



A Study on Economic Stressors During the COVID-19 Pandemic Among Intimate Partner and Sexual Violence Survivors in the United States

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Abstract

Systemic racism and racialized poverty are socially produced structural determinants that shape health outcomes during infectious disease outbreaks. Public health emergencies compound vulnerabilities for survivors of intimate partner violence (IPV) and sexual violence (SV) and those who self-identify as people from racial and ethnic minority groups. We describe findings from an online survey designed to collect data on financial conditions faced by survivors of IPV and SV to understand these conditions during the COVID-19 pandemic. Our analyses were limited to a sample of women in the United States (91.4%, $n = 523$) who reported IPV or SV to whom we refer as survivors. We characterize the differences of economic stressors across White and aggregated categories of self-identified race, i.e., Black and Brown Latinx women and non-Black or non-Brown Latinx women of color, to highlight disparities between White and non-White populations in our sample. Logistic regressions were used to examine the relationships among racial categories, food insecurity, housing insecurity, and economic insecurity during the COVID-19 pandemic. Black and Brown Latinx women survivors were twice as likely as White women to report housing, financial, and economic insecurity during the COVID-19 pandemic. Approximately one-third of all survivors anticipated taking on more debt than they would want to cover their expenses due to COVID-19. The results of this study have implications for public health responses that involve coordinating economic relief measures among populations

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disparately affected by public health crises and disasters to ensure that the economic needs of the most impacted are addressed.

Keywords

Brown Latinx; Black; Sexual violence; Intimate partner violence

Introduction

Emerging evidence suggests that the COVID-19 pandemic has amplified existing racial inequalities and gender disparities that unfairly disadvantage Black, Indigenous, and Latino/Hispanic persons and women in the U.S. and beyond [1–22]. Systemic racism and racialized poverty are socially produced structural determinants that shape health outcomes during infectious disease outbreaks [23]. As such, they also negatively influence outlooks for recovery from the physical, economic, and emotional traumas that result. Before the COVID-19 pandemic, survivors of intimate partner violence (IPV) and sexual violence (SV) were already among those most likely to be impacted by socio-structural burdens [24]. Given that public health emergencies compound vulnerabilities for survivors, our study focused on examining the financial conditions faced by survivors of IPV and SV in the United States during the COVID-19 pandemic [25, 26]. The purpose of the study was to provide leading anti-violence advocacy organizations with data about these conditions that could assist in developing evidence-based emergency response programs for survivors of IPV and SV in the U.S. during this quickly evolving public health emergency [27, 28].

Two analytical frameworks guided the development of this study. The primary framework is intersectionality. This framework theorizes structures of oppression as overlapping, co-creating, and mutually reinforcing one another [29–34]. The intersectionality framework has been a cornerstone of IPV and SV research across the lifespan since its adaptation from legal theory and introduction to the literature on racial and ethnic health disparities in the 1990s [35, 36]. It has been an especially useful framework for theorizing the complex convergence of social and institutional forces that produce health inequalities and diminished life chances for IPV and SV survivors of color. It has also been valuable in designing culturally specific services and provider models of care that better respond to survivor’s needs based on known racial and gender disparities in society (and the institutional interplay of these disparities and health outcomes) [37–40]. The theoretical framework is particularly important for revealing the *compounded and cumulative structural burdens* on survivors simultaneously facing multiple forms of marginalization, such as racism, sexism, and poverty [38]. Research has shown that many of the multifactorial drivers of health inequities during the COVID-19 pandemic are associated with compounded and cumulative structural burdens and that “structural racism laid the foundation for increased risk of COVID-19 in racial and ethnic minority communities” [41]. Intersectionality as a theory of structural vulnerability allows researchers to investigate the nexus of gendered racism and economic precarity during public health emergencies to identify populations at greatest risk of adverse economic impacts from compounded financial effects of these emergencies with those of IPV and SV.

The financial dimensions of IPV and SV and the economic costs and fallout from weathering these forms of abuse are particularly acute for survivors [42]. Intersectional research suggests that these costs would be compounded for survivors who are women of color, especially for under-resourced and low-income women of color [43]. We chose to focus on the financial and economic burdens faced during the COVID-19 pandemic because disasters not only exacerbate but entrench the impacts of structural inequalities [44, 45]. They remove many of the safety nets available and limit the possible exit strategies out of situations worsened by multiple structural vulnerabilities, including IPV and SV.

The pandemic removed many of the already limited ways of escaping the racial, economic, and gender-based harms available to those made most vulnerable by systems of exploitation and abuse. Intersectionality as a theory of structural vulnerability understands systems of oppression not only as patterns of inequality but as stable and resilient structures that manifest harmful material consequences for the most vulnerable across our social institutions. And emerging research suggests that the pandemic has strengthened many of the systems of oppression that structurally produce these harms predictably and reliably for specific populations. Intersectionality remains a core analytic lens across contemporary public health approaches to social inequality, such as in ecosocial theory, social determinants of health research, and biomedical research that all routinely report widespread socio-economic disparities in health outcomes and health consequences of discrimination [46–48]. Based on this theoretical framework, we hypothesized that survivors of IPV and SV who self-identified as Black/African descent or as Brown Latinx would report worse economic challenges than White survivors during the COVID-19 pandemic.

The secondary framework we used was community-based participatory research (CBPR). CBPR is an established approach to health research that emphasizes equity in collaboration, collective participation, and community-led responses to health inequity [49–51]. It has been used alongside intersectional research methods to promote “coalitional” approaches to collaboration among academic researchers and grassroots and nonprofit activist organizations [52]. Virtual CBPR protocols for COVID-19 were implemented for this study [53]. After virtual discussions with the advocacy organizations, we understood this coalitional approach to require incorporating the organizations’ intersectional approaches and organizational vocabularies into study conceptualization, instrument design, participant recruitment, and data analysis [54, 55].

Based on this approach, we characterized the differences in economic stressors according to self-identified racial categories. We then combined the self-identified categories into aggregated racial categories for “populations of color” (e.g., Black and Brown Latinx and non-Black or non-Brown Latinx people of color), resulting in a racial classification system that highlighted population-level structural disparities. This classification system contains racial categories (such as Brown Latinx) that are distinct from those named in the Office of Management and Budget (OMB) standards for racial and ethnic categorization. In the “Discussion” section, we discuss this grouping choice as part of a response to (1) conceptual concerns with identity-based applications of intersectional methods in public health research and (2) the need to produce translational research that can be quickly and efficiently communicated to the public during an emergency. We also address this issue as part of an

evolving academic discussion responsive to shifting public attitudes in “socially racialized and statistically invisible” racial categories and the need to disaggregate within-group racial differences among Hispanics to address the so-called “Hispanic Paradox” [56–58].

Lastly, because our study was created in response to a rapidly evolving public health emergency, our CBPR implementation process was influenced by emergency response research (ERR). Public health emergency response research features evidence-based approaches to the evolving preparedness and response needs posed by public health emergencies, such as the 2009–2010 H1N1 influenza pandemic, the 2014–2016 Ebola epidemic in West Africa, and the COVID-19 pandemic [59, 60]. It draws from adaptive disaster preparedness and response models used by national infrastructure and international relief agencies to mitigate the fallout, contain the spread, provide relief, and prevent the recurrence of natural disasters such as wildfires, floods, and man-made mass casualty events through research and infrastructure preparedness (including training and resource development).

In disaster response research, the positive influence of cash assistance, cash transfer programs, and direct cash grants is well established [61]. ERR further supported our selection of econometric variables for this study. Most importantly, this choice was responsive to the infrastructure already in place within the advocacy organizations to deliver cash assistance programming, consistent with CBPR models that prioritize action in research outcomes [62]. It was also responsive to increasing evidence in IPV research that cash transfer programs decrease IPV through promoting economic security and emotional well-being [62]. Our research question produced in this emergency response and organizational need context asked: Are there racial disparities in the financial conditions faced by survivors of IPV and SV in the U.S. during the COVID-19 pandemic?

While our study found that Black and Brown Latinx women survivors were twice as likely as White women to report housing, financial, and economic insecurity during the COVID-19 pandemic, we highlight the constraints on inferring a causal relationship from this association with COVID-19. We also suggest the need for further study while advocating for intersectional approaches to public health that attend to the needs of the most vulnerable populations and that foreground facilitating economic relief measures for those who experience severe economic burdens from public health crises and disasters.

Method

Sample and Survey Administration

The university’s Institutional Review Board approved the survey design, questions, and resources. Between June 23 and July 27 of 2020, an online survey was distributed via the “me too” website (metoomvmt.org) and its corresponding social media platforms (e.g., Twitter).

Eligible participants were adults 18 years or older. Adults with and without a history of IPV and SV were able to participate. No incentives were used for participant recruitment.

A total of 737 adults consented to participate in the study. Participants who did not indicate lifetime IPV and SV were dropped from the analytic sample, as well as participants who indicated that they resided outside the United States. Our sample consisted of 572 participants who reported IPV, SV, or both, which we refer to as survivors. Participants were able to select multiple categories for the race/ethnicity question: Alaskan/Native American, Asian, Black/African Descent, Brown Latinx, Hispanic, Middle Eastern, Native Hawaiian or Pacific Islander, White, I prefer to self-describe, and I prefer not to answer. There were also multiple-choice selections available for gender: women, men, transgender, cisgender, genderqueer/genderfluid, nonbinary, I prefer to self-describe, and I prefer not to answer.

Descriptive and statistical analyses were limited to the survivor sample of women (91.4%, $n = 523$) given the small sample of men (1.9%, $n = 11$) and gender-diverse individuals (5.2%, $n = 30$). Gender-diverse participants included those who self-identified as transgender, genderqueer/genderfluid, nonbinary, two-spirit, and other or missing (1.4%, $n = 8$).

The Black and Brown Latinx category is composed of survivors who selected “Black/African Descent” or “Brown Latinx” in the race/ethnicity question, no participants selected both, and participants who selected “Brown Latinx” and “Hispanic” were also included in this category. The White women category is composed of survivors who only selected “White,” and the non-Black or non-Brown Latinx women of the color category is composed of survivors who selected a response option other than “White,” “Black/African Descent,” or “Brown Latinx” (i.e., Alaskan Native/Native, Asian, Hispanic, Middle Eastern, Native Hawaiian or Pacific Islander).

Measures

Intimate Partner Violence Victimization—Lifetime experiences of intimate partner violence were measured with the following prompt and question: Relationship violence refers to physical, verbal, emotional, economic and/or sexual violence by someone with whom you are or have been in a close or intimate relationship. Have you experienced relationship violence? [63]. The response options for these items were “Yes,” “No,” “I don’t know,” or “Prefer not to answer.”

Sexual Violence Victimization—Lifetime sexual violence was measured with the following prompt and question: Sexual violence refers to any unwanted sexual act including sexual touching, sexual comments, or attempts to obtain sexual acts through coercion, and can be perpetrated by anyone regardless of their relationship to the victim. Have you experienced sexual violence? [63] The response options for these items were “Yes,” “No,” “I don’t know,” or “Prefer not to answer.”

Economic Stressor Variables—Food and housing insecurity items were derived from the Behavioral Risk Factor Surveillance System’s Social Context module [64, 65]. Participants were first presented with the prompt: *In March the COVID-19 (coronavirus) outbreak in the US was considered a national emergency.* The food insecurity indicator was presented as *Since then, how often would you say you were worried or stressed about having enough money to buy nutritious meals?* The housing insecurity indicator followed as *Since then, how often would you say you were worried or stressed about having enough*

money to pay your rent or mortgage? Participants responded on a 5-point Likert-type scale from 0 (*never*) to 4 (*always*). Economic insecurity was a combined measure of food and housing insecurity with three levels: high, medium, and low. Participant awareness of housing resources was asked with the question *Are you aware of existing housing-related resources for survivors?* The response items were “Yes,” “No,” “I don’t know,” and “Prefer not to answer.”

Additional questions related to financial instabilities related to COVID-19 were presented to participants. To assess the type of bills participants were unable to pay, they were asked: *Which of the following bills have you been unable to pay (in part or in whole) because of the impacts of COVID-19?* Options included rent, mortgage, electric, water/sewage, internet, cable, telephone (landlines or cellular), homeowner association fees, property taxes, renter’s or house insurance, medical bills, other bill(s), and prefer not to answer. Participants were asked to indicate the numerical amount of money they had access to at the time of the survey with *How much money do you estimate you have right now that you alone can access? (This can be in cash, savings, or prepaid cards).*

Experience of financial abuse since COVID-19 was measured with *Since then, has your partner/the person who caused you harm monitored, controlled or restricted your access to any of the following?* Options included respondent’s paycheck/wages, cash, bank account/savings account, credit/debit card, other financial resources, prefer not to answer, or does not apply. Anticipated debt due to COVID-19 was asked with the question *Do you anticipate taking on more debt than you want to cover your expenses due to COVID-19?* The response options were “Yes,” “No,” “I don’t know,” and “Prefer not to answer.” Information about the importance of the following financial resources was asked on a 5-point Likert-type scale from 1 (not at all important) to 5 (extremely important): (1) credit card debt relief, (2) utility bill relief, (3) rent, mortgage, temporary housing cost relief, (4) property tax relief, (5) medical bills, (6) direct cash, and (7) other.

Statistical Analysis

All analyses were conducted with R software [66]. The response items “I don’t know” and “Prefer not to answer” were coded as missing for all measures. To examine resource inequities within an intersectional framework, the data were analyzed using racial aggregation among women survivors, which yielded three racial categories: Black and Brown Latinx women, non-Black or non-Brown Latinx women of color, and White women. Logistic regressions were used to examine food and housing insecurity differences by racial category (i.e., Black and Brown Latinx women, non-Black or non-Brown Latinx women of color, and White women), with White as the reference group. There were no adjustments made to the model.

The significance threshold was at $p < .05$. The MASS package was used to conduct an ordinal logistic regression, which was used to examine the effect of the racial category (i.e., Black and Brown Latinx women, non-Black or non-Brown Latinx women of color, and White women) on levels of economic insecurity (i.e., low, medium, high). The economic insecurity variable is a combined measure of the food and housing insecurity variables [64]. The economic insecurity levels were determined by a pre-specified range in the composite

score. A composite score of 6–8 was labeled as “high,” 3–5 was labeled as “medium,” and 0–2 was labeled as “low.” A chi-square test was used to examine the relationship between racial categories and the dichotomous variable struggling to pay multiple bills. Significant differences were determined by p values $< .05$.

Results

See Table 1 for detailed demographic characteristics of the analytic sample. As shown in Table 2, a logistic regression indicated that the odds of Black and Brown Latinx women survivors experiencing food insecurity during the COVID-19 pandemic are 2.42 times the odds that White women survivors experience (OR = 2.42 [CI = 1.43 to 4.08], $p < .001$), and the odds of Black and Brown Latinx women survivors experiencing housing insecurity are 2.10 times the odds of White women survivors experiencing the same (OR = 2.10 [CI = 1.25 to 3.53], $p < .01$). There were no significant differences between non-Black or non-Brown Latinx women of color survivors and White women survivors with odds of experiencing food insecurity ($p = .22$) or housing insecurity ($p = .15$). Black and Brown Latinx women survivors (OR = 2.56 [1.66 to 3.98]) were more likely to report high levels of economic insecurity than White women survivors, but this was not the case for non-Black or non-Brown Latinx women of color survivors (OR = 1.65 [.97 to 2.82]). A total of 69.46% of women reported that they were unaware of housing-related resources specifically for survivors.

A total of 11.47% ($n = 60$) of women reported an experience of financial abuse by the person who caused them harm since the COVID-19 pandemic. The data presented in Tables 3, 4 and 5 are descriptive, and significant differences were not tested. White women survivors had seven times the average amount of financial resources that Black and Brown Latinx women had (see Table 3). Additional descriptive information about survivors' experience with financial abuse is reported in Table 3. Approximately one-third of all survivors anticipated taking on more debt than they would want to cover their expenses due to COVID-19. Table 4 presents the mean level of importance for various financial resources for women across the three racial categories (i.e., Black and Brown Latinx women, non-Black or non-Brown Latinx women of color, White women) with the highest selected response option being direct cash. Survivors also selected the type of bills they have been unable to pay because of the COVID-19 pandemic. Medical bills were most common for non-Black or non-Brown Latinx women of color and White women, and rent was most common among Black and Brown Latinx women (see Table 5). The study also assessed potential differences in the inability of survivors to pay multiple bills due to COVID-19 based on race. Analysis indicated a significant relationship between racial categories and inability to pay multiple bills due to COVID-19 impacts among women, $\chi^2(2) = 14.32$, $p < .001$. Black and Brown Latinx women reported the highest rate of struggling with multiple bills (39.29%, $n = 22/56$) in comparison to White women (15.49%, $n = 22/142$) and non-Black or non-Brown Latinx women of color (14.81%, $n = 4/27$).

A logistic regression examined specific group differences by their inability to pay multiple bills. The analysis indicated that the odds of Black and Brown Latinx women not being able to pay multiple bills due to the COVID-19 pandemic is 3.53 times the odds White

women experience (OR = 3.53 [CI = 1.75 to 7.13], $p < .001$), and there was no significant difference in the odds of non-Black or non-Brown Latinx women of color not being able to pay multiple bills due to the COVID-19 pandemic compared to White women experiencing the same (OR = .95 [CI = .30 to 3.01]).

Discussion

The COVID-19 pandemic propelled the widening of socioeconomic and health-related inequities that have renewed interest in using an intersectional framework to analyze overlapping structural burdens in diverse populations [34,71]. Structural vulnerabilities for survivors of IPV and SV are compounded during disasters and states of emergency, which was evidenced by the COVID-19 pandemic; in fact, nearly one in three women globally experienced IPV [72, 73]. We employed intersectionality primarily as a theory of structural vulnerability, rather than as a wholly group-centered or identity-centered framework, in order to hypothesize that Black and Brown Latinx IPV and SV survivors would experience disproportionate financial challenges during the COVID-19 pandemic [74, 75]. Identity-centered approaches are those that examine the overlap between social categories (e.g., “woman” and “Black”) associated with specific social locations. They prevail in public health research because they facilitate categorical analyses that can describe the distribution of outcomes across multiple social categories, but they do not examine the distribution of outcomes across racial groups as socially produced structural phenomena that reinforce systems of oppression [76].

Intersectionality as a theory of structural vulnerability allows researchers to study and predict the ways that systems of oppression co-produce and compound one another through shared institutional mechanisms and processes. Based on this framework, it is not surprising that the results of this study show that among survivors of IPV and SV, women who self-identified as “Black/African descent” or “Brown Latinx” reported more economic challenges than White women survivors of IPV and SV during the COVID-19 pandemic.

As a whole, our findings align with economic research on gender and racial wealth gaps showing that White women consistently have more median wealth and assets than their Black and Brown Latinx counterparts across the life course [77–79]. In this study, White women survivors had seven times more than the average amount of financial resources that Black and Brown Latinx women survivors had. This finding underscores the continuing structural role of economic hardship and socially produced disadvantage in securing safety and well-being for women of color survivors of IPV and SV, as well as the relationship between survivors’ financial standing and their ability to recover from compounded “shocks” across the life course.

The economic shocks associated with survivorship, such as medical bills and job loss, were made worse during the COVID-19 pandemic, and these compounded effects may make economic recovery more difficult for survivors of racial and ethnic minority groups [42, 80]. Nearly one-third of all survivors surveyed in our study anticipated taking on more debt than they desired to cover their expenses due to the COVID-19 pandemic. Despite the fact that assets have been shown to have a wide variety of positive associations with

health and socio-economic outcomes for survivors and that debt (both freely undertaken and coerced) is associated with a range of negative consequences, researchers focusing on health sciences have paid relatively little attention to the centrality of economic resources for recovery and the role of economic abuse in gender-based violence for survivors of color [81–84]. This underscores the need for researchers to partner with experienced advocacy organizations who prioritize and administer economic relief programs as an essential public health intervention for survivors of IPV and SV and to further explore emergency response approaches to gender-based violence in public health research, particularly for underserved populations.

Public health emergencies pose the potential for increased pathways for cumulative abuse and disadvantage tied to socio-economic status and potentially divergent recovery trajectories for women survivors from racial and ethnic minority groups. Crises like the COVID-19 pandemic can further endanger IPV and SV survivors and create barriers to safety by limiting access to safe housing (due to quarantine restrictions and rent burdens) and increasing exposure risks to violence [85–87]. Compared to White women survivors, Black and Brown Latinx women survivors were twice as likely to report that they were facing housing insecurity due to the pandemic.

It is worth briefly elaborating on our decision to follow our partner organizations' linguistic practice of aggregating racial groups into wider underrepresented population categories (such as “Black and Brown women” or “women of color”) in our sample grouping of “Black and Brown Latinx women,” “non-Black or non-Brown Latinx women of color,” and “White women” populations. This grouping allowed us to quickly and effectively communicate racial disparities between “White” and “non-White” populations as they were generally understood by the community partners and the public most likely to access data visualizations published on their websites.

Given our framework of intersectionality as a theory of structure, the use of distinct self-identification options for both “Brown Latinx” and “Hispanic” was an important mechanism to track the connectedness of racism and structural burdens to group identity categories. As Cobas et al. have pointed out, the category “Hispanic” collapses together White Latin Americans and White Europeans from the Iberian Peninsula (or Euro Latinos) in the U.S. with those of Afro and Indigenous descent [88]. A 2015 survey by the Pew Research Center showed that “11% of American adults with Latin American ancestry still do not identify as ‘Hispanic’,” and these percentages continue to rise [89].

Because “Hispanic” is a multiracial ethnic category that captures many, but not all, people of Latin American descent, we included it as a self-identification option. But, because it collapses different structural positions, we also used participant self-selection of either “White” or “Brown Latinx” as a determining factor in where to place participants within our racial aggregation groupings. The term “Brown Latino/x/o/a/e” emerged in U.S. urban contexts as a way to distinguish those who self-identify as primarily of Indigenous Amerindian descent (and less commonly, Afro descent) from “White Latino” populations, who identify primarily as being of European Iberian peninsula descent (or as both “Hispanic” and “White”). This distinction is important for capturing the different lived

experiences of those who have visibly non-White skin tones and tracking their experience as people of color, but who do not identify as Black Latinx, Afro-Latinx, or Black and Hispanic [90–93]. Using both categories, “Hispanic” and “Brown Latinx,” allowed us to disaggregate subpopulations of Latin American descent that face different types of structural vulnerabilities due to their distinct relations to racism.

The results of this study have implications for public health responses that involve the coordination of economic relief measures (e.g., economic impact payments, food assistance programs, and low-income or expanded unemployment benefits) among populations disparately affected by public health crises and disasters to ensure the financial needs of the most impacted are addressed [94, 95]. The study also highlights the usefulness of intersectionality, primarily as a theory of structure and structural vulnerability, to aid in pandemic preparedness and emergency response efforts by anticipating how existing economic burdens among socially marginalized communities are likely to be compounded and magnified by public health emergencies.

Limitations

There are several limitations to acknowledge with the study design and participant sample. Our study included “Brown Latinx” as an additional response option to attempt to capture Afro and Indigenous descendants who self-identify as “Brown Latinx” rather than “Hispanic” only. We recognize that the categories of “Hispanic” and “Brown Latinx” sometimes overlap, as do the categories of “Hispanic” and “White.” Because it was possible for participants to select any combination of racial categories in their self-identification, and some identified as “Hispanic” without also selecting an additional category of either “White” or “Brown Latinx,” it is not possible to definitively disaggregate ingroup racial differences between respondents who identified across multiple categories that included “Hispanic.” It is also not known the degree to which Afro-Latinx, Black Latinx, and Black Hispanics self-identify as Brown Latinx among the U.S. adult population. Future studies could expand the scope of this work by examining the realities of changing demographics and patterns of self-identification among “Hispanics.”

Although participants were prompted with COVID-19 pandemic–related questions and asked about their financial and housing experiences since the occurrence of the pandemic, our study was cross-sectional rather than longitudinal. It is thus limited in its ability to examine the financial impacts of the pandemic in a way that reflects a specifically causal relationship between variables [96]. Also, these findings cannot be generalized to all survivors of IPV and SV in the United States since we implemented a non-probability sampling method and have a higher representation of people who self-identified as women than as other gender identities and a majority of the sample self-reported within the White race category. Further, the specific geographic location of respondents could have moderated the effect of the respondents’ financial situation after the pandemic. Another factor to consider is that economic insecurity was a self-reported perception of participants and their perception about housing and financial security may be impacted by their individual history.

Additionally, the data collection time frame represents a few months after the COVID-19 pandemic reached the United States. The economic reality of participants could have

differed between the time they took the survey and when the availability of vaccines and economic support at the state and national level became widespread. Future research could consider oversampling for men and gender-diverse individuals, especially those who identify as persons from racial and ethnic minority groups, to better characterize the financial stressors that survivors of IPV and SV endure during a public health emergency.

Virtual CBPR protocols mitigated some of the pandemic's disruption of critical participatory action research (PAR) protocols and community engagement norms that include face-to-face dialogue, stakeholder feedback, and direct co-planning across all features of research. However, it is not known the extent to which the sudden shift to virtual protocols impacted CBPR methods and outcomes for the study. Future research could interrogate the impact of the COVID-19 pandemic on CBPR protocols with nonprofit, grassroots, and advocacy organizations.

Conclusion

Among survivors of IPV and SV, Black and Brown Latinx women reported worse financial conditions when compared to White women during the COVID-19 pandemic. Our findings suggest a need to explore more ways to effectively deliver extended economic relief measures for survivors of racial and ethnic minority groups in response to public health emergencies and other economic disasters. Given the compounding and disproportionate financial burden that survivors endured because of the COVID-19 pandemic, strengthening economic support may be an appropriate strategy to support survivors of IPV and SV during a public health emergency as well as an appropriate method of prevention for these forms of violence [97, 98]. An intersectional framework that considers the compounding nature of systemic burdens for economically and socially marginalized populations can also help identify the need for various direct relief measures for survivors of IPV and SV.

Disclaimer

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References

1. DiRago NV, et al. COVID-19 vaccine rollouts and the reproduction of urban spatial inequality: disparities within large US cities in March and April 2021 by racial/ethnic and socioeconomic composition. *J Urban Health*. 2022;99(2):191–207. [PubMed: 35118595]
2. Navarro SA, Hernandez SL. *The color of COVID-19: the racial inequality of marginalized communities*. Routledge, 2022.
3. Melaku TM, Beeman A. Navigating White academe during crisis: the impact of COVID-19 and racial violence on women of color professionals. *Gend Work Organ*. 2023;30(2):673–91.
4. Camp AM, Zamarro G. Determinants of ethnic differences in school modality choices during the COVID-19 crisis. *Educ Res*. 2022;51(1):6–16.
5. Meghji A, Niang SM. Between post-racial ideology and provincial universalisms: critical race theory, decolonial thought and COVID-19 in Britain. *Sociology*. 2022;56(1):131–47.
6. Johnson S. Women deserve better: a discussion on COVID-19 and the gendered organization in the new economy. *Gend Work Organ*. 2022;29(2):639–49.

7. Lin Z, Liu H. A national study of racial–ethnic differences in COVID-19 concerns among older Americans: evidence from the Health and Retirement Study. *J Gerontol: Ser B*. 2022;77(7):e134–41.
8. Ganguli-Mitra A, Qureshi K, Curry GD, Meer N. Justice and the racial dimensions of health inequalities: a view from COVID-19. *Bioethics*. 2022;36(3):252–9. [PubMed: 35245392]
9. Francis DV, Weller CE. Economic inequality, the digital divide, and remote learning during COVID-19. *Rev Black Polit Econ*. 2022;49(1):41–60. [PubMed: 35291320]
10. Parolin Z, Lee EK. The role of poverty and racial discrimination in exacerbating the health consequences of COVID-19. *Lancet Reg Health-Am* 2022;7:100178. [PubMed: 35018358]
11. Cheng P, et al. Sleepless in COVID-19: racial disparities during the pandemic as a consequence of structural inequity. *Sleep*. 2022;45(1):zsab242. [PubMed: 34788453]
12. Welsh RO. School discipline in the age of COVID-19: exploring patterns, policy, and practice considerations. *Peabody J Educ*. 2022;97(3):291–308.
13. Abedi V, et al. Racial, economic, and health inequality and COVID-19 infection in the United States. *J Racial Ethn Health Disparities*. 2021;8(3):732–42. 10.1007/s40615-020-00833-4. [PubMed: 32875535]
14. Okonkwo NE, et al. COVID-19 and the US response: accelerating health inequities. *BMJ Evid-Based Med*. 2021;26(4):176–9.
15. Dang H-AH, Nguyen CV. Gender inequality during the COVID-19 pandemic: income, expenditure, savings, and job loss. *World Dev*. 2021;140:105296. [PubMed: 34548740]
16. Fisher AN, Ryan MK. Gender inequalities during COVID-19. *Group Process Intergroup Relat*. 2021;24(2):237–45.
17. Reichelt M, Makovi K, Sargsyan A. The impact of COVID-19 on gender inequality in the labor market and gender-role attitudes. *Eur Soc*. 2021;23(sup1):S228–45.
18. Gauthier GR, Smith JA, García C, Garcia MA, Thomas PA. Exacerbating inequalities: social networks, racial/ethnic disparities, and the COVID-19 pandemic in the United States. *J Gerontol: Ser B*. 2021;76(3):e88–92.
19. Chen JT, Waterman PD, Krieger N, Krieger N. COVID-19 and the unequal surge in mortality rates in Massachusetts, by. *Population*. 2020;25014(B25014_013E):B25014_001E.
20. Cowger TL, et al. Comparison of weighted and unweighted population data to assess inequities in coronavirus disease 2019 deaths by race/ethnicity reported by the US Centers for Disease Control and Prevention. *JAMA Netw Open*. 2020;3(7):e2016933–e2016933. [PubMed: 32721026]
21. Malghan D, Swaminathan H. Inside the black box: intra-house-hold inequality and a gendered pandemic. Luxembourg Income Study (LIS) Working Paper Series, No. 797. 2020.<https://www.econstor.eu/bitstream/10419/228348/1/1726181227.pdf>.
22. Bime C, et al. Disparities in outcomes of COVID-19 hospitalizations in native American individuals. *Front Public Health*. 2023;11:1220582. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10465166/pdf/fpubh-11-1220582.pdf>. [PubMed: 37649785]
23. Gravlee CC. Systemic racism, chronic health inequities, and COVID-19: A syndemic in the making?. *Am J Hum Biol*. 2020;32(5):1–8.
24. Doyle K, Durrence A, Passi S. Survivors know best: how to disrupt intimate partner violence during COVID-19 and beyond. In: Reports. FreeFrom. 2020.<https://www.freefrom.org/wp-content/uploads/2021/06/Survivors-Know-Best.pdf>.
25. Buttell F, Ferreira RJ. The hidden disaster of COVID-19: intimate partner violence. *Psychol Trauma Theory Res Pract Policy*. 2020;12(S1):S197.
26. Cange CW, McGaw-Césaire J. Long-term public health responses in high-impact weather events: hurricane Maria and Puerto Rico as a case study. *Disaster Med Public Health Prep*. 2020;14(1):18–22. [PubMed: 31679557]
27. Ruíz E, Ruvalcaba Y, Berenstain N, Fluegeman S. Research: the economic impact of COVID-19 on survivors of color. MeToo International. <https://metoomvmt.org/the-work/research-the-economic-impact-of-covid-19-on-survivors-of-color/>. Accessed 28 March 2023.

28. Ruíz E, Ruvalcaba Y, Berenstain N, Fluegeman S. Measuring the impact of COVID-19 on survivors of color. In: Reports. FreeFrom. 2020. <https://www.freefrom.org/wpcontent/uploads/2021/06/Measuring-Economic-Impact.pdf>. Accessed 28 March 2023.
29. Cho S, Crenshaw KW, McCall L. Toward a field of intersectionality studies: theory, applications, and praxis. *Signs: J Women Cult Soc.* 2013;38(4):785–810.
30. Cole ER. Intersectionality and research in psychology. *Am Psychol.* 2009;64(3): 170. [PubMed: 19348518]
31. Ruíz E. Framing Intersectionality. In: Taylor P, Alcoff L, Anderson L, editors. *The Routledge companion to the philosophy of race.* New York: Routledge; 2018.
32. Overstreet N, Rosenthal L, Case K. Intersectionality as a radical framework for transforming our disciplines, social issues, and the world. *J Soc Issues.* 2020;76(4):779–95.
33. Bowleg L. The problem with the phrase women and minorities: intersectionality—an important theoretical framework for public health. *Am J Public Health.* 2012;102(7): 1267–73. [PubMed: 22594719]
34. Bowleg L We're not all in this together: on COVID-19, intersectionality, and structural inequality. *American Journal of Public Health.* 2020;110(7):917. [PubMed: 32463703]
35. Crenshaw KW. Mapping the margins: intersectionality, identity politics, and violence against women of color. In: Fineman MA, editor. *The public nature of private violence.* New York: Routledge; 1994.
36. Bograd M Strengthening domestic violence theories: intersections of race, class, sexual orientation, and gender. *J Marital Fam Ther.* 1999;25(3):275–89. [PubMed: 10405915]
37. West CM. Black women and intimate partner violence: new directions for research. *J Interpers Violence.* 2004;19(12):1487–93. [PubMed: 15492062]
38. Rice J, West CM, Cottman K, Gardner G. The intersectionality of intimate partner violence in the Black community. In: Geffner R, White JW, Hamberger LK, Rosenbaum A, Vaughan-Eden V, Vieth V, editors. *Handbook of interpersonal violence and abuse across the lifespan.* Switzerland: Springer Nature Switzerland; 2022.
39. Kulkarni S Intersectional trauma-informed intimate partner violence (IPV) services: narrowing the gap between IPV service delivery and survivor needs. *J Fam Violence.* 2019;34(1):55–64.
40. O'Neal EN, Beckman LO. Intersections of race, ethnicity, and gender: reframing knowledge surrounding barriers to social services among Latina intimate partner violence victims. *Violence Against Women.* 2017;23(5):643–65. [PubMed: 27137341]
41. Nana-Sinkam P, et al. Health disparities and equity in the era of COVID-19. *J Clin Transl Sci.* 2021;5(1):e99. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8167251/pdf/S2059866121000236a.pdf>. [PubMed: 34192054]
42. Peterson C, et al. Lifetime economic burden of intimate partner violence among US adults. *Am J Prev Med.* 2018;554:433–444. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6161830/pdf/nihms-989537.pdf>.
43. Loya RM The role of sexual violence in creating and maintaining economic insecurity among asset-poor women of color. *Violence Against Women.* 2014;20(11):1299–320. [PubMed: 25288596]
44. Reid M Disasters and social inequalities. *Sociol Compass.* 2013;7(11):984–97.
45. Ratcliffe C, Congdon W, Teles D, Stanczyk A, Martín C. From bad to worse: natural disasters and financial health. *J Hous Res.* 2020;29(sup1):S25–53.
46. López N, Gadsden VL. Health inequities, social determinants, and intersectionality. In: Alexander C, Murry VM, Bogard K, editors. *Perspectives on health equity and socialdeterminants of health.* Washington: National Academies Press (US); 2017.
47. Hankivsky O et al. The odd couple: using biomedical and intersectional approaches to address health inequities. *Global Health Action.* 2017;10(sup2):1326686. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5645663/pdf/zgha-10-S2-1326686.pdf>. [PubMed: 28641056]
48. Krieger N The ostrich, the albatross, and public health: an ecosocial perspective--or why an explicit focus on health consequences of discrimination and deprivation is vital for good science

- and public health practice. *Public Health Rep.* 2001;116(5):419, [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1497366/pdf/12042606.pdf>. [PubMed: 12042606]
49. Centers for Disease Control and Prevention. Principles of community engagement. CDC/ATSDR Committee on Community Engagement. 1997.
 50. Israel BA, Schulz AJ, Parker EA, Becker AB. Community-based participatory research: policy recommendations for promoting a partnership approach in health research. *Education for health.* 2001;14(2):182–97. [PubMed: 14742017]
 51. Wallerstein NB, Duran B. Using community-based participatory research to address health disparities. *Health Promot Pract.* 2006;7(3):312–323, 2006. [Online]. Available: https://core.ac.uk/reader/192841041?utm_source=linkout. [PubMed: 16760238]
 52. Cole ER. Coalitions as a model for intersectionality: from practice to theory. *Sex Roles.* 2008;59:443–53.
 53. Valdez ES, Gubrium A. Shifting to virtual CBPR protocols in the time of corona virus/COVID-19. *Int J Qual Methods.* 2020;19:1609406920977315.
 54. Abrams JA, Tabaac A, Jung S, Else-Quest NM. Considerations for employing intersectionality in qualitative health research. *Soc Sci Med.* 2020;258:113138. [PubMed: 32574889]
 55. Burke T MeToo was started for black and brown women and girls. They’re still being ignored. *The Washington Post.* 2017;9:2017.
 56. Jabbar AJ Socially racialized and statistically invisible: US Census Recognition of The Middle Eastern and North African Diaspora. Thesis: The Graduate Center, City University of New York; 2024.
 57. Kauh TJ, Read JnG, Scheitler A. The critical role of racial/ethnic data disaggregation for health equity. *Popul Res Policy Rev* 2021;40(1):1–7. [Online]. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7791160/pdf/11113_2020_Article_9631.pdf. [PubMed: 33437108]
 58. Valles SA. The challenges of choosing and explaining a phenomenon in epidemiological research on the “Hispanic Paradox”. *Theor Med Bioeth.* 2016;37:129–148. [Online]. Available: <https://link.springer.com/article/10.1007/s11017-015-9349-1>. [PubMed: 26754488]
 59. Redd SC, Frieden TR. CDC’s evolving approach to emergency response. *Health Secur.* 2017;15(1):41–52. [PubMed: 28146366]
 60. Downey A, Brown L, Calonge N. Evidence-based practice for public health emergency preparedness and response. Washington: National Academies Press; 2020.
 61. Bagstagli F, Hagen-Zanker J, Harman L, Barca V, Sturge G, Schmidt T. Cash transfers: What does the evidence say? A rigorous review of programme impact and the role of design and implementation features. Overseas Development Institute. 2016.
 62. FreeFrom. Comments of FreeFrom on the office of management and budget’s request for information on methods and leading practices for advancing equity and support for underserved communities through government, OMB-2021–0005. FreeFrom. 2021. https://www.google.com/url?sa=t&rcrt=j&q=&esrc=s&source=web&cd=&ved=2ahUKEwi38LnizYSHAxU9v4kEHSBfBBsQFnoECBEQAQ&url=https%3A%2F%2Fdownloads.regulations.gov%2FOMB-2021-0005-0147%2Fattachment_1.pdf&usg=AOvVaw1SsK47L7FaCDh-GtSWW8GQ&opi=89978449. Accessed 28 March 2023.
 63. Garcia-Moreno C, Jansen HA, Ellsberg M, Heise L, Watts CH. Prevalence of intimate partner violence: findings from the WHO multi-country study on women’s health and domestic violence. *Lancet.* 2006;368(9543):1260–9. [PubMed: 17027732]
 64. Breiding MJ, Basile KC, Klevens J, Smith SG. Economic insecurity and intimate partner and sexual violence victimization. *Am J Prev Med.* 2017;53(4):457–64. [PubMed: 28501239]
 65. Centers for Disease Control and Prevention. “Behavioral Risk Factor Surveillance System Survey Questionnaire.” U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. <https://www.cdc.gov/brfss/questionnaires/index.htm>. Accessed 15 June 2020.
 66. Centers for Disease Control and Prevention. 2020 Behavioral Risk Factor Surveillance System Survey Questionnaire. In: BRFSS Questionnaires. Centers for Disease Control and Prevention. 2020. <https://www.cdc.gov/brfss/questionnaires/index.htm>. Accessed 15 June 2020.

67. R Core Team. R: A language and environment for statistical computing. R Foundation for Statistical Computing. 2020. <https://www.R-project.org/>
68. Dineen K, Autzen B, Alwan NA. Children, intersectionality, and COVID-19. *Lancet*. 2022;399(10327):799.
69. Jung A-S, et al. From dichotomisation towards intersectionality in addressing COVID-19. *bmj*. 2021;375.
70. Jung AS, Haldane V, Neill R, Tan MM, Abdalla SM, Bartos M, Shresha P, Chua AQ, Nordström A, Legido-Quigley H. From dichotomisation towards intersectionality in addressing-COVID-19. *BMJ*. 2021. 10.1136/bmj-2021-067500
71. Siller H, Aydin N. Using an intersectional lens on vulnerability and resilience in minority and/or marginalized groups during the COVID-19 pandemic: a narrative review. *Front Psychol*. 2022;13:894103. [Online]. Available: <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9158486/pdf/fpsyg-13-894103.pdf>. [PubMed: 35664166]
72. Kifle ME, Aychiluhm SB, Anbesu EW. Global prevalence of intimate partner violence during the COVID-19 pandemic among women: systematic review and meta-analysis. *BMC Women's Health*. 2024;24(1):127. [Online]. Available: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC10874578/pdf/12905_2023_Article_2845.pdf. [PubMed: 38368323]
73. Klein A, Alisa Klein Policy Consulting, Sexual violence in disasters: a planning guide for prevention and response. [Online]. Available: https://www.nsvrc.org/sites/default/files/2012-04/Publications_NSVRC_Guides_Sexual-Violence-in-Disasters_A-planning-guide-for-prevention-and-response_0.pdf. Accessed 18 March 2023.
74. Klein A, Alisa Klein Policy Consulting. Sexual violence in disasters: a planning guide for prevention and response. Louisiana Foundation Against Sexual Assault (LaFASA) & National Sexual Violence Resource Center (NSVRC). 2008. https://www.nsvrc.org/sites/default/files/2012-04/Publications_NSVRC_Guides_Sexual-Violence-in-Disasters_A-planningguide-for-prevention-and-response_0.pdf. Accessed 28 March 2023.
75. Carastathis A The invisibility of privilege: a critique of intersectional models of identity. *Les ateliers de l'éthique*. 2008;3(2):23–38.
76. Bauer GR, Scheim AI. Methods for analytic intercategory inter-sectionality in quantitative research: discrimination as a mediator of health inequalities. *Soc Sci Med*. 2019;226:236–45. [PubMed: 30674435]
77. Zaw K, Bhattacharya J, Price A, Hamilton D, Darity W Jr. Women, race and wealth. *Res Brief Ser*. 2017;1(1):1–4.
78. Sullivan L, Meschede T. Race, gender, and senior economic well-being: how financial vulnerability over the life course shapes retirement for older women of color. *Public Policy Aging Rep*. 2016;26(2):58–62.
79. Chang M Lifting as we climb: women of color, wealth, and America's future. Berkeley: Insight Center for Community Economic Development. ed, 2010.
80. Max W, Rice DP, Finkelstein E, Bardwell RA, Leadbetter S. The economic toll of intimate partner violence against women in the United States. *Violence Vict*. 2004;19(3):259–72. [PubMed: 15631280]
81. Sanders CK. Savings for survivors: an individual development account program for survivors of intimate-partner violence. *J Soc Serv Res*. 2014;40(3):297–312.
82. Adams AE. Measuring the effects of domestic violence on women's financial well-being. *Cent Financ Secur Univ Wisconsin-Madison Issue Brief*. 2011;5:1–6.
83. Stylianou AM Economic abuse within intimate partner violence: a review of the literature. *Violence Vict*. 2018;33(1):3–22. [PubMed: 29195516]
84. Bullock HE, Reppond HA, Truong SV, Singh MR. An intersectional analysis of the feminization of homelessness and mothers' housing precarity. *J Soc Issues*. 2020;76(4):835–58.
85. Klein L, Chesworth BR, Howland-Myers JR, Rizo CF, Macy RJ. Housing interventions for intimate partner violence survivors: a systematic review. *Trauma Violence Abuse*. 2021;22(2):249–64. [PubMed: 30913998]

86. Davies L, et al. Patterns of cumulative abuse among female survivors of intimate partner violence: links to women's health and socioeconomic status. *Violence Against Women*. 2015;21(1):30–48. [PubMed: 25576314]
87. Mitman K, Rabinovich S. Whether, when and how to extend unemployment benefits: theory and application to COVID-19. *J Public Econ*. 2021;200:104447. [PubMed: 34934254]
88. Cobas JA, Duany J, Feagin JR. *How the United States racializes Latinos: White hegemony and its consequences*. Routledge, 2015.
89. Cobas JA, Duany J, Feagin JR. *How the United States racializes Latinos: White hegemony and its consequences*. New York: Routledge; 2016.
90. Lopez MH, Gonzalez-Barrera A, López G. Hispanic identity fades across generations as immigrant connections fall away. Pew Research Center. 2017. https://www.pewresearch.org/hispanic/wp-content/uploads/sites/5/2017/12/Pew-Research-Center_Hispanic-Identity-Report_12.20.2017.pdf. Accessed 28 March 2023.
91. López N, Hogan H. What's your street race? The urgency of critical race theory and intersectionality as lenses for revising the US office of management and budget guidelines, census and administrative data in Latinx communities and beyond. *Genealogy*. 2021;5(3):75. Accessed 28 March 2023.
92. Vargas ED, Juarez M, Stone LC, Lopez N. Critical 'street race' praxis: advancing the measurement of racial discrimination among diverse Latinx communities in the US. *Crit Public Health*. 2021;31(4):381–91.
93. Gonzalez D, et al. Observing race and ethnicity through a new lens. 2022.
94. Gonzalez D, López N, Karpman M, Furtado K, Kenney GM, McDaniel M, O'Brien C. Observing race and ethnicity through a new lens. Urban Institute. 2022. <https://www.urban.org/sites/default/files/2022/12/Observing%20Race%20and%20Ethnicity%20through%20a%20New%20Lens.pdf>.
95. Raifman J, Bor J, Venkataramani A. Association between receipt of unemployment insurance and food insecurity among people who lost employment during the COVID-19 pandemic in the United States. *JAMA Netw Open*. 2021;4(1):e2035884–e2035884. [PubMed: 33512519]
96. Maxwell SE, Cole DA, Mitchell MA. Bias in cross-sectional analyses of longitudinal mediation: partial and complete mediation under an autoregressive model. *Multivar Behav Res*. 2011;46(5):816–41.
97. Basile KC, et al. STOP SV: a technical package to prevent sexual violence. National Center for Injury Prevention and Control; Centers for Disease Control and Prevention, Atlanta, GA, 2016.
98. Basile KC, DeGue S, Jones K, Freire K, Dills J, Smith SG, Raiford JL. STOP SV: A technical package to prevent sexual violence. National Center for Injury Prevention and Control; Centers for Disease Control and Prevention. 2016. <https://stacks.cdc.gov/view/cdc/39126>
99. Niolon PH, Kearns MC, Dills J, Rambo K, Irving S, Armstead TL, Gilbert L. Preventing intimate partner violence across the lifespan: A technical package of programs, policies, and practices. National Center for Injury Prevention and Control; Centers for Disease Control and Prevention. 2017. <https://stacks.cdc.gov/view/cdc/45820>.

Demographic characteristics of participants who reported intimate partner violence or sexual violence victimization (*n* = 572) in the United States

Table 1

Demographic characteristic	Intimate partner violence survivors		Sexual violence survivors		All survivors ^a	
	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total	418		540		572	
Gender^b						
Women	393	94	505	93.5	536	93.7
Men	6	1.4	11	2	12	2.1
Transgender	5	1.2	6	1.1	6	1.0
Cisgender	41	9.8	66	12.2	66	11.5
Genderqueer/genderfluid	6	1.4	10	1.9	10	1.7
Nonbinary	14	3.3	3	3.3	18	3.1
I prefer to self-describe	4	1	6	1.1	6	1
I prefer not to answer	2	0.5	2	0.4	2	0.3
Race/ethnicity^b						
Alaskan Native/Native American	23	5.5	22	4.1	24	4.2
Asian	13	3.1	19	3.5	19	3.3
Black/African descent	66	15.8	72	13.3	82	14.3
Brown Latinx	16	3.8	20	3.7	20	3.5
Hispanic	42	10	56	10.4	58	10.1
Middle Eastern	5	1.2	8	1.5	8	1.4
Native Hawaiian or Pacific Islander	2	0.5	3	0.6	3	0.5
White	293	70.1	381	70.6	401	70.1
I prefer to self-describe	23	5.5	28	5.2	29	5.1
I prefer not to answer	10	2.4	13	2.4	14	2.4
Age						
18–24	56	13.4	88	16.3	91	15.9
25–29	54	13.0	76	14.1	81	14.2
30–39	98	23.4	118	21.9	125	21.9
40–49	85	20.3	109	20.0	115	20.0
50–59	72	17.2	84	15.6	91	15.9

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	<u>Intimate partner violence survivors</u>		<u>Sexual violence survivors</u>		<u>All survivors^a</u>	
	<u>418</u>		<u>540</u>		<u>572</u>	
Demographic characteristic	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
60–64	27	6.5	36	6.7	37	6.5
65 +	26	6.2	29	5.4	32	5.6

^aParticipants who responded “Yes” to either being a survivor of intimate partner violence, sexual violence, or both were coded as survivors

^bParticipants were able to select all that apply for gender and race/ethnicity; as such, they are non-orthogonal categories

Table 2

Association between racial categories (Black and Brown Latinx women, non-Black or non-Brown Latinx women of color, and White women) with food, housing, and economic insecurity during COVID-19 pandemic

Economic stressors ^a	OR (95% CI) ^d	Beta	SE
Food insecurity			
Black and Brown Latinx women	2.42 (1.43–4.08)***	0.88	0.27
Non-Black or non-Brown Latinx women of color	1.44 (0.80–2.58)	0.36	0.3
Housing insecurity			
Black and Brown Latinx women	2.10 (1.25–3.53)**	0.74	0.27
Non-Black or non-Brown Latinx women of color	1.55 (0.86–2.80)	0.44	0.30
Economic insecurity			
Black and Brown Latinx women	2.56 (1.66–3.98)***	0.94	0.22
Non-Black or non-Brown Latinx women of color	1.65 (0.97–2.82)	0.50	0.27
Inability to pay multiple bills			
Black and Brown Latinx women	3.53 (1.75–7.13)***	1.26	0.36
Non-Black or non-Brown Latinx women of color	0.95 (0.30–3.01)	-0.05	0.59

** $p < .01$;

*** $p < .001$

^aReference group White

Average amount of financial resources at the time of survey, indication of anticipating more debt, and experience of financial abuse among women^a survivors of IPV and/or SV

Table 3

Racial group	Total		Money access ^b		Anticipate more debt ^c		Financial abuse	
	<i>M</i>	(<i>SD</i>)	<i>n</i>	%	<i>n</i>	%	<i>n</i>	%
Total	523	\$7577.6 (27050.9)	171	32.7	60	11.5		
Black and Brown Latinx women	107	\$1340.6 (3314.3)	34	31.8	14	13.1		
Non-Black or non-Brown Latinx women of color	66	\$6579.02 (14875.0)	20	30.3	9	13.6		
White women	327	\$9856.8 (33060.1)	109	30.3	34	10.4		

^a A total of 23 women did not report race/ethnicity

^b The cells in the column represent the average numerical text responses in USD currency for the question “How much money do you estimate you have right now that you alone can access?”

^c The cells in the column represent respondents who indicated “Yes” to the question “Do you anticipate taking on more debt than you want to cover your expenses due to COVID-19?”

Table 4

Mean scores^a of importance level among women survivors of IPV and/or SV for various types of financial resources

Racial group	Credit card debt relief	Utility bill relief	Rent, mortgage, temporary housing cost relief	Property tax relief	Medical bills	Direct cash	Other
	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)	M (SD)
Total	2.8 (1.7)	2.7 (1.5)	3.1 (1.6)	1.9 (1.4)	3.1 (1.6)	3.4 (1.5)	2.9 (1.8)
Black and Brown Latinx women	3.3 (1.7)	3.5 (1.5)	3.8 (1.5)	2.0 (1.5)	2.9 (1.6)	4.0 (1.3)	3.1 (1.8)
Non-Black or non-Brown Latinx women of color	3.1 (1.7)	2.6 (1.6)	3.3 (1.6)	2.0 (1.4)	3.6 (1.6)	3.7 (1.3)	2.9 (1.7)
White women	2.6 (1.6)	2.4 (1.5)	2.8 (1.5)	1.9 (1.4)	3.0 (1.6)	3.1 (1.5)	2.9 (1.9)

^aThe response options were from 1 (*not at all important*) to 5 (*extremely important*)

Table 5
Type of bill women survivors of IPV and/or SV were unable to pay because of the impacts of COVID-19

Type of bill	Racial group					Total	523	Black and Brown Latinx women		107	Non-Black and non-Brown Latinx women of color		66	White women	327
	n	%	n	%	n			%	n		%				
Rent	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	70	13.38	24	22.43	10	15.15	34	10.40							
Mortgage	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	17	3.25	3	2.80	2	3.03	10	3.06							
Electric	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	62	11.85	24	22.43	6	9.09	29	8.87							
Water/sewage	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	27	5.16	10	9.35	1	1.52	14	4.28							
Internet	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	55	10.52	16	14.95	6	9.09	28	8.56							
Cable	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	29	5.54	7	6.54	3	4.55	16	4.89							
Telephone	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	59	11.28	20	18.69	4	6.06	32	9.79							
Home owner's association fees	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	3	0.57	1	0.93	0	0.00	2	0.61							
Property taxes	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	20	3.82	5	4.67	2	3.03	12	3.67							
Renter's or house insurance	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	21	4.02	7	6.54	3	4.55	11	3.36							
Medical Bills	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	122	23.33	19	17.76	19	28.79	80	24.46							
Other	n	%	n	%	n	%	n	%	n	%	n	%	n	%	n
	117	22.37	23	21.50	10	15.15	75	22.94							