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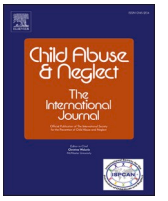

Prevalence of childhood exposure to domestic violence in 10 low- and middle-income countries: Analysis of Violence Against Children and Youth Survey data

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ABSTRACT

Background: Childhood exposure to domestic violence and abuse (DVA) is associated with lasting impacts on child development, mental health, and future violence risk. However, global estimates are outdated, based largely on high-income countries, and often use inconsistent measures. This study provides updated prevalence estimates from 10 LMICs, using a standardized indicator of exposure.

Objective: To generate updated, cross-national prevalence estimates of childhood exposure to DVA in LMICs using a consistent measurement approach.

Participants and setting: Nationally representative data were drawn from 10 Violence Against Children and Youth Surveys, conducted between 2013 and 2019 across Africa, Asia, Eastern Europe, and Latin America. Respondents aged 13–24 were asked retrospectively about witnessing or hearing physical violence between caregivers before age 18.

Methods: Weighted prevalence estimates were calculated by sex and country based on responses to a standardized item. Country-specific population data were used to estimate the number of exposed individuals.

Results: Prevalence ranged from 11.80 % to 30.68 %. In most countries, female respondents reported a higher prevalence of exposure than males. Across the 10 countries, an estimated 19.84 million adolescents and young adults were exposed to DVA before age 18. These figures represent 7.21 % to 14.91 % of UNICEF's 2006 global estimate, despite being derived from only 10 countries and a narrow definition of exposure.

Conclusions: Childhood exposure to DVA remains widespread and under-recognized in LMICs, and global estimates substantially understate the scale of the issue. Improved surveillance using standardized, cross-culturally appropriate indicators is urgently needed to inform prevention, policy, and child protection efforts.

1. Introduction

In 2006, UNICEF estimated that between 133 and 275 million children globally were exposed to domestic violence and abuse

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(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 standardized 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 parts of South Asia, the Middle East, and Eastern Europe, further limiting their global applicability and reinforcing the need for updated, geographically inclusive data (UNICEF, 2006). Regional differences in the rates of DVA in have been reported, with the highest prevalence rates observed in Africa (World Health Organization, 2021).

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 (Evans et al., 2008; Holden, 2003). DVA most often occurs in the context of intimate partner violence against women, meaning that children are frequently exposed to violence in which their mother or female caregiver is also a direct victim. This creates a complex set of vulnerabilities, with more than one victim within the same family unit. Recognizing the gendered nature of DVA is important, as male and female children may face different patterns of risk, coping, and long-term consequences. Gender norms and socialization can shape how violence is perceived, the likelihood of disclosure, and the types of harm experienced – with evidence suggesting differential risks for emotional and behavioral outcomes by sex (Evans et al., 2008; Holt et al., 2008). This intersection between violence against women and violence against children requires sensitive recognition in research and policy, as interventions that address only one form of victimization risk overlooking the other.

A substantial body of evidence has confirmed that childhood exposure to DVA is associated with a wide range of negative outcomes. These include emotional and behavioral 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 characterize many LMICs (Gilbert et al., 2024; 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 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 standardized, 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 highlighted how large-scale disruptions can heighten risks of 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. This has renewed attention to the need for robust, comparable data on children's exposure to DVA, particularly in LMICs, and highlights the importance of understanding how both large-scale disruptions, such as pandemics, and smaller-scale crises can heighten risks for exposure. Such insights should inform preparedness planning and violence prevention strategies in these settings. However, the ability to design and evaluate such strategies is limited by the absence of reliable and comparable prevalence data on children's exposure to DVA in many countries.

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 standardized 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 harmonized item on exposure to interparental physical violence across 10 nationally representative surveys. Although the measure is necessarily narrow in scope, focusing on the most observable and behaviorally specific form of DVA, it reflects the current methodological constraints in this research area. Other forms of DVA, such as emotional abuse, coercive control, or sexual violence, are often less visible to children, more difficult to define behaviorally for survey purposes, and currently lack validated measures of childhood exposure, particularly within LMICs (Harris et al., 2024). It also provides one of the few opportunities to compare prevalence across multiple LMICs using a consistent definition.

This study addresses these gaps by providing updated prevalence estimates and absolute numbers of childhood exposure to DVA using data from the Violence Against Children and Youth Surveys (VACS; Chiang et al., 2016). These nationally representative surveys, conducted in collaboration with national governments and technical partners, were explicitly designed to measure the prevalence and contexts of multiple forms of violence affecting children, adolescents, and young adults. They include a standardized item asking whether the respondent saw or heard physical violence between parents or stepparents. The VACS offers one of the only sources of harmonized, cross-country data on this form of harm in LMICs, making it uniquely valuable for generating robust, comparable

prevalence estimates and for addressing the critical evidence gaps this study seeks to fill. Although one prior study analyzed 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 standardized, 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 10 countries in Africa, Asia, Eastern Europe, and Latin America. By estimating both the proportion and absolute number of children exposed in each country, the study aims to strengthen the evidence base for global, regional, and national action on both violence against women and violence against children.

2. Methods

2.1. Data sources and participants

This study draws on data from 10 nationally representative Violence Against Children and Youth Surveys (VACS), conducted in Cambodia (2013), Colombia (2018), Côte d'Ivoire (2018), Honduras (2017), Lesotho (2018), Malawi (2013), Moldova (2019), Namibia (2019), Nigeria (2014), and Zambia (2014). 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 standardized 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.

2.2. 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 – El Salvador (2017), Eswatini (2007), Haiti (2012), Kenya (2010), Tanzania (2009), and Zimbabwe (2017) – were excluded due to inconsistent measurement of exposure (e.g., missing items, conceptual inconsistencies, flawed skip patterns, or non-standardized wording), or substantial missing data.

2.3. Measurement of childhood exposure to DVA

Childhood exposure to DVA was defined as self-reported exposure to physical violence between caregivers before the age of 18. All 10 surveys included a similarly worded item asking whether the respondent had ever seen or heard one parent or stepparent physically attacking the other. For respondents aged 13–17 years, the question was asked as “ever,” whereas for respondents aged 18–24 years, it was asked as “before you turned 18,” to ensure consistent reference to the childhood period. 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.

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.

2.4. 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; Nguyen et al., 2019). For each estimate, 95 % confidence intervals were computed. Statistical significance of differences between male and female prevalence rates were addressed using non-overlapping 95 % confidence intervals. All analyses were conducted using Stata SE 17.

To contextualize 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 among current children of all ages. For each country, population estimates correspond to the specific year in which the survey was conducted (e.g., 2013 for Cambodia), as reported in the 2024 revision. This approach uses the most up-to-date and accurate estimates for past years, enabling more robust and comparable absolute figures across countries.

3. Results

Table 1 presents the prevalence of childhood exposure to domestic violence and abuse (DVA) across the 10 countries included in this analysis, disaggregated by sex, along with the estimated number of children exposed in each setting. Fig. 1 visualizes these differences in prevalence by country and sex.

3.1. Prevalence of childhood exposure to DVA

Across the 10 countries included in this analysis, the weighted prevalence of 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 generally reported higher prevalence of exposure before the age of 18 than males, with 7 out of the 10 countries in this situation. Females had significantly higher prevalence 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 (21.24 % vs. 19.57 %), prevalence was slightly higher among males, although there was no statistically significant difference between sexes.

3.2. Estimated number of exposed children

The number of 13–24 years olds estimated in these 10 countries to have been exposed to DVA before the age of 18 is 19.84 million (95 % CI: 17.93 million-21.89 million). 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 the four remaining countries, the estimated number of adolescents and young adults who were exposed is 3.14 million, with the majority in Colombia (over 2 million). Smaller numbers, reflecting the smaller populations in these countries, were seen in Cambodia (769,000) and Honduras (289,000).

As expected, the number of females affected was higher, with a total of 10.82 million across all countries (95 % CI: 9.37 million-12.42 million), compared with 8.99 million males (95 % CI: 7.82 million-10.24 million). Again, these differentials were driven by Nigeria, where there were an estimated 1.32 million more females affected than males.

4. Discussion

This study provides new, standardized prevalence estimates of childhood exposure to DVA in 10 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 existing global estimates and underscore the persistent under-recognition of this form of harm (UNICEF, 2006), as well as highlighting the large scale of the issue.

Although the sample includes only 10 countries, the estimated 19.84 million adolescents and young adults affected represents between 7.21 % and 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, these results account for between 43.71 % and 47.84 % of UNICEF's 2006 estimate for the entire Sub-Saharan African region (UNICEF, 2006). While direct comparisons must be made cautiously due to differences in measurement and scope, these findings suggest that the true scale of childhood exposure to DVA may be considerably higher than previously recognized. The high absolute numbers observed underscore an urgent need for improved surveillance across LMICs to determine whether these patterns are consistent in other contexts, or reflect particularly high prevalence in the countries analyzed.

The high rates of exposure observed in many of the countries, particularly in Sub-Saharan Africa, highlight the urgent need to prioritize childhood exposure to DVA in both research and policy agendas. Crucially, these findings also need to be understood within the broader context of intimate partner violence, which is the most common setting for DVA and disproportionately affects women. In many cases, children are not only exposed to violence but live alongside a non-abusing caregiver (most often their mother) who is also a victim. Addressing the safety, well-being, and rights of both the child and the non-abusing caregiver is essential, as their vulnerabilities are interconnected and responses that focus on one while neglecting the other risk leaving underlying harms unaddressed.

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 than those in Latin America or Eastern Europe, reflecting both broader

Table 1

Prevalence and estimated number of children aged 13–24 exposed to DVA during childhood in 10 LMICs, by sex.

Values reflect weighted prevalence (%) of respondents aged 13–24 reporting exposure to physical domestic violence before age 18, from nationally representative Violence Against Children and Youth Surveys. Corresponding estimates of the number of individuals exposed were calculated using United Nations 2024 population data for 13–24-year-olds in the specific survey year for each country. Countries are grouped by region, and values rounded to the nearest whole person. DVA = domestic violence and abuse. CI = confidence interval.

Region	Country (survey year)	Estimates of people aged 13–24 exposed to DVA before the age of 18 in 10 LMICs					
		Prevalence (%; 95 % CI)			Number exposed (rounded to nearest person; 95 % CI)		
		Overall	Male	Female	Overall	Male	Female
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	**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)
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)

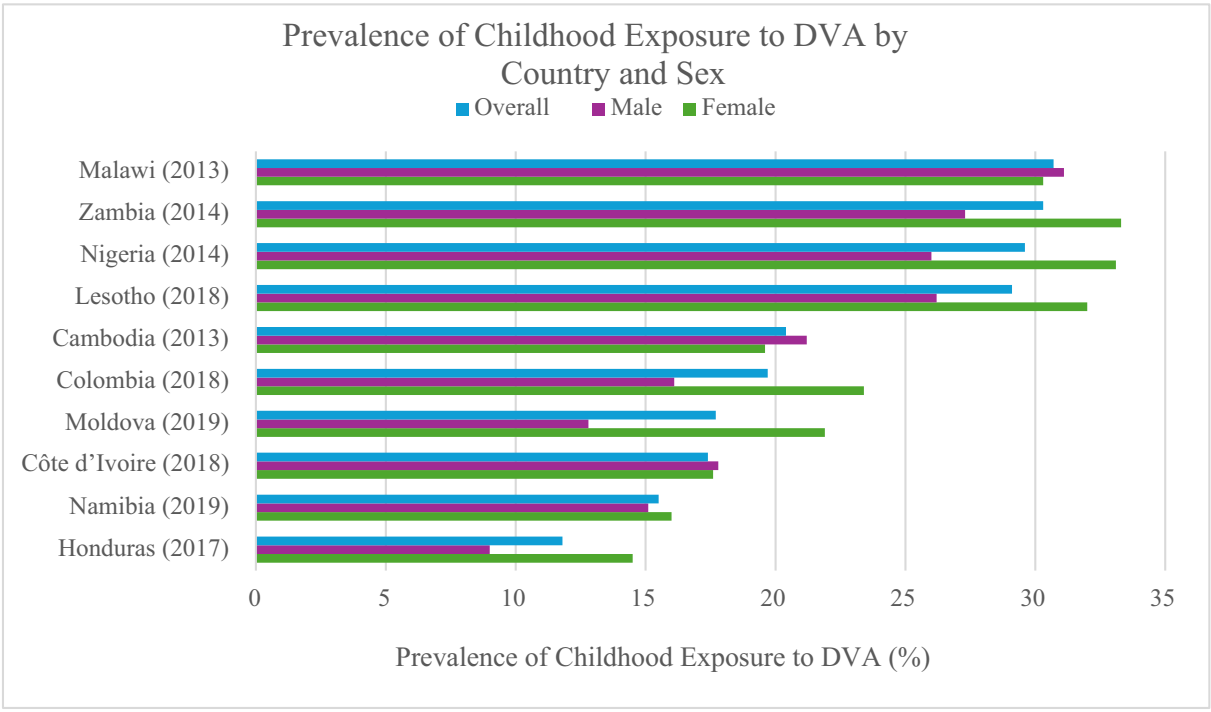

Fig. 1. Prevalence of childhood exposure to DVA by country and sex.
Bar chart showing the prevalence (%) of childhood exposure to domestic violence and abuse (DVA) in 10 low- and middle-income countries (LMICs), based on nationally representative data from the Violence Against Children and Youth Surveys. Estimates are weighted and reflect survey design. Prevalence represents the percentage of respondents aged 13–24 who reported seeing or hearing physical violence between caregivers before age 18, disaggregated by sex. Countries are ordered from highest to lowest based on the overall prevalence of childhood exposure to DVA. DVA = domestic violence and abuse.

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, including gender norms that can influence disclosure of exposure to DVA, access to support, and the perceived acceptability of violence.

The prevalence estimates and extrapolated population counts are based 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, underscoring the need for gender-sensitive approaches to both measurement and intervention design. These differences matter because the implications of exposure may also differ by gender, with varying trajectories of internalizing or externalizing behaviors, all of which warrant further investigation in LMIC contexts (Evans et al., 2008; Jewkes et al., 2015). While this paper centers on children, recognizing that the violence they are exposed to often co-occurs with violence against a non-abusing caregiver reinforces the case for integrated responses that protect both. Unlike previous multi-country studies of ACEs (e.g., Amene et al., 2024; Kieselbach et al., 2021), this study provides sex-disaggregated prevalence estimates and absolute counts of those exposed. Among the 10 countries analyzed, these data provide a more actionable foundation for targeted policy responses because they (1) allow policymakers to quantify the scale of the problem in absolute numbers, which can be compelling for advocacy and resource allocation; (2) identify priority populations and high-burden countries for targeted intervention; (3) tailor programming to different risk patterns for boys and girls; and (4) provide a benchmark for monitoring progress toward national and global violence prevention goals. While these implications are specific to the countries included in this analysis, they also highlight the value of incorporating similar measures into other national surveys to build a broader evidence base.

These results have critical implications for public health, education, and child protection. Exposure to DVA is linked to a wide range of negative outcomes, yet in most LMICs there are few policies or programs specifically designed to support affected children (Guedes et al., 2016; UNICEF, 2014). The country-specific and sex-disaggregated prevalence estimates presented here can be used to guide targeted policy responses in the 10 countries studied – for example, integrating child- and caregiver-focused support into national child protection strategies, prioritizing resources to the highest-burden settings, and designing gender-specific prevention programs. While these findings are directly actionable within the included countries, they also highlight the broader priorities that may be relevant across other LMICs, although further country-specific data would be needed to tailor responses appropriately. Effective prevention and response require a whole-family approach, integrating services for children with support and protection for adult victims, and tackling

the underlying drivers of intimate partner violence as well as its impact on children. The World Health Organization's INSPIRE framework – a package of seven evidence-based strategies to end violence against children – provides a useful foundation for guiding such responses (World Health Organization, 2016). In the context of this study's findings, INSPIRE strategies such as "Response and support services" (ensuring that both children and non-abusing caregivers receive coordinated care), "Education and life skills" (strengthening school-based programs to address violence and gender norms), and "Norms and values" (challenging social acceptance of violence in the home) are particularly relevant. Positioning national action plans within the INSPIRE framework can help align LMIC policy responses to internationally recognized standards while adapting them to local contexts. Multi-sectoral collaboration between health, education, justice, and social protection systems will be essential, alongside investment in community-based prevention initiatives and the development of interventions that are both evidence-based and locally adapted (World Health Organization, 2016). Rather than routine universal screening in schools or health facilities, policies should strengthen safe identification and referral pathways for those at risk, ensuring that any disclosure leads to timely, appropriate, and trauma-informed support. The absolute figures presented in this paper can support policymakers and practitioners in targeting resources, tailoring interventions, and advocating for greater investment where the burden of exposure is highest.

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 harmonized 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). Broader definitions of both exposure and of DVA may capture additional cases not identified through narrower indicators, and future work should focus on the development and validation of measures which can be used within large surveys for other forms of exposure to DVA – an area where no standardized tools currently exist, particularly in LMICs (Harris et al., 2024). 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 standardized 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.

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 harmonized 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 standardized data collection is becoming increasingly challenging due to shifting funding priorities across major survey programs (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.

5. Conclusion

In conclusion, childhood exposure to DVA remains a significant and under-recognized issue in LMICs. The updated estimates provided in this study should prompt renewed commitment to research, policy, and practice aimed at identifying, preventing, and responding to this form of harm. Existing global estimates of childhood exposure to DVA are likely to substantially underestimate the true scale of the problem. This study provides new prevalence data from 10 LMICs using a harmonized, cross-national measure, and uniquely translates these rates into the estimated number of children affected – revealing that tens of millions have been exposed, even when measured narrowly. By improving the quality of data and expanding the reach of support services, there is an opportunity to better protect the wellbeing and development of children globally.

CRediT authorship contribution statement

Rebecca Jane Harris: Writing – review & editing, Writing – original draft, Visualization, Validation, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Data curation, Conceptualization.

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Declaration of competing interest

The author declares no conflicts of interest.

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Data availability

The authors do not have permission to share data.

References

Amene, E. W., Annor, F. B., Gilbert, L. K., McOwen, J., Augusto, A., Manuel, P., … 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*, Article 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), 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

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

Gilbert, L. K., Annor, F. B., Brown, C., & Dube, S. R. (2024). Introduction to the child abuse and neglect special issue "Epidemiology, risk factors, and impacts of adverse childhood experiences in low- and middle-income countries". *Child Abuse & Neglect, 150*, Article 106748. https://doi.org/10.1016/j.chiabu.2024.106748

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), Article 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*, Article 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

Khaki, J. J., Molenaar, J., Karki, S., Olal, E., Straneo, M., Mosuse, M. A., … Beňová, L. (2025). When health data go dark: The importance of the DHS Program and imagining its future. *BMC Medicine, 23*(1), Article 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), Article 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*, Article 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

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

Nguyen, K. H., Kress, H., Villaveces, A., & Massetti, G. M. (2019). Sampling design and methodology of the Violence Against Children and Youth Surveys. *Injury Prevention, 25*(4), 321–327. https://doi.org/10.1136/injuryprev-2018-042916

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 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*, Article 100348. https://doi.org/10.1016/j.eclinm.2020.100348

World Health Organization. (2016). INSPIRE: Seven strategies for ending violence against children. World Health Organization. https://www.who.int/publications/i/item/9789241565356.

World Health Organization. (2021). Violence against women prevalence estimates, 2018. https://www.who.int/publications/i/item/9789240022256.