Mental Health Outcomes Associated with Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries

Rebecca Jane Harris

IUSSP 30th International Population Conference, 13-18th July 2025, Brisbane, Australia

Background and Rationale

In 2006, UNICEF estimated that between 133 and 275 million children globally were exposed to domestic violence and abuse (DVA), most often by witnessing violence between caregivers in the home (UNICEF, 2006). These figures have shaped global understanding and policy direction for nearly two decades, but were derived from a synthesis of studies – most from high-income countries – that varied widely in their definitions of DVA, methods of measurement, and population samples. Most of these studies did not use standardised tools or definitions of either exposure or DVA, raising questions about the validity and comparability of the resulting estimates, especially across low- and middle-income countries (LMICs), where children face disproportionate risks of both violence and structural disadvantage (UNICEF, 2006). In addition, the 2006 UNICEF estimates lacked data from entire regions, including Northern Africa and South-Eastern Asia, further limiting their global applicability and reinforcing the need for updated, geographically inclusive data (UNICEF, 2006).

Childhood exposure to DVA does not have a standard definition, but it is understood as when a child visually observes, overhears, is directly involved in, or witnesses the effects of violent acts between adults and caregivers in their home (Evans et al., 2008; Holden, 2003). A substantial body of evidence has found that childhood exposure to DVA is associated with a wide range of negative outcomes, including emotional and behavioural problems, mental health conditions such as depression, anxiety, and post-traumatic stress, difficulties in peer relationships, reduced educational attainment, and an increased likelihood of experiencing or perpetrating violence in later life (Evans et al., 2008; Holt et al, 2008; Kitzmann et al., 2003). Neurobiological and developmental pathways have been proposed to explain these associations, suggesting that chronic exposure to violence may alter stress responses, attachment systems, and patterns of social learning (De Bellis, 2001; Margolin, 2005). These effects are compounded in settings with limited access to child protection services, mental health care, or safe schooling environments – conditions that characterise many LMICs (Guedes et al., 2016).

Despite these risks, few countries systematically monitor childhood exposure to DVA. In global surveys on violence against children, items on direct physical or sexual abuse are often included, but exposure to DVA is frequently overlooked or inconsistently captured. Where data do exist, they tend to be drawn from convenience samples, clinic-based populations, or subnational studies, making it

difficult to derive nationally representative or internationally comparable estimates (Kieselbach et al., 2022). A recent multi-country study using VACS data in five Sub-Saharan African countries addressed this gap for broader adverse childhood experiences (ACEs), including witnessing interparental violence, and highlighted the high prevalence of such exposures using nationally representative data (Amene et al., 2024). However, no study to date has produced standardised, cross-national prevalence estimates focused specifically on childhood exposure to DVA – or translated those estimates into the absolute number of children affected. This absence of robust data has implications not only for research but also for the design and implementation of effective interventions and policies.

The COVID-19 pandemic has further heightened concerns about childhood exposure to DVA. Lockdowns, economic stress, school closures, and reduced access to services all increased the risk of violence within the home, while simultaneously increasing children's time at home and their likelihood of exposure to such violence (Van Gelder et al., 2020) and limiting opportunities for disclosure and support. Although some countries reported increases in helpline calls and DVA reports, the extent to which children were exposed remains largely undocumented. Renewed attention to this issue, particularly in LMICs, is therefore urgently needed.

A recent systematic review by Kieselbach et al. (2022) underscored the high prevalence of childhood exposure to intimate partner violence in LMICs, estimating a pooled lifetime prevalence of 29% across studies. However, the authors also highlighted significant heterogeneity in study methods, definitions, and measurement tools – with most studies lacking standardised or cross-culturally validated measures, a limitation common in research on childhood exposure to DVA (Harris et al., 2024). The present study addresses these gaps by using a harmonised item on exposure to interparental physical violence across ten nationally representative surveys, and using this item to explore mental health outcomes associated with childhood exposure to DVA. While the measure is necessarily narrow in scope, it provides one of the few opportunities to compare across multiple LMICs using a consistent definition.

This study addresses these gaps by providing updated prevalence estimates and associated mental health outcomes of childhood exposure to DVA using data from the Violence Against Children Surveys (VACS; Chiang et al., 2016). These nationally representative surveys, conducted in collaboration with national governments and technical partners, include a standardised item asking whether the respondent saw or heard physical violence between parents or stepparents. Although not originally designed to focus on childhood exposure to DVA, the VACS offer one of the only sources of harmonised, cross-country data on this form of harm in LMICs. Although one prior study analysed VACS data from three countries to explore associations between witnessing DVA and later mental distress (Kieselbach et al., 2021), no study to date has produced standardised, cross-national prevalence estimates using nationally representative data across multiple LMICs. This paper presents

the first multi-country analysis of these data, using surveys conducted between 2013 and 2019 across ten countries in Africa, Asia, Eastern Europe, and Latin America. By estimating both the proportion and absolute number of children exposed in each country, alongside associations with adverse mental health outcomes, this analysis contributes to a renewed evidence base for global, regional, and national action.

Data and Methods

Data Sources and Participants

This study draws on data from ten nationally representative Violence Against Children Surveys (VACS), conducted between 2013 and 2019 in Cambodia, Colombia, Côte d'Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, and Zambia. These surveys were coordinated by national governments with technical support from the US Centers for Disease Control and Prevention (CDC) and the Together for Girls partnership. They employed a multi-stage, stratified cluster sampling design to generate representative estimates of violence among males and females aged 13-24 (Chiang et al., 2016). Each survey adhered to a standardised protocol but was adapted for cultural and linguistic relevance in each setting.

All surveys received ethical approval from relevant national review boards and the CDC. Informed consent (or assent with parental consent for minors) was obtained from all participants. The current secondary analysis was approved by the University of Southampton.

Inclusion Criteria

Countries were included in this analysis if they met the following three criteria: (1) availability of full survey microdata via the Together for Girls data archive; (2) inclusion of a question assessing childhood exposure to interparental physical violence; and (3) sufficient sample size when disaggregated by sex for robust estimates. Six additional countries with VACS data were excluded due to inconsistent measurement of exposure (e.g. missing items, flawed skip patterns, or non-standardised wording), or substantial missing data.

Measurement of Childhood Exposure to DVA and Mental Health

Childhood exposure to DVA was defined as self-reported exposure to physical violence between caregivers before the age of 18. All ten surveys included a similarly worded item asking whether the

respondent had ever seen or heard one parent or stepparent physically attacking the other[1]. Any minor variations in question phrasing were reviewed to ensure that conceptual consistency of exposure. Responses were recoded into a binary variable indicating exposure (any frequency) or non-exposure. Responses of "don't know" or "declined to answer" were treated as missing and excluded from prevalence estimates.

Mental health was conceptualised by internalising and externalising symptoms, as these dimensions provide a comprehensive understanding of an individual's mental health status, covering emotional and behavioural aspects (Masten et al., 2005), along with contextual aspects (Nikstat & Riemann, 2020), making them a valuable measure in assessing mental health across an individual's life. The ten VACS datasets were examined in line with the literature review for variables related to internalising and externalising symptoms which were consistently asked across the datasets to allow for a multi-country analysis. Internalising symptoms included four outcomes: psychological distress in the past 30 days, and lifetime prevalence of intentional self-harm, suicidal thoughts, and suicide attempt. Externalising symptoms comprised three outcomes: engagement in risky behaviours in the past 30 days (defined as any one of binge drinking, drug use, or tobacco use), and lifetime prevalence of perpetration of physical domestic violence and physical non-partnered violence.

Statistical Analysis

Weighted prevalence estimates were calculated for each country and stratified by sex. Survey weights were applied to account for unequal probability of selection and non-response, in accordance with the VACS methodology (Centers for Disease Control and Prevention, 2022). For each estimate, 95% confidence intervals were computed. All analyses were conducted using Stata SE 17.

To contextualise the proportions of respondents who reported exposure, national population data from the 2024 revision of the UN World Population Prospects (United Nations Department of Economic and Social Affairs, Population Division, 2024) were used to estimate the absolute number of adolescents and young adults (aged 13-24) exposed to DVA in each country. This age group was chosen as it mirrored the age group sampled in the surveys, and as a result it does not reflect exposure amongst current children of all ages.

[1] It is important to note that this measure captures only one form of DVA exposure – seeing or hearing physical violence between caregivers – and does not include exposure to emotional abuse, coercive control, or any other indirect forms of exposure (Holden, 2003). While limited in scope, the item provides a rare opportunity to compare prevalence across diverse national settings using a consistent indicator.

To assess the association between childhood exposure to DVA and each mental health outcome, bivariate analysis, followed by binary logistic regression modelling[2] were used. Separate models were run for each country and outcome. Results are presented as odds ratios (ORs)[3] with 95% confidence intervals. The bivariate and regression analyses are presented in tables grouped by MDG Region[4] to allow for the examination of similarities and differences between and within regions.

Results

Prevalence of Childhood Exposure to DVA

Table 1 presents the prevalence of childhood exposure to DVA in each of the ten countries, disaggregated by sex, along with estimates of the absolute number of children affected. Figure 1 illustrates these patterns visually, highlighting variation across countries and between males and females.

Across the ten countries, self-reported exposure to DVA during childhood ranged from 11.80% to 30.68%. The highest prevalence was recorded in Malawi (30.68%), followed by Zambia (30.31%), Nigeria (29.60%), and Lesotho (29.12%). The lowest reported prevalence was in Honduras (11.80%). Namibia (15.45%), Moldova (17.36%), Côte d'Ivoire (17.69%), Colombia (19.68%), and Cambodia (20.41%) fell within a mid-range. These findings indicate substantial variation between countries, with countries in Sub-Saharan Africa generally reporting higher levels of exposure than those in Latin America or Eastern Europe.

Across all countries, females were generally more likely to report exposure before the age of 18 than males, with seven out of the ten countries in this situation. Females had significantly higher proportions in Moldova, Honduras and Nigeria. In Moldova, the difference between male and female prevalence rates exceeded nine percentage points (12.82% for males, 21.92% for females). The difference between the sexes was 7.11% in Nigeria and 5.59% in Honduras. Similar gender disparities were evident in Zambia (33.25% vs. 27.27%) and Colombia (23.39% vs. 16.12%), albeit without a significant difference. Conversely, in Malawi (31.12% males vs. 30.29% females) and Cambodia

[2] Variables also included in the model: respondent sex, education level, wealth, death of a biological parent, living with both biological parents, multiple children in household, exposure to community violence, and societal acceptance of DVA. The variable of 'suicide attempt' was not included in the regression analyses, as everyone within this variable would have also been included under the 'suicidal thoughts' variable. The 'suicide attempt' variable also had relatively low sample sizes across some countries.

[3] Although results are presented as odds ratios, predicted probabilities calculated from the same models demonstrated similar patterns of association. In all countries, those exposed to DVA in childhood had higher predicted probabilities of adverse mental health outcomes than their unexposed peers, supporting the robustness of the findings.

[4] Millennium Development Goal (MDG) regions are used throughout this paper for regional classification, to align with the UNICEF (2006) global estimates.

(21.24% vs. 19.57%), males were slightly more likely to report exposure although there was no difference statistically in the proportion affected by sex.

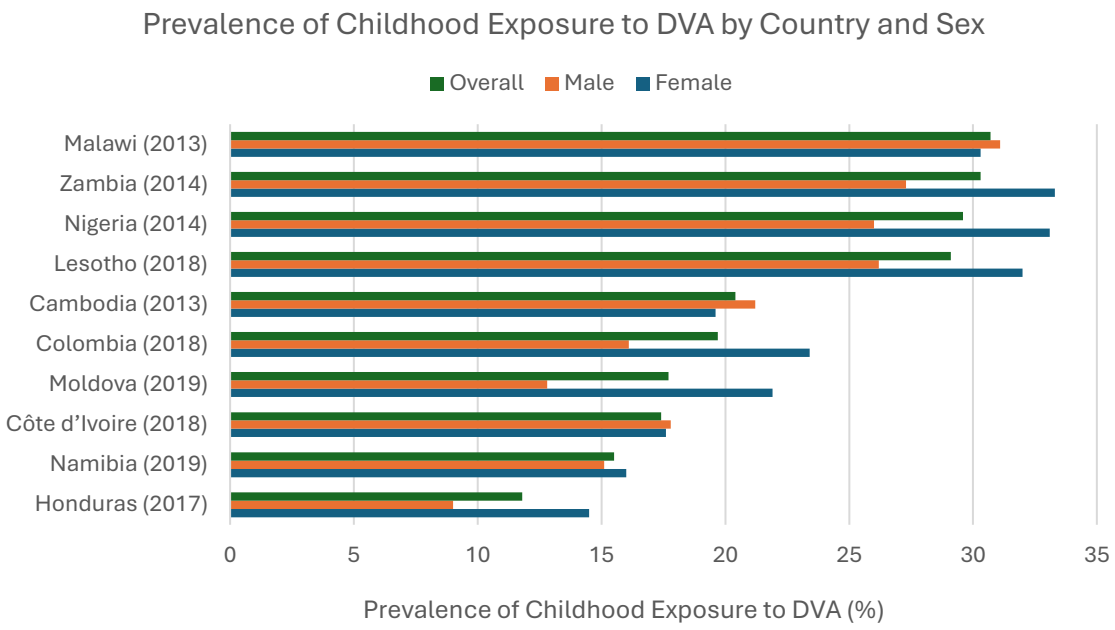

Figure 1 Prevalence of childhood exposure to DVA by country and sex

Estimated Number of Exposed Children

Based on population data from the 2024 UN World Population Prospects, an estimated 19.84 million adolescents and young adults (95% CI: 17.93-21.89 million) across these ten countries were exposed to DVA before age 18. Nigeria alone accounted for nearly 13 million cases, a figure driven by both its large population and relatively high prevalence rate. The six Sub-Saharan African countries included in this analysis (Malawi, Nigeria, Zambia, Lesotho, Namibia, and Côte d'Ivoire) account for an estimated 16.70 million cases.

In contrast, the four countries outside Sub-Saharan Africa (Colombia, Honduras, Cambodia, and Moldova) accounted for a combined 3.14 million, with Colombia contributing the majority (over 2 million). Smaller numbers, due to the smaller populations in these countries, were seen in Cambodia (769,182) and Honduras (288,990).

As expected, there are a higher number of females affected, with a total of 10.82 million across all countries, with the 95% confidence interval ranging from 9.37 million to 12.42 million. For males there are nearly 9 million affected (7.82 million to 10.24 million). Again, these differentials are driven by Nigeria, where there are 1.32 million more females affected than males.

Table 1 Estimates of Childhood Exposure to DVA in Ten LMICs

MDG Region	Country (Survey Year)	People Aged 13-24 Reporting Childhood Exposure to DVA in Ten LMICs					
		Prevalence (Weighted %, 95% CI)			Estimated Number Exposed (rounded, 95% CI)		
		Overall	Male	Female	Overall	Male	Female
Sub-Saharan Africa	Côte d'Ivoire (2018)	**17.69** (15.48-20.15)	**17.77** (15.06-20.84)	**17.62** (14.27-21.55)	**1,101,036** (963,484-1,254,148)	**569,582** (482,718-667,985)	**531,905** (430,777-650,542)
	Lesotho (2018)	**29.12** (26.83-31.52)	**26.23** (22.27-30.61)	**32.02** (30.31-34.10)	**156,013** (143,744-168,871)	**69,999** (59,431-81,687)	**86,099** (81,501-91,692)
	Malawi (2013)	**30.68** (27.43-34.14)	**31.12** (27.13-35.41)	**30.29** (25.28-35.81)	**1,240,310** (1,108,922-1,380,189)	**612,670** (534,118-697,129)	**628,214** (524,307-742,699)
	Namibia (2019)	**15.45** (13.64-17.46)	**15.05** (12.41-18.13)	**15.95** (13.60-18.62)	**94,959** (83,834-107,313)	**46,258** (38,144-55,725)	**49,007** (41,787-57,211)
	Nigeria (2014)	**29.60** (27.19-32.13)	**25.99** (23.09-29.12)	**33.10** (29.34-37.09)	**12,893,849** (11,844,046-13,955,925)	**5,760,249** (5,117,512-6,453,961)	**7,082,398** (6,277,872-7,936,137)
	Zambia (2014)	**30.31** (27.97-32.76)	**27.27** (24.44-30.30)	**33.25** (30.27-36.36)	**1,209,234** (1,115,878-1,306,978)	**539,857** (483,832-599,841)	**668,285** (608,391-730,793)
Latin America and the Caribbean	Colombia (2018)	**19.68** (16.21-23.68)	**16.12** (12.50-20.54)	**23.39** (17.73-30.21)	**2,012,112** (1,657,334-2,421,078)	**835,905** (648,189-1,065,105)	**1,178,536** (893,350-1,522,171)
	Honduras (2017)	**11.80** (10.77-12.91)	**8.95** (7.70-10.39)	**14.54** (13.03-16.18)	**288,990** (263,765-316,175)	**111,865** (96,254-129,863)	**174,361** (156,253-194,028)
South-Eastern Asia	Cambodia (2013)	**20.41** (18.32-22.68)	**21.24** (18.50-24.28)	**19.57** (16.47-23.09)	**769,182** (690,417-854,731)	**394,847** (343,911-451,359)	**373,724** (314,524-440,944)
Eastern Europe	Moldova (2019)	**17.36** (14.70-20.39)	**12.82** (9.78-16.62)	**21.92** (18.03-26.37)	**70,860** (60,003-83,228)	**25,767** (19,657-33,405)	**45,415** (37,356-54,635)

Association Between DVA Exposure and Mental Health Outcomes

The relationship between childhood exposure to DVA and seven adverse mental health outcomes was examined using both bivariate analysis (illustrated in Figures 2 and 3) and binary logistic regression. Results are grouped by internalising and externalising symptom domains.

Table 2 presents odds ratios (ORs) from the binary logistic regression models, showing the strength of association between DVA exposure and each mental health outcome, stratified by country. Statistical significance is indicated at the 10%, 5% and 1% levels.

Internalising Symptoms

Bivariate analysis revealed consistently higher prevalence of internalising symptoms: psychological distress, intentional self-harm, and suicidal thoughts, among individuals exposed to DVA during

childhood (Figure 2). In countries such as Colombia, Cambodia, and Moldova, exposed individuals reported notably higher levels of both mild/moderate and severe psychological distress[5]. The same pattern held for suicidal thoughts, with all countries showing higher lifetime prevalence among the exposed group, except for Nigerian males, where the difference was marginal.

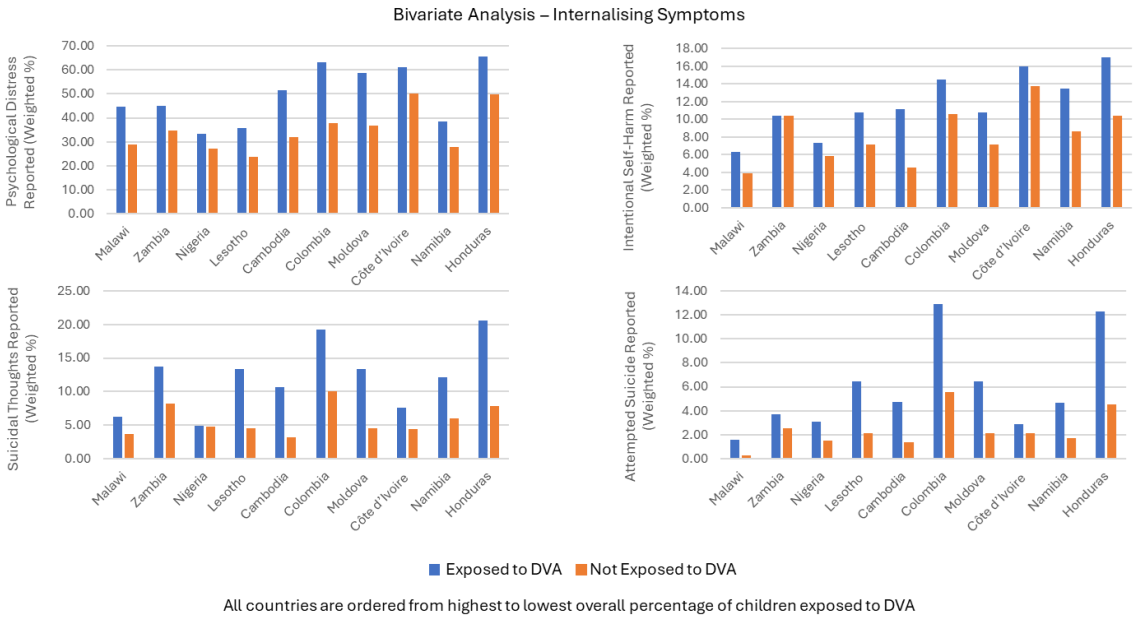

Figure 2 Clustered bar graphs illustrating the percentage of respondents reporting internalising symptoms (bivariate analysis)

Binary logistic regression models (Table 2) supported these findings. Exposure to DVA was significantly associated with increased odds of psychological distress in all ten countries, with odds ratios ranging from 1.31 (Nigeria) to 2.61 (Colombia). For suicidal thoughts, statistically significant associations were found in nine countries, with the strongest odds observed in Cambodia (OR = 3.43) and Moldova (OR = 2.22). In Nigeria, no significant difference was observed. Although intentional self-harm was more prevalent among the exposed in bivariate comparisons, significant associations in regression were limited to Cambodia (OR = 2.48) and Honduras (OR = 1.43), suggesting variability across countries.

Externalising Symptoms

As shown in Figure 3, exposure to DVA was also associated with higher prevalence of externalising symptoms, including engaging in risky behaviours, perpetration of DVA, and perpetration of physical

[5] Respondents were classed has having any psychological distress if they fit into the 'mild/moderate psychological distress' or 'severe psychological distress' category. The variable was based on the Kessler 6 (K6) scale (Kessler et al., 2003), an instrument which has demonstrated excellent internal consistency and reliability across different cultures and ethnic groups, including in many LMICs (Easton, Safadi, Wang, & Hasson, 2017; Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011; Van der Auwera, Debacker & Hubloue, 2012; Vissoci et al., 2018).

non-partnered violence. These differences were consistent across countries, although the magnitude varied.

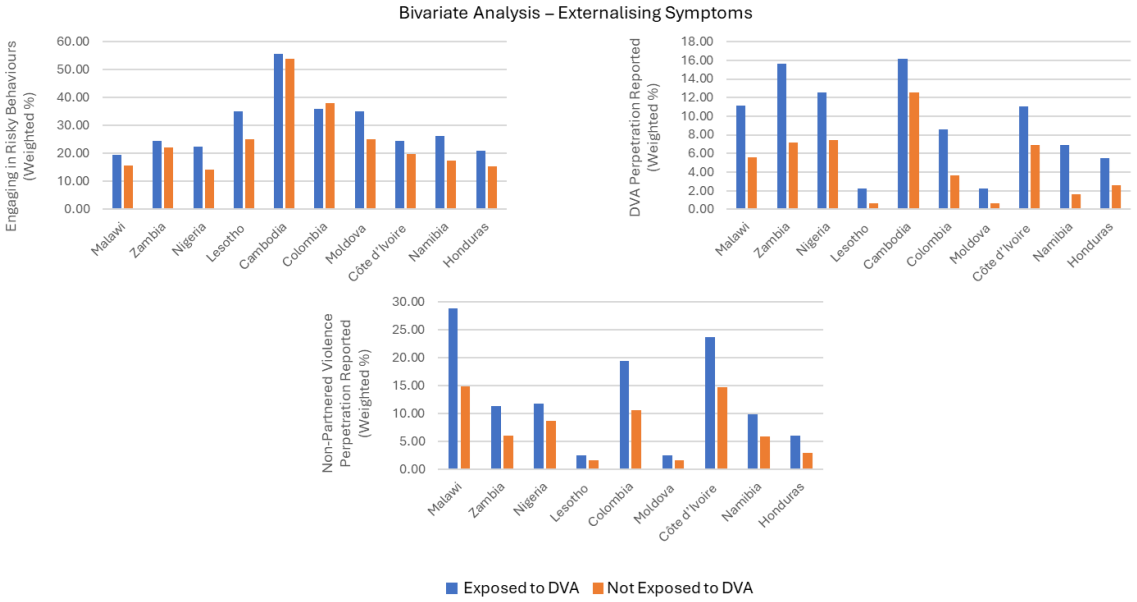

Figure 3 Clustered bar graphs illustrating the percentage of respondents reporting externalising symptoms (bivariate analysis)

Binary logistic regression models (Table 2) found significant associations between DVA exposure and risky behaviours in five countries, particularly Nigeria (OR = 1.61) and Namibia (OR = 1.27). Associations with DVA perpetration were significant in four countries, most notably in Namibia (OR = 3.95), Zambia (OR = 2.24), and Malawi (OR = 2.01). For perpetration of non-partnered violence, significant associations were observed in six of nine countries[6], with the highest odds recorded in Colombia (OR = 3.09) and Malawi (OR = 2.39).

[6] The variable on perpetration of physical non-partnered violence was not assessed in Cambodia due to the absence of the relevant question in that country's questionnaire.

Table 2 Associations Between Childhood DVA Exposure and Mental Health Outcomes, Presented as Odds Ratios.

MDG Region	Country (Survey Year)	Mental Health Outcome					
		Internalising Symptom			Externalising Symptom		
		Psychological distress (last 30 days)	Intentional self-harm (lifetime)	Suicidal thoughts (lifetime)	Risky Behaviours (last 30 days)	Perpetration of [Physical] DVA (lifetime)	Perpetration of [Physical] Non-Partnered Violence (lifetime)
Sub-Saharan Africa	Côte d'Ivoire (2018)	1.46***	1.09	2.01**	1.15	1.50	1.46*
	Lesotho (2018)	1.57***	1.36	1.98***	1.15***	1.82	1.90***
	Malawi (2013)	1.94***	1.39	1.78*	1.54	2.01***	2.39***
	Namibia (2019)	1.40**	1.30	1.70**	1.27***	3.95***	1.24
	Nigeria (2014)	1.31**	1.32	0.93	1.61***	1.41	1.11
	Zambia (2014)	1.40**	0.95	1.71***	2.38	2.24***	1.88***
Latin America and the Caribbean	Colombia (2018)	2.61***	1.29	1.84**	1.18	2.04	3.09**
	Honduras (2017)	1.61***	1.43***	2.32***	0.83***	1.67*	1.72***
South-Eastern Asia	Cambodia (2013)	2.15***	2.48***	3.43***	1.47	1.25	-
Eastern Europe	Moldova (2019)	2.25***	1.34	2.22***	0.97***	3.38	1.73

Note: *$p < .10$, **$p < .05$, ***$p < .01$.

Together, these findings demonstrate a consistent cross-national pattern: children exposed to DVA face significantly higher risks of both internalising symptoms (e.g. psychological distress, suicidal thoughts) and externalising behaviours (e.g. violence perpetration), with similar associations observed across countries and symptom types.

Discussion

This study provides new, standardised prevalence estimates of childhood exposure to DVA and its associated mental health outcomes in ten LMICs, based on nationally representative data (Chiang et al., 2016). These findings build on recent analyses of ACEs using VACS data in Sub-Saharan Africa (Amene et al., 2024), but offer a more focused lens on childhood exposure to interparental violence, with broader geographic coverage and estimates expressed in absolute population terms. Exposure to DVA was found to be widespread, with prevalence rates ranging from 11.80% to 30.68%. In absolute terms, nearly 20 million adolescents and young adults across these countries were estimated to have seen or heard physical violence between caregivers before the age of 18. These figures raise important

questions about the adequacy of global estimates and underscore the persistent under-recognition of this form of harm (UNICEF, 2006), as well as highlighting the scale and urgency of the issue.

Although the sample includes only ten countries, the estimated 19.84 million adolescents and young adults affected represents between 7.21% to 14.91% of the 2006 UNICEF global estimate (UNICEF, 2006) – suggesting that previous figures may substantially understate the current reality. Furthermore, despite being derived from just 6 of the 46 countries in the region, these results account for between 43.71% to 47.84% of UNICEF's 2006 regional estimate for the entire Sub-Saharan African region (UNICEF, 2006). The high rates of exposure observed in many of the countries, particularly in Sub-Saharan Africa, alongside the increased risk of adverse mental health outcomes, highlight the urgent need to prioritise childhood exposure to DVA in both research and policy agendas. The regional variation observed in this analysis also underscores the importance of context-specific understanding of risk. Countries in Sub-Saharan Africa tended to report higher prevalence rates of exposure than those in Latin America or Eastern Europe, reflecting both broader patterns of intimate partner violence in the region and lower access to child protection systems (De Bellis, 2001). These patterns also likely reflect cultural, social, and economic factors, as well as variations in how likely individuals are to disclose exposure within surveys.

In addition to documenting prevalence, this study provides new cross-national evidence linking childhood exposure to DVA with a wide range of mental health outcomes in adolescence and early adulthood. In nearly all countries, those who had witnessed interparental violence had significantly higher odds of experiencing internalising symptoms, including psychological distress, suicidal thoughts, and intentional self-harm, as well as externalising symptoms such as risky behaviours and the perpetration of physical violence. These findings are consistent with longstanding evidence from high-income countries (e.g., Kitzmann et al., 2003; Evans et al., 2008), but extend the global evidence base by demonstrating that these associations hold across diverse cultural and geographic contexts. Although some variation was observed across countries and outcomes, the direction and magnitude of effects were strikingly consistent. These results suggest that childhood exposure to DVA functions as a strong and consistent, cross-national risk factor for poor mental health, with implications not only for individual wellbeing but also for patterns of violence and public health more broadly. The findings support theories of intergenerational transmission of violence and social learning (Bandura, 1973; Widom, 1989), reinforcing the urgency of early intervention and trauma-informed responses. These mental health consequences, coupled with the high prevalence of exposure, highlight the need for integrated child protection and mental health systems that are adequately resourced and contextually grounded in LMICs.

As with many population-based studies, the prevalence and mental health associations reported here rely on retrospective self-reports. As such, they may be influenced by recall bias, particularly among older respondents, and by the cultural acceptability of disclosing violence. Additionally, the VACS

item captures only seeing or overhearing physical violence between caregivers, excluding other forms of harm such as emotional abuse, coercive control, or other forms of indirect exposure (Holden, 2003).

Gender differences in reported exposure were apparent in most countries. This points to the need for gender-sensitive approaches to addressing exposure, but also to both data collection and intervention design. It is also important to consider how gender norms and expectations may influence willingness to disclose or identify experiences as abusive (Jewkes et al., 2015). The implications of exposure also appear to differ by gender, with varying trajectories of internalising or externalising symptoms, all of which warrant further investigation in LMIC contexts (Evans et al., 2008). Unlike previous multi-country studies of ACEs (e.g. Amene et al., 2024; Kieselbach et al., 2021), this analysis provides disaggregated prevalence estimates and absolute counts of those exposed, offering a more actionable foundation for targeted policy responses.

These results have critical implications for public health, education, and child protection. Exposure to DVA is linked to a wide range of negative outcomes, and yet in most LMICs there are few policies or programmes specifically designed to support affected children (Guedes et al., 2016; UNICEF, 2014). These absolute figures can support policymakers and practitioners in targeting resources, tailoring interventions, and advocating for greater investment in child protection systems where the burden of exposure is highest. Addressing this gap will require multi-sectoral collaboration, including integration of DVA screening into school and health systems, investment in community-based prevention initiatives, and the development of evidence-based interventions tailored to local needs (World Health Organization, 2016).

This study reinforces the value of retrospective self-reports among adolescents and young adults as a source of information on childhood exposure. Although subject to limitations such as recall bias and social desirability effects, such data provide a critical window into otherwise hidden experiences (Hardt & Rutter, 2004). These insights are particularly important in LMICs, where administrative data systems may be weak or where violence within the home is rarely acknowledged in public discourse (UNICEF, 2014). The VACS data demonstrate that meaningful prevalence estimates can be generated even with a single harmonised item, suggesting a path forward for incorporating similar measures in future surveys. However, due to the retrospective nature of the data and potential cultural influences on willingness to disclose, these figures should be interpreted with caution. Disclosure patterns may be influenced by social norms, gendered expectations around emotional expression, or perceptions of violence within the home.

Despite its contributions, this study has several limitations. First, the measure of DVA exposure used is narrowly focused on seeing or hearing physical violence between caregivers and does not capture other forms of harm, such as emotional abuse, coercive control, or indirect forms of exposure

(Holden, 2003). As such, the estimates reported here likely underrepresent the true scale of exposure. In Cambodia, for example, a country-specific item asking whether respondents saw or heard threats or the use of a weapon between adults produced slightly higher prevalence figures when combined with the standard item. Although modest (from 20.41% [95% CI 18.32-22.68] to 22.94% [95% CI 20.70-25.39]), the increase suggests that broader definitions of exposure may capture cases otherwise missed by narrower indicators. Second, although the VACS are nationally representative, underreporting may still occur due to stigma or fear of reprisal (Ellsberg et al., 2001). Finally, the analysis is cross-sectional and cannot account for trends over time or the effects of recent global events such as the COVID-19 pandemic (Van Gelder et al., 2020).

Nevertheless, these limitations are balanced by the strengths of the study, particularly its use of large, representative samples and standardised measurement across diverse settings. The findings presented here offer one of the most comprehensive snapshots to date of childhood exposure to DVA in LMICs and suggest that the burden is both widespread and underestimated. Together, the prevalence and mental health findings presented here provide a rare cross-national baseline for understanding the scale and consequences of childhood DVA exposure in LMICs.

At the international level, the findings support calls for improved global surveillance of violence against children, with specific attention to DVA exposure. The inclusion of harmonised items in national surveys – such as those used in the VACS – represents an important step toward building a more accurate and actionable evidence base. Ongoing efforts should also ensure that measures used are culturally relevant and validated, as highlighted by both this study and prior critiques of global prevalence data (Harris et al., 2024; Kieselbach et al., 2022). This is particularly critical in the current global context, where standardised data collection is becoming increasingly challenging due to shifting funding priorities across major survey programmes (Khaki et al., 2025). Without continued investment in comprehensive surveillance and data collection, the experiences of children exposed to violence will remain largely invisible, limiting opportunities for prevention and reducing their visibility within global and national policy agendas. Only with robust, sustained investment in data infrastructure and child-focused policy can this hidden form of harm be effectively addressed at scale.

Conclusion

Childhood exposure to DVA remains a significant and under-recognised issue in LMICs, with consistently strong associations with adverse mental health outcomes in adolescence and early adulthood. This study provides the most comprehensive cross-national prevalence estimates to date, using harmonised data from ten LMICs and translating these into absolute population counts – revealing that tens of millions of children have been exposed, even under narrow definitions of DVA.

Among those exposed, the risks of both internalising symptoms (such as psychological distress, suicidal thoughts, and self-harm) and externalising behaviours (including risky behaviours and violence perpetration) are significantly elevated. These findings underscore the urgent need for coordinated responses that integrate DVA exposure into child protection, mental health, and public health strategies, particularly in resource-constrained settings. Strengthening data systems, expanding access to trauma-informed services, and ensuring that DVA exposure is recognised within national policy agendas are critical steps towards addressing this overlooked form of harm and safeguarding the wellbeing and development of children globally.

References

Amene, E. W., Annor, F. B., Gilbert, L. K., McOwen, J., Augusto, A., Manuel, P., N'gouanma Nobah, M. T. V., & Massetti, G. M. (2024). Prevalence of Adverse Childhood Experiences in sub-Saharan Africa: A multicountry analysis of the Violence Against Children and Youth Surveys (VACS). Child Abuse & Neglect, 150, 106353. https://doi.org/10.1016/j.chiabu.2023.106353

Centers for Disease Control and Prevention. (2022). VACS Country Reports and Data. https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/country-reports.html

Chiang, L., Kress, H., Sumner, S., Gleckel, J., Kawemama, P., & Gordon, R. (2016). Violence Against Children Surveys (VACS): Towards a global surveillance system. Injury Prevention, 22 Suppl 1(Suppl 1), i17–i22. https://doi.org/10.1136/injuryprev-2015-041820

De Bellis, M. D. (2001). Developmental traumatology: The psychobiological development of maltreated children and its implications for research, treatment, and policy. Development and Psychopathology, 13(3), 539–564. https://doi.org/10.1017/S0954579401003078

Easton, S. D., Safadi, N. S., Wang, Y., & Hasson, R. G. (2017). The Kessler psychological distress scale: Translation and validation of an Arabic version. Health and Quality of Life Outcomes, 15(1), 215. https://doi.org/10.1186/s12955-017-0783-9

Ellsberg, M., Heise, L., Pena, R., Agurto, S., & Winkvist, A. (2001). Researching Domestic Violence Against Women: Methodological and Ethical Considerations. Studies in Family Planning, 32(1), 1–16. https://doi.org/10.1111/j.1728-4465.2001.00001.x

Evans, S. E., Davies, C., & DiLillo, D. (2008). Exposure to domestic violence: A meta-analysis of child and adolescent outcomes. Aggression and Violent Behavior, 13(2), 131–140. https://doi.org/10.1016/j.avb.2008.02.005

Guedes, A., Bott, S., Garcia-Moreno, C., & Colombini, M. (2016). Bridging the gaps: A global review of intersections of violence against women and violence against children. Global Health Action, 9(1), 31516. https://doi.org/10.3402/gha.v9.31516

Hardt, J., & Rutter, M. (2004). Validity of adult retrospective reports of adverse childhood experiences: Review of the evidence. Journal of Child Psychology and Psychiatry, 45(2), 260–273. https://doi.org/10.1111/j.1469-7610.2004.00218.x

Harris, R. J., Channon, A. A., & Morgan, S. A. (2024). Childhood exposure to domestic violence: Can global estimates on the scale of exposure be obtained using existing measures? Frontiers in Public Health, 12, 1181837. https://doi.org/10.3389/fpubh.2024.1181837

Holden, G. W. (2003). Children Exposed to Domestic Violence and Child Abuse: Terminology and Taxonomy. Clinical Child and Family Psychology Review, 6(3), 151–160. https://doi.org/10.1023/A:1024906315255

Holt, S., Buckley, H., & Whelan, S. (2008). The impact of exposure to domestic violence on children and young people: A review of the literature. Child Abuse & Neglect, 32(8), 797–810. https://doi.org/10.1016/j.chiabu.2008.02.004

Jewkes, R., Flood, M., & Lang, J. (2015). From work with men and boys to changes of social norms and reduction of inequities in gender relations: A conceptual shift in prevention of violence against women and girls. The Lancet, 385(9977), 1580–1589. https://doi.org/10.1016/S0140-6736(14)61683-4

Kessler, R. C., Barker, P. R., Colpe, L. J., Epstein, J. F., Gfroerer, J. C., Hiripi, E., Howes, M. J., Normand, S.-L. T., Manderscheid, R. W., Walters, E. E., & Zaslavsky, A. M. (2003). Screening for Serious Mental Illness in the General Population. Archives of General Psychiatry, 60(2), 184. https://doi.org/10.1001/archpsyc.60.2.184

Khaki, J. J., Molenaar, J., Karki, S., Olal, E., Straneo, M., Mosuse, M. A., Fouogue, J. T., Hensen, B., Baguiya, A., Musau Nkola, A., Wong, K. L. M., Ba, O. A., Kikula, A., Grovogui, F. M., Semaan, A., Asefa, A., Macharia, P. M., Chikwari, C. D., Ouédraogo, M. O., … Beňová, L. (2025). When health data go dark: The importance of the DHS Program and imagining its future. BMC Medicine, 23(1), 241. https://doi.org/10.1186/s12916-025-04062-6

Kieselbach, B., Kimber, M., MacMillan, H. L., & Perneger, T. (2022). Prevalence of childhood exposure to intimate partner violence in low-income and lower-middle-income countries: A systematic review. BMJ Open, 12(4), e051140. https://doi.org/10.1136/bmjopen-2021-051140

Kieselbach, B., Kress, H., MacMillan, H., & Perneger, T. (2021). Prevalence of childhood exposure to intimate partner violence and associations with mental distress in Cambodia, Malawi and Nigeria: A cross-sectional study. Child Abuse & Neglect, 111, 104807. https://doi.org/10.1016/j.chiabu.2020.104807

Kitzmann, K. M., Gaylord, N. K., Holt, A. R., & Kenny, E. D. (2003). Child witnesses to domestic violence: A meta-analytic review. Journal of Consulting and Clinical Psychology, 71(2), 339–352. https://doi.org/10.1037/0022-006X.71.2.339

Krieger, N., Kosheleva, A., Waterman, P. D., Chen, J. T., & Koenen, K. (2011). Racial Discrimination, Psychological Distress, and Self-Rated Health Among US-Born and Foreign-Born Black Americans. American Journal of Public Health, 101(9), 1704–1713. https://doi.org/10.2105/AJPH.2011.300168

Margolin, G. (2005). Children's Exposure to Violence: Exploring Developmental Pathways to Diverse Outcomes. Journal of Interpersonal Violence, 20(1), 72–81. https://doi.org/10.1177/0886260504268371

Masten, A. S., Roisman, G. I., Long, J. D., Burt, K. B., Obradović, J., Riley, J. R., Boelcke-Stennes, K., & Tellegen, A. (2005). Developmental Cascades: Linking Academic Achievement and Externalizing and Internalizing Symptoms Over 20 Years. Developmental Psychology, 41(5), 733–746. https://doi.org/10.1037/0012-1649.41.5.733

Nikstat, A., & Riemann, R. (2020). On the etiology of internalizing and externalizing problem behavior: A twin-family study. PLOS ONE, 15(3), e0230626. https://doi.org/10.1371/journal.pone.0230626

UN Women. (2020). COVID-19 and ending violence against women and girls. UN Women. https://www.unwomen.org/-/media/headquarters/attachments/sections/library/publications/2020/issue-brief-covid-19-and-ending-violence-against-women-and-girls-en.pdf?la=en&vs=5006

UNICEF. (2006). Behind Closed Doors: The impact of domestic violence on children. https://belfastwomensaid.org.uk/themainevent/wp-content/uploads/2021/09/UNICEF_BehindClosedDoors.pdf

UNICEF. (2014). Hidden in Plain Sight: A Statistical Analysis of Violence Against Children. UNICEF. https://www.unicef.org/reports/hidden-plain-sight

United Nations Department of Economic and Social Affairs, Population Division. (2024). World Population Prospects: The 2024 Revision. https://population.un.org/wpp/

Van der Auwera, M., Debacker, M., & Hubloue, I. (2012). Monitoring the mental well-being of caregivers during the Haiti-earthquake. PLoS Currents, 4, e4fc33066f1947. https://doi.org/10.1371/4fc33066f1947

Van Gelder, N., Peterman, A., Potts, A., O'Donnell, M., Thompson, K., Shah, N., & Oertelt-Prigione, S. (2020). COVID-19: Reducing the risk of infection might increase the risk of intimate partner violence. EClinicalMedicine, 21, 100348. https://doi.org/10.1016/j.eclinm.2020.100348

Vissoci, J. R. N., Vaca, S. D., El-Gabri, D., de Oliveira, L. P., Mvungi, M., Mmbaga, B. T., Haglund, M., & Staton, C. (2018). Cross-cultural adaptation and psychometric properties of the Kessler Scale of Psychological Distress to a traumatic brain injury population in Swahili and the Tanzanian Setting. Health and Quality of Life Outcomes, 16(1), 147. https://doi.org/10.1186/s12955-018-0973-0

World Health Organization. (2016). INSPIRE: Seven Strategies for Ending Violence Against Children. World Health Organization. https://www.who.int/publications/i/item/9789241565356