Islamophobia & GBV among Muslim Populations in Ottawa:

Risk & Protective Factors & Barriers to Service Access

Equality Insights Lab

March 2026
Final Project Report

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Suggested Citation:

Sharma V, Abdel-Majid R, Bartels S, Scott J (2026). Islamophobia & GBV among Muslim Populations in Ottawa: Risk & Protective Factors & Barriers to Service Access. Final Project Report. Ottawa, Canada.

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This research on Islamophobia and gender-based violence among Muslim communities in Ottawa was co-led by Equality Insights Lab (EIL) and Ottawa Muslim Community Services (OMCS), in collaboration with researchers at Queen's University.

We extend our sincere thanks to the women and men who shared their experiences and perspectives, and especially to the survivors whose contributions are central to this report. We also thank the community and faith leaders, service providers and organizations who contributed their time and knowledge to the research. Their insights have helped deepen understanding of the intersection of Islamophobia and GBV and informed the priorities for action presented here.

We gratefully acknowledge the Ottawa field team for their work supporting the research and engaging with participants.

Funding:

This project was funded by Women and Gender Equality Canada.

OMCS

Queen's University

Women and Gender Equality Canada | Femmes et Égalité des genres Canada

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Introduction:

Gender-based violence (GBV), including intimate partner violence (IPV), is a major public health concern with far-reaching health, social and economic consequences. IPV includes physical, sexual and psychological abuse and controlling behaviours within intimate relationships, with effects that extend to families and communities.[1]

Violence occurs across communities, but the circumstances shaping risk and access to support vary. For immigrant, newcomer and refugee women, gender, race, religion, immigration status and socioeconomic circumstances may intersect in ways that influence experiences of violence and help-seeking. Language barriers, social isolation, economic insecurity and discrimination can create additional obstacles to obtaining assistance.[2]

For Muslim women, these issues also need to be understood in relation to Islamophobia. Anti-Muslim prejudice and stereotyping can affect interactions with institutions and services, creating barriers to appropriate support. Understanding this intersection requires attention to women's diverse experiences, rather than generalized assumptions about Islam or Muslim communities.[3]

Canadian research has identified a need for stronger evidence concerning racialized and newcomer populations and the effectiveness of culturally responsive prevention and support.[4] This report focuses on the intersection of Islamophobia and GBV among Muslim communities in Ottawa, with particular attention to immigrant, newcomer and refugee women. It aims to inform prevention efforts and improve access to safe and appropriate support.

44%

of ever-partnered women in Canada reported lifetime IPV

42%

of surveyed Muslim women reported discrimination in Canada

[1] Exner-Cortens, D., Wells, L., Lee, L., & Spiric, V. (2019). Building a culture of intimate partner violence prevention in Alberta, Canada through the promotion of healthy youth relationships. Prevention Science. doi:10.1007/s11121-019-01011-7.

[2] Ford-Gilboe, M., et al. (2017). A tailored online safety and health intervention for women experiencing intimate partner violence: The iCAN Plan 4 Safety randomized controlled trial protocol. BMC Public Health, 17, 273. doi:10.1186/s12889-017-4143-9

[3] Okeke-Ihejirika, P., Tetreault, B., Punjani, N., & Olukotun, M. (2022). Intimate partner violence interventions within immigrant populations: A scoping review of the G7 nations, including Canada. Canadian Ethnic Studies, 54(2), 67–97. doi:10.1353/ces.2022.0014

[4] Wathen, C. N., et al. (2024). A scoping review of intimate partner violence research in Canada. Trauma, Violence, & Abuse. doi:10.1177/15248380241275979

Key Definitions:

The table below clarifies key terms and concepts used throughout this report, including gender-based violence, intimate partner violence, Islamophobia and related forms of discrimination. It also explains terminology concerning religious identity and dress, and distinguishes between GBV prevention and response. These definitions provide a common reference for interpreting the findings and recommendations, while recognizing the diversity of identities, experiences and practices within Muslim communities.

Term	Definition
Gender-based violence (GBV)	Violence directed at someone because of their gender or shaped by unequal gender relations. It can include physical, sexual, psychological, emotional and economic violence.
Intimate partner violence (IPV)	Violence perpetrated by a current or former intimate partner. This report examines psychological, physical and sexual IPV, alongside controlling behaviours within intimate relationships.
Islamophobia	Anti-Muslim prejudice, stereotyping, hostility and discrimination directed at people who are Muslim or perceived to be Muslim. This report considers how Islamophobia is experienced and anticipated in everyday life, institutions and services.
Intersectionality	A framework for understanding how identities such as gender, race and religion interact with systems of power and discrimination to shape experiences and access to support.
Bias	Assumptions or judgments that influence how people are perceived and treated. Within services, bias may affect how disclosures are received, credibility is assessed, risk is interpreted and support is provided.
Microaggressions	Subtle, often normalized discriminatory interactions, including dismissive language and assumptions about religious or cultural practices. Their cumulative effects can undermine trust, safety and belonging.
Visible Muslim identity	Visible markers through which someone may be perceived as Muslim. These include garments worn by some Muslim women: hijab (a head covering with the face visible), niqab (a face covering leaving the eyes visible), and abaya (a loose-fitting, full-length outer garment), as well as other religious dress or a beard.
Risk and protective factors	Characteristics, experiences or conditions associated with a higher (risk factors) or lower (protective factors) likelihood of experiencing or perpetrating GBV. They can operate and interact at individual, relationship, family, community, institutional and societal levels.
GBV prevention	Actions intended to prevent violence by addressing risk factors and strengthening protective behaviours, relationships, community support and institutional conditions.
GBV response	Support and interventions provided when violence is experienced or identified, including safety planning, crisis assistance, health and psychosocial care, referrals, and longer-term recovery support.
Mainstream service providers	Staff and organizations providing formal mandated and non-mandated support, including GBV, health, shelter, housing, settlement, legal, police, child welfare and social services.
Ethnocultural organizations	Community-based organizations that primarily serve ethnocultural, immigrant, refugee, or religious populations and may provide settlement, social, health, GBV, shelter, navigation, advocacy, or related supports.
Faith-based and community leaders	Individuals engaged because of their religious, cultural, social, or community leadership roles, including imams, sheiks, community leaders, and trusted community members. They may support disclosure, provide informal guidance, and facilitate referrals to services.

Project Background:

Funded by Women and Gender Equality Canada (WAGE), this community-based research project brought together Equality Insights Lab, Ottawa Muslim Community Services and researchers from Queen's University. The project was designed to generate practical evidence about the intersection of Islamophobia and GBV among Muslim populations in Ottawa, with a particular focus on immigrant, newcomer and refugee women.

The research built on needs identified through OMCS's culturally integrative social and anti-violence services. These services span community education, prevention, early intervention, social support and responses to violence. The project sought to strengthen this work by examining how Muslim women experience and navigate support, where service gaps arise, and how community organizations and mainstream providers can work together more effectively.

The project was also intended to inform current and future prevention programming, including OMCS's work with the Culturally Integrative Family Safety Response (CIFSR) approach and interventions involving informal supporters and bystanders. CIFSR combines prevention, intervention, social support and coordinated responses to GBV within the context of migration and collectivist cultures. Its emphasis on cultural humility, gender analysis and an intersectional, ecological framework provided an important context for the project's focus on culturally responsive prevention and support.

Research Questions:

1. What are the key risk and protective factors for GBV among Muslim communities in Ottawa, particularly immigrant, newcomer and refugee women, and how do these intersect with Islamophobia?
2. How do Muslim women use formal and informal support, and how does Islamophobia influence access to and use of GBV services?
3. What changes do survivors, community members and service providers identify as priorities for improving access to safe and appropriate support?
4. How can the evidence strengthen community-based GBV prevention and interventions involving informal supporters and bystanders?

02 Methodology

Project Methodology:

The study used a community-based, mixed-methods approach to examine GBV risk and protective factors, experiences of Islamophobia, and access to formal and informal support among Muslim populations in Ottawa. The research brought together survey findings with community, survivor and service-provider perspectives to examine both patterns across participants and the experiences underlying those patterns.

The project was implemented over 31 months, from September 2023 to March 2026. It included the following activities: community consultation and study development; quantitative and qualitative data collection; analysis and interpretation; and the development and sharing of recommendations. Community engagement occurred across the entire research process to ensure all stages of the research reflected community needs and preferences.

Activity	Approach and Participation	Focus
Community consultations and dialogue	A partner inception workshop on **28 February 2024** and **four community workshops** informed research priorities, tools and recruitment. A **nine-member Community Advisory Board** provided guidance, including through a meeting in February 2025.	Identify priorities, capture perspectives and refine the research approach and methods.
Quantitative survey	Questionnaire completed by **198 participants** in Ottawa who self-identified as members of the Muslim community: **135 women and 63 men.** Participants included members of Arab, Afghan, Persian, Somali and Pakistani communities.	Participant characteristics, IPV and controlling behaviours, social isolation, discrimination, and experiences and perceptions of help-seeking.
In-depth interviews and focus groups	**29 in-depth interviews and two focus group discussions**, involving community leaders, service providers from mainstream and ethnocultural organizations, and survivors.	Experiences of GBV and Islamophobia, risk and protective factors, formal and informal support, service gaps and priorities for improvement.
Arts-based research	Repeated sessions combined painting, collage, discussion and short questionnaires to explore experiences over time. A group of **five participants completed sessions between October 2024 and January 2025**.	Lived experiences of GBV, migration and Islamophobia, including isolation, safety, belonging and community connection
Validation, knowledge sharing and recommendations	Findings were shared through **six dissemination and dialogue sessions**. Community members, service providers and other stakeholders reflected on the findings, contributed to their interpretation and helped develop practical recommendations.	Bring findings together and identify action-oriented priorities for prevention, service delivery and institutional change

Project Methodology:

Recruitment and data collection

Participants were recruited through OMCS's community relationships, partner organizations, service providers, community events and social media, alongside telephone and in-person outreach. Interviewers were selected for their language skills and community knowledge and received training in interviewing, GBV, participant safety and confidentiality. Survey questions were piloted and refined, and survey instruments and consent materials were translated into Arabic, Farsi and Urdu. Recruitment approaches, scheduling and participation arrangements were adapted to respond to participants' needs and concerns about discussing sensitive topics.

The survey collected data on GBV, Islamophobia, risk and protective factors, and access to services. Interviews and focus groups provided opportunities for survivors, service providers and community leaders to discuss these issues in greater depth. The longitudinal story- and arts-based component explored experiences over time through painting, collage, discussion and short questionnaires. Together, these approaches offered different ways for participants to share their perspectives.

Participant safety and confidentiality

Ethics approval was obtained from Queen's University. Participation was voluntary, and verbal informed consent was obtained in participants' preferred language. Participants could pause or stop at any time without affecting their access to services. Data collection took place in private settings, identifying information was protected, and information about support resources was available. Focus group participants were also informed about the limits of confidentiality within group discussions.

Analysis and recommendations

Survey data were analyzed separately for women and men. Interview and focus group recordings were transcribed and translated into English. Qualitative data were analyzed through a rapid thematic review to identify recurring themes and differences in experience. Findings from the survey, qualitative discussions and arts-based activities were considered together to inform the overall interpretation.

Findings were shared through dissemination and dialogue sessions. Community members, service providers and other stakeholders were invited to reflect on whether the findings aligned with their experiences, identify areas requiring greater nuance and discuss practical priorities for change. This feedback informed the recommendations.

The report organizes findings across the **GBV care pathway**, including prevention, early identification and disclosure, crisis response, and recovery and ongoing support. This helps connect experiences to opportunities for action at different stages. It is important to note that women may seek help through different routes and need support across several stages at the same time.

The GBV Care Pathway:

03 Findings: Experiences of GBV and Islamophobia

Key Findings:

3 Experiences of GBV and Islamophobia

This section presents findings on women's experiences of IPV, controlling behaviours and social isolation, alongside experienced and anticipated Islamophobia. It examines connections between these experiences and differences across participants, providing context for the more detailed findings on GBV risk and the care pathway that follow.

3.1 Experiences of IPV and Related Risk Factors

Quantitative findings highlight the prevalence of IPV and associated risk dynamics within the study population. Among women surveyed, **24% reported experiencing psychological, physical, and/or sexual IPV in their lifetime**. Indicators of controlling behaviour and relationship stress were common, including jealousy by their partner (31%), monitoring of their whereabouts (24%), and feeling like they were "walking on eggshells" (27%). These findings highlight experiences of control and insecurity within intimate relationships among women in the study.

Social isolation also emerged as a key contextual factor: 39% of women reported feeling isolated in the past 12 months while 38% reported that community members were unlikely to help them during a crisis. In addition, 13% reported they could not leave the home without being accompanied by a relative.

Together, these findings indicate that many women were navigating violence within contexts of limited social support and constrained mobility, which may increase vulnerability to abuse and reduce access to help.

3.2 Experienced and Anticipated Islamophobia

The survey captured both experiences of discrimination and concerns about how Muslim identity might affect safety and access to support. **Twenty percent of women surveyed reported recent discrimination, while 28% reported that visible religious identity often or sometimes increased their risk of gender-based harassment or violence.** The latter reflects participants' perceptions of risk rather than a measured increase in incidents.

24%

of women experienced lifetime psychological, physical and/or sexual IPV

39%

of women reported feeling isolated in past 12 months

20%

of women reported experiencing recent discrimination

Key Findings:

Concerns about Islamophobia were particularly apparent in responses about reporting GBV and seeking support. **Nineteen percent of women hesitated to report GBV due to fear of Islamophobia from service providers**, 54% anticipated that service providers would focus more on their Muslim identity than their experience of violence, and 56% believed their experience of GBV would be attributed to Islam rather than gender inequality.

These findings demonstrate that Islamophobia operates not only through direct experiences of discrimination, but also through expectations and perceptions that shape decision-making and access to services.

In addition, **women who reported recent discrimination were 2.6 times more likely to report experiencing IPV.** This association suggests that Islamophobia is not only present but is statistically linked to increased IPV risk within the study population.

3.3 Variation in Experiences

Qualitative findings showed that experiences of Islamophobia and its implications for safety and support were not uniform across participants. **Experiences varied based on visibility (e.g., wearing hijab or niqab), racialization, immigration and sponsorship status, and language proficiency**. Participants described compounded challenges for Black Muslim women, newcomers and refugees, and women facing language barriers or sponsorship dependence. These differences shaped both exposure to discrimination and access to support, highlighting the need for intersectional approaches in both research and service provision.

Overall, the findings demonstrate that Islamophobia is prevalent as both an experienced and anticipated form of discrimination and is closely linked to the dynamics of GBV and IPV. Quantitative data establish its measurable presence and association with IPV risk, while qualitative findings illustrate its role as a structural and contextual force shaping vulnerability, help-seeking, and outcomes. The next section examines Islamophobia across the GBV care pathway, highlighting system gaps and structural barriers that shape women's access to support and experiences of care.

2.6x

Women who experienced discrimination were 2.6x more likely to report IPV

28%

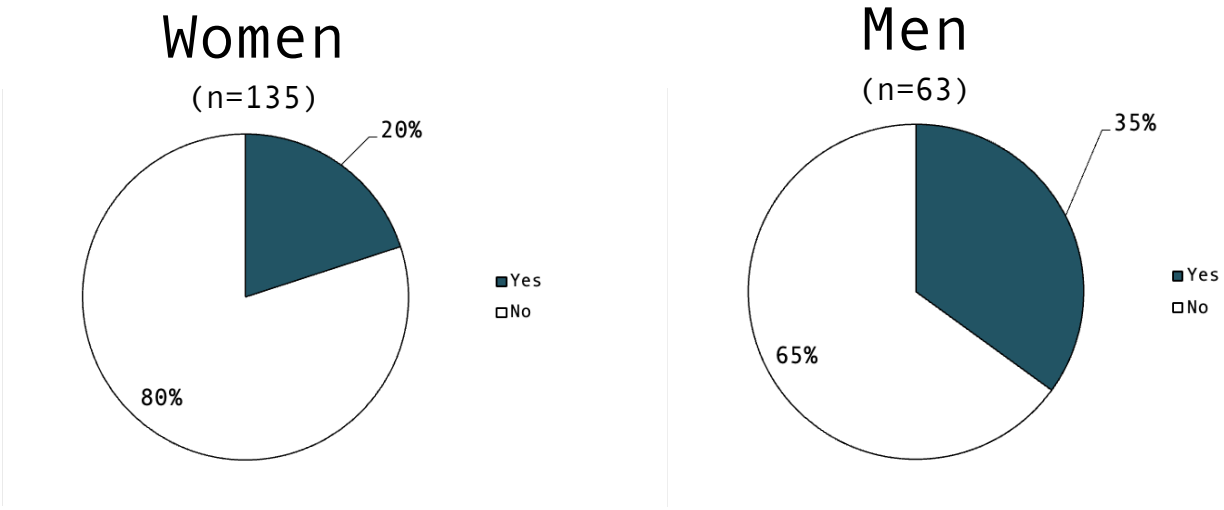
of women reported visible Muslim identity increased risk of GBV

19%

of women hesitated to report GBV due to fear of Islamophobia from service providers

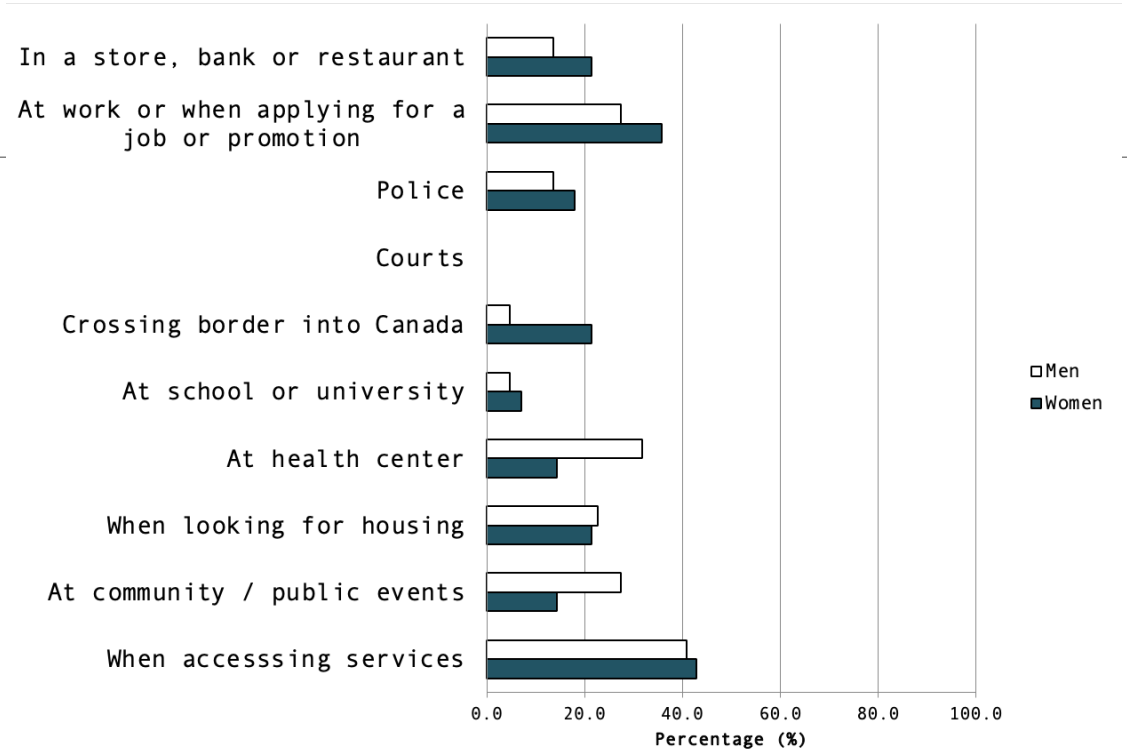
Experiences of Discrimination

Proportion of women and men who have experienced recent discrimination:

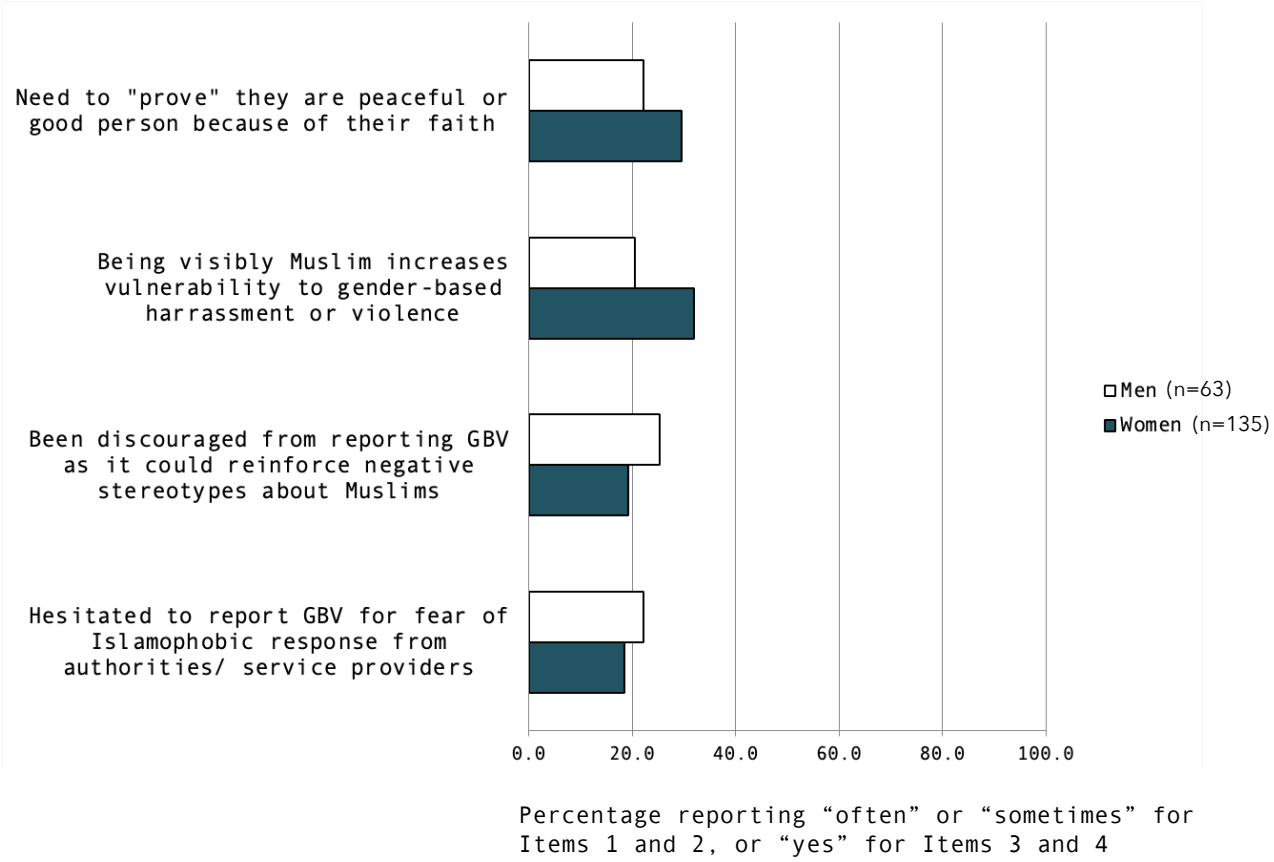


Where women and men experienced recent discrimination*

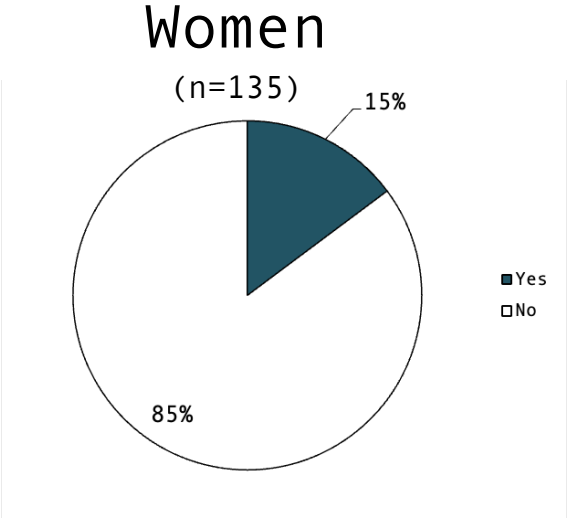
*of all women (n=28) and men (n=22) who reported experiencing recent discrimination

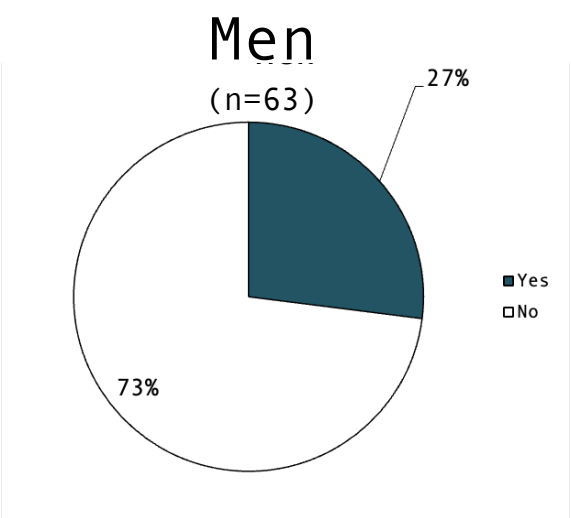


Islamophobia, GBV & Help-seeking



Proportion of women and men who reported receiving different treatment from authorities when seeking help for GBV because of their Muslim identity:





Unsafe at Home, Unsafe Outside It

“She said, I felt alienated. I felt like I have to remove my hijab for me to be accepted amongst those residents… She said, when I came here, not only I felt unsafe with this man, but also I felt unsafe anywhere else. So really, my options were either feel unsafe with someone that's also someone from my culture, or feel unsafe with someone that's not from my culture, that's going to still stigmatize me. She said, that's why I came back with him, because it felt at least familiar.”

Mainstream service provider speaking of a Muslim woman’s experience

04 System Gaps and Structural Barriers in Addressing GBV and Islamophobia

Key Findings:

4.1 Islamophobia Across the GBV Care Pathway

Islamophobia can shape the care journey at every stage of the GBV pathway, creating barriers that affect both access to support and the quality of care received. Islamophobia can appear at any stage of the GBV care pathway with **intake and the first point of contact emerging as particularly important points where bias, stereotyping, or mistrust may affect access.** From the outset, fear of discrimination or mistrust in systems may discourage individuals from seeking help at all. When they do reach out, the intake process can be influenced by profiling and assumptions, where quick judgments are shaped by stereotypes and incomplete information.

This can continue into risk assessment, where misunderstandings may lead to the misinterpretation of a person's level of vulnerability or need, which may in turn contribute to inaccurate or inappropriate safety planning. During referrals, fragmentation of services and a lack of cultural alignment can disrupt continuity of care, leaving individuals to navigate systems that may not feel safe or responsive. Even when services are accessed, ongoing care can suffer from weak follow-up and lack of culturally appropriate services, further compounding feelings of isolation or neglect. Over the longer term, structural barriers, such as systemic inequities and limited culturally appropriate resources, can hinder recovery and make it more difficult for survivors to rebuild stability and well-being.

Findings from this study identify a series of recurring system gaps and structural barriers that shape how Muslim women experience and navigate support systems in the context of GBV and IPV. These gaps were described across multiple formal systems and service settings, including police, child welfare, shelters, health care, schools, as well as some community-based services.

A key insight is that many of these gaps appear to reflect broader institutional and structural patterns rather than isolated incidents, and are often reinforced through institutional practices, assumptions, and structural conditions.

"When individuals fear discrimination, stereotyping because of their religion, they may hesitate to seek help to begin with, or even just delay accessing any services altogether because of the anxiety around it."

Key Findings:

4.2 Bias, Stereotyping, and Microaggressions in Early Interactions

Participants identified bias and stereotyping as important concerns, particularly during initial points of contact such as intake, screening, and first disclosure. Participants described frontline interactions during which assumptions about Muslim women as oppressed or submissive, and assumptions about Muslim families and communities, influenced how they experienced service responses. These biases can influence how disclosures are received, how risk is interpreted, and how credibility is assessed.

These early interactions play a key role in shaping service trajectories. When women experience dismissive, judgmental, or culturally uninformed responses, they are less likely to continue engaging with services, increasing their vulnerability to ongoing violence.

In addition to more overt forms of bias, participants frequently described experiences of microaggressions within service interactions. These included subtle, often normalized behaviours such as dismissive language, assumptions about cultural or religious practices, mispronunciation of or disregard for names, and differential treatment based on visible markers of Muslim identity. While individually these interactions may appear minor, participants emphasized their cumulative impact, describing how repeated exposure contributed to feelings of being misunderstood, unwelcome, or judged within services.

These experiences were significant at early points of contact, where trust is still being established. Microaggressions were identified as contributing to reduced confidence in service providers, partial disclosure, and, in some cases, disengagement from support altogether. As such, they represent an important but often under-recognized mechanism through which systemic bias is experienced in practice.

Participants' accounts suggest that these experiences may reflect not only individual bias, but also broader gaps in institutional training, accountability, and culturally informed practice.

"When they saw me as a Muslim. With a hijab… They change."

"From the first interview, she looked at me from top to bottom… when she saw me, she changed her treatment."

Key Findings:

4.3 Mistrust and Fear of Formal Systems

A second major gap relates to widespread mistrust of formal systems, particularly police, legal systems, and child welfare.

Findings indicate that this mistrust is rooted in both direct experiences and anticipated discrimination, including concerns about profiling, over-surveillance, and disproportionate intervention in Muslim families. Fear of consequences, such as child removal, legal repercussions, or community stigma, frequently influenced decisions about whether to seek help.

This mistrust may contribute to delayed or avoided disclosure, and in some cases, greater reliance on informal supports or community-based organizations. These sources of support differ considerably in their roles, capacity, and ability to respond to complex GBV situations.

The persistence of this gap suggests a need to address not only service delivery, but also broader structural dynamics related to systemic racism and institutional trust.

4.4 Fragmentation and Lack of Coordination Across Services

The study also identifies significant challenges related to fragmentation within the GBV support system.

Participants described navigating multiple services with limited coordination, inconsistent communication, and unclear referral pathways. In many cases, women were required to retell their experiences multiple times or were referred to services that did not align with their needs.

This fragmentation was particularly problematic when combined with language barriers, cultural mismatches, and limited system familiarity, increasing the burden on women to navigate complex systems during periods of crisis.

The lack of integrated and coordinated care pathways reduces the effectiveness of interventions and can contribute to disengagement from services.

4.5 Limited Availability of Culturally Safe and Responsive Services

Participants identified gaps in the

"Muslim women specifically are intimidated by system players like police officers, judges, people in position of authority."

"I think sometimes women are influenced because they feel like they may be misunderstood by community partners who would receive that information. And they don't want to contribute to Islamophobic narratives, that portray Muslim families as violent or patriarchal."

Key Findings:

availability of culturally safe and responsive services such as limited access to interpretation and language-congruent services, lack of accommodation for religious practices (e.g., prayer, halal food, gender preferences), and insufficient understanding of Muslim family dynamics and community contexts.

These gaps were particularly evident in shelters, crisis services, and health care settings, where standardized models of care did not always align with the needs of Muslim women.

Participants' accounts suggest that cultural and religious considerations were sometimes treated as secondary, rather than as integral components of safety and effective care.

4.6 Gaps in Long-Term Recovery and Reintegration Supports

While much of the system is oriented toward crisis response, findings indicate significant gaps in long-term recovery and reintegration supports. Participants described ongoing challenges related to housing stability, employment and income security, and social isolation and community reintegration. These challenges are compounded by experiences of discrimination in employment and public life, which continue beyond the immediate crisis period.

The limited availability of sustained, culturally appropriate support contributes to incomplete recovery trajectories and, in some cases, increases the risk of returning to unsafe environments. A few Muslim women survivors described ongoing exposure to Islamophobia as significantly impeding their recovery and healing, even years after the IPV had subsided.

4.7 Under-Recognized Systems: The Role of Schools and Early Environments

An additional gap identified in the study is the limited recognition of certain systems, particularly schools, as sites where Islamophobia and gendered harm intersect.

Participants identified schools as environments where anti-Muslim bullying, stigma, and identity-based discrimination occur, often with limited institutional response. Despite this, schools are not consistently integrated into GBV prevention or response frameworks.

"The recovery is just going to be very difficult and long because they've been experiencing Islamophobic microaggressions for a long time. So, the healing will also take a long time."

"Organizations should offer culturally and religiously responsive approaches to ensure equity and access and safety… specifically for Muslim women, it is providing female-only spaces and female staff where possible… respecting the religious dress codes and prayer times for women… and offering halal food and in the shelter systems"

Key Findings:

This gap highlights the need to consider earlier intervention points and to expand the scope of GBV-related systems to include institutions that shape identity, safety, and belonging from an early age.

4.8 Critical Systems of Concern: Police, Child Welfare, and Family Courts

Across both survivor and service provider interviews, three systems were consistently identified as high-impact points of concern: police, child welfare, and family courts. While experiences varied, these systems were frequently described as sites of heightened risk, fear, and unintended harm, particularly when intersecting with Islamophobia and broader systemic inequities.

A key pattern across these systems is that they are often engaged at critical moments of crisis, where decisions carry significant and long-lasting consequences for women and their families. As a result, challenges within these systems can have disproportionate effects on safety, stability, and recovery trajectories.

4.9 Police and Legal Systems

Participants described complex and often cautious relationships with police services. Concerns related to profiling, lack of cultural understanding, and inconsistent responses to GBV contributed to hesitancy in engaging law enforcement.

In some cases, participants indicated that interactions with police were shaped by assumptions about Muslim families or gender roles, affecting how situations were interpreted and addressed. Concerns about not being believed, not being taken seriously, or being misunderstood were also noted.

These dynamics contribute to delayed or avoided reporting, which can increase risk and limit access to immediate protection.

At the same time, the findings suggest that when responses are perceived as respectful, informed, and supportive, police engagement can play an important protective role—highlighting variability in experiences.

> "They feel scared to reach out… they always feel scared that maybe this information will go through the children's society, and they will take the children from her."

Key Findings:

4.10 Child Welfare Systems

Child welfare systems were frequently associated with fear and mistrust, particularly related to the potential for child removal and over-surveillance.

Participants described concerns that Muslim families may be disproportionately scrutinized or misinterpreted, especially where cultural or religious practices are not well understood. This perception, whether based on direct experience or anticipation, was a significant factor influencing decisions about disclosure and help-seeking.

Fear of child welfare involvement was described as contributing to delayed engagement with services, including in situations of high risk. This highlights the need for approaches that balance child safety with culturally informed and non-punitive engagement with families.

4.11 Family Courts and Legal Processes

Family courts emerged as a critical yet under-examined area of concern, particularly in relation to the length and complexity of legal processes.

Delays in obtaining court orders, especially for child support, can place women in situations of heightened financial vulnerability, particularly where they are economically dependent on their partners. This has direct implications for housing stability, access to resources, and the ability to provide for children during the post-separation period.

In addition to financial impacts, the duration of family court proceedings may also have social and personal consequences. For some Muslim women, unresolved marital status can limit their ability to move forward with their lives, including decisions related to remarriage, within the context of religious norms. As a result, prolonged legal processes can extend not only economic hardship, but also personal and social instability during recovery.

Together, these findings highlight that police, child welfare, and family courts function as high-stakes systems within the GBV care pathway, where institutional practices and timelines can significantly shape outcomes.

"The legal system is traumatic in and of itself. It is not friendly to survivors."

"People struggle with that system and often tell us that it feels like they're being abused all over again when they go through that family law system."

Key Findings:

While these systems are designed to provide protection and accountability, the data suggest that, in practice, they may also contribute to fear, delayed engagement, and prolonged vulnerability, particularly when responses are not experienced as culturally informed, equitable, and responsive to the realities of Muslim women's lives.

Finally, the findings point to a set of interconnected system gaps that operate across the GBV care pathway. These include bias in early interactions, mistrust of formal systems, fragmentation of services, lack of culturally safe care, insufficient long-term supports, and under-recognized intervention points.

Together, these gaps reflect broader structural barriers that limit the accessibility, effectiveness, and equity of GBV responses for Muslim women. Addressing these barriers requires not only service-level improvements, but also system-level change that acknowledges and responds to the role of Islamophobia within the GBV ecosystem. These gaps are reinforced not only through formal policies and decisions, but also through everyday interactions, including microaggressions, biases, and stereotypes that shape how services are experienced in practice.

"I'm still recovering. Because my situation is getting better. The psychological aspect is affecting my health.

I can't sleep because of the pressure and the shock. It affects my health. The feeling of oppression and humiliation."

Arts-based reflections: isolation, fear, and the search for community

A small arts-based research component provided a more intimate view of how Muslim women experienced the intersecting pressures of GBV, migration, and Islamophobia over time. Through painting, collage, and group reflection, participants expressed the emotional weight of leaving behind familiar systems of care and trying to rebuild connection in a new and uncertain environment. Their reflections highlighted how family and community gatherings in their countries of origin were closely tied to belonging, memory, comfort, and mutual support. In Canada, by contrast, many described limited social ties, few opportunities for informal gathering, and reliance on service organizations as some of the only spaces available for connection.

These views deepen the study's findings on isolation and barriers to care-seeking. Participants described new social spaces as important but fragile: they could bring happiness, reduce homesickness, and help build friendships, but they could also generate anxiety. One participant described feeling "**relaxed, but at the same time, we are afraid,**" capturing how community connection can coexist with fear about the future, unemployment, instability, and what lies ahead. This emotional ambivalence is important for understanding responses to violence. For women facing IPV in a context shaped by Islamophobia, weak social networks, uncertainty, and fear of judgment or exclusion may intensify isolation and make it harder to seek help.

This process also showed the value of non-verbal and creative methods for exploring sensitive experiences. Images and collages can make visible emotions that are difficult to articulate directly, including grief, displacement, loneliness, and the need for belonging.

"Two and a half months passed or maybe two months maybe three months later I decided to leave Ottawa because there was no hope. There was no one who could support me. The police didn't help me. Even the safety of living in a shelter wasn't there."

Belonging and Fear

Artwork created by a research participant

“We feel relaxed, but at the same time, we are afraid.”

When Everyday Islamophobia Shapes IPV

“Because we are part of this intersection, we face violence very often outside. We see it everywhere. We see micro violence that looks and sounds like someone just assuming that we are choosing oppression because of our culture…

if we are somebody that wears hijab, we face microaggressions. We face discrimination everywhere we go…

So, the fact that we face that violence almost at least 10 times a week, we minimize our experience regarding the violence that we live with our partners.

And that affects our wish to leave the relationship because we normalize the violence. It minimizes our experience and it minimizes also our entitlement to safety.”

Artwork created by a research participant

05 Recommendations

Tackling GBV and Islamophobia Together:

The findings highlight the need to address Islamophobia both as **part of the conditions shaping GBV risk** and as **a barrier across the GBV care pathway**. Improving safety requires coordinated action across prevention, early identification, crisis response and recovery, addressing discrimination both within services and in the wider environments in which women live.

No single organization or sector can address these challenges in isolation. Participants consistently highlighted the importance of **collaboration, trust-building, and coordinated responses across sectors.** Drawing on the study findings, the following recommendations identify priorities for service providers, community-based organizations and leaders, and systems, institutions and funders in Ottawa. The community-based category includes NGOs and community groups, whether or not they have an ethnocultural or faith-based focus, as well as Muslim-led organizations and community and faith leaders. **Organizations may have roles across more than one category and should draw on the recommendations relevant to their work.**

Artwork created by research manager

Across all settings, responses should centre survivors' safety, dignity, autonomy and informed choice. **Muslim women should not be treated as a homogeneous group**. Services and interventions should recognize differences associated with visible Muslim identity, race, migration and sponsorship circumstances, language and socioeconomic position.

These actions should be **developed, implemented and reviewed with diverse Muslim women**, including survivors, ensuring that their experiences, priorities and choices guide service improvements and prevention efforts. **Men's active participation should be integral to prevention**, while maintaining women's safety and choices at the centre.

Service providers

These recommendations apply to health, social, GBV, housing, settlement and justice services, including those delivered by mainstream, ethnocultural and other community-based organizations.

1. Strengthen service providers' knowledge, skills and tools to recognize and address Islamophobia

Provide mandatory, ongoing training on Islamophobia and GBV that builds cultural humility, understanding of diverse Muslim women's experiences, and skills to recognize discrimination in providers' own practice and service procedures. Tailor training and tools to each sector's responsibilities. Develop and use practical tools, including self-reflection prompts, anti-bias intake and assessment checklists, and guidance for responding to discriminatory incidents. Equip providers to identify stereotyping and misinterpretation of risk, challenge discriminatory behaviour, respond to survivors' reports of discrimination and correct biased decisions. Co-develop these resources with Muslim women and community partners, and reinforce their use through supervision and survivor feedback.

2. Enhance trust-building and survivor-centred practices

Create safe, non-judgmental and trauma-informed environments that support disclosure and ongoing engagement. Avoid imposing expectations about disclosure, reporting, separation or family relationships. Respect survivors' choices and recognize that delayed or partial disclosure may reflect fears of discrimination, institutional involvement or reinforcing negative stereotypes about Muslim families. Risk assessment and safety planning should address economic insecurity, sponsorship dependence, isolation and anticipated discrimination, recognizing that leaving an abusive relationship does not necessarily mean entering an environment perceived as safe.

3. Improve accessibility and navigation of services

Treat language access as a safety requirement by providing professional interpretation, culturally relevant information and practical navigation assistance. Ensure that shelter and health services accommodate individual needs and preferences, including access to female providers where needed, privacy, prayer space, halal food and respect for religious dress. Provide supported referrals, or "warm handoffs," and follow-up, while maintaining multiple routes to support through mainstream and community-based services. Offer access through mainstream, ethnocultural, community or faith-based supports according to survivors' preferences, without assuming that any one route suits all Muslim women.

Community-based organizations and leaders

These recommendations apply to NGOs, community groups, Muslim-led, ethnocultural and faith-based organizations, and community and faith leaders.

4. Increase community education and awareness

Expand culturally relevant education for women, men and informal supporters about GBV, controlling behaviours, rights and available services. Include practical guidance for friends, relatives and peers on recognizing abuse, responding to disclosures without judgment, protecting confidentiality and helping survivors access support safely. Address stigma, the normalization of violence and concerns that disclosure will reinforce negative stereotypes about Muslim families. Education should address the intersection of Islamophobia and GBV without presenting Muslim culture or religion as the cause of violence.

5. Adapt evidence-based IPV prevention programs for Muslim women and men

Adapt, pilot and evaluate evidence-based IPV prevention programs for Muslim women and men in Ottawa. Co-develop adaptations with community members and specialist partners, retaining core gender-transformative components and integrating explicit content on the intersection of Islamophobia and GBV while ensuring women and men are able to safely participate in culturally appropriate ways. Encourage men's participation in IPV prevention activities, ensuring dedicated activities to challenge harmful gender norms and controlling behaviours, prevent perpetration and build equitable, non-violent relationships. Prioritize women's safety and choices throughout design and delivery.

6. Create safe spaces for dialogue, connection and disclosure

Develop trusted, confidential and non-judgmental community spaces where women can discuss violence, safety and well-being without pressure to disclose personal experiences. Include opportunities for peer support and social connection to address isolation, while responding to concerns about stigma, judgment and confidentiality. Ensure that women can access support through different community settings according to their needs and preferences.

Community-based organizations and leaders (cont.)

7. Strengthen faith and community leaders' capacity for GBV prevention and safe response

Provide practical training for imams and other faith and community leaders on recognizing GBV, responding without judgment, protecting confidentiality and connecting survivors with specialist support. Establish clear procedures for handling disclosures and referrals confidentially. Address advice or practices that prioritize preserving the family over survivors' safety and choices. Engage leaders in challenging the normalization of violence and supporting men's participation in prevention. Faith-based support should complement, rather than replace, specialist GBV services.

8. Strengthen partnerships with service providers

Build sustained partnerships between Muslim-led organizations, ethnocultural agencies, community and faith leaders, and formal service providers. Strengthen referral knowledge and connections so that trusted community contacts can facilitate access to appropriate support. Enable mutual learning about cultural contexts and barriers to engagement, while ensuring that community organizations are adequately supported rather than expected to compensate for gaps in formal services.

Systems, institutions and funders

These recommendations apply to government bodies, institutional leaders, school boards, policymakers, and public and private funders.

9. Strengthen cross-sector collaboration and coordination

Develop coordinated care pathways across community organizations, health services, victim services, shelters, settlement agencies, child welfare, law enforcement and legal services. Address fragmented referrals, inconsistent communication and gaps in follow-up, particularly during transitions between crisis response and longer-term support. Coordination should reduce the burden on survivors to navigate multiple systems and repeatedly recount their experiences, while protecting confidentiality and respecting their choices about information sharing.

10. Invest in culturally responsive services, prevention and long-term supports

Provide sustained funding for culturally responsive services, interpretation and community partnerships. Resource ethnocultural organizations' service-delivery and partnership roles without transferring responsibility for gaps in mainstream or statutory services onto them. Fund the adaptation, delivery and evaluation of evidence-based IPV prevention programs involving women and men, including facilitator training and survivor-support pathways. Extend investment beyond crisis response to housing stability, mental health care, employment and income-related support, and system navigation. Recognize housing and income security as integral to safety, and address the isolation and discrimination that can undermine long-term recovery.

11. Address systemic barriers and experiences of Islamophobia

Review institutional policies and practices that contribute to discrimination, mistrust and inequitable access. Establish anti-bias standards for intake and assessment, alongside accountability mechanisms to identify and address discriminatory practices. Prioritize reducing profiling in police and legal services, addressing over-surveillance in child welfare, and tackling legal delays affecting safety and recovery. Extend action to Islamophobia in employment and public settings, recognizing its implications for women's economic independence and options for safety. Responsibility for change should rest with institutions, rather than with women navigating these barriers.

Systems, institutions and funders (cont.)

12. Strengthen schools' role in preventing and responding to gendered Islamophobia

Strengthen responses to anti-hijab bullying, religious stigma and identity-based harassment through education about Islam and religious practices, culturally responsive accommodation and clear responses to reported incidents. Increase diversity among staff and teachers and ensure that students can access appropriate support. Include schools in cross-sector prevention and early-intervention efforts, recognizing their role in shaping safety, identity, belonging and future help-seeking.

Summary of Recommendations

The table below brings together the 12 recommendations across the GBV care pathway, highlighting priorities for prevention, early identification and disclosure, crisis response, and recovery and ongoing support. It complements the audience-based recommendations in the preceding section by showing where the actions of service providers, community organizations and institutions connect and reinforce one another. The final row identifies priorities that underpin the entire pathway, including anti-Islamophobia knowledge and practical tools, partnerships, sustained funding and institutional accountability. These stages are interconnected: women may seek support through different routes, and coordinated responses are needed throughout their help-seeking and recovery journeys. Several recommendations therefore appear at more than one stage, with the numbers linking each priority to the corresponding recommendation in the preceding section.

Stage	Priority Actions	Related Recommendations
Prevention	Adapt, pilot and evaluate evidence-based IPV prevention programs for Muslim women and men, integrating content on Islamophobia and GBV; expand community education, bystander support and dialogue; engage faith and community leaders; address gendered Islamophobia in schools.	4, 5, 6, 7, 12
Early identification and disclosure	Build trust and create safe disclosure spaces; equip providers with skills and tools to recognize and address bias at first contact; improve language access; train faith and community leaders to respond safely.	1, 2, 3, 6, 7
Crisis response	Provide culturally informed assessment and safety planning, interpretation and appropriate accommodation; use anti-bias assessment tools; strengthen supported referrals and coordination; identify and address discriminatory responses.	1, 2, 3, 7, 8, 9, 11
Recovery and ongoing support	Maintain follow-up and continuity of care; strengthen social connection; sustain housing, mental health, employment and income-related support, and navigation assistance.	3, 6, 9, 10
Across all stages	Embed cultural humility and anti-Islamophobia knowledge, skills and practical tools in service delivery; strengthen community partnerships and cross-sector coordination; provide sustained funding and institutional accountability.	1, 8, 9, 10, 11

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