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Impact of COVID-19 pandemic on characteristics, extent, and trends in child maltreatment in 34 Euro-CAN COST Action Countries: a scoping review of the literature

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ABSTRACT

Background: The COVID-19 pandemic intensified known risk factors for child maltreatment (CM). Yet, globally inconsistent trends were reported. Little is known about CM trends across Europe, given varying surveillance systems.
Objective: This scoping review systematically examined evidence on CM trends during the pandemic in 34 European countries in the COST Action Euro-CAN network.
Participants and Setting.
CM (physical, sexual, psychological abuse, neglect, and online harms) across various settings (population, healthcare, social care including NGOs, child protection services, judicial/police).
Methods: We searched PubMed, EMBASE, PsycINFO, Scopus, Web of Science, OPENGREY, and Google Scholar (January 2020–November 2024). Eligible studies included primary research and systematic or narrative reviews. Two reviewers independently screened and extracted data. Findings were synthesized narratively by CM type, sector, country, and study design, and reported following the PRISMA-ScR.
Results: Of 4658 records screened, 87 records were included (72 primary research, 15 reviews). Most studies used quantitative methods ($n = 64$, 89 %) and reported healthcare and population-based data. Physical abuse was the most frequently reported type ($n = 42$, 58 %). Results were mixed, showing increase, decrease, or no change in CM. The most consistent signal was an

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increase in physical abuse identified in French hospital datasets. Qualitative studies highlighted concerns about children's safety during school closures and changes in referral patterns.
Conclusion: This is the first comprehensive review of CM trends in Europe during the pandemic, covering the longest timeframe. Fragmented evidence reflects heterogeneous definitions, reliance on institutional data and underrepresentation of vulnerable groups. Findings stress for harmonised definitions and resilient surveillance systems.

1. Introduction

Child maltreatment (CM) is a serious and pervasive global health issue. CM epitomises a multifaceted problem with profound lifelong consequences (WHO, 2022). It is commonly encountered by professionals in healthcare, social services, education, and law enforcement, with documented burdens in both low- and high-income countries (WHO, 2013). The World Health Organization (WHO, 2022), defines CM as any actual or potential harm to a child's health, survival, development, or dignity, caused by physical, sexual, psychological abuse, or neglect. Despite this broad definition, there is a lack of consensus on how CM should be operationalised, leading to substantial variability across studies and national systems (Cowley et al., 2025). A global review estimated that over one billion children, more than half of all 2–17 year olds, experience past-year violence (Hillis, James, Adaugo, & Howard, 2016). Among the most commonly reported forms are physical and sexual abuse (Moody, Cannings-John, Hood, Kemp, & Robling, 2018; Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2015). Earlier meta-analyses estimated lifetime rates of 23 % for physical and 13 % for sexual abuse (Stoltenborgh, Bakermans-Kranenburg, van Ijzendoorn, & Alink, 2013; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011). More recent data suggests that 19 % of females and 15 % of males experience sexual violence, and 17 % of children are exposed to domestic physical violence globally (Cagney et al., 2025; Whitten, Tzoumakis, Green, & Dean, 2024). At the onset of the COVID-19 restrictions, global estimates predicted a 20–30 % increase in CM cases, with substantial rises also anticipated in Europe (WORLD VISION INTERNATIONAL, 2020). In global comparison, Europe had shown the lowest minimum prevalence of past-year violence against children prior to the pandemic (Hillis et al., 2016). Yet, self-reported lifetime data revealed substantial prevalence rates: for physical abuse 12 % for females and 27 % for males, and for sexual abuse 13 % for females and 6 % males (Moody et al., 2018) During the pandemic, some studies reported an increase in physical abuse or related injuries and/or emergency room visits, while others observed no change or even declines, possibly reflecting underreporting (Akova et al., 2023; Calvano et al., 2022; Loiseau et al., 2021; McDonnell et al., 2022; Obry et al., 2023; Sidpra, Abomeli, Hameed, Baker, & Mankad, 2021). This stands in contrast with US studies, which noted declines in CM-related hospitalisations and official reports (Kaiser et al., 2021; Rapoport, Reisert, Schoeman, & Adesman, 2021). Reports on online child abuse were also inconsistent (Augusti, Saetren, & Hafstad, 2021; Patchin & Hinduja, 2023; Schunk, Zeh, & Trommsdorff, 2022). The COVID-19 pandemic amplified existing vulnerabilities and intensified known risk factors for CM. Unemployment, economic strain, enforced social isolation, increased parental stress, and deteriorating mental health converged to heighten CM risk (Garner, Self-Brown, Emery, Wootten, & Tiwari, 2024). These stressors, coupled with pre-existing high prevalence rates, created a volatile environment for children's safety during lockdowns. CM is globally known to be widely underreported. Many cases never reach child protection services or being captured by formal surveillance systems due to a range of barriers, including stigma, fear of disclosure, and systematic shortcomings in detection and reporting mechanisms. This long-standing issues complicate efforts to estimate the true prevalence of CM, both globally and in Europe (Everson et al., 2008; Lynne, Gifford, Evans, & Rosch, 2015; Mathews, Lee, & Norman, 2016). During the pandemic, these challenges were further exacerbated. School closures and the suspension of children's activities disrupted primary detection systems for CM by limiting contact with potential reporters, thus increasing the risk of unreported abuse (Metcalf, Dickerson, Lavoie, & Quas, 2022; UNICEF, 2020). Furthermore, increased internet usage during the pandemic raised concerns about online child abuse, including cyberbullying, sextortion, and cyberstalking (UNICEF, 2023). Despite the growing research interest during the pandemic, methodological challenges continue to limit accurate assessments of CM prevalence and trends. Prevalence estimates vary widely depending on data sources: informant-based records often report very low rates (0.3–0.4 %), whereas lifetime self-report surveys indicate much higher prevalence (up to 23 % for physical and 13 % for sexual abuse) (Mathews, Pacella, Dunne, Simunovic, & Marston, 2020; Mehta et al., 2023; Stoltenborgh et al., 2015). These inconsistencies are compounded by the lack of standardized CM definitions, validated measurement tools, and harmonised national CM registers in many European countries, where large-scale, population-based surveys also remain rare (Mathews et al., 2020). This definitional and methodological fragmentation limits cross-country comparability and hampers evidence-informed policy making. More coordinated, high-quality data collections systems are urgently needed to inform child protection efforts and build resilience for future crises. In response to the persistent lack of standardized definitions, fragmented data systems, and the scarcity of large-scale, population-based studies in Europe, the European Cooperation on Science and Technology Association (COST) Euro-CAN (Multi-Sectoral Responses to Child Abuse and Neglect in Europe: Incidence and Trends) network was established. It brings together child protection practitioners and researchers from 34 European nations and surrounding regions to develop a unified CM data collection system. This scoping review was conducted by Euro-CAN's Working Group 5, focusing specifically on CM trends during and after the COVID-19 pandemic (CA19106., 2025). While global reviews of violence against children during the pandemic exist (Cappa & Jijon, 2021; Garner et al., 2024; Lee et al., 2023), they are limited in scope, often focusing on the early pandemic period, grouping together vastly different national contexts, or failing to differentiate findings by reporting sector. None has provided a comprehensive synthesis across Europe over the entire pandemic and into the recovery period.

This review therefore addresses a critical evidence gap. By systematically examining data from 34 European countries, covering the

full duration of the COVID-19 pandemic and an 18-month post-pandemic period (2020–2024) across healthcare, education, child protection, and justice sectors, it provides the most comprehensive account of CM trends in Europe to date.

Beyond mapping patterns of increase, decrease, or stability, the review also identifies persistent methodological limitations and highlights opportunities for building more resilient, harmonised child protection systems in preparation for future crises. The review was guided by a central research questions: What is the nature, extent and limitations of available evidence on CM in Euro-CAN COST Action countries during the COVID-19 pandemic, and how did the prevalence and characteristics of maltreatment change compared to the pre-pandemic period? To address this question, the review's primary aim was to map the available evidence and identify gaps and limitations in research on CM during the COVID-19 pandemic across Euro-CAN network countries. A secondary aim was to examine changes in CM prevalence and characteristics during the pandemic compared to the pre-pandemic period, where data allowed.

2. Methods

We conducted a scoping review of publications between January 2020 and November 2024 and followed the methodological framework by the Joanna Briggs Institute and reports according to current international guidelines (Preferred Reporting Items for Systematic Reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR)) (Peters et al., 2020, 2021; Peters et al., 2022; Tricco et al., 2018). Given the broad and complex nature of the topic, we conducted a pilot study that highlighted substantial heterogeneity in CM data sources, study designs, and reporting practices across Europe. In light of this variability and the diversity of available information, a scoping review was deemed the most appropriate method to map the existing evidence, as the conditions for a systematic review or meta-analysis were not met (Carsley et al., 2024; Jud et al., 2024). This approach allowed for a structured synthesis across countries, sectors and data sources.

The full methodology is reported in detail in the study protocol: Cankardas S et al. BMJ Open.2024;14(1)e080183 (Cankardas et al., 2024). Ethical approval was not required as the review analyzed data collected from existing literature. Neither patients nor the public were involved in conducting the review. To address the recurring challenge of definitional heterogeneity in CM research, the WHO framework (physical, sexual, psychological abuse, or physical/psychological neglect) was applied as the guiding standard (WHO, 2022) Studies with operational definitions partially mapped onto the WHO framework (e.g. those including children witnessing domestic violence or experiencing online harms such as cyberbullying or grooming) were reviewed with care and included where an alignment with WHO categories was possible. Studies with definitions that could not be mapped directly to the WHO framework (e.g. those referring to household dysfunction without specifying whether it constituted abuse or neglect) were excluded. For studies using broad or ambiguous terminology (e.g., “violence” or “assault”), data were included only if confirmation of child-specific maltreatment cases was possible. This process enhanced the transparency and consistency of study selection and directly addresses the limitation of definitional inconsistency in the literature (Cowley et al., 2025; Laajasalo et al., 2023). All forms of CM were included, regardless of severity, setting, perpetrator, or case status (new or ongoing) (Laajasalo et al., 2023; WHO, 2022). Online child abuse (e.g., cyberbullying, grooming, image-based abuse) was included as it is reported to have increased during the pandemic (Glitch & End Violence, 2020) psychological abuse, as defined by the International Classification of Violence against Children (ICVAC), was considered to include children who witnessed domestic violence (UNICEF, 2023). Domestic violence was considered CM when victims were under 18. The review was limited to Euro-CAN COST Action countries during the COVID-19, accounting for pandemic-related factors like lockdowns, parental stress, and family tensions (Supplement table 1). To ensure a comprehensive understanding of the evidence, both primary studies and secondary reviews were included. Only primary study data were extracted and analyzed, while secondary reviews helped map the broader research landscape and contextualize findings. A range of study designs and data sources from diverse contexts were considered to capture the complexity of CM research. To maintain relevance, the review excluded non-empirical sources (e.g., books, editorials, guidelines, opinions, blogs) and studies on adult survivors of childhood maltreatment. The review included searches across multidisciplinary databases—PubMed, EMBASE, PsycINFO, Scopus, and Web of Science, covering medicine, health, and social sciences. Additional studies were identified via Google Scholar, OpenGrey, and expert consultation. The search strategy was structured around four major concepts central to the review: children, maltreatment, COVID-19, and Euro-CAN COST countries. No linguistic restrictions were used in the study selection. A standardized data charting form was developed and refined to capture key information from included studies. Two reviewers independently extracted data, with discrepancies resolved by consensus or a third reviewer.

2.1. Data analysis

The results of this review were organized both in tabulated (see Table 1, Supplement tables 4 and 5) and narrative form around the research questions, key identified factors, and emergent themes. The focus was on the types and extent of CM, detailing variations and patterns identified across the different studies. The review provides a descriptive account of the type and volume of literature available over the specified period. This was aggregated by study design, country, setting, data sources and timing of the study in relation to the COVID-19 pandemic. Summaries of the outcomes categorized changes in the number and/or type of maltreatment over time and across contexts. This structure facilitates meaningful comparison of CM trends by country, sector, and time period, while also helping to identify key methodological differences and thematic patterns in reporting.

2.2. Primary research data

A more detailed description of primary research data included was undertaken and the quantitative and qualitative research data were considered separately. Quantitative data was described in a tabulated form by children's age and gender, type of CM, key outcome

Table 1
Characteristics of included studies are listed by study design and in alphabetical order of authors).

Primary research					
Reference	Country	Type of record	Setting	Source of information	Observation/reporting/literature search period
Quantitative study design					
Cross-sectional and time-series					
Akova S (2023) Eastern Mediterranean Health Journal,. doi:10.26719/emhj.23.032.	Turkey	Journal article	Healthcare	Medical record	P1: 1 Jul 2019–8 Mar 2020^{op}, P2: 9 Mar-21 Dec 2020^{op}
Almeida CT (2024). Children and Youth Services Review,.doi:https://doi.org/10.1016/j.childyouth.2023.107370	Portugal	Journal article	Population	Questionnaire-based	P1: 'pre-pandemic'^{op}, P2:'during and after confinement in Covid19 lockdown'^{op}, P3: Feb-Apr 2022^{rp}
Atay N (2024). Journal of Pediatric Nursing. doi:https://doi.org/10.1016/j.pedn.2024.08.011	Turkey	Journal article	Population	Questionnaire-based	P1: Apr-Nov 2023^{rp}
Augusti EM (2023). Child Abuse and Neglect.doi:https://doi.org/10.1016/j.chiabu.2023.106023.	Norway	Journal article	Population	Questionnaire-based	P1: Jan 2019^{rp}(=pre-pandemic^{OP}); P2: June 2021^{rp}(=pandemic^{OP});
Bäker N (2023). COVID. doi:https://doi.org/10.3390/covid3020022.	Germany	Journal article	Population	Questionnaire-based	P1: "spring 2020"^{op}, P2: "spring 2021"^{op}
Beez T (2023). Child's Nervous System. doi:https://doi.org/10.1007/s00381-023-05873-9	Germany	Conference proceeding (Abstract)	Healthcare	Electronic records	P1: 2016-2019^{op}, P2: 2020^{op}
Bell V (2023). Irish Journal of Medical Science. doi:https://doi.org/10.1007/s11845-022-03115-6.	Ireland	Journal article	Healthcare	Medical record	P1: 13 Mar-31 Aug 2019^{op}; P2: 13 Mar-31 Aug 2020^{op}
Bertomeu Panisello P (2023). Anuario de Psicología/The UB Journal of Psychology. doi: https://doi.org/10.1344/ANPSIC2023.53/2.2	Spain	Journal article	Population	Questionnaire-based	P1: "before COVID"^{op}, P2: Aug-Dec 2020 ("during COVID")^{op}
Bruns N (2022). Children-Basel. doi:https://doi.org/10.3390/children9030363.	Germany	Journal article	Healthcare	Electronic records	P1: 16 Mar-31 May 2017^{op}; P2: 16 Mar-31 May 2018^{op}; P3: 16 Mar-31 May of 2019^{op} P4: 16 Mar-31 May 2020^{op};
Calvano CL (2022). European Child and Adolescent Psychiatry doi:https://doi.org/10.1007/s00787-021-01739-0.	Germany	Journal article	Population	Questionnaire-based	P1: normative sample pre Covid, P2: 3 Aug-11 Aug 2020^{rp}
Calvano CL (2023). European Child and Adolescent Psychiatry. doi:https://doi.org/10.1007/s00787-023-02147-2.	Germany	Journal article	Population	Questionnaire-based	P1: normative sample pre Covid, P2: 3–11 Aug 2020^{rp} P3: 10 Dec-13 Dec 2021^{rp}
Caron FP (2022). European Journal of Pediatrics. doi:https://doi.org/10.1007/s00431-022-04387-x	France	Journal article	Healthcare	Medical record	P1: 2018^{op}; P2: 2019^{op}; P3: 2020^{op}; P4: May 2018^{op}; P5: May 2019^{op}; P6: May2020^{op}; P7: Dec 2018^{op}; P8: Dec 2019^{op}; P9: Dec 2020^{op}
Davidson M (2021). In Abstracts, BMJ Publishing Group Ltd. doi:https://doi.org/10.1136/bmjpo-2021-RCPCH.247	UK	Conference proceeding (Abstract)	Healthcare	Medical records	P1: 23 Mar-4 Jul 2019^{op}, P2: 23 Mar-4 Jul 2020^{op}
Ebert C (2021). Bulletin of the World Health Organization. doi:https://doi.org/10.2471/BLT.20.270983	Germany	Journal article	Population	Questionnaire-based	22 Apr-8 May 2020^{rp}
Fletcher CH (2022). Archives of Disease in Childhood. doi:https://doi.org/10.1136/archdischild-2022-rcpch.474	UK	Conference proceeding (Abstract)	Healthcare	Medical record	P1: 1 Mar-30 Sep 2019^{op}; P2: 1 Mar-30 Sep 2020^{op}
Fomenko EL (2022). BMC public health.doi:https://doi.org/10.1186/s12889-022-14,135-3	Belgium	Journal article	Population	Questionnaire-based	P1: before 13 Mar 2020^{op}; P2: 13 Mar 2020-end of Oct 2020^{op}; P3: 1 Nov 2020-end of Feb 2021^{op}; P4: 14 Jan-28 Feb 2021^{rp};
Garstang J (2020). BMJ Open doi:https://doi.org/10.1136/bmjopen-2020-042867	UK	Journal article	Healthcare	Electronic records	P1: 18-weeks from late Feb to late Jun 2018^{op}; P2: 18-weeks from late Feb to

(*continued on next page*)

Table 1 (*continued*)

Primary research					
Reference	Country	Type of record	Setting	Source of information	Observation/reporting/literature search period
					late Jun 2019[op]; P3: 18-weeks from late Feb to late Jun 2020[op]
Geprags AD (2023). Child and Adolescent Psychiatry and Mental Health. doi:https://doi.org/10.1186/s13034-023-00571-5	Germany	Journal article	Population	Questionnaire-based	P1: 28 Jul-¯1 Oct 2021[rp]
Giansante F (2021). Acta Paediatrica. doi: https://doi.org/10.1111/apa.16022	Italy	Report	Healthcare	Medical records	P1: 1 Jan 2019–31 Dec 2019[op]; P2: 1 Jan 2019–31 Dec 2020[op]
Grzejszczak, JA (2022). International Journal of Environmental Research and Public Health. doi:https://doi.org/10.3390/ijerph192113958	Poland	Journal article	Population	Questionnaire-based	P1: "before the pandemic"[op], P2:"during the pandemic"[op]
Handi MS (2021). Archives of Disease in Childhood. doi:https://doi.org/10.1136/archdischild-2021-rcpch.95	UK	Conference proceeding (Abstract)	Healthcare	Medical records	P1: Apr-May 2019[op]; P2: Apr-May 2020[op]
Harriott, J (2021). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-rcpch.222	UK	Conference proceeding (Abstract)	Healthcare	Medical record	Nov 2020[op]
Heimann, TJ (2021). Monatsschrift fur Kinderheilkunde doi:https://doi.org/10.1007/s00112-021-01135-7.	Germany	Journal article	Healthcare	Questionnaire-based	P1: Mar-Apr 2019[op]; P2: Mar-Apr 2020 [op]
Hennocq QC (2022). Injury doi:https://doi.org/10.1016/j.injury.2022.08.013	France	Journal article	Healthcare	Medical record	P1: 17 Mar-11 May 2019[op]; P2: 17 Mar-11 May 2020[op]
Herrmann L (2024). European Child & Adolescent Psychiatry doi:https://doi.org/10.1007/s00787-024-02396-9	Germany	Journal article	Healthcare	Questionnaire-based	P1: Jan 2020-Dec 2022[rp]
Katsos K (2023). Cureus. doi:https://doi.org/10.7759/cureus.46054	Greece	Journal article	Healthcare	Medical record	P1: 4 May-31 May 2019[op], P2: 4 May-31 May 2020[op]
Kliem SA (2023). Journal of interpersonal violence doi:https://doi.org/10.1177/08862605221143194	Germany	Journal article	Population	Questionnaire-based and interview-based	P1: Jan-Mar 2016[op]; P2: Feb-Mar 2021[op]; P3: Jun 2021-Oct 2021[op]
Loiseau M (2021). Child Abuse and Neglect. doi:https://doi.org/10.1016/j.chiabu.2021.105299	France	Journal article	Healthcare	Electronic records	P1: Mar-Apr 2017[op]; P2: Mar-Apr 2018[op]; P3: Mar-Apr 2019[op], P4: Mar-Apr 2020[op];
Lupariello F (2024). Forensic Science, Medicine and Pathology doi:https://doi.org/10.1007/s12024-024-00890-9	Italy	Journal article	Healthcare	Medical records	P1: Mar 2018-Mar 2019[op], P2: Mar 2020-Mar2021[op]
Majeed-Ariss R (2023). Journal of forensic and legal medicine doi:https://doi.org/10.1016/j.jflm.2023.102550	UK	Journal article	Healthcare	Electronic records	P1: April-Aug 2019[op], P2: Sep-Nov 2019[op], P3: Dec 2019-Jan 2020[op], P4: Feb 2020[op], P5: Mar 2020[op], P6: April-Aug 2020[op], P7: Sep-Nov 2020[op], P8: Dec 2020-Jan2021[op], P9: Feb 2021[op], P10: Mar 2021[op]
Massiot LE (2022). Child Abuse and Neglect. https://dx.doi.org/https://doi.org/10.1016/j.chiabu.2021.105443	France	Journal article	Healthcare	Electronic records	P1: weeks 12–192018[op]; P2: weeks 12–192019[op]; P3: weeks 12–192020[op]; P4: weeks 20–332,018 [op]; P5: weeks 20–332019[op]; P6: weeks 20–332020[op];
McDonnell C (2021). Pediatric Radiology. doi:https://doi.org/10.1007/s00247-021-05192-8	Ireland	Conference proceeding (Abstract)	Healthcare	Medical record	P1: 1Mar-30 Sep 2019[op]; P2: 1Mar-30 Sep 2020[op]
McTier A (2022). Child maltreatment doi:https://doi.org/10.1177/10775595221108661	UK	Journal article	Child protection services, Judicial, Police	Electronic records	P1: Apr-Jun 2020[op]; P2: Jul-mid-Dec 2020[op]; P3: mid-Dec 2020-Mar 2021[op]; P4: Apr-Aug 2021[op];

(*continued on next page*)

Table 1 (*continued*)

Primary research					
Reference	Country	Type of record	Setting	Source of information	Observation/reporting/literature search period
Obry S (2023. Child Abuse Negl doi:https://doi.org/10.1016/j.chiabu.2023.106063	France	Journal article	Healthcare	Electronic records	P1: Mar 2018-Jun 2019^{op}; P2: Mar 2020-Jun 2021^{op}, P3: Mar-May 2018^{op}, P4: Jun-Oct 2018^{op}, P5: Nov-Dec 2018^{op}, P6: Jan-Mar 2019^{op}, P7: Apr-2019^{op}, P8: May 2019^{op}, P9^{LD1}: Mar-May 2020^{op}, P10^{PLD1}: Jun-Oct 2020^{op}, P11^{LD2}:Nov-Dec 2020^{op}, P12^{PLD2}: Jan-Mar 2021^{op}, P13^{LD3}: Apr 2021^{op}, P14^{PLD3}: May 2021^{op}
Perumal TL (2021). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-rcpch.249	UK	Conference proceeding (Abstract)	Child protection services	Electronic records	P1: 16 Mar-1 Jun 2019^{op}; P2: 16 Mar- 1 Jun 2020^{op}
Platero RL (2022). Social Inclusion. doi:10.17645/si.v10i2.4950	Spain	Journal article	Population	Questionnaire-based	P1: "pre-confinement"^{op}; P2: 15 Mar-21 June 2020^{op}
Puppi ML (2023).International Journal of Environmental Research and Public Health doi:https://doi.org/10.3390/ijerph20032028	Italy	Journal article	Healthcare	Electronic records	P1: 2017-2019^{op}; P2: 2020-2021^{op}
Reina F (2022). European Psychiatry doi:https://doi.org/10.1192/j.eurpsy.2022.362	Italy	Journal article	Child protection services	Electronic records	P1: 2019^{op}; P2: 2020 ^{op}; P3: Jan-Aug 2021^{op}
Rengasamy ER (2022). Child Abuse and Neglect doi:https://doi.org/10.1016/j.chiabu.2021.105386	UK	Journal article	Healthcare, Child Protection Services and Population	Electronic records	P1: 23 Mar-30 Sep 2019^{op}; P1: 23 Mar-30 Sep 2020^{op};
Ribeiro R (2022). Victims & Offenders doi:https://doi.org/10.1080/15564886.2022.2052214	Portugal	Journal article	Social care (incl. NGOs)	Electronic records	P1: 22 March-3 May 2019^{op}; P2: 22 March-3 May 2020^{op}
Riddell AS (2022). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2022-rcpch.466	UK	Conference proceeding (Abstract)	Healthcare	Medical record	P1: 2019-2020^{op}; P2: 2020-2021^{op}
Rittossa D (2022). Zbornik Pravnog Fakulteta Sveucilista U Rijeci doi:10.30925/zpfsr.43.2.2.	Croatia	Journal article	Judicial, Police	Police records	P^{LD}: Mar-May 2020^{op}, P^{PLD}: Jun–Sep 2020^{op}
Sari NP (2022). Child maltreatment doi:https://doi.org/10.1177/10775595211024748.	The Netherlands	Journal article	Population	Questionnaire-based	P1: Apr 2005–Jan2009^{op}, P2: 17 Apr–10 May 2020^{op}s
Schunk F (2022). Computers In Human Behavior doi:https://doi.org/10.1016/j.chb.2021.107035	German, Switzerland	Journal article	Population	Questionnaire-based	P1: "pre-pandemic"^{op}, P2: May–June 2020^{rp+op}
Soeiro C (2023). Social Sciences doi:https://doi.org/10.3390/socsci12020091	Portugal	Journal article	Social care (incl. NGOs)	Electronic records	P1: 2019^{op}; P2: 2020^{op}; P3: 22 Mar-3 May 2019^{op}; P4^{ldp}: 22 Mar-3 May 2020^{op};
Stivaros SM (2022). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-323,444	UK	Journal article	Healthcare	Electronic records	P1: Jan 2018-Feb 2020^{op}; P2: Apr 2020-Jul 2020^{op}
Teh C (2021). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-rcpch.18	UK	Conference proceeding (Abstract)	Child protection services	Electronic records	P1: (Q1)-2019/20^{op}; P2: "start of pandemic": (Q1)-2020/21^{op}
Timmis VF (2021). BMJ Pediatrics Open.doi:https://doi.org/10.1136/bmjpo-2021-RCPCH.86	UK	Conference proceeding (Abstract)	Healthcare	Medical records	P1: Apr-Jun 2019^{op}, P2: Apr-Jun 2020^{op}, P3: Sep-Nov 2020^{op}
van Koppen MV (2023). International journal of offender therapy and comparative criminology doi:https://doi.org/10.1177/0306624X221144298	The Netherlands	Journal article	Judicial, Police	Electronic records	P1: 16 Aug-30 Nov 2019^{op}; P2: 16Mar-30 June 2020^{op}
Vejmelka L (2021). Information doi:https://doi.org/10.3390/info12100399	Croatia	Journal article	Population	Questionnaire-based	Dec 2020^{rp}

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Table 1 (*continued*)

Primary research					
Reference	Country	Type of record	Setting	Source of information	Observation/reporting/literature search period
Vejmelka L (2022). Information (Switzerland).doi:https://doi.org/10.3390/info13120586	Croatia	Journal article	Population	Questionnaire-based	P1: 2017[rp]; P2: Dec 2020[rp]
Vermeulen S (2023). Child maltreatment. Doi:https://doi.org/10.1177/10775595211064885	The Netherlands	Journal article	Population	Questionnaire-based	P1: „period without Lockdown" (3 month in 2017)[rp], P2: May-Jun and Sep 2020[rp]
Combined: Cross-sectional (1st sample) / Cohort (2nd sample = subsample of 1st sample)					
Augusti EM (2021). Child Abuse and Neglect https://doi.org/10.1016/j.chiabu.2021.105156	Norway	Journal article	Population	Questionnaire-based	P1: Jan 2019[rp]; P2: Jun 2020[rp]
Cohort					
Barroso R (2022). Psicologia.doi:10.17575/psicologia.1715	Portugal	Journal article	Population	Questionnaire-based	P1: Sep-Dec 2019[op]; P2: 27Apr-30 April 2020[op]; P3: 22 Jun-26 Jun 2020[op]
Lazarescu AM (2022). JAMA Network Open doi:https://doi.org/10.1001/jamanetworkopen.2022.26182	France	Journal article	Healthcare	Medical record	P1: 2017[op]; P2: 2018[op],P3: 2019[op], P4: 2017-2019[op], P5: 2020[op], P6: 2021[op]
Leith E (2021). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-rcpch.533	UK	Conference proceeding	Healthcare	Electronic records	P1: 23 Mar2019–6 Sep 2019[o], P2: 23 Mar 2020–6 Sep 2020[op];
McDonnell C (2021). Pediatric Radiology doi:https://doi.org/10.1007/s00247-021-05192-8.	Ireland	Journal article	Healthcare	Medical record	P1:1 March 2016–28 Feb 2017[op], P2: 1 March 2017–28 Feb 2018[op], P3: 1 March 2018–28 Feb 2019[op], P4:1 March 2019–28 Feb 2020[op], P5: 1 March 2020–28 Feb 2021[op],
Salisbury T (2022). Br Ir Orthopt J. doi:10.22599/bioj.265	UK	Journal article	Healthcare	Medical record	P1: Mar–Jun 2019[op]; P2: Mar–Jun 2020[op]
Verheyden CE (2022). Child Abuse and Neglect doi:https://doi.org/10.1016/j.chiabu.2022.105903	Belgium	Journal article	Child protection services	Electronic records	P1: 13 Mar 2017–14 May 2017[op]; P2: 13 Mar 2018–14 May2018[op]; P3: 13 Mar 2019–14 May 2019[op]; P4: 12 January 2020–12 March 2020[op]; P5: 13 March 2020–14 May 2020[op];
Case report/series					
Focardi MS (2022). Frontiers in Pediatrics doi:https://doi.org/10.3389/fped.2022.949922	Italy	Journal article	Healthcare	Medical record	P1: 2018-2019[op]; P2: 2020-2021[op]; P3: Mar-May 2019[op]; P4: Mar-May 2020[op];
Friday D (2020). International Journal of STD and AIDS. doi:https://doi.org/10.1177/0956462420967532	UK	Conference proceeding	Healthcare	Electronic record	"during the coronavirus pandemic"[op]
Heimann T (2021). Child Abuse Review https://doi.org/10.1002/car.2714	Germany	Journal article	Healthcare	Electronic record	15 Mar-20 May 2020[op]
Holt NJ (2022). Archives of Disease in Childhood 1 doi:https://doi.org/10.1136/archdischild-2022-rcpch.475	UK	Conference proceeding (Abstract)	Healthcare	Medical record	P1:2018[op], P2:2019[op], P3:2020[op]
Case-control					
Dack R (2021). Archives of Disease in Childhood doi:https://doi.org/10.1136/archdischild-2021-rcpch.580	UK	Conference proceeding	Healthcare and Child protection services	Medical and electronic records	1–14 Oct 2020[op]
Qualitative study design					
Driscoll J (2020). London: King's College London. https://ovidsp.ovid.com/ovidweb.cgi?T=JS&CSC=Y&NEWS=N&PAGE=fulltext&D=sopp&AN=SCIEa116f00000UubGlAAJ	UK	Report	Population, Healthcare, Child protection services, Social services	Interview-based	Jun-Sep 2020[rp]

(*continued on next page*)

Table 1 (*continued*)

Primary research					
Reference	Country	Type of record	Setting	Source of information	Observation/reporting/literature search period
van Gelde NE (2021). BMC health services research doi:https://doi.org/10.1186/s12913-021-06674-z.	The Netherlands	Journal article	(incl. NGOs), Judicial, Police Population, Healthcare, Social services (incl. NGOs), Judicial, Police	Interview-based	20 Aug-08 Oct 2020[rp]
Saurel-Cubizolles MJ (2022). Santé Publique doi:https://doi.org/10.3917/spub.216.0905	France	Journal article	Population, Healthcare	Interview-based	"1st semester of 2020"[op]
Tener DA (2020). Child abuse & neglect: doi:https://doi.org/10.1016/j.chiabu.2020.104779	Israel	Journal article	Child protection services	Interview-based	May 2020[rp]
Mixed study design					
Hietamäki J (2024). Violence and Victims doi:10.1891/VV-2022-0188.*	Finland	Journal article	Social care (incl. NGOs)	Questionnaire-based survey and focus group	P1: "12mo preceding the COVID-19 pandemic, which began in March 2020"[op], P2: " COVID-19 pandemic from March 2020"[op], P3: Dec 2020-Mar 2021[rp]
Holt NJ (2022). Archives of Disease in Childhood doi:10.1136/archdischild-2022-rcpch.475	Ireland	Journal article	Child protection services	Questionnaire-based survey	P1: pre-COVID[op], P2: COVID-19-LD [op], P3: 1 Sep 2020-12 Nov 2020[rp]
Ringrose J (2024). Youth doi:10.3390/youth4030066	UK	Journal article	Population	Quantitative part: questionnaire-based, qualitative part: interview-based	P1:May-Sep 2021[rp-questionnaire], P2: May-Jun2021[rp-interviews]
Tierolf B (2021). Child Abuse and Neglect doi:10.1016/j.chiabu.2020.104800	The Netherlands	Journal article	Child protection services	Questionnaire-based survey and qualitative interviews	P1: Jan-Feb 2020[rp]; P2: after 16 Mar 2020[rp];

measure of interest to our study question, the respective sample size and the outcome in connection with the time period described. We indicated whether included studies provided additional data which were not necessarily appropriate for the description of our study question, but also presented data in connection with the COVID-19 pandemic. In the quantitative studies, a distinction was made as to whether there was evidence (statistical significance on analysis) for an increase, no change or decrease in CM frequency. The study results are presented according to this meaning of evidence and in the following order: from increase in CM frequency, no change to a decrease in CM frequency. Qualitative research was presented similarly in a tabulated form describing participants, type of CM described, methods of analysis, key reported themes and whether the study data contained perceived information on CM increase, decrease or no change. Quantitative results of the included mixed methods studies were presented separately from the qualitative results of the respective studies in the quantitative result section. Vice versa the qualitative results of mixed studies were presented in the qualitative results section.

2.3. Role of the funding source

The funder of the study had no role in study design, data collection, data analysis, data interpretation, or writing of the report.

3. Results

3.1. Records selection process

A systematic search across multiple databases identified a total of 4658 records. After removing duplicates, 2496 titles and abstracts were screened, and 197 records were identified as potentially relevant. Of these, 195 underwent full-text review as two records could not be retrieved. An additional 856 records were identified through grey literature ($n = 883$) and expert recommendations ($n = 11$). Eight of those were identified as potentially relevant and reviewed in full. In total, 87 papers and reports met the inclusion criteria and were included in this scoping review. The selection process is presented in the PRISMA flow diagram (Fig. 1). A list of excluded references with reasons for exclusion and the two records that could not be retrieved is presented in Supplement table 2.

3.2. Characteristics of included papers and reports

Of the 87 included records, the highest number of studies originated from the United Kingdom ($n = 27$), then Germany ($n = 17$), and then France ($n = 9$). Seven papers reported on CM across multiple countries. Study designs were largely heterogeneous, ranging from case reports (Heimann, Berthold, Clemens, Witt, & Fegert, 2021) and case series to large population-based cohorts, with sample sizes of up to 1 million participants (Loiseau et al., 2021). The main characteristics of the included studies are summarised in Table 1. Seventy-two studies presented primary research, and 16 studies presented secondary research, which were not included in further analysis (Supplement table 3). All primary research studies included in the review were observational in design. The majority were quantitative ($n = 64$, 89 %), with three (4 %) using qualitative and four (6 %) mixed methods. Among the quantitative studies, most employed a cross-sectional design ($n = 52$, 81 %), followed by cohort (n = 6, 9 %), case report/series ($n = 4$, 6 %), combined cross-sectional / cohort (n = 1, 2 %), and a single case-control study (n = 1, 2 %). Primary research records originated mainly from healthcare ($n = 38$, 53 %) and population-based ($n = 25$, 35 %) settings. The studies were published between April 2020 and November 2024. Most of these studies were published in 2022 (n = 27, 38 %), in 2021 ($n = 20$, 28 %) and in 2023 ($n = 16$, 22 %). Other settings included child protection services ($n = 12$, 15 %), social services including NGOs (n = 5, 7 %), judicial or police settings (n = 5, 7 %). Six records included data from multiple settings. The most common data sources in quantitative studies were medical records (n = 25, 39 %), electronic records ($n = 21$, 33 %) or questionnaire-based (n = 20, 31 %). One study used police records (2 %) and another combined questionnaire- and interview-based data (2 %). All qualitative studies were interview-based including focus group interviews, while mixed-methods studies used questionnaires alone or in combination with interviews. The primary research studies investigated all types of CM, with 32 (44 %) investigating multiple types. Of those included, 42 studies (58 %) examined physical abuse, 24 (33 %) sexual abuse, 25 (35 %) psychological abuse, and 18 (25 %) neglect. Online abuse, including cyberbullying, online grooming and image-based abuse, was reported in 11 studies (15 %), and seven studies (10 %) addressed children as victims of domestic violence. Twelve studies (17 %) used general terms, such as “child maltreatment” or “child abuse and neglect”. Four studies (6 %) used alternative descriptions. The distribution of study focus by type of CM is presented in Fig. 2.

3.3. Quantitative findings of CM trend during the COVID-19 pandemic

Supplement table 4 summarises findings from 66 quantitative primary studies included in the review. Of the 66 quantitative records included (64 quantitative-only and two mixed methods), 44 did not provide statistically significant evidence of an increase, decrease or a change of CM during the COVID-19. In contrast, the remaining 22 records provided statistically significant evidence (referred to as “evidence”) as concluded by the respective authors of an increase, decrease or no change. 14 records reported evidence of an increase in at least one type of CM (Augusti, Myhre, Wentzel-Larsen, & Hafstad, 2023; Bell et al., 2023; Caron et al., 2022; Holt, Elliffe, Gregory, & Curry, 2023; Lazarescu et al., 2022; Loiseau et al., 2021; Massiot et al., 2022; McTier & Soraghan, 2022; Obry et al., 2023; Puppi, Rota, Scotti, Rabbone, & Gino, 2023; Salisbury, Qurashi, & Mansoor, 2022; Sari & van IJzendoorn, 2022; Vejmelka, Matkovic, & Rajter, 2022; Vermeulen, Alink, & van Berkel, 2023). Nine reported evidence of a decrease, (Bell et al., 2023; Bruns et al., 2022; Caron et al., 2022; Garstang et al., 2020; Grzejszczak, Gabryelska, Gmitrowicz, Kotlicka-Antczak, & Strzelecki, 2022; Hennocq

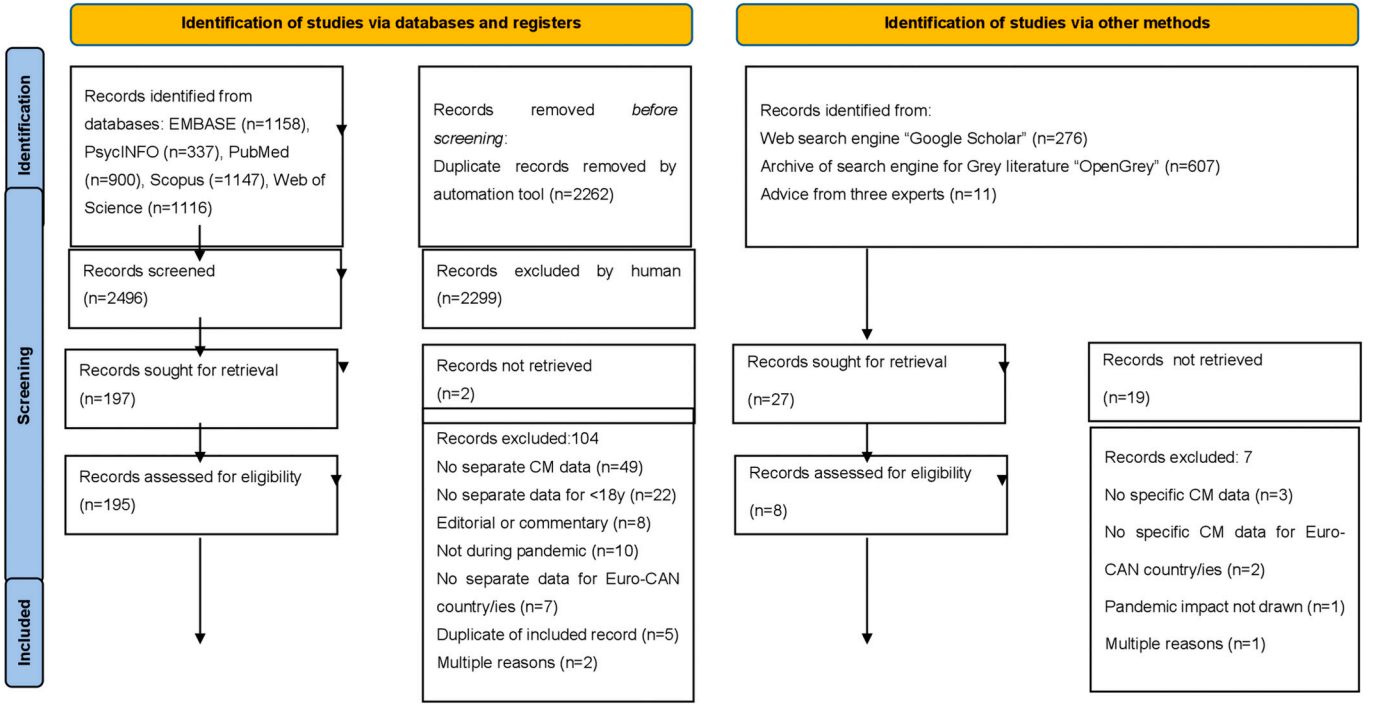

Fig. 1. PRISMA flowchart of papers selection process.

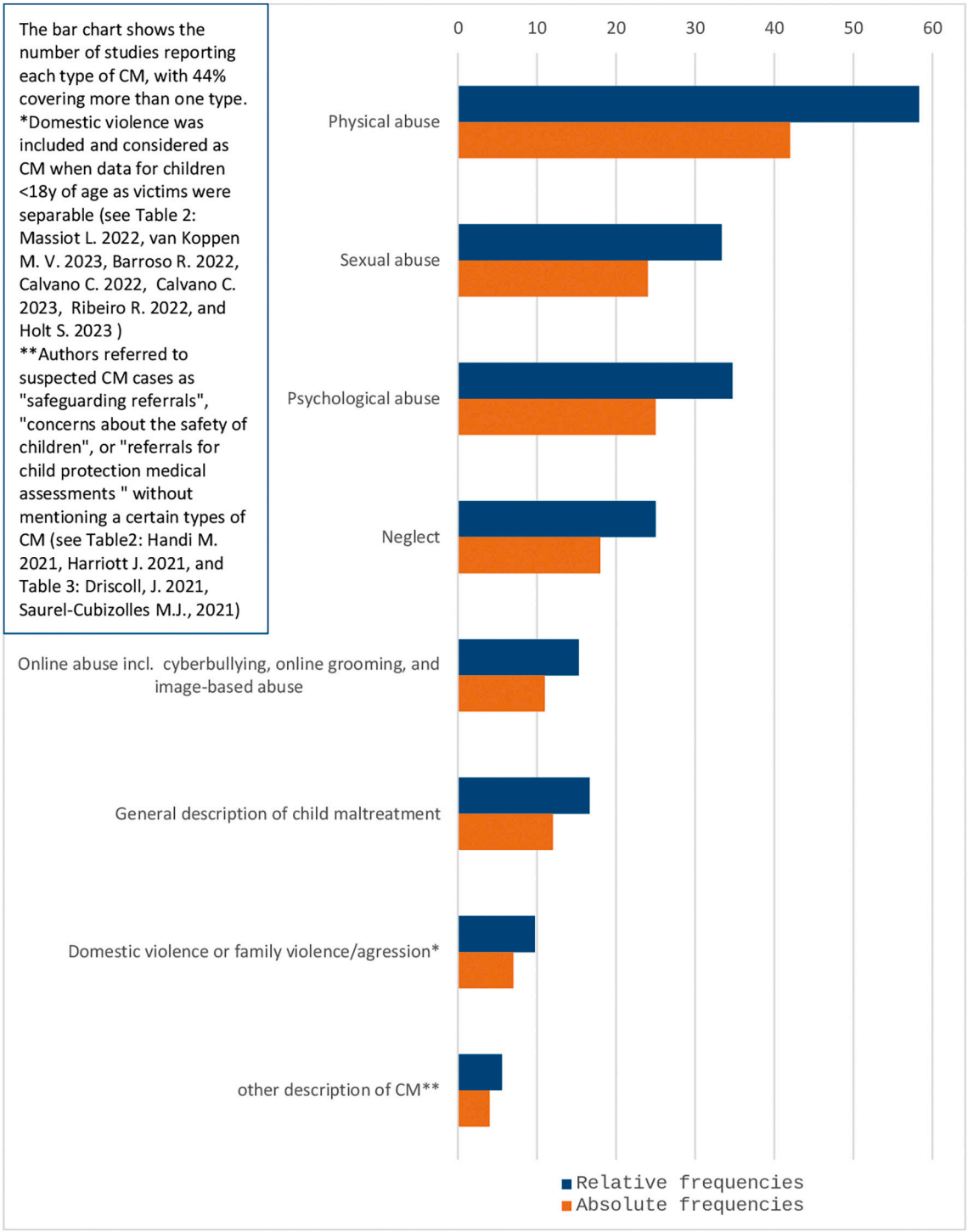

Fig. 2. Frequencies of CM types.

et al., 2022; Massiot et al., 2022; McTier & Soraghan, 2022; Vejmelka et al., 2022). Thirteen records found evidence of no-change in CM frequency compared to the pre-pandemic period (Akova et al., 2023; Augusti et al., 2023; Grzejszczak et al., 2022; Hennocq et al., 2022; Lazarescu et al., 2022; Massiot et al., 2022; McDonnell et al., 2022; McTier & Soraghan, 2022; Puppi et al., 2023; Stivaros et al., 2022; Tierolf, Geurts, & Steketee, 2021; van Koppen, Bruggeman, Houston, & Harte, 2023; Verheyden, Van Dooren, Van Holen, Stroobants, & Vanderfaeillie, 2022). Several studies presented mixed findings. Twelve records showed combinations of statistically significant evidence for increase, decrease, and/or no change across different CM types. Moreover, two records reported statistically

significant evidence of increases in some outcomes but no statistically significant evidence in other outcomes on CM rates presented in the same record. The number of records reporting statistically significant evidence on CM in- or decrease or no-change or combinations of these are tabulated in Supplement table 6.1. Number of evidence (statistically significant) on CM in- or decrease or no change in total, per type of CM, per country, per setting and per data source are tabulated in Supplement table 6.2. We found the largest number of studies reporting statistically significant evidence for an increase, decrease or no-change in rates of physical abuse (18 records). In addition, we found 13 records reporting statistically significant changes in rates of psychological abuse, seven in sexual abuse and 11 in neglect. It is important to note here that physical abuse was the only type of CM for which we found statistically significant evidence of an increase, decrease or no change, when it was the only type of CM reported in the records. All other CM types were reported in various combinations with other types of CM. This means that we could not perform a separate analysis for the other types of CM except for physical CM. Of all studies reporting on physical abuse, in combination with other types of CM or alone, 11 studies showed a significant increase in CM during COVID-19, another nine showed no change and six showed a decrease. Regarding the studies that only reported physical abuse, the picture is similar: four studies report an increase, three report no change and one reports a decrease in physical abuse rates of prevalence estimates. Although we could not consider sexual abuse, psychological abuse and neglect separately, we found a tendency for sexual abuse to increase. Five records showed a statistical significant increase, five studies showed no-change and two studies showed a decrease. For psychological abuse and neglect we found a more balanced picture. For psychological abuse, six studies showed a statistical significant increase, five studies showed no-change and five studies showed a decrease. For neglect there were five records with evidence for a statistical significant increase, five records with no-change and four with a decrease. The greatest number of the statistical significant evidence on CM increase and/or decrease and/or no change, came from studies conducted in France (six records). UK studies (four records) were next, followed by the Netherlands (three records) and Ireland (three records). To better understand country-specific trends, we examined the settings and data sources for each study. Among studies from France (six records), all evidence came from healthcare settings, split equally between medical records and electronic health records. UK studies (four records) mostly relied on healthcare data as well (two medical records, one electronic records), with one study using judicial/law enforcement data. In Ireland (three records), two studies used healthcare data based on medical records, while one study was based on child protection service (CPS) data. In contrast, none of the four studies from the Netherlands relied on healthcare sources. Instead, two used population-based questionnaire data, one used CPS questionnaire data, and one drew from judicial/police sources. Notably, all statistically significant evidence from France was derived from healthcare settings either from medical records (three records) or from electronic records (three records). It is striking that five of these studies reporting on physical abuse data (three studies exclusively physical abuse data, two studies physical abuse and other types of CM) documented evidence for an increase of CM. Among studies that reported exclusively on physical abuse, all found statistically significant evidence of an increase but none found evidence of a decrease. One of those three studies also reported data showing no-change of CM rates in addition to the data that reported an increase. Two additional studies that included physical abuse along with other types of CM also reported decreases of CM, but these were observed in the other CM types. Finally, one study that did not distinguish between CM types reported only statistically significant evidence for no-change and decrease of CM, without any evidence of an increase. In contrast to the identifiable trends observed in French data, which allowed for clearer description, the studies from the UK, Ireland and The Netherlands, were more variable and did not yield similarly consistent trends. In the UK three out of four studies drew on healthcare data. Two of these studies reported exclusively physical abuse data and one study reported data on psychological abuse and neglect to physical abuse. These studies showed greater diversity by reporting an increase, no change and a decrease. The fourth study from the UK based on judicial/police data without specifying types of CM, also presented more mixed findings (an increase, a no-change and a decrease in one study). In Ireland, evidence indicated a slight tendency toward increases in CM. General CM data from a child protection service setting showed only an increase, whereas two healthcare-based studies, revealed a more even distribution across increase, no change, and decrease in CM. Of these, one reported exclusively physical abuse and the other reported physical abuse in combination with other types of CM. Interestingly, none of the Dutch studies used healthcare data. Instead, two studies used questionnaire-based population data, one study with questionnaire-based child protection service data and one study with judicial/police data. Both population studies showed an increase in CM, while the child protection service and judicial/police data showed no changes.

3.4. Qualitative findings of CM trend during the COVID-19 pandemic

Eight papers with qualitative data provided in-depth insights of CM during the pandemic. Almost all the data analysis were thematic (seven records). Most of the studies (six records) were conducted among health or social professionals. One study was based on the work of the French High council for Public Health. Two studies were conducted with young patients who had potentially experienced violence. Most of the studies focused on domestic violence in general, and two were specifically concerned with cyberbullying and sexual violence. Key themes identified included; increased concerns about children's safety during school closures, a change in the number of referrals to the respective authorities due to suspected CM, modified patterns in regard to suspected type of abuse (e.g. increase in coercive control, online threats including cyberbullying and image-based abuse). Supplement table 5 illustrates the key themes and sub-themes derived from qualitative analyses.

4. Discussion

This scoping review provides the most comprehensive synthesis to date of evidence on CM trends in Europe during the COVID-19 pandemic and its aftermath (2020–2024). Data from 87 studies across 34 countries and multiple sectors revealed the significant fragility of European child protection systems under crisis conditions. The findings advance understanding in three main ways: 1.

documenting the diversity of evidence across settings and countries, 2. identifying the most consistent signals of increased CM, particularly in healthcare-based data from France, where detection and reporting continued during lockdowns, 3. inconsistent definitions and reliance on institutional data that limit the interpretability and comparability of findings. This review reveals significant variation in recorded CM across Europe during the COVID-19 pandemic. Most included studies came from healthcare (53 %) or population-based (35 %) settings, while sectors like child protection services, NGOs and social services, or judicial system were less represented. Geographically, the evidence base was uneven, with certain countries like the UK, Germany, and France being most represented. No healthcare data were available from the Netherlands. Evidence from low- and middle-income countries was largely absent. Vulnerable minorities, like children form immigrant background, as well as children with disabilities or in out-of-home care were underrepresented. This imbalance may reflect access constrains during the pandemic, as well as sectoral differences in data infrastructure and research capacities. This reflects both the fragility and potential resilience of child protections systems under crisis situations. Possible contributing factors to this underrepresentation are barriers in accessing healthcare, protective services and other community based institution, like kindergartens and school, during the pandemic (Marmor, Cohen, & Katz, 2023; WHO, 2022). It highlight the critical role of community-based professionals, such as teachers, pediatricians, social workers, and other frontline service providers, in identifying and reporting CM. In Europe, early in the pandemic, school and kindergarten closures were among the most broadly implemented public health measures, as tracked by the Oxford COVID-19 Government Response Tracker (OxCGRT) and expert panels (Paulo et al., 2023). While these closures were intended to reduce viral spread, they disrupted routine contact points where children are regularly observed by community reporters. For instance, school closures were associated with sharp declines in reports of suspected CM, particularly from education professionals who normally serve as mandated reporters, especially for children with disabilities and those from poorer backgrounds (Chaabane, Doraiswamy, Chaabna, Mamtani, & Cheema, 2021). Similar patterns were seen in US national child protection data, where school-based reporting dropped markedly during the early pandemic (Shusterman, Fluke, Nunez, Fettig, & Kebede, 2022). Our review revealed mixed findings regarding trends in CM occurrence from included studies with some showing increases, others showing decreases, or no change. The clearest signal came from France, where rises in hospital-detected physical abuse were consistent across data sources. In contrast, findings from the UK, Germany, the Netherlands, and Ireland were less consistent, with different sectors showing divergent patterns. These French figures may appear surprising compared to findings from other countries. Still, multiple French studies consistently reported increases in confirmed CM cases during lockdown. These results were based mainly on different healthcare data source, including national and hospital records. The findings were further supported by helpline statistics and ministerial reports. Notably, only two studies used national data, suggesting that the observed increase was not limited to one database. As already mentioned above, this stands in sharp contrast with findings form the US, which consistently reported declines in CM-related hospitalisations and official reports (Kaiser et al., 2021; Rapoport et al., 2021). According to Oxford University analyses (Hale et al., 2023), lockdown in the US were generally longer and more restrictive than in France. Earlier school reopening and quicker reconnection to healthcare and social services in France may have facilitated the earlier detection and reporting of abuse compared to the US. This pattern may also point to relative resilience within parts of the French child protection system. Importantly, observed decreases in reported CM cases during lockdowns must be critically interpreted with caution, in light of long-standing issues of underreporting. Official statistics often reflect only a fraction of actual cases, largely due to barriers in disclosure, under-recognition by professionals, and systemic gaps in surveillance and reporting (Everson et al., 2008; Lynne et al., 2015; Mathews et al., 2016). This underestimation is particularly pronounced during emergencies like COVID-19, when many standard reporting channels are disrupted (Cappa & Jijon, 2021; Jud et al., 2024). As such, declining reports may reflect impaired detection rather than reduced incidence. This is not merely a methodological limitation but a substantive finding that highlights as well the fragility of child protection infrastructures under crisis conditions. For example, if in several European countries, official reports from education sources to social services had dropped substantially during school closures, while healthcare-based reporting had shown smaller declines or vice versa, this would indicate that different reporting types are unequally affected by crisis conditions. Furthermore, the included qualitative studies offered important contextual insights. Professionals across health and social services consistently expressed increased concerns about children's safety during school closures and documented changes in referral pathways and patterns of suspected abuse. Overall, while the true burden of CM during the pandemic cannot be precisely quantified, system weaknesses are clear. Cases were less likely to be identified when schools closed, but it seems that detection remained more robust in healthcare, where physical abuse was more often identified. This indicates that apparent declines in CM reports reflected impaired detection rather than a trued decrease in incidence, a pattern consistently observed in global reviews (Cappa & Jijon, 2021; Jud et al., 2024; Mojahed, Mack, Specht, Sandoz, & Garthus-Niegel, 2023; Rapp, Fall, Radomsky, & Santarossa, 2021).

4.1. Comparisons with other reviews

Numerous global reviews on children's exposure to violence during the COVID-19 pandemic have been published (Cappa & Jijon, 2021; Carsley et al., 2024; Garner et al., 2024; Huang et al., 2023; Jud et al., 2024; Karbasi, Safdari, & Eslami, 2022; Lee et al., 2023; Letourneau et al., 2022; Marmor et al., 2023; Mojahed et al., 2023; Niu et al., 2024; Rapp et al., 2021), most of which do not focus specifically on Europe. These reviews also faced challenges regarding heterogeneity in case definitions, sampling strategies, data sources, data collection and reporting practices; outcome measures, analytical approaches, observation periods; and in some cases, how these issues were addressed (Jud et al., 2024). Our focus on Europe (Euro-CAN countries) and the extended time frame (2020–2024) provides distinctive insights that global reviews may obscure. Just as recent epidemiological modeling work uses graph theory to show how local network structure significantly alters COVID-19 spread dynamics compared to global models uses (Adamopoulos et al., 2025), our regional focus offers similar value. It enables detection of sector-specific reporting patterns and detection across sectors (healthcare versus education), discover country-specific underrepresentation of vulnerable groups, and better

trace how public health measures (like school closures) affect reporting systems. This regional perspective thus strengthens the contribution of our study by highlighting what is unique in Europe and what policy implications may be distinct from those observed in non-European contexts. Two systematic reviews by Niu et al. (Niu et al., 2024) and Lee et al. (Lee et al., 2023) investigating global rates of CM, included European studies, but these did not examine changes relative to pre-pandemic baselines. According to Niu et al. (Niu et al., 2024) emotional violence and peer bullying were the most frequently reported forms of CM, while physical violence was less commonly identified. Lee et al. (Lee et al., 2023), who focused specifically on physical and psychological abuse, reported psychological violence in 38 % of cases and physical violence in 18 %. In contrast, in our review, physical abuse was the most frequently reported form of CM. The methodological differences, specifically in data source type, recall period, and search scope, may account for the higher prevalence of physical abuse observed in our findings compared to those reported in Lee et al. (Lee et al., 2023) and Niu et al. (Niu et al., 2024). On the other hand, part of our results concur with other reviews: increases in CM during the COVID-19 pandemic were most consistently observed in healthcare-based studies (Cappa & Jijon, 2021; Mojahed et al., 2023; Rapp et al., 2021), whereas administrative data from non-healthcare sources often indicated a decrease (Jud et al., 2024; Mojahed et al., 2023; Rapp et al., 2021).

Most published reviews did not separate out different types of CM (Carsley et al., 2024; Garner et al., 2024; Jud et al., 2024; Marmor et al., 2023; Mojahed et al., 2023; Niu et al., 2024; Rapp et al., 2021). Those that did, found that physical abuse was the most frequently reported (Cappa & Jijon, 2021; Huang et al., 2023). Our review supports this: 58 % of included studies examined physical abuse, with psychological abuse and sexual abuse reported in 35 % and 33 % of studies, respectively. We also noted a greater awareness of image-based abuse and online sexual abuse since the pandemic (Anillo, Feldman, & Kennedy, 2023; Oostrom, Cullen, & Peters, 2023; Ringrose, Milne, Horeck, & Mendes, 2024). This aligns with broader concerns about digital harms emerging in recent years (Childlight – Global Child Safety Institute, 2024). In our review only 10 % of included papers focused on the impact of domestic violence on children, which may reflect the fact that domestic violence has only recently been formally recognized as a form of CM in classifications such as ICVAC (UNICEF, 2025).

4.2. Strengths and limitations of the review

This review offers a number of notable strengths. To our knowledge, it is the most temporally comprehensive review focused on CM during the COVID-19 pandemic in Europe covering studies between January 2020 and November 2024. By including a wide range of data sources across multiple sectors and data types, the review provides a broad and detailed overview of the available evidence. This is reflected in the tabular presentation of findings (see Table 1, Supplement table 3–6), which illustrates the geographic, sectoral, and data source coverage, and maps the results of 66 quantitative records ordered by reported statistically significant evidence on CM in- or decrease or no change (Supplement table 4), as well as the relevant results of 8 quantitative studies. This structured mapping enables direct response to the central research question in a clear an systematic manner to inform future research and policies. However, several limitations must be acknowledged. Recurring across the included studies were the lack of definitional consistency, the pervasive underreporting linked to a heavy reliance on institutional data sources and the scarcity of standardized national registers, and the heterogeneity of study designs, outcome measures, and observation periods. As well, data quality and validation of included were generally poor. Very few studies discussed biases, sample representativeness or data completeness. Although we only focused on empirical studies reporting original quantitative or qualitative data contrary to other reviews that included letters or commentaries (Cappa & Jijon, 2021; Kourti et al., 2021; Rapp et al., 2021; Saulle, Minozzi, Amato, & Davoli, 2021; Viner et al., 2022), this did not substantially improve the overall quality or comparability of the available evidence. Central to our review and evident across the underlying evidence base and standard reporting systems, is the persistent lack of standardized definitions of CM. CM encompasses a broad and complex set of behaviors and harms, yet the terminology and thresholds used to identify, report, and record cases vary widely across countries and sectors (Cowley et al., 2025; Jud et al., 2024; UNICEF, 2025). Many studies used overlapping or ambiguous terminology (e.g., “violence” or “assault”) or partial definitions, and some included forms of CM such as peer violence or online exploitation, while others did not. This made it difficult to assess comparability or ensure consistent inclusion. To address this, we applied the WHO classification framework and included only those studies where operational definitions could be clearly mapped. Even so, definitional inconsistency and the lack of coordinated data collection systems, restricted comparability across studies, hindered the interpretation of cross-national trends, and complicated the assessment of system responsiveness under crisis conditions. In addition, while conducting a meta-analysis was not the aim of this review, the vast heterogeneity of study designs, definitions, and data sources would have made quantitative analysis inappropriate. During the pandemic, these discrepancies became especially consequential, as detection patterns seem to have shifted from education and child protection services to healthcare-based settings. Without a shared conceptual and operational foundation, it is difficult to determine whether observed changes reflect true shifts in CM prevalence, changes in reporting and detection, or methodological artefacts. This underscores the urgent need for harmonised CM definitions and classification frameworks, but also for resilient intersectoral surveillance systems that can maintain detection and reporting capacities during crises. Strengthening these foundations should be a policy priority to improve child protection preparedness across contexts for future public health emergencies (Cowley et al., 2025; WHO, 2006). Another major limitation across the included studies is the lack population-based surveillance and the heavy reliance on institutional and administrative sources, such as hospital records, police reports, or administrative child protection data, which are known to underestimate the true scope of CM due to systemic underreporting and dependence on formal detection mechanisms (Jud et al., 2024). Data from child protection services, NGOs, law enforcement, and judicial systems were limited. Furthermore, the absence of studies from low- and middle-income countries within Europe, particularly those in Eastern and Southeastern regions, limits the generalizability of our findings. These countries often face greater structural challenges in child protection systems (Eurochild, 2024; European Union Agency for Fundamental Rights, 2015; Nikolaidis et al., 2012). Their underrepresentation may obscure important variation in system resilience,

especially during the pandemic, and restricts insights into the full spectrum of vulnerabilities that exist within the European context. Similarly, gaps in the representation of vulnerable populations emerged across the evidence base. Children from ethnic minority and immigrant backgrounds, as well as children with disabilities or in out-of-home care were underrepresented. Possible contributing factors to this underrepresentation are barriers in accessing healthcare, protective services and other community based institution, like kindergartens and school, during the pandemic (Marmor et al., 2023; WHO, 2022). It highlight the critical role of community-based professionals, such as teachers, pediatricians, social workers, and other frontline service providers, in identifying and reporting CM. Finally, to ensure we captured all relevant published information, our literature search covered from January 2020 to November 2024. This inclusion period, allowed for coverage of the entire pandemic through to post-pandemic, making it the most temporally comprehensive European-focused review to date. However, the added value of this extensive timeframe must be balanced with caution due to persistent heterogeneity in study designs, populations, settings, definitions, and outcome measures, all of which limit comparability.

Also, the varied and inconsistently reported lockdown periods across the European countries made it impossible to evaluate associations between public health restrictions and CM outcomes, and this is another limitation of our review. These challenges are not merely technical, they shape what can be known about CM and where policy interventions are most urgently needed. By highlighting these systemic limitations and synthesizing evidence from a uniquely European lens, this review contributes new insights for cross-country learning. It offers a stronger empirical basis for developing more resilient child protection systems in preparation for future crises.

4.3. Implication for research and policy

Given these limitations, the feasibility of a conventional systematic review or meta-analysis based on the current evidence base is low. If future researchers aim to undertake such an analysis, it may be more appropriate to narrow the scope to specific CM types, such as physical abuse within defined settings like healthcare in the European region, where definitions and reporting mechanisms are relatively more standardized. Population-based prevalence studies conducted both before and during the pandemic would provide the most reliable evidence to assess trends in CM (Fluke et al., 2021). However, such studies remain extremely scarce. Much of the currently available evidence derive from institutional or administrative sources, which are known to identify and document a small percentage of real CM cases. This review underscores the need for high-quality, population-based data across Europe. Beyond issues of data completeness, the uneven impact of the pandemic on reporting mechanisms across sectors points to deeper structural fragilities. In several European countries, reports from education and social service sectors declined sharply during school closures, while healthcare-based reporting often showed smaller declines, or in some cases increases. These differences reveal that detection systems are unequally resilient under crisis conditions. Comparative examination of these sectoral responses could help identify the structural supports and coordination mechanisms needed to sustain detection and reporting capacities during future emergencies. Strengthening such intersectoral resilience should be a central policy goal for child protection preparedness. Several studies from France stood out for the consistent increases in hospital-detected physical abuse during lockdowns, in contrast to declining reports elsewhere. These patterns suggest that parts of the French healthcare system remained resilient and functional during the crisis. Continued access to hospital care and earlier school re-openings may have supported sustained detection. Identifying and understanding the structural features behind this resilience could offer valuable lessons for strengthening child protection systems across Europe. Although, this review highlights the need for future research to focus on specific types of CM within well-defined settings, using harmonised definitions and timeframes. For example, examining physical abuse trends within population-based healthcare datasets could be a feasible next step, though even this would require caution given national differences in diagnostic coding and service access (Cowley et al., 2025; Jud et al., 2024; UNICEF, 2020).

5. Conclusion

To our knowledge, this scoping review is the only review focused on CM trends in Europe during and after the COVID-19 pandemic and with the longest timeframe to date. While some findings suggest increases in physical abuse, particularly in hospital datasets, overall results remain mixed and inconclusive due to substantial heterogeneity across studies. This review makes a useful contribution by mapping the available evidence and exposing the significant methodological and definitional gaps that continue to impede robust conclusions. Rather than definitive answers, the findings highlight hypotheses worth testing in future research. Addressing these evidence gaps is crucial for building resilient systems to protect children in the face of future public health emergencies and global crises.

CRediT authorship contribution statement

Eva Anna Mora-Theuer: Writing – original draft, Formal analysis, Conceptualization. **Aideen Naughton:** Writing – review & editing, Methodology, Formal analysis. **Sinem Cankardas:** Writing – review & editing, Formal analysis, Conceptualization. **Clarissa Sammut-Scerri:** Writing – review & editing, Supervision. **Chryssa Grylli:** Writing – review & editing, Supervision. **Anastasia Pantazidou:** Writing – review & editing, Supervision. **Jolanta Pivoriene:** Writing – review & editing, Supervision. **Melanie Loiseau:** Writing – review & editing, Formal analysis. **Brigitta Kariene:** Writing – review & editing. **Johanna Schöggl:** Writing – review & editing, Methodology. **Nara Tagiyeva:** Writing – review & editing, Methodology, Conceptualization. **Catherine Quantin:** Writing – review & editing, Formal analysis.

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Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.chiabu.2025.107810.

Data availability

Post-publication, the study data will be made available to researchers upon request (E-mail address).

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