors those of studies implemented in countries other than the U.S. where the fear of COVID itself was more prevalent than fear of job loss, financial insecurity, uncertainty, and social unrest (Hossain, MA. 2020; Harper, et al., 2020; Cori, et al., 2020; Balkhi, et al., 2020; Ahuja, et al., 2020). Aspects of **cultural collectivism were recorded as buffers** to these socioeconomically based fears, especially in a survey of non-Islamic Indians (n=600) where social connection and prioritization of family safety over individual health were protective factors against uncertainty and stress (Ahuja, et al., 2020).

Another aspect of message framing is choosing the appropriate messenger. At the beginning of the outbreak the American Samoan government issued an edict closing all church services. This was done without consulting the Council of Churches or any church leadership. The government's reaction to the virus was not collaborative and did not leverage the relationships and value of church and family in the Pacific Islander community. Had they garnered the support of the church leaders as messengers of beneficial health information the public may have adhered to government restrictions on movement and gatherings. Internationally, various religious groups have emerged as the trusted leaders in their communities for all things COVID-related (Bruns, et al., 2020). Additionally, different cultures interpret disease and health differently. When considering new diseases, especially those who often affect victims asymptomatically like COVID-19, the literature supports the assessment and integration of cultural beliefs and assumptions (Bruns, et al., 2020; Napier, et al, 2014).

Building upon this psychology, social marketing literature offers principles, tools, techniques and concepts to effectively communicate information that can promote or discourage behaviors that benefit society. This ideology emphasizes the use of behavior theory as a critical foundation for affecting attitudes, norms, behavioral intention and perceived behavioral control. These constructs are embodied in the Theory of Planned Behavior (Fishbein, et al., 2006), just one of several 'theories of change'. Because fear and safety emerge as the primary themes of this literature review, effectively framing messages around cultural collectivism and behavioral change theory may mitigate reactance behavior in the context of fa'aSamoa or Samoan way of life. Possibly, the collective framework of social norms that supports the fa'aSamoa may also support victims of violence. Chopra et al. (2020) recommends empowering and strengthening communities to support others to protect their own health. Strategies for achieving this include dissemination of authentic information and conducting fact checks, educating the public about false information, and promoting eHealth Literacy.

While the literature points to fear as a basis for mental unwellness, there is also support for a '*certain level of fear about the illness incorporated into messaging that could encourage safety promoting behaviors*' (Harper, 2020). Research shows that fear can motivate virus-mitigating behaviors, and that by tracing those fears back to tangible causes healthcare providers and allied professionals may effectively frame messages to help the public cope rather than react, and trigger empathy rather than negative polarity. Transparency and perceived ability to manage crises enhance the feeling of confidence and lead to a sense of inclusion, of being part of the solution (Olcer et al., 2020). The majority of literature reviewed found that mass and social media are the sources of fear and anxiety but offer no remedy or path to safety.

Six studies suggest that the frames people *'adopt when thinking about health challenges influence their optimism about overcoming those challenges*' and that '*optimism can positively impact health*' (Briley, et al., 2020). These findings support the positive framing of messaging, which enhances one's ability to cope with stress and foster better health behavior. Optimism can be sustained by messaging that is collectively cohesive, '*we are all in this together'* (Chandan, et al. 2020, AHRQ, 2011). More media messaging should be framed from a positive, inclusive perspective.

2b. Effective Modes of Communication with Victims of Domestic Violence During a Pandemic

Message-based communication of knowledge alone is unlikely to lead to sustained behavior change. An emphasis is placed on **interpersonal engagement** to prevent violence through behavior change (Jewkes, et al. 2020). Messengers must identify and engage stakeholders, seek advice from media experts, and use audience segmentation to tailor framing and delivery strategies (Brownson et al 2020). Several articles emphasize the need for validated and culturally adapted screening instruments and leveraging the exposure healthcare providers have to DV victims (Sanchez, 2020, Viera, et al., 2020, Moreira, et al. 2020)

Health professionals are essential for screening and responding to DV during the pandemic. The health sector and its professionals are recognized as the cornerstone of the screening and identification process. (Sanchez et al., vanGelder et al, Boserup et al, Chandan et al., Mazza, etal, Roesch et al 2020). For example, dental care professionals may be the first call for DV victims due to their facial injuries and avoidance of hospitals during a pandemic. Likewise, fractures most indicative of abuse are those to upper and lower extremities, upper trunk, head and neck (Loder et al 2020) so radiologists may be first responders and can be proactive in engaging with patients, identifying and supporting DV victims

(Matoori et al 2020). Authors support building healthcare capacity to identify and address DV using brief interventions including disclosure questions to engage victims (Coulthard et al., 2020). The ALIVES framework is an example for inquiring about and responding to a disclosure of DV: Ask, Listen, Inquire, Validate, Enhance Safety, Support. (Neil, J. 2020). Providers can also easily share the Safety Behavior Checklist of 15 items with suspected victims (McFarlane, J., 2002). A random control trial found that the Checklist was highly effective when offered following an abusive incidence and remained so for at least six months afterward. The RARA risk management framework is a validated approach that providers can adopt to Remove risk, help victims Avoid risk, Reduce risk, and Accept the risk as something requiring continuous planning and support (Richards, L., 2009). The framework comes with intake sheet templates and question prompts.

The Weinberger-Litman study in New York demonstrated ways in which religious institutions can play a vital role in promoting the well-being of members, and opportunities for government to partner with communities (2020). The lack of transparency and a consistent approach psychologically affects individuals during the COVID-19 pandemic, highlighting the importance of presenting qualified information on social media (Olcer, et al., 2020) followed up with interactive communication. Efforts geared towards general education about COVID and the rationale for quarantine and public health info provided to the general public can reduce stigmatization and be applied to DV during the pandemic (Bruns, et al., 2020).

Italy was one of the first countries to mandate complete public lockdowns. From this experience the **Trinita Health Education Model** emerged as a way to reduce stigma surrounding COVID. The mayor of an Italian town in Sardinia with a population of 2208 gathered epidemiology experts and respiratory specialists to organize online events with the primary aim of explaining the key features of COVID. The aim was to divert the public's attention from sensationalized misinformation and change or prevent dangerous behaviors and attitudes. The interactive program allowed every citizen to ask questions and receive direct answers from the speaker. The events were promoted in the local community using an official website, Facebook and WhatsApp groups. Feedback from participants confirmed the successful reduction of stigma and improvement of public knowledge and beliefs about COVID-19 (Sotgiu, et al. 2020).

Several tools for communicating safety and reducing fear during pandemics were piloted prior to the COVID-19 outbreak. Digital interventions have been confirmed to promote and enable safety behaviors (Decker, et al. 2020). Virtual interventions have been successfully tested in a number of high-risk minoritized populations to address gendered burdens and their impact specifically on women (Viveiros, et al 2020). Various narrative reviews on the use of web-based interventions reveal that there are few rigorously conducted studies explicitly validating their use to establish safety behaviors among victims of violence. However, a few surveys indicate that victims prefer guided online support and found webs-based interventions '*supportive and a motivation for action'* (Hegarty, et al., 2019, Jewkes, et al., 2020, Koziol-McLain, et al., 2018).

The literature produced the following web-based applications to help victims establish safety:

I-DECIDE – the study was completed pre-COVID to see if the app would increase women's self-efficacy and improve depressive symptoms compared to an IPV info website. The research demonstrated that that online IPV interventions are acceptable and can be safely used (Hegarty, et al., 2019).

myPlan – the app content, interface and implementation can be adapted for use in American Samoa. A study in Kenya demonstrated its high feasibility, and the acceptability of community-partnered technology-based safety planning interventions like this (Decker, et al, 2020). MyPlan has a 'My Safety' risk assessment section that converts responses to validated levels of exposure to danger. The 'My Priorities' section is an interactive visual aid to set priorities for safety – gauging importance between priorities such as privacy, severity of violence, wellbeing of children, social support etc. and emphasizes importance of safety and inclusiveness (Glass, et al. 2015, Decker, et al., 2020, Emezue, 2020).

iCan Plan 4 Safety – is an online safety and health intervention proven effective in a Canadian study (Ford-Gilboe, et al., 2020).

iSafe – is a web-based safety decision aid piloted pre-COVID that produced measures of effectiveness and emphasized the importance of timely follow ups (3, 6, 12 months) in the Maori population (Kosiol-McLain). This product was developed with the intention of being inclusive and culturally appropriate.

Where resources are limited, such as in American Samoa where many do not have safe, consistent access to internet, a **safe system of alert** using low/no tech is a critical need to provide victims with little/no resources entry points to alert advocates of their needs (Erskine, 2020, Emezue, 2020, Ford-Gilboe et al., 2020). Emerging solutions include adapting existing safe spaces for women into 'phone booth stations' accommodating limited seating/gathering guidelines for COVID, 'no-dial or off line chat' phone options, service integration in high traffic areas like grocery stores, pharmacies, markets; alert chains using disclosure or code words (Usher et al., 2020).

Objective 3: Recommendations For DV Service Providers During a Pandemic

Weinberger-Litman and colleagues (2020) examined the ways in which religious institutions and leadership responded to a community's need for tangible, social, informational and spiritual support as a means of reducing their stress and anxiety. DV service providers could tailor these categories of assistance to the needs of the American Samoan community. Tangible support included a community volunteer system for ensuring those in isolation – quarantine, clinically high risk, immobile, etc. received food deliveries, prescriptions, mail and ran errands. Social support included providing virtual chat groups, support groups, telemedicine and counseling and keeping people connected. There is a critical need for social safety nets – social support networks online (van Gelder, et al., 2020). Informational support is focused on the what's happening in the community – closures, restricted hours, help hotlines, virtual town halls with health professionals. Remote participation in religious services was cited by Weinberger-Litman et al. as a significant value to the Jewish community they surveyed. Community engagement was a critical factor tying the support system together.

The successful efforts reported by the community were the result of several strategic approaches to service provision. First, they exhibited sensitivity and solidarity. This can be applied to DV in the form of enhanced surveillance like 'neighbor watch' and using code words or wearable warning signs – a coordinated observation and reporting system on behalf of victims. The literature also supports collaboration with neighborhood health clinics, pharmacies, and other allied professionals to screen and report signs of abuse.

Second, community leadership actively engaged their members. They listened to their needs and experiences and worked with them to provide for those needs in ways that were acceptable to them

and followed quarantine guidelines. Third, community leadership advocated for their members. UN Women recommends raising visibility of increased violence and building strong advocacy by leveraging partnerships, creating united messaging and community mobilization (2020). The following UN hashtag links inquiries to a diverse array of resources: #AntiDomesticViolenceDuringEpidemic.

Several articles encouraged advocating for inclusivity, protecting women's rights and access to reproductive healthcare, funding to add housing/shelters, exempting DV shelters from lockdown closures, declaring DV services as essential, limiting access to guns and alcohol with purchase limits and curfews, streamlining legal protocols to include online filing for protective orders. Various types of gender-based restrictions were enacted since March 2020. For example, Peru and Panama instituted a gender-based curfew: men were allowed outside the home on Monday, Wednesday and Friday; women on Tuesday and Thursday (Juarez, S. 2020). This excludes members of the LGBTQ community, who were persecuted or forced to validate their identities in order to shop or see a doctor. Six states in the U.S. suspended abortion services, citing them as 'elective surgeries', and effectively violating women's rights. Advocacy on behalf of women, children, and victims in general is a key service that domestic violence organizations are encouraged to implement.

The literature also recommends teaching coping skills with a focus on people age 35 and under. The 2019 IPSOS Pub poll shows 1 in 5 Americans under age 35 sought professional counseling since the pandemic began which indicates a need to address the impact of social isolation among young people. Tools like the Daily Coping Toolkit focuses on wellbeing in the face of COVID related environmental changes that impact mental health outcomes (smartpatients.com). The SAVE-9 tool identifies symptoms of mental distress and is validated for use with health professionals (Tavormina, et al., 2020). Several domestic violence and mental health websites offer tools to apply 'psychological first aid' to address health anxiety – stress directly resulting from COVID-19 and related impacts (Sexana, et al., 2020, AZ Coalition, 2020, FL Coalition, 2020).

Web-based behavior interventions are beneficial to victims and providers as evidenced by structured reviews on the effectiveness of devices such as kiosk-based computer assisted self-interviewing, interactive video, internet applications etc. in a meta-analysis of 17 studies which revealed improved knowledge and/or behavioral outcomes for participants using web-based interventions. (Wantland, et al., 2020).

Objective 4: Evidence for Effective Information Dissemination to DV/IPV Victims and Service Providers

The WHO defines health education as any combination of learning experiences tailored to support persons to improve their health by improving their knowledge and affecting their behaviors and attitudes (Sotgiu, et al., 2020). The ultimate dissemination goal is to get evidence-based information and programming into use by organizations whose job is to prevent domestic violence and help those experiencing it.

The literature supports application of the social marketing approach to translate science to implementation (Harris, et al., 2012, Gibbs, P. 2020). Marketing can increase demand for a service i.e. greater awareness of DV creates demand for social services. Dissemination, or distribution, delivers information and interventions to victims of violence. A customer, or victim, centered dissemination system uses data driven segmentation strategies to inform both.

Marketing and distribution systems must be built for use throughout the continuum of 'dissemination' to identify users, promote programs and information, provide access, allow participatory evaluation, and supports users during implementation (Kreuter et al., 2009). DV providers must promote programs strategically, tailor products and delivery modes for segmented audience, systematically identify proven programs, transform research tested interventions to maximize readiness for use in practice settings, build system of user support (Gibbs, P., 2020).

The HPRC (health promotion research center) Dissemination framework is an alternative which focuses on active dissemination processes with an emphasis on collaboration between researcher (source of evidence), disseminator (service provider), and user (Harris, et al. 2020). Collaboration being the key, this may framework may be a good fit with community-based organizations.

The COVID-19 Information Dissemination ID Project (Community Dev & Health Network, 2020) is *'committed to improving people's health literacy about COVID by providing accurate and up to date information which will increase knowledge, understanding and confidence and enable people to make good health decisions*.' This is an excellent basis from which to develop dissemination of domestic violence information in the context of a pandemic. The ID Project employs strategies similar to other organizations in the review: (1) disseminates official information (2) fact checks (3) counteracts misinformation (4) identifies gaps in info for people in specific communities (5) supports pharmacies by disseminating info about their role.

There are three fronts on the battle against COVID-19: containment and mitigation, innovation of treatment and cure, and diffusion of those innovations (Gibbs, P., 2020). Diffusion of COVID innovation is critical to ensure the equitable distribution, access to, and use of COVID vaccines, an effort that when applied to domestic violence can address the various socioecological factors associated with the increase in DV incidence during the pandemic.

Information must be disseminated to policy makers in new ways when advocating to integrate domestic violence in COVID-related public health efforts. Messages must be framed to better resonate with target audience. Access is a major barrier to the use of peer reviewed journals, as is time and literacy levels (Brownson et al 2018). Alternative dissemination products include policy briefs, fact sheets, chartbooks, posters and infographics, promotional products, white/working papers (Schroeder, et al., 2019). The literature also points to the need for ADA access to media, especially web-based resources.

Clear communication between government and the public is one of the best ways to maintain calm among the public and contribute to greater social cooperation (Shorey, et al., 2020). Authors support use of mass media to increase awareness, support social safety networks with focus on families with prior DV reports – set up online social assistance that intervenes periodically to verify security of the family environment (Sacco, et al., 2020).

Specific recommendations for dissemination include identifying target audiences and specific organizations representing those audiences, building relationships with key people in each organization, developing a cohesive campaign plan of information and dissemination products that focuses on a single overriding message, and delivering the message using appropriate language and framing (Carpenter, et al. 2005).

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