



Domestic violence during the pandemic

Healthcare systems have failed to respond adequately despite increased need globally

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Domestic violence and abuse is a violation of human rights that damages the health and wellbeing of survivors and their families. Although both men and women are affected, incidence and severity are much greater for women: the World Health Organization recently estimated that a third of women worldwide experience domestic violence or abuse in their lifetime.¹

The factors driving this startling prevalence range from the personal to the structural, including pandemics and other public health crises. A *BMJ* editorial in May 2020 discussed the effects of economic disruption during pandemics, isolation within the home enforced by lockdowns, and reduced access to statutory and voluntary services that support survivors.² Domestic violence has been magnified by the covid-19 pandemic in two senses: incidence has increased globally, and the presence of domestic violence within all societies has also been revealed more clearly, alongside other adversities and inequalities. The societal response must be multisectoral. Here, we focus on challenges to the healthcare response.

Meeting the needs of survivors and their families requires additional healthcare resources and must be informed by accurate data on the incidence and effect of domestic violence and abuse, and by an understanding of the experience of survivors seeking support. Uncertainty remains about the size of the increase in domestic violence globally during the covid-19 pandemic. Calls to support services and to the police have varied over the past year, with large increases in most countries, including the UK,³ Brazil,⁴ and Nepal. Yet, emergency department attendance for domestic violence and non-partner sexual violence has fallen substantially, along with general emergency department attendance.⁵

We have no data yet from population surveys, and administering these during lockdowns is challenging as it may not be safe for someone to disclose violence or abuse when perpetrators are likely to be present.⁶ In the UK, domestic violence includes abuse by an adult within a household or family who is not a spouse or intimate partner. This type of abuse is also likely to have increased, but we have no supporting data. Nor do we understand how children's exposure to domestic violence interacts with other adversities amplified by pandemic restrictions.⁷

Healthcare settings should be safe places for disclosure of abuse, for managing the direct effects on health—including both physical and mental harm—as well as for referral for specialist support, when available. This can be problematic in facilities with insufficient privacy or when the victim is prevented from seeing a doctor or nurse on their own.

In many parts of the world, the shift to remote (audio or video) consultations makes confidential conversation difficult, inhibiting disclosure. Yet healthcare may be the only contact that an abused person—isolated by the perpetrator from friends and family—has with the outside world. In the UK, resources for clinicians, including specific guidance on remote consultations, are available from IRISi, a social enterprise set up to promote a better healthcare response to gender based violence.⁸

Estimates extrapolated from calls to hotlines suggest that the incidence of domestic violence has increased during the pandemic in Latin America. Domestic violence was increasing even before the pandemic in Brazil because of cuts in social and healthcare funding and to support programmes. Local government and non-governmental organisations responded to pandemic related increases by launching hotlines and online resources, but the healthcare sector has yet to contribute meaningfully.⁹ Reports of domestic violence from the Brazilian healthcare sector fell by 34% compared with 2019, for example.¹⁰ Services for victims of sexual violence and sexual health services more generally have also been affected by the pandemic. For example, 55% of the Brazilian hospitals that performed abortions before the pandemic stopped this service as resources were redeployed to treat patients with covid-19.¹¹

In south Asia, calls to the national helpline in Nepal doubled between April and June 2020 compared with the previous year.¹² Women who experienced violence disclosed to friends or community based human rights organisations rather than healthcare professionals.¹³ The response of clinicians to patients experiencing domestic violence was already limited through lack of training, but reduced access to health services during the pandemic made recognition of abuse and appropriate support even more difficult.

Although better data on the incidence of domestic violence during the pandemic are necessary to quantify the resources needed for extra services, we don't need to wait to provide safe spaces for disclosure in healthcare settings, or to invest in advocacy and support services that are fully integrated with healthcare. After the pandemic, we must target resources on improving the healthcare response by building on the increased visibility of this kind of abuse, our improved understanding of its association with other inequalities, and the likelihood that healthcare in many countries will continue to use a blend of remote and face-to-face consultations.

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