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Assistance strategies for women victims of gender-based violence during the COVID-19 pandemic

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ABSTRACT

The objective was to analyze the scientific evidence on assistance strategies provided to women, victims of gender violence, in several countries, in the COVID-19 pandemic. It is a narrative review of the literature, by searching PubMed, Scopus and Virtual Health Library databases, using the keywords "COVID-19" and "women" and "violence". Seventy-six publications were initially found. After the selection, based on the inclusion criteria and the answers to the guiding question, 25 articles were used, submitted to the analysis of semantic content. There were five categories of analysis: Internet accessibility, telehealth and digital exclusion; Emergency telephone lines for reporting violence during the pandemic; Readjustment/expansion of services to combat COVID-19 to assist women victims of violence; Health education and intersectoral actions - interface with media programs; State actions and society responses. It is concluded that the main evidenced actions are anchored in the support and intersectoral actions proposed by the governments. It will help the State to develop strategies, enabling health professionals to rethink their practice, in a contextualized way to the current reality, from welcoming women to notification of suspicion, as well as health education for the empowerment of victims.

Keywords: Coronavirus infections; pandemics; intimate partner violence; gender and health; women's health.

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INTRODUCTION

Between the end of 2019 and the beginning of 2020, the world was immersed in one of the greatest health problems, with dire consequences for all social segments: the infection by the new coronavirus (SARS-CoV-2) and the coronavirus disease syndrome (COVID-19), which reached pandemic proportions after its outbreak was detected in the Chinese province of Hubei, due to its rapid spread and a high potential for contamination[1,2].

The World Health Organization (WHO) directed the implementation of strict measures to prevent and control the spread of the new coronavirus, which were adopted by several governments. These measures include mass confinement and isolation,

strict restrictions on the population's movement on city streets, social distancing, and the use of masks[1-3]. It is noteworthy that many countries have shown insufficient amounts of diagnostic tests (leading to underreporting), the inability of health services to absorb the sick population, increasing the potential mortality, especially in groups of people who experience the invisibility of the State[3,4].

In this context of invisibility and state negligence, women stand out, whose gender disparities, specifically violence, have increased, according to news media reports, reports in social networks and reports from organizations that are focused on monitoring and supporting women, although with scarce official data, due to underreporting[5]. In the period before the pandemic, official data indicated that one in three women was physically or sexually assaulted by intimate partners and, in terms of femicide rates, more than a third were perpetrated by intimate partners[5,6]. Another study found that some 243 million women or girls worldwide had experienced intimate partner violence, increasing during this pandemic period and revealing a damaging facet of social isolation and confinement of entire families at home for longer periods[7].

It should be noted that the concept of gender adopted for this study refers to the historical and social constructions of functions, roles/activities, or behaviors expected by society and adopted by people according to their biological sex[8]. In this sense, gender violence occurs to the extent that the roles played by women in society are not what is expected of their subordination to men.

In turn, patriarchy can be understood in interface with the notion of gender, since it is theoretically delimited to give meaning to the power relations that are established in society between men and women for the maintenance of male supremacy in public spaces at the expense of invisibility and restriction of the female figure in private spaces, being the woman, therefore, in a condition of subordination to man within the patriarchal system[9].

Studies have shown, using police data, the growth of this phenomenon during the pandemic, in several localities such as Jianli, China, in the whole territory of the United Kingdom (25% increase), in Cyprus (more 30%), as well as in other European countries such as Spain and Italy, whose patriarchy is marked, after the implementation of the mandatory forty to the population[10-13]. In Brazil, the indicators of violence and femicide are even more terrifying, since it is one of the countries with the highest rates of gender inequality and feminicide[6].

The consequences arising from the conflicting roles played by men and women in society are magnified in events of humanitarian crises, however, they are little registered, because many women are forced to expose themselves to the dangers of living with the aggressor for much longer in the domestic environment[5,12]. The simple suggestions of the records of violence in historical epidemics indicate reflections on the status quo, since they affect social and economic life, with developments in male unemployment and, consequently, in the image of the home provider[4,6,13,14] .

Thus, the woman's overload is exacerbated, since she has to take care of the demands of the house, the needs of the children and the husband, as well as the external work (in case she is in home office)[4,5,14]. Thus, this study is relevant in the reflection about the strategies and care provided to the health of women who suffer violence, transversal with gender and health issues, seeing herself unable to face the situation and the aggressor alone.

Given this situation, numerous needs emerge for these women, who need an emotional and psychological support network, since the situation of restriction to the home makes their contact with family members difficult, promotes financial restriction, and difficulty in accessing basic daily necessities, such as accessing health services (important for sexual and reproductive health), shelters, and police/legal assistance. These demands can be further aggravated by the fear of men (more present in the home) and of SARS-CoV-2 contamination[15].

Thus, the guiding research question was: what has the scientific literature shown about the assistance provided to women victims of violence in different countries and global contexts, in the face of the COVID-19 pandemic?

To help answer this question, this study aimed to analyze the scientific evidence on the care provided to women victims of violence in several countries in the context of the COVID-19 pandemic.

METHODS

This is a narrative literature review, used so that new knowledge can be updated or achieved, involving the following phases: choice of theme; definition of keywords; identification in databases; preparation of a summary table of the results found; categorization of the studies found; analysis from a method for interpretation; interpretation of results and comparisons with other research[16]. It is noteworthy that, in order to carry out the narrative review, a guiding question was established for the database search.

The 27-item PRISMA checklist for systematic reviews was adapted to help collect the information needed to select articles from the databases and observe the main results. In addition, the four-step flowchart, also guided by PRISMA, was used for the identification, eligibility, and inclusion of articles[17].

The integrated search system of the PubMed, Scopus, and Virtual Health Library (VHL) databases - which integrates the search in Medline and Lilacs databases - was used to collect data to find publications of scientific articles related to the study topic from 2019 to 2020 (this cutoff was chosen based on the milestone when the cases of COVID-19 started to manifest themselves in the world), presented in Figure 1.

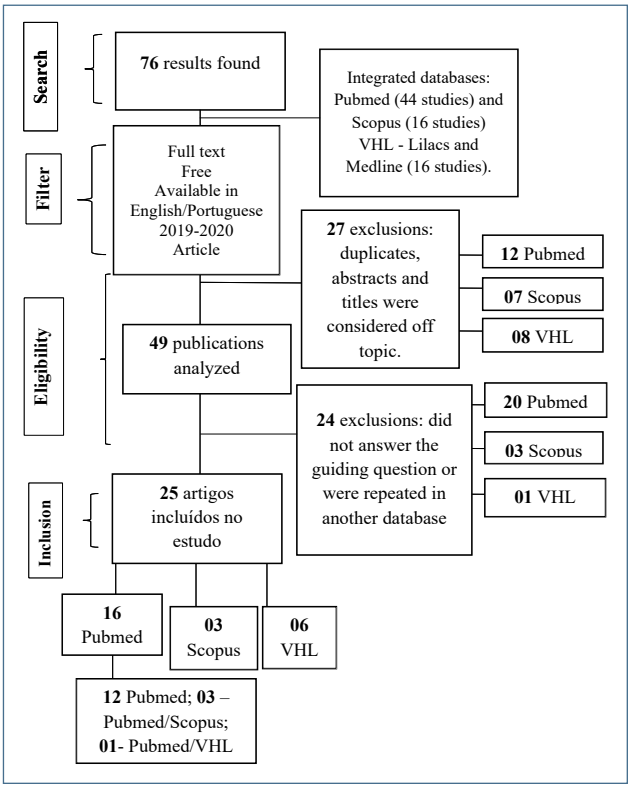

Figure 1: Detailed flowchart of the systematic selection of the articles included in the study. PubMed, Scopus and Virtual Health Library (VHL) from 2019 to 2020.

It was used for the collection in the online databases, "all indexes" and "all sources" selection, which allow a broad search, detailed in titles, abstracts and texts. Using the keywords "COVID-19" and "woman" and "violence", 76 total results (only articles) were found in the adopted databases (44 in PubMed, 16 in Scopus and 16 in VHL), after applying the filters for inclusion criteria: full text available, free of charge, in article document type format (only scientific productions), in all languages, with a time frame of 2019 and 2020. Of these, 27 productions were later excluded (12 in PubMed, 7 in Scopus, and 8 in VHL), since there was duplicity, they were about a resolution, and/or the abstracts pointed to an escape from the theme: children and adolescents, gynecological disorders and sexual and reproductive health, mental disorders, as shown in Figure 1.

Thus, 49 studies were selected and, subsequently, an exhaustive reading was carried out, focusing on the results and conclusions, in order to verify whether they answered the guiding question. Therefore, 24 articles were excluded, due to repetition (duplicity in another database) and not answering the question, totaling 25 articles, which were included for the composition and final analysis of the study.

For the integration and grouping of the results, a table was built to summarize the most relevant information of the articles that met the inclusion criteria, as well as to facilitate the visualization of the results of the articles, according to the answer to the guiding question. The table contains the systematization of the main information: manuscript (with the identification code), author (alphabetically)/year, databases, study design and country involved or where the research was developed.

Subsequently, semantic content analysis was performed for the interpretation of the results, starting with floating reading and critical reading of the selected material. Then, we proceeded with the identification of similarities and divergences in the interpreted results, survey of the units of meaning and decoding of the information, classification of the semantic similarities of the analyzed content, which allowed the evidence of the categories and, finally, favored the construction of inferences and interpretations[18]. The analysis revealed five thematic categories.

RESULTS

The 25 articles included in this study were published mostly in English, but also a few in Portuguese. According to the Table 1, of these total articles, 60% referred their study to the Global Level; 40% highlighted the United States; 12% to Spain, Italy, and China; 8% to the United Kingdom and Ireland; 4% (in other words, one of each article) referred to England, France, Brazil, Ecuador, India, Bangladesh. and Australia.

According to the information contained in the table, regarding the study design, it is mostly reflection studies (60%), and of these, one reported the experience with conducts to combat violence perpetrated against women. However, documentary analysis (12%), epidemiological research (12%), meta-analysis, narrative review, letter to the editor, and integrative review, corresponded to 4% each.

After a thorough reading of the publications, the main results of each of the 25 articles, which answered the guiding question, were gathered. Following the semantic content analysis of the articles' results, the five categories of analysis emerged and were organized for the distribution of the articles that contributed to each one of them (Table 2).

DISCUSSION

The discussion is systematized and will be developed from the five thematic categories, evidenced in the results, and derived from the exhaustive reading, semantic content analysis, interpretation, and inferences.

Internet accessibility, telehealth, and digital exclusion

The United Nations (UN) categorizes *internet* access as a basic human right[19]. Nevertheless, as other studies have shown, many

Table 1: Characterization of the articles surveyed in the Pubmed, Scopus and VHL databases, for the keywords "COVID- 19" and "woman" and "violence" from 2019 to 2020

Author/Year	Reference	Database	Study Design	Countries or regions involved/ discussed in the studies
Anurundran et al. 2020	**27**	Pubmed	Reflection Study	Global. United States (Hurricane Andrew) and Australia (Severe fires in 2009), severe crises.
Bouillon-Minois, et al. 2020	**28**	Pubmed	Reflection Study	Global.
Carballea & Rivera 2020	**26**	VHL	Reflection Study	Global.
Choi et al. 2020	**30**	Scopus	Epidemiological research	Global
Emezue. 2020	**7**	VHL	Reflection Study	Global. United States, United Kingdom, Beijing (China).
van Gelder et al. 2020	**24**	Pubmed/Scopus	Reflection Study	Global.
Ghoshal 2020	**11**	Pubmed	Documentary analysis	India and the government in the Kerala region.
Gosangi et al. 2020	**23**	Pubmed	Epidemiological research	Northeast region United States.
Gulati & Kelly 2020	**29**	Pubmed/Scopus	Reflection Study	Ireland.
Hamadani Jet al. 2020	**36**	Pubmed/Scopus	Epidemiological research	Bangladesh.
Janecke & Flanagan 2020	**18**	VHL	Reflection Study	Global.
Jhon et al. 2020	**35**	Pubmed	Reflection Study	Global. United States, Ecuador, Italy, and China (Beijing).
Kaukine 2020	**19**	Pubmed	Reflection Study	United States.
Marques et al. 2020	**20**	Pubmed	Reflection Study	Brazil.
Matori et al. 2020	**32**	Pubmed	Reflection Study	United States.
Milne et al. 2020	**25**	VHL	Meta-analysis	Dublin (Ireland) and England.
OPAS 2020	**17**	VHL	Reflection Study	Americas.
Roesch et al. 2020	**5**	Pubmed	Reflection Study	Global.
Rossi et al. 2020	**21**	Pubmed	Reflection study/experience report	United States.
Ruiz-Pérez, Pastor-Moreno 2020	**13**	Scopus	Documentary analysis	Spain.
Sánchez et al. 2020	**30**	Pubmed	Integrative Rexiew	Global.
Silva et al. 2020	**22**	Pubmed	Narrative review	Global.
Vieira et al. 2020	**6**	VHL/Pubmed	Documentary analysis	Global. France.
Vora et al. 2020	**33**	Scopus	Letter to the Editor	Global.
Wenham et al. 2020	**34**	VHL	Reflection Study	Global.

Table 2: Distribution of articles according to the analysis categories.

Category number	Analysis Category	References
01	Internet accessibility, telehealth, and digital exclusion.	6; 7; 11; 17; 18; 19; 21; 22; 20; 23; 24; 25; 26
02	Emergency phone lines for reporting violence during the Pandemic.	6; 13; 11; 17; 19; 20; 22
03	Readjustment/expansion of COVID-19 services to assist women victims of violence.	5; 6; 11; 13; 17; 20; 21; 23; 24; 25; 27; 28; 29; 30; 31; 33
04	Health education and intersectoral actions: interface with media programs.	11; 13; 17; 20; 24; 21; 32
05	State actions and society's responses.	5; 11; 13; 17; 18; 19; 20; 22; 24; 25; 26; 27; 29; 30; 31; 33; 34; 35; 36

women in different contexts around the world have been deprived of the enjoyment of this guarantee[7,13,20-22] due to factors related to poverty, geographic distance from large urban centers, low signal quality or speed offered by providers and, above all, due to the absence of public policies that promote the democratization of internet access[6,15,23,24], among other aggravating factors.

The internet can be used as an effective strategy to battle domestic violence, since women can make complaints and requests for help through digital platforms, social networks, and specific applications for cell phones, as well as seek refuge online in support networks[6,7,20]. Even though the Internet provides important forms of communication between victims and the people who assist them, the physical traumas resulting from violence may be neglected by health professionals who work remotely, because they are not visualized or inspected as well as they would be in person[6,13,23].

In countries such as the United Kingdom, China and the United States, there is widespread promotion of the use of programs and applications for cell phones and tablets to combat domestic violence[7]. However, it is necessary to highlight the reality that many women, especially those affected by poverty and precarious social conditions, are denied access to these technological devices, or cannot afford internet services[13,22,25,26]. The pandemic of COVID-19 context has highlighted the digital exclusion, which is associated with the most vulnerable social strata, as well as revealing the sparse or total absence of governmental actions that aim to transmute this reality.

Telehealth services are also alluded to in the studies as an important means of helping women victims of violence[13,20,21,23,26],

considering the possibility of offering, through this category, telecounseling services, telepsychiatry, telemedicine, in addition to qualified listening, a practice that is essential to those who suffer from the silencing imposed by the numerous setbacks that pervade intradomicile violence[7,19,26,27].

However, despite the benefits of using the internet in the different contexts of combating domestic violence, this resource will prove to be insufficient if its accessibility and the distribution of digital tools[15,28] does not occur equally for all women, and is no longer restricted to those who belong to the wealthiest social classes. Therefore, it is up to the State to implement public policies of democratization of access to the internet, adapted to its diverse realities[7,27,28].

Emergency phone lines for reporting violence during the Pandemic

The expansion of emergency phone lines is one of the best and most powerful protection measures, in order to receive reports from victims and quickly and effectively send police assistance, as has already been done in countries such as Colombia (91%), 60% in Mexico, 40% in Australia, 30% in Cyprus, and 20% in the United States[13,15,22,24]. This means is fundamental and fast for the victim to be heard and helped in a fast and effective way, especially when associated with messages (text messages, social networks or digital media) of awareness that are disseminated to the population about these numbers, as happens in the United States[21]. However, it is a challenge for countries whose patriarchal culture is still imperative when men protect men, since the attendant (a man) tends to support the aggressor (almost always a man) and thus persuade women not to report it.

India and Brazil are two examples of predominantly patriarchal countries in which victims still feel intimidated or afraid that their complaints will not be accepted[13,23]. However, there are already regions in India that count on the expansion of emergency numbers, which work 24 hours a day, available for survivors to contact more quickly[13]. In Brazil, the number 180, the dial 100 (human rights violation) and 190 (civil police) have served as telephone numbers to receive the denunciation[22]. The federal government of France has authorized supermarkets and pharmacies to install teams for prevention and rapid response to the violence perpetrated by partners, in addition to installing telephone networks to report the aggressor in these places[6].

Spain, Italy, France, and Canada are three examples of the efficiency of this type of service, as they have expanded the 24-hour emergency report hotlines, favoring online reporting with the use of applications[15,24]. It is urgent that the companies, servers of the emergency numbers and the State provide training and make available means to raise awareness of the attendants to receive the complaint by women, free of judgments or coercion[13,19,22], and training of more women attendants, given the greater ability to empathize and understand the victim's demand[19].

Readjustment/expansion of COVID-19 services to assist women victims of violence

Intersectionality in prevention, screening, intake, and intervention have been essential to address domestic, family, and intimate partner gender violence, along with the implementation of policies and strategies with a gender and human rights focus, in partnership and concurrent with services designed to address COVID-19[22,29].

Faced with the expansion of such services, because of the course of the pandemic that pointed to the strangulation of the health sector, this grievance of global proportions also revealed another facet and reality, which demanded from states and governments policies of readjustment of services to combat COVID-19: taking advantage of these spaces to serve women victims of intimate partner violence[26,30,31]. This is a strategy pointed out by several studies and that has already been implemented in other countries, such as the United States, India, Ireland, England, and Spain[19,20,25,27,32].

The orientations start from the establishment of new forms of flow and referrals in the network of assistance to women in situations of violence, to the services destined to the treatment of victims of COVID-19, with the intention of bypassing the perpetrators and guaranteeing to the women that, during triage, the professionals themselves can welcome them and proceed with the denunciations and protection[5,19,22].

Some studies also recommend that health facilities (fixed or temporary) used in the pandemic, such as COVID-19 testing sites, should identify support services available for survivors (hotlines, shelters, rape crisis centers, counseling) and ensure partnerships with domestic violence response organizations to incorporate domestic violence screening[23,26,20], in addition to maintaining essential medical services such as post-rape care[5,33].

The expansion of institutional and intersectoral support networks, whether medical or informal, allows domestic violence to occur in a less isolated and potentially fatal manner, as has been done efficiently and qualitatively in Spain, England, and Ireland, because it ensures the normal functioning of the 24-hour information apparatus and the emergency care and reception of women at risk[19,27,29].

Health education and intersectoral actions: interface with media programs

The practices of health education include various concepts, from the areas of health and education, but present symmetry as to their purpose: to expand the autonomy of individuals for the development of self-care. In this sense, many studies are emphatic about the relevance of the use of this tool to combat domestic violence, especially in association with the media (radio, television, internet)[13,15,34], while its actions instrumentalize women - with knowledge, information, guidance - and enable them to identify abusive behavior of their partners, empowering them to denounce and subvert the arbitrary practices of their aggressors[13,22,26].

This discussion reiterates the findings shown here, for example from India, which highlight the importance of providing guidance to women victims of violence to ensure their own safety, such as approaching neighbors or relatives, withdrawing from the household where the violence is perpetrated, and seeking safe shelter[13].

The health education processes will present more effective and fruitful results when articulated with intersectoral actions[15,20,22,30,32] that include the mobilization of media (television stations, radio stations, YouTube channels, internet pages, blogs), given their visibility and possibility of reaching, capable of expanding society's awareness about domestic violence, thus promoting information, sensitization of the population, besides encouraging anonymous complaints and social support to the victims[26].

Countries such as Spain, Brazil and India reinforce the importance of publicity actions as a tactic to spread the information that domestic violence cannot be justified, for whatever reason, nor tolerated[13,23]. A study carried out in the United States found that, in many situations, police measures, whose focus is only the punishment of the aggressor, do not always present satisfactory results[19]. To overcome this setback, we have as an alternative the use of television programs, aiming to clarify the viewers'[11-23] doubts, as in the campaigns that have been broadcast in Spain[6,15,22].

State actions and society's responses

The State has been pointed out by several studies as the main responsible for declaring the fight against this violence as an essential service for comprehensive care, encourage positive responses from society, articulate strategies to combat, confront and reduce injuries that place women in a situation of vulnerability to violence perpetrated by the intimate partner[20-21,34,35].

Programmatic actions and public policies must be formulated to break with the culture of violence, maintained by patriarchy. In periods before the pandemic, this phenomenon already reverberated in femicide, let alone in times when countries experience serious humanitarian crises, as now in the COVID-19 pandemic[13,20-21,26] or formerly in the severe fires in Australia or the destruction caused by Hurricane Andrew in the United States, in which people were/are forced into home confinement, increasing the time of contact with the perpetrator[19,29,34-36].

The expansion of the services offered by the institutions that attend COVID for the care and welcoming of victims of partner violence is preponderant for actions to be implemented in a more agile way[3-5,15,35]. Such strategies have already been practiced by governments in rich countries such as the United States, China, and the United Kingdom (England and Ireland), as well as in developing countries like Brazil and Bangladesh (the latter has had very effective actions with great response from society)[22,28,31,37,38].

Governments must equip themselves with a careful combination of legal measures, such as increased resources, preparation of health and safety systems to track cases of violence and intervention (arrest and recovery of perpetrators, restraining orders, safety orders, lobbying legislators for increased funding)[24,32,37,38] associated with increased awareness in front-line community services[5,19,21,31]. Countries must overcome structural problems and address gender inequities that cut across race, religion, ethnicity, location, disability, and class[15,26,27,36,39].

Conclusion

Many countries, both rich (United States, Canada, China, England, France, Spain, and other European countries) and under-development (India, Bangladesh, Brazil, and Ecuador), have made efforts to combat intimate partner violence against women during the COVID-19 pandemic because of the increased number of reports.

Furthermore, several actions are implemented or recommended, intersectoral articulations, increase of financial incentives, readjustment of the services destined to the care of people who are ill by COVID-19, to care for the health of women who are victims of gender violence, through triage, counseling, and referrals of the demands presented by them. In addition, there is the effort to readjust places that offer essential materials such as pharmacies and supermarkets, so that women can find in these sectors someone to take their complaint, as well as the use of digital media, expansion of emergency phone lines, and smartphone applications with help buttons that call directly to the police services.

It is suggested that other studies be conducted to deepen the cause-and-effect relations between the use of strategies in countries that are still formulating or are in the process of implementing public policies to combat gender violence in this period of the COVID-19 pandemic with noticeable results in reducing the cases, because these were the gaps and limitations found in the reviewed studies. Another limitation to be highlighted is that most of the publications were reflection studies and did not present data/results from questionnaires or interviews with the victims, regarding the effectiveness or not of the strategies used to combat this type of gender violence.

REFERENCES

1. World Health Organization (WHO). Emergency Committee. Statement on the second meeting of the International Health Regulations (2005) Emergency Committee regarding the outbreak of novel coronavirus (COVID-19). Available from: https://www.who.int/news-room/detail/30-01-2020-statement-on-the-second-meeting-of-the-international-healthregulations-(2005)-emergency-committee-regarding-the-outbreakof-novel-coronavirus-(COVID-19).

2. Gilbert M, Pullano G, Pinotti F, Valdano E, Polleto C, Boelle PY, et al. Preparedness and vulnerability of African countries against importations of COVID-19: a modelling study. Lancet. 2020;395(10227):871-77. https://doi.org/10.1016/S0140-6736(20)30411-6

3. Wu F, Zhao S, Yu B, Chen YM, Wang W, Song ZG, et al. A new coronavirus associated with human respiratory disease in China. Nature. 2020;579(7798):265-69. https://doi.org/10.1038/s41586-020-2008-3

4. Couto PLS, Montalvão BPC, Vieira ARS, Vilela ABA, Marques SC, Gomes AMT, et al. Social representations of female sex workers about their sexuality. Invest Educ Enferm. 2020;38(1):e03. https://doi.org/10.17533/udea.iee.v38n1e03

5. Roesch E, Amin A, Gupta J, García-Moreno C. Violence against women during covid-19 pandemic restrictions. BMJ. 2020;369:m1712. http://dx.doi.org/10.1136/bmj.m1712

6. Vieira PR, Garcia LP, Maciel ELN. Isolamento social e o aumento da violência doméstica: o que isso nos revela?. Rev Bras Epidemiol. 2020;23 e200033. http://dx.doi.org/10.1590/1980-549720200033

7. Emezue C. Digital or Digitally Delivered Responses to Domestic and Intimate Partner Violence During COVID-19. JMIR Public Health Surveill. 2020;6(3):e19831. http://dx.doi.org/10.2196/19831

8. Beauvoir S. O Segundo sexo. Rio de Janeiro: Nova Fronteira, 2009.

9. Álvares MLM. Beauvoir, o patriarcado e os mitos nas relações de poder entre homens e mulheres. Rev NUFEN. 2014;6(1):6-14.

10. Wanqing Z. Domestic violence cases surger during COVID-19 Epidemic. Sixth Tone. Available from: https://www.sixthtone.com/news/1005253/domestic-violence-cases-surge-during-covid-19epidemic

11. La Provincia. Coronavirus: casi di violenza sulle donne raddopiatti in emergenza. La Provincia. Available from: https://www.laprovinciacr.it/news/italia-e-mondo/244892/coronavirus-casi-di-violenza-sulle-donne-raddoppiati-in-emergenza.html

12. Staff R. Calls to Spain's Gender Violence Helpline Sharply During Lockdown. Available from: https://www.nytimes.com/reuters/2020/04/01/world/europe/01reuters-health-coronavirus-spain-domestic-violence.html

13. Ghoshal R. Twin public health emergencies: Covid-19 and domestic violence. Indian J Med Ethics. 2020;1-5. http://dx.doi.org/10.20529/IJME.2020.056

14. Cepeda Z, Arenas C, Vilardo V, Hilton E, Dico-Young T, Green C. Dominican Republic gender analysis: study of the impact of the Zika virus on women, girls, boys and men. United Kingdom: Oxfam GB, 2017.

15. Ruiz-Pérez I, Pastor-Moreno G. Measures to contain gender-based violence during the COVID-19 pandemic. Gac Sanit. 2020;S0213-9111(20):30088-1. http://dx.doi.org/10.1016/j.gaceta.2020.04.005

16. Toledo JA, Rodrigues MC. Teoria da mente em adultos: uma revisão narrativa da literatura. Bol Acad Paul Psicol. 2017;37(92):139-56.

17. Galvão TF, Pansani TSA, Harrad D. Principais itens para relatar Revisões sistemáticas e Meta-análises: A recomendação PRISMA. Epidemiol Serv Saude. 2015;24(2):335-42. https://doi.org/10.5123/S1679-49742015000200017

18. Bauer MW. Análise de conteúdo clássica: uma revisão. In: Bauer MW, Gaskell G. Pesquisa qualitativa com texto, imagem e som: um manual prático. Petropólis: Vozes, 2002.

19. World Health Organization. (WHO). COVID-19 and violence against women: what the health sector/system can do. Available from: https://apps.who.int/iris/handle/10665/331699

20. Jarnecke AM, Flanagan JC. Staying safe during COVID-19: How a pandemic can escalate risk for intimate partner violence and what can be done to provide individuals with resources and support. Psychol Trauma. 2020;12(S1):S202-4. http://dx.doi.org/10.1037/tra0000688

21. Kaukinen C. When Stay-at-Home Orders Leave Victims Unsafe at Home: Exploring the Risk and Consequences of Intimate Partner Violence during the COVID-19 Pandemic. Am J Crim Justice. 2020;1-12. http://dx.doi.org/10.1007/s12103-020-09533-5

22. Marques ES, Moraes CL, Hasselmann MH, Deslandes SF, Reichenheim ME. Violence against women, children, and adolescents during the COVID-19 pandemic: overview, contributing factors, and mitigating measures. Cad Saude Publica. 2020;36(4):e00074420. http://dx.doi.org/10.1590/0102-311X00074420

23. Rossi FS, Shankar M, Buckholdt K, Bailey Y, Israni ST, Iverson KM. Trying Times and Trying Out Solutions: Intimate Partner Violence Screening and Support for Women Veterans During COVID-19. J Gen Intern Med. 2020;35(9):2728-31. http://dx.doi.org/10.1007/s11606-020-05990-0

24. Silva AFD, Estrela FM, Soares CFSE, Magalhães JRF, Lima NS, Morais AC, et al. Marital violence precipitating/intensifying elements during the Covid-19 pandemic. Cien Saude Coletiva. 2020;25(9):3475-80. http://dx.doi.org/10.1590/141381232020259.16132020

25. Gosangi B, Park H, Thomas R, Gujrathi R, Bai CP, Raja AS, et al. Exacerbation of physical intimate partner violence during COVID-19 Lockdown. Radiol. 2020;202866. http://dx.doi.org/10.1148/radiol.2020202866

26. van Gelder N, Peterman A, Potts A, O'Donnell M, Thompson K, Shah N, et al. COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. E Clin Med. 2020;21:100348. http://dx.doi.org/10.1016/j.eclinm.2020.100348

27. Milne SJ, Corbett GA, Hehir MP, Lindow SW, Mohan S, Reagu S, et al. Effects of isolation on mood and relationships in pregnant women during the covid-19 pandemic. Eur J Obstet Gynecol Reprod Biol. 2020;252:610-11. https://doi.org/10.1016/j.ejogrb.2020.06.009

28. Carballea D, Rivera RM. Coronavirus and interpersonal violence: A need for digital mental health resources. Psychol Trauma. 2020;12(S1):S208-9. http://dx.doi.org/10.1037/tra0000849

29. Sánchez OR, Vale DB, Rodrigues L, Surita FG. Violence against women during the COVID-19 pandemic: An integrative review. Int J Gynaecol Obstet. 2020;1-8. http://dx.doi.org/10.1002/ijgo.13365

30. Anurudran A, Yared L, Comrie C, Harrison K, Burke T. Domestic violence amid COVID-19. Int J Gynaecol Obstet. 2020;150(2):255-6. http://dx.doi.org/10.1002/ijgo.13247

31. Bouillon-Minois JB, Clinchamps M, Dutheil F. Coronavirus and Quarantine: Catalysts of Domestic Violence. Viol Aga Women. 2020. http://dx.doi.org/10.1177/1077801220935194

32. Gulati G, Kelly BD. Violência doméstica contra a mulher e a pandemia COVID-19: qual o papel da psiquiatria?. Int J Law Psychiatry. 2020;71:101594. http://dx.doi.org/10.1016/j.ijlp.2020.101594

33. Choi KR, Records K, Low LK, Alhusen JL, Kenner C, Bloch JR, et al. Promotion of Maternal-Infant Mental Health and Trauma-Informed Care During the COVID-19 Pandemic. J Obstet Gynecol Neonatal Nurs. 2020;49(5):409-15. http://dx.doi.org/10.1016/j.jogn.2020.07.004

34. Matoori S, Khurana B, Balcom MC, Kon DM, et al. Intimate partner violence crisis in the COVID-19 pandemic: how can radiologists make a difference?. Eur Radiol. 2020; 30:6933–6. http://dx.doi.org/10.1007/s00330-020-07043-w

35. Vora M, Malathesh BC, Das S, Chatterjee SS. COVID-19 and domestic violence against women. Asian J Psychiatr. 2020;53:102227. http://dx.doi.org/10.1016/j.ajp.2020.102227

36. Wenham C, Smith J, Davies SE, Feng H, Grépin KA, Harman S, et al. Women are most affected by pandemics - lessons from past outbreaks. Nature. 2020;583(7815):194-8. http://dx.doi.org/10.1038/d41586-020-02006-z

37. John N, Casey SE, Carino G, McGovern T. Lessons Never Learned: Crisis and gender-based violence. Dev World Bioeth. 2020;20(2):65-8. http://dx.doi.org/10.1111/dewb.12261

38. Hamadani JD, Hasan MI, Baldi AJ, Hossain SJ, Shiraji S, Bhuiyan MSA, et al. Immediate impact of stay-at-home orders to control COVID-19 transmission on socioeconomic conditions, food insecurity, mental health, and intimate partner violence in Bangladeshi women and their families: an interrupted time series. Lancet Glob Health. 2020;S2214-109X(20):30366-1. http://dx.doi.org/10.1016/S2214-109X(20)30366-1

39. Rosa JPF, Oliveira MM, Oliveira Filho MM, Fernandes CE, Oliveira E. Violência sexual no ABC Paulista: retrato de 142 casos. ABCS Health Sci. 2018; 43(1):41-46 https://doi.org/10.7322/abcshs.v43i1.994