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The Effects of the COVID-19 Pandemic on Family Violence: A Meta-Analytical Investigation

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Abstract: The association between family violence and the COVID-19 pandemic remains complex. This meta-analysis aimed to determine trends in the observed changes in family violence comparing the pre-pandemic period to the pandemic period. A systematic search was performed in electronic databases to identify all relevant research reporting on COVID-19 and family violence. There was a statistically significant increase in family violence after the first lockdown. The odds ratio for the prevalence of physical and sexual violence together was 7.24 (95% CI = 4.74, 11.03 $p < 0.001$). A small marginal increase in the prevalence of various types of family violence leading to hospitalization was found, however, the result was not statistically significant (OR = 1.91, 95% CI = 0.91, 3.96, $p = 0.09$). A small significant increase in the prevalence of victims with a perception of increased violence during the pandemic lockdown was observed (proportion = 33%, 95% CI = 15.72%, 50.34%, $p = 0.002$). This meta-analysis found that during the COVID-19 lockdown, there was an increase in the prevalence of overall family violence, a small, non-significant, increase in the prevalence of hospitalizations due to family violence, as well as an increase in the perception of family violence by victims. These results are clinically relevant for implementing effective measures of violence prevention to safeguard vulnerable populations.

Keywords: meta-analysis; COVID-19; pandemic; violence; family violence

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1. Introduction

Violence is defined as the intentional use of force or power that results in emotional, psychological, physical, sexual, or financial harm against adults and children, regardless of gender or sexuality. Family violence is defined as violence inflicted by a perpetrator who has family ties with the victim or is a current or former intimate partner of the victim [1]. Therefore, family violence is used to refer to a broad spectrum of violence within family or domestic contexts. This includes intimate partner violence (IPV) or domestic violence (DV), which both involve current or former intimate partners, elder abuse, child abuse, and abuse perpetrated by children. Elder abuse is understood as harm directed at elderly individuals by caregivers, guardians, or any family member, while child abuse is understood as

harm inflicted on children by caregivers, guardians, or any family member, including siblings. While sibling violence is a form of family violence, it remains underexplored in the literature [2,3]. Similarly, violence perpetrated by minors against caregivers, guardians, or parents, sometimes referred to as child-to-parent violence (CPV), is acknowledged as family violence but is understudied [4]. Family violence annually impacts approximately 10 million individuals (including both adults and children) and results in over 1500 deaths according to data provided by the United States [5]. Annually, approximately 5 million acts of domestic violence target women, while 3 million target men [5]. Additionally, 10% of children are witnesses of IPV or DV each year, among which many become victims of child abuse, including sibling violence [2,3,5]. Elderly abuse is estimated to affect 3% to 10% of the elderly population [5]. Family violence has many personal and societal repercussions, including its documented negative impacts on victims, such as an increase in mental health problems, reduced self-esteem, self-harm, and injuries that can lead to hospitalization and/or death [6,7]. The cost to individuals and society is significant. For instance, family violence has been associated with $12 billion USD in national economic costs annually, of which $8 billion USD are medical and mental health care service expenses [5]. This number is estimated to be much higher for chronic conditions [5].

The association between the disruption of social structures, such as humanitarian crises and pandemics, is not a new phenomenon. It has been observed through history to increase violence [8–12]. The coronavirus disease (COVID-19) was declared a global pandemic at the beginning of 2020, and it quickly spread worldwide, infecting over 589 million people and leaving over 6 million deaths, causing many countries to impose strict confinement measures to limit social contact to possibly curb the spread of the virus. This resulted in school and business closures, social distancing, and prioritizing working from home when possible [13]. These strict confinement measures not only limited the spread of the virus, but also had an impact on mental health and family relationships [14–16]. The increased levels of anxiety influenced the levels of family violence during the pandemic [14–16]. For instance, being quarantined with family members possibly undergoing socioeconomic instability from the pandemic, such as loss of employment, social isolation, and fear of being infected by the virus, has increased levels of anxiety in vulnerable families, and therefore the risk of violence in recurring and new victims [17].

Several studies evaluated the levels of violence during the COVID-19 pandemic, with some focused on interpersonal violence, and others specifically on family violence. The conflictual results of these studies have limited our understanding of the association. Certain studies (i.e., [18–20]) have reported an increase in family violence, although others have reported a decrease in family violence (i.e., [21–23]). Research suggests that past individual history of violence is the strongest predictor of future violence [24]. However, some data from a meta-analysis showed that in many cases, DV or IPV started for the first time during the COVID-19 pandemic, with a 16% increase in the number of first-time abuse cases on average [25]. The unique context of the pandemic and its socioeconomic instability may have created conditions that triggered first-time abuse cases or amplified pre-existing abuse cases [17]. Thus, changes in the prevalence of family violence might depend on the abuser's perception of the pandemic-related consequences. For example, a study evaluated the abuser's perception of physical, sexual, and emotional IPV during the pandemic. The results showed that abusers' perceptions of loneliness, stress, fear, and boredom were linked to higher odds of reporting perpetrating IPV, while hopefulness is associated with a 34% decrease in reporting perpetrating IPV [26]. Also, a study showed that parents who reported feeling isolated during the pandemic were 124% more likely to self-report using physical violence against their children more often than usual since the beginning of the pandemic [27]. Additionally, a study assessed the perception of certified

providers of a home visiting program on child maltreatment, finding that 87% of providers perceived an increase in child maltreatment during the pandemic [28]. Given that both abusers' and external observers' perceptions of family violence have increased, victims' perceptions may follow a similar pattern. It is also important to explore whether victims' perceptions reflect the actual presence of family violence or if the pandemic has shaped in a certain way how victims perceive their experience. Thus, the association between family violence and the COVID-19 pandemic remains complex and may also depend on other factors, like the type of violence, the victim, and the timeline.

Previous meta-analyses have explored this relationship, but with limitations, as they incorporated non-physical and nonsexual family violence, which are less standardized. One included emotional violence and indirect violence, such as witnessing an act of violence within a family or domestic context, as part of the analysis [25]. Another included disturbances, threats, neglect, and protective order violations, within a family or domestic context as part of the analysis [29]. Neither of them included self-reports to evaluate victims' perceptions of family violence [25,29]. Similarly, other meta-analyses that estimated standardized physical and/or sexual violence separately did not address victims' self-reported perceptions [25,30–32]. Therefore, there is a gap in the literature on the prevalence of standardized physical and sexual family violence and its perception by victims. We therefore decided to conduct a meta-analysis to synthesize and combine the empirical literature on the observed effects of the COVID-19 pandemic on family violence, with a specific interest in physical and sexual violence because they are more systematically standardized in the literature. For this study, we focused our search on all forms of family violence as commonly defined in the literature: IPV, DV, child abuse, including sibling abuse, elder abuse, and CPA. We aimed to determine trends in the observed changes in family violence, comparing the pre-pandemic period to the pandemic period, focusing on (1) the prevalence of family violence, (2) the prevalence of hospitalizations due to family violence, and (3) the perception of family violence by victims. We hypothesize that the lockdown period of the pandemic may have caused an increase in family violence, due to the context of disruption of social structures, families being quarantined together and potentially quarantined with an abusive family member without access to support services, increased levels of anxiety due to socioeconomic instability, and increased substance abuse as a coping mechanism. We aim to further explore in the discussion these possible reasons for the observed changes in family violence.

2. Materials and Methods

2.1. Search Strategy

A systematic search was performed on 27 September 2023 in the electronic databases of PubMed, PsycINFO, Web of Science, and Google Scholar to identify all relevant research reporting on COVID-19 and family violence from the start of the pandemic (2020) until the search date. Search terms were inclusive for COVID-19 (e.g., [COVID or coronavirus or COVID-19 or synonyms]) and violence (e.g., [violence or abuse or battery or synonyms]). A full electronic search strategy is available in Table S1 of the Supplementary Material Section. The search syntax was tailored for each database. The reference lists of the included articles were scanned to ensure no pertinent studies were missed. No setting nor geographical restrictions were applied. Searches were limited to English and French language sources, as these are the languages spoken by the authors. Abstracts and full texts were screened by L.D, T.S.G, and M.H. A similar methodology has been employed in prior published work by the research team (i.e., [33–36]).

2.2. Study Eligibility

Studies were not restricted so long as they evaluated any type of physical and/or sexual violence (i.e., clinical observation, self-report), as defined by the authors of the corresponding papers. Selected studies were included if they met the following criteria: (1) the type of violence was physical and/or sexual family violence in adults and children, (2) the time period was restricted to a comparison of family violence results during the COVID-19 lockdown in 2020 to the same time period in 2019 (i.e., March to May 2020 vs. March to May 2019), and (3) a cross-sectional, longitudinal, or retrospective design was used. Police reports were included if they clearly described the type of violence (physical and/or sexual) and specified that it was of a family nature. Discussions on the inclusion of studies were held between L.D, T.S.G, and M.H. to ensure agreement, and discrepancies were discussed with A.D. Studies were excluded if they did not specify the type of violence (i.e., emotional, psychological, physical, sexual, financial), if the violence was not of family nature (i.e., armed robbery, assault, or shooting against a non-family member), if there were no clear dates for when the results were taken (i.e., lifetime violence), and if studies were the wrong study type (i.e., editorial, systematic reviews, qualitative studies). Further studies were excluded if they contained methodological issues (i.e., missing data, or inadequate data to compute any effect size). Maltreatment studies were excluded if they did not describe physical and/or sexual maltreatment (i.e., negligence). Studies reporting calls and complaints to police not leading to official police reports were excluded.

2.3. Data Extraction

Data were extracted with a standardized form created by the team as used in prior published systematic reviews (i.e., [33–36]) and double-checked for consistency by the authors. The following data were extracted: study design, country of the study, description of the sample, type of family violence, timeline of the COVID-19 lockdown in the studied district, timeline of the study, and prevalence before and during the lockdown. Studies were divided into multiple categories such as overall family violence, adult or child physical family violence, adult or child sexual family violence, and hospital admissions for family violence (adult and child). A category was also added for victims' perception of violence during the pandemic. During the extraction, the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines were followed. Table S3, which summarizes the data, can be found in the Supplementary Materials Section.

2.4. Statistical Analysis

Data were entered into an electronic database and the analyses were conducted using R and metafor package [37]. Analyses were chosen and conducted by C-E. G, an experienced statistician. The analyses that combined different outcomes from the same study were conducted using multivariate analyses by including a random effect on the intercept by study. Sub-analyses were conducted regarding: (1) the type of violence (i.e., physical, or sexual), (2) the population (i.e., adults, children), (3) victims' perception of violence during the pandemic. The perception of family violence by victims was measured in the included manuscripts with self-reported victimization questionnaires, e.g., using the validated 5-item, Extended Hurt, Insulted, Threatened, and Scream (E-HITS) construct [18] or a modified version of the validated Conflict Tactics Scales (CTS) [38], among others. The questionnaires were administered during the COVID-19 lockdown (between March and May 2020) and inquired about the participants' current experiences of family violence. The questionnaires included additional questions asking the participants to recall their experiences of family violence prior to the COVID-19 pandemic (between March and May 2019). These time frames were then compared. The following interpretations for the

prevalence of various types of violence reported as odds ratios were used: small (range, 1.0–1.5), moderate (range, 1.6–2.5), strong (range, 2.6–9.9), and very strong (over 10.0). Heterogeneity was assessed with the Q statistic [39], with its magnitude quantified with the I2 index [40]. An adaptation of Egger's test for our multivariate data based on residual data was used to evaluate the risk of publication bias, alongside funnel plots [41].

3. Results

3.1. Study Characteristics

After completing a literature search, 16,059 articles were identified. Duplicates were removed, which left 12,220 articles for screening, after which, 1371 articles remained for further analysis. The full texts were read, and 1353 articles were excluded as they did not meet the inclusion criteria. After the final revision, 18 articles were included as they met our eligibility criteria. The PRISMA Flowchart is found in Figure S1 of the Supplementary Materials Section. Out of the 18 included articles, 12 were cross-sectional and six were longitudinal. Among these articles, seven addressed children, with two of them also addressing adults. The remaining studies focused solely on adults. Out of the 18 included studies, seven were from the United States of America, one from Canada, one from Germany, one from France, two from England, one from Turkey, one from India, one from Singapore, one from Bangladesh, one from Nepal, and one from Uganda.

3.2. Prevalence of Various Types of Violence

The difference in the percentage of different types of violence (combining the data for both physical and sexual family violence) between the pre and post-COVID-19 lockdown was examined (see Figures S2 and S3 of the Supplementary Materials Section). For this analysis, two articles [42,43] were included providing four effect sizes, based on a large sample of women and children (n = 4007). Ebert and Steinert [42] employed a cross-sectional design, while Puri et al. [43] used a longitudinal design. Results show a statistically significant increase in both physical and sexual family violence combined after the first lockdown. The odds ratio for the prevalence of physical and sexual violence together was 7.24 (95% CI = 4.74, 11.03 $p < 0.001$). For the global analysis, there was minimal heterogeneity (Q = 15.27, $p = 0.002$, I2 = 0%). Egger's test (t = −0.69, $p = 0.49$) indicated no publication bias. Specifically, for the prevalence of physical violence only (see Figure S4 of the Supplementary Materials Section), the effect was not statistically significant, and the odds ratio was 3.19 (95% CI = 0.66, 19.95 $p = 0.14$). No analysis was possible for the prevalence of sexual violence only, as only one article remained.

3.3. Prevalence of Various Types of Violence Leading to Hospitalization

The difference in the prevalence of different types of family violence (combining the data for both physical and sexual violence) resulting in hospitalized patients between the pre and post-COVID-19 lockdown was examined in 10 articles [19–23,44–48] (12 effect sizes), with a considerable total sample of 681,326 men, women, and children (see Figures S5, S6 and S7 of the Supplementary Materials Section). A small marginal increase in the prevalence of both physical and sexual family violence combined leading to hospitalization was found, however, the result was not statistically significant. The odds ratio for the prevalence of both types of family violence combined leading to hospitalization was 1.91 (95% CI = 0.91, 3.96, $p = 0.09$). Sub-analyses were conducted by the type of violence (physical only, sexual only, both violence, or non-specified) and by the type of victim (adult and child), which were not statistically significant. Large heterogeneity between the overall studies (Q = 82.25, $p < 0.001$, I2 = 92.1) was observed, though there was no publication bias (t = −1.65, $p = 0.10$).

3.4. Victims with a Perception of Increased Violence During the Pandemic

The prevalence of victims who perceived an increase in family violence (combining the data for both physical and sexual), during the COVID-19 lockdown was examined in five articles [18,38,49–51] (10 effect sizes), with a total sample of victims of 264 men and women (see Figures S8–S10 of the Supplementary Materials Section). This analysis reported that 33% of the victims perceived increased family violence during the COVID-19 lockdown. This indicates a small and statistically significant rise in the prevalence of perceived increased family violence during the COVID-19 lockdown (proportion 33%, 95% CI = 15.72%, 50.34%, p = 0.002). Sub-analyses conducted separately for each type of violence (physical only and sexual only) and by victim's sex were not statistically significant (Q = 6.43, p = 0.09). Moderate heterogeneity across the studies was found (Q = 12.13, p = 0.21, I2 = 45.79%) and Egger's test showed no publication bias (t = −1.04, p = 0.30).

4. Discussion

The purpose of this study was to determine whether the COVID-19 pandemic led to any changes in family violence, in particular physical and sexual violence, in both children and adults, by comparing the pre-pandemic period to the pandemic period. This meta-analysis showed a statistically significant increase in both physical and sexual family violence combined after the first lockdown. Moreover, a small although non-significant marginal increase in the prevalence of hospitalizations due to family violence during the COVID-19 lockdown was observed. A possible explanation for hospitalizations may be the limited access to social welfare, mental health resources, and medical and legal services, since the beginning of the pandemic [52]. Another explanation for hospitalizations is the underreporting of cases of family violence, as this is a recognized problem in family violence quantitative studies [53–55]. This underreporting could be attributed to victims' fear of reprisal or escalation of violence, causing them to hesitate to report less severe incidents and only report cases that pose a substantial threat to their lives as a last resort. This meta-analysis also showed a small and statistically significant rise (33%) in the prevalence of perceived increased family violence during the COVID-19 lockdown. A greater perception of increased family violence may reflect the actual presence of family violence or may indicate that victims were more attuned to family violence, which has become more apparent due to the specific context of the pandemic, such as acute stressors and the social proximity resulting from the confinement. Our study suggests a concordance between the two, meaning that victims' perceptions of violence align in general with the actual presence of violence.

Coherently with our hypothesis, the findings of our paper showed a statistically significant increase in family violence after the first lockdown of the COVID-19 pandemic. All these findings are derived from studies not only yielding a large sample size of adults and children (male, female), but also showing no publication bias. It is noteworthy that the lack of a significant decrease implies that the confinement measures did not mitigate the pervasive issue of family violence. Moreover, these results are consistent with those of previous reviews on family violence during the COVID-19 pandemic [25,30–32]. Extending from our initial objectives, we will explore below several potential explanations to help explain our findings concerning the increase in family violence.

First, extensive meta-analyses have established that contexts of humanitarian crises and emergencies tend to increase violence, including family violence [8–12]. This manifests as opportunistic violence, wherein perpetrators take advantage of vulnerabilities and environments of impunity. Perpetrators span a wide spectrum, including armed militias, security or border personnel, as well as peacekeepers and humanitarian workers [8–12].

Concerning sexual violence, opportunistic sexual violence may involve the exploitation of trust for sexual purposes by trading survival supplies for sexual acts [8–12]. While sexual violence predates humanitarian crises and emergencies, these situations exacerbate sexual violence due to the breakdown of regular norms and additional stressors on relationships [8–12]. Furthermore, evidence focused specifically on refugee camp settings confirms that these conditions increase family violence [56–60]. Community systems and structures often fail to endure displacement, thereby restricting the capacity of displaced communities to prevent and address family violence [56–60]. Consequently, agencies operating in camps frequently assume the responsibility of implementing mechanisms to safeguard people. Typically, the United Nations High Commissioner for Refugees (UNHCR) serves as the lead agency, collaborating with various implementing partners within refugee camps [56–60]. However, challenges such as high staff turnover, financial constraints, and time limitations impede the adoption of community-based, participatory approaches, which may be perceived as complex, contentious, and time-consuming [56–60]. Other meta-analyses found increased family violence in the context of natural disasters, including earthquakes, cyclones, hurricanes, wildfires, and volcanic eruptions [61–63]. Some disaster experiences are associated with a higher likelihood of conflict and violent means of resolution. In essence, a disruptive event like a natural disaster can be an added stressor and thereby amplify tensions within family settings [61–63].

Second, the prolonged periods of confinement and enforced proximity during the COVID-19 lockdowns likely contributed to an increase in family violence. The restrictions imposed kept families at home for extended durations and reduced opportunities for victims to distance themselves from perpetrators. Thus, the duration families spend together is a situational trigger for such violence, which can be explained by the exposure reduction theory [64]. This theory posits that family violence, modeled as a crime of opportunity, increases in the amount of time victims and perpetrators spend in proximity, and conversely decreases primarily from reduced exposure of victims to perpetrators [64]. Strong support for this theory was provided, as the rate of violence increased in proportion to the time partners spent together, as measured by domesticity [64]. Evidence from situations where perpetrators and victims are temporarily separated shows that rates of violence decrease. For example, employed women are less likely to be victims of DV because they spend less time at home in a vulnerable position with their perpetrator [65].

Third, the economic insecurities brought by the COVID-19 pandemic, such as loss of employment, limited employment prospects, debt, and low income, likely contributed to an increase in family violence. The pandemic's economic fallout created circumstances that mirror well-documented drivers of other economic fallouts through history linked to family violence. For instance, a meta-analysis found that resource deprivation and poverty are underlying causes of violence [66]. Essential resource deprivation, such as lack of access to food, housing, and childcare, can cause frustration stemming from the inability to meet basic needs. This frustration, in turn, can escalate into diffuse hostility and aggression directed against a target of opportunity [66]. In situations of confinement, family members are the most accessible target for this violence [66]. Additionally, a feeling of relative resource deprivation induced by income inequality, through social comparison, likely intensified these dynamics [66]. This feeling can become more apparent when one community member is experiencing economic insecurities while another remains unaffected [66–68]. Another meta-analysis found that financial stress is a strong predictor of perpetrating family violence because it is a trigger for conflict and arguments. In particular, the type of financial stressors as well as the overall number of experienced financial stressors were associated with perpetrating family violence [69]. Individuals who were evicted from their homes were 2.39 times more likely to perpetrate severe physical IPV

compared to those who were not evicted [69]. Children from economically insecure families experience three to nine times more maltreatment as compared to their counterparts from economically secure families [70]. This economic insecurity results in heightened parenting stress, which increases harsh parenting [70].

Fourth, substance use became a coping mechanism for some individuals to manage the psychological strain caused by the drastic changes in society due to the COVID-19 pandemic [71,72]. During the lockdown, limited access to detoxification centers and mental health services made it challenging for some individuals struggling with substance use to manage their addiction [73]. Consistently, substance abuse has been identified as a contributor to family violence by many meta-analyses [24,74–78]. Substance-induced psychotic disorders are conditions characterized by prominent delusions or hallucinations that develop during or following substance use [79]. Substance-induced psychosis causes global cognitive impairment and global and domain-specific cognitive functioning impairment [80]. Neurological impairment in psychosis contributes to impulsive or aggressive behaviors [81]. There is evidence that chronic use of illicit drugs like opioids, amphetamines, marijuana, or PCP can eventually alter the nervous system. These changes can disrupt social communications and potentially escalate altercations into violence [81]. Also, the association between substance abuse and violence can remain strong even during withdrawal. This state of depletion is associated with psychopharmacological effects like agitation, irritability, disinhibition, and intensification of negative emotions, which may lower the level of stimulation needed to trigger a violent response [82]. Other symptoms can be somatic like hyperalgesia, insomnia, nausea, tremors, and weakness [83,84]. Precisely, individuals who have daily drug use may resort to violence in their desperation to obtain more drugs that they believe will alleviate their distress [81]. Since a history of violence is the best predictor of future violence [24], individuals who exhibit aggression sober are more likely to show heightened aggression when intoxicated [85].

Limitations

Our findings should be considered in light of the methodological constraints of this study. First, the heterogeneity in operational definitions of violence across the studies included in our meta-analysis introduces a challenge when synthesizing the results. Studies that did not explicitly refer to family violence, IPV, DV, elder abuse, child abuse, and CPV may not have been identified. Additionally, our definition of physical and sexual violence did not encompass negligence to ensure a more easily identifiable definition, while ensuring coherence in our analysis of the available literature. We also acknowledge that our narrow inclusion and exclusion criteria may restrict the generalizability of the findings to a broader population. These restrictions were necessary to ensure comparability, and thus the reliability of our conclusions. Our methodological standards can be a foundation for future research to build upon and broaden the scope of investigations already conducted. Second, a few studies included in this meta-analysis accounted for confounding factors such as living arrangements (e.g., cohabitation with a partner or a child residing full-time with a parent), the type of perpetrator, and the history of violence. Despite conducting sub-analyses on types of violence and types of victims, an exploration into cofounding factors could have provided a more nuanced understanding of the association. Third, the included studies were limited by the lack of assessment on elderly abuse, sibling abuse, and CPV. Fourth, the limited number of studies included did not allow for a sub-analysis on the prevalence of sexual family violence alone. Fifth, in the analysis of the prevalence of family violence leading to hospitalization, the included studies were all retrospective, with some tracking data from a single hospital and others tracking the same patients over time. This limitation may contribute to the observed heterogeneity, as it may reflect trends

specific to that hospital rather than a broader pattern across populations. Sixth, the search excluded studies with titles, abstracts, or full texts in languages other than English and French. Unfortunately, we were also unable to conduct a sub-analysis based on the country of the study, whereas most were from North America. We acknowledge that countries may have differed based on social, legal, and cultural aspects. Lockdown time frames and policies across countries and regions may have differed. We tried to minimize this bias by choosing the COVID-19 lockdown period that overlapped across countries, ensuring the analysis focused on the same time frame for each location. The aim of this study was to assess the immediate impact of COVID-19 aligned with the lockdown period (March to May 2020), yet we acknowledge that the effects of the pandemic may have persisted in the dynamic of interpersonal relationships beyond this time frame. Future research should explore the longitudinal effects of the pandemic on family violence, encompassing a broader time span to capture the potential continued impact and fluctuations over an extended period.

5. Conclusions

Family violence is a predominant issue, and certain aspects could possibly impact its levels. This meta-analysis found that during the COVID-19 lockdown, there was an increase in the prevalence of overall family violence, a small, non-significant, increase in the prevalence of hospitalizations due to family violence, as well as an increase in the perception of family violence by victims. Contexts of humanitarian crises and emergencies like pandemics can augment levels of violence as they cause societal changes that inflict high levels of stress. This study emphasizes the importance of providing victims with safe places away from their abusers, such as shelters. The pandemic response has highlighted the importance of a public health approach to addressing violence, necessitating preventative strategies at multiple levels: structural, community, household, and individual.

Supplementary Materials: The following supporting information can be downloaded at: https://www.mdpi.com/article/10.3390/covid5020013/s1. Figure S1: PRISMA flow chart; Figure S2: Forest plot of the meta-analysis of prevalence of various types of violence; Figure S3: Funnel plot of the meta-analysis of prevalence of various types of violence; Figure S4: Funnel plot of the meta-analysis of prevalence of physical violence; Figure S5: Forest plot of various types of abuse leading to hospitalization; Figure S6: Funnel plot of the meta-analysis of prevalence of types of abuse leading to hospitalization; Figure S7: Funnel plot of the meta-analysis of prevalence by various types of violence and victim type; Figure S8: Forest plot on the percentage of victim with perception of increased violence during pandemic lockdown; Figure S9: Funnel plot for the percentage of victim with perception of increased violence during pandemic lockdown; Figure S10: Funnel plot of victim with perception of increased violence during the pandemic, by type of violence and sex of victim; Table S1: Electronic search strategy for the meta-analysis conducted in September 2023; Table S2: PRISMA Checklist; Table S3: Details of the retrieved studies included.

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