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REVIEW ARTICLE

A systematic review of childhood exposure to intimate partner violence and mental health outcomes: Evidence from five African countries

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Abstract. Intimate partner violence (IPV) refers to physical, sexual, psychological, or controlling behaviours perpetrated by a current or former intimate partner. Childhood IPV exposure is associated with many adverse mental health outcomes. Despite much evidence from high-income countries, evidence from Africa remains limited and unsynthesized. Following the PICO framework and PRISMA guidelines, this study searched six databases (African Journals Online, PsycINFO, PubMed, Scopus, Embase, and CINAHL) for observational studies focusing on Africans who experienced childhood IPV and reported long-term mental health outcomes. Quality appraisal was conducted through the Newcastle–Ottawa Scale for cross-sectional studies. The present review has synthesised data from five cross-sectional studies published between 2021 and 2022 and span five African countries (Nigeria, Uganda, Malawi, Zambia, and South Africa). Childhood IPV exposure was prevalent and linked to adverse mental health outcomes, such as psychological distress, depression, PTSD, and suicidal ideation. Several factors were identified between childhood IPV exposure and mental health outcomes, such as gender, age, marital status, and attitudinal acceptance of IPV. Four studies were judged "good, "while non-random sampling and self-reporting were the main weaknesses. This mini-systematic review synthesised evidence from five studies across five African countries, identifying the association between childhood IPV exposure and long-term mental health outcomes. Although the current evidence base remains limited, the findings underscore childhood IPV as an important public health issue requiring coordinated prevention and intervention strategies. Future research should employ longitudinal designs, examine culturally specific protective and risk factors, and expand geographical coverage to better understand the mechanisms linking childhood IPV exposure to mental health across Africa.

Keywords: childhood exposure, intimate partner violence (IPV), mental health outcomes, Africa, mini-systematic review

INTRODUCTION

Intimate partner violence (IPV) refers to physical, sexual, psychological, or controlling behaviours perpetrated by a current or former intimate partner (Mazza et al., 2021). Exposure to IPV during childhood, whether through witnessing violence between caregivers or experiencing its consequences within the household, is increasingly recognised as a major public health concern (Louis & Reyes, 2023). Globally, an estimated 275 million children are exposed to domestic violence each year (Louis & Reyes, 2023). Such exposure constitutes an important form of adverse childhood experience (ACE) that can disrupt emotional regulation, cognitive development, interpersonal functioning, and social adjustment, with consequences that may persist across the life course (Hughes et al., 2017; Vu et al., 2016). Evidence from longitudinal studies indicates that childhood exposure to IPV is prospectively associated with both internalising and externalising adjustment problems, with some adverse associations becoming more pronounced over time (Vu et al., 2016).

IPV encompasses a wide range of abusive behaviours, including physical violence (e.g., hitting, kicking, or beating), sexual coercion, psychological abuse (e.g., intimidation, humiliation, or isolation), and controlling behaviours that restrict access to social or economic resources (MacMillan et al., 2020; Patra et al., 2018). Childhood exposure is commonly defined as seeing or hearing violence between intimate partners or otherwise being aware of violence occurring within the household

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(World Health Organization, 2013). Increasingly, the literature recognises that children should not be conceptualised merely as passive witnesses because awareness of coercion, threats, violence, and their consequences can affect children's sense of safety and family functioning even when they do not directly observe the violent episode. Recent reviews have consequently emphasised the substantial developmental and mental health burden associated with children's exposure to IPV, including depression, anxiety, post-traumatic stress symptoms, behavioural difficulties, and broader psychosocial impairment (Asiedu & Baliki, 2025; Vu et al., 2016).

Despite growing recognition of childhood exposure to IPV, evidence regarding its prevalence and consequences in African settings remains fragmented. Existing studies indicate that IPV is common in some African countries. For example, approximately 35% of women in Nigeria have experienced IPV, predominantly psychological violence (Issah et al., 2022), while similar prevalence estimates have been reported among women in South Africa (34%) and Ghana (34%) (Alangea et al., 2018; Barnett et al., 2018). Evidence from nationally representative Violence Against Children Surveys further suggests that childhood witnessing of IPV may be substantial in some African settings; for example, research using data from Malawi and Nigeria reported childhood IPV exposure among sizeable proportions of young people and found associations with subsequent psychological distress (Kieselbach et al., 2021). Although childhood exposure appears to affect boys and girls at comparable rates, gender differences may exist in reporting childhood maltreatment and subsequent mental health outcomes (Shields et al., 2020). Recent synthesis also suggests that age and gender may shape the manifestation of mental health consequences following childhood IPV exposure, reinforcing the need to consider developmental and sociodemographic heterogeneity rather than treating exposed children as a homogeneous population (Asiedu & Baliki, 2025).

A growing body of evidence demonstrates that childhood exposure to IPV is associated with a wide range of adverse mental health outcomes. Individuals exposed to IPV are at increased risk of depression, anxiety, post-traumatic stress disorder (PTSD), suicidal ideation, eating disorders, and other psychological problems later in life (Karakurt et al., 2014; Nowshad et al., 2022). Meta-analytic evidence from longitudinal studies further supports prospective associations between childhood IPV exposure and subsequent adjustment difficulties (Vu et al., 2016), while research on multiple ACEs indicates that cumulative childhood adversity is strongly associated with mental ill-health and other adverse health and behavioural outcomes across the life course (Hughes et al., 2017). Beyond its direct psychological effects, childhood exposure to violence may increase vulnerability to revictimisation and future involvement in violent relationships, perpetuating the intergenerational cycle of violence (Machisa et al., 2016; Sanz-Barbero et al., 2019). A recent Africa-focused systematic review and meta-analysis similarly found substantial associations between childhood IPV exposure and later IPV victimisation and perpetration, demonstrating that the consequences of childhood exposure can extend into subsequent intimate relationships (Wadji et al., 2025).

In many settings, sociocultural norms that normalise or tolerate violence against women may further exacerbate adverse outcomes and hinder disclosure and help-seeking behaviours (Okenwa-Emegwa et al., 2016). IPV has also been associated with adverse reproductive and maternal health outcomes, including reduced antenatal care utilisation, unintended pregnancy, and pregnancy loss (Ahinkorah et al., 2020). Children who grow up in violent households are also more likely to experience or perpetrate violence in adulthood, highlighting the intergenerational transmission of IPV (Tenkorang & Owusu, 2018). Multiple structural and individual factors contribute to IPV, including low educational attainment, socioeconomic disadvantage, and gender inequality (Reyal et al., 2024). Consequently, effective prevention requires interventions operating at multiple levels, including education, economic empowerment, conflict resolution, and psychosocial support for affected families (Bacchus et al., 2024; John et al., 2022; Paphitis et al., 2022). In addition, nationally representative surveillance systems and context-specific research are needed to generate robust evidence for policy development and intervention planning across African countries (Kuchukhidze et al., 2023).

However, the existence of a broader literature on IPV in Africa should not be interpreted as evidence that the long-term mental health consequences of childhood IPV exposure have been adequately investigated. Much of the available African evidence focuses on adult IPV victimisation, IPV prevalence and risk factors, reproductive health, HIV-related outcomes, or the intergenerational transmission of IPV rather than specifically examining mental health outcomes following childhood exposure. Even within the broader African literature on the intergenerational consequences of childhood IPV exposure, longitudinal evidence remains strikingly scarce. For example, Wadji et al. (2025) identified 48 studies from 29 African countries examining childhood IPV exposure and later IPV victimisation or perpetration, yet their review identified no longitudinal studies. This methodological gap is particularly consequential for mental health research because cross-sectional designs cannot establish temporal ordering and are vulnerable to retrospective recall, shared-method, and residual confounding biases.

The paucity is even more pronounced when the question is restricted specifically to childhood IPV exposure and subsequent mental health outcomes in African populations. Although international reviews have synthesised substantially larger bodies of evidence linking childhood IPV exposure with later psychological difficulties (Asiedu & Baliki, 2025; Vu et al., 2016), comparable evidence from African settings remains geographically sparse, methodologically heterogeneous, and dominated by cross-sectional data. Indeed, the present review ultimately identified only five eligible studies, all of which used cross-sectional designs. Rather than constituting a sufficiently developed evidence base from which continent-wide conclusions can be drawn, this small body of research should itself be regarded as an important finding. It indicates a severe paucity of directly relevant evidence, particularly longitudinal evidence capable of examining the temporal relationship between childhood IPV exposure and later mental health. The limited number of eligible studies also raises concerns regarding geographical representativeness, differences in exposure and outcome measurement, population heterogeneity, and the extent to which current prevention and mental health policies can be informed by robust Africa-specific evidence.

Accordingly, this mini-systematic review aimed not only to synthesise the available observational evidence on childhood exposure to IPV and mental health outcomes in African settings, but also to characterise the limitations and substantive gaps in the existing evidence base. Using a PICO-informed framework in which childhood IPV exposure was treated as the exposure of interest, the review addressed the following research questions: (1) Among populations in

African countries with childhood exposure to IPV, what long-term mental health outcomes have been reported compared with individuals without such exposure? (2) What demographic, socioeconomic, and contextual factors are reported to be associated with or to modify the relationship between childhood IPV exposure and mental health outcomes? and (3) What methodological, population, and geographical gaps characterise the existing African evidence base? By addressing these questions, the review seeks to distinguish what can reasonably be concluded from the available studies from what remains uncertain, while identifying priorities for future longitudinal, geographically diverse, and methodologically rigorous research.

METHODS

Study design

This mini-systematic review followed Preferred Reporting Items for Systematic Reviews and Meta-analysis (PRISMA) guidelines. This approach was selected for three reasons: its suitability for synthesising evidence from diverse sources (Sriganesh, Shanthanna & Busse, 2016); its capacity to leverage university library search systems for a thorough literature review (Bramer et al., 2017); and its use of explicit, systematic processes that minimise bias and yield trustworthy evidence (Sobieraj & Baker, 2021).

Eligibility criteria

Population, Intervention, Comparison, and Outcome (PICO) guided the selection framework (Speckman & Friedly, 2019). Population: Africans who experienced childhood (before age 18) IPV were included. Outcomes: Long-term mental health outcomes, such as anxiety, depression, and post-traumatic stress disorder (PTSD). Study design: Observational studies, such as cross-sectional, cohort, or case-control designs. Review-type articles or non-peer-reviewed literature, such as commentaries, editorials, and conference abstracts, were excluded. Language and date: Only English-language studies published from 2014 onwards were included.

Search strategy

The search involved six databases (African Journals Online, PsycINFO, PubMed, Scopus, Embase, and CINAHL) because of their extensive coverage of health literature and relevance to the study's focus on Africa and mental health outcomes.

Search terms were ("childhood trauma" or "childhood distress" or "early-life trauma") AND ("anxiety" or "nervousness" or "depression" or "low mood" or "Post-Traumatic Stress Disorder" or "PTSD") AND ("intimate partner violence" or "spousal violence" or "relationship abuse" or "domestic violence" or "family violence" or "household abuse"). Additional search phrases include demographic terms such as "African countries," the names of all 21 East African countries, all 17 West African countries, and South Africa. The PubMed search string is presented in Table S1.

Data selection and extraction

In accordance with the PRISMA framework (Parums, 2021), duplicate entries were removed by the system or manually. Titles, abstracts, and full texts were screened, yielding articles for data extraction. Data such as the first author's name, publication year, study design, population, sample size, IPV measurement, IPV type, mental health outcomes, and study findings were extracted (Table 1).

Synthesis results

IPV exposures and mental health outcomes were synthesised through a thematic approach, including familiarising oneself with the data, generating initial codes, searching for themes, reviewing these themes, defining and naming/tagging them, and writing the report (Sovacool, Iskandarova, and Hall, 2023). Other characteristics were synthesised through a narrative approach.

Quality appraisal

The Newcastle–Ottawa Scale (NOS), adapted for cross-sectional studies, was used to assess the methodological quality of the included studies (Modesti et al., 2016). The scale awards a maximum of 10 points, with studies classified as follows: very good, 9–10 points; good, 7–8 points; satisfactory, 5–6 points; and unsatisfactory, 0–4 points (Modesti et al., 2016). The appraisal was conducted independently by two reviewers, with disagreements resolved through discussion.

RESULTS OF STUDY

Study Selections and Characteristics

Identified 3943 entries from 6 databases, 291 were duplicated, 2704 were excluded from screening, yielding five articles eligible for data extraction (Figure 1). The characteristics of the included studies are in Table 1. All five included studies were cross-sectional designs and published between 2021 and 2022. Five African countries were pictured: Nigeria (Ibala, Seff and Stark, 2021; Kieselbach et al., 2021), Uganda (Ainamani et al., 2022; Ibala, Seff and Stark, 2021), Malawi (Ibala, Seff and Stark, 2021; Kieselbach et al., 2021), Zambia (Lee et al., 2022), and South Africa (Hatcher et al., 2022). Three studies surveyed both genders (Ainamani et al., 2022; Kieselbach et al., 2021; Lee et al., 2022), while the other two focus only on females (Hatcher et al., 2022; Ibala, Seff, and Stark, 2021).

Childhood IPV Exposure

Across the included studies, childhood exposure to IPV was common, although prevalence varied by country and study population. A multi-country study reported that childhood exposure to IPV affected 30.6% of females and 31.2% of males in Malawi, and 34.3% of females and 26.6% of males in Nigeria (Kieselbach et al., 2021). Similarly, 30.2% of Zambian youth aged 18–24 years reported witnessing IPV during childhood (Lee et al., 2022). In Uganda, children and adolescents commonly witnessed IPV against their parents or siblings (Ainamani et al., 2022). Among South African women, 12.9% reported childhood sexual abuse and 63.1% reported childhood physical abuse, while 5.3% had experienced IPV in the previous year (Hatcher et al., 2022). Likewise, approximately 15% of girls in Uganda and Malawi and 8.9% of girls in Nigeria reported exposure to IPV during childhood (Ibala, Seff, & Stark, 2021). Together, these findings demonstrate that childhood exposure to IPV remains highly prevalent across five African countries.

Mental Health Outcomes

All included studies reported a significant association between childhood exposure to IPV and adverse mental health outcomes. Three studies found that individuals who witnessed IPV during childhood were more likely to experience moderate to severe psychological distress (Ibala, Seff, & Stark, 2021; Kieselbach et al., 2021; Lee et al., 2022). Specifically, Kieselbach et al. (2021) reported that adults who had witnessed childhood IPV had higher odds of moderate to severe mental distress than those without such exposure.

Two studies further demonstrated associations between childhood IPV exposure and other mental health conditions (Ainamani et al., 2022; Hatcher et al., 2022). Hatcher et al. (2022) found that South African women who experienced childhood violence had increased odds of depressive symptoms, with combined exposure to childhood violence and past-year IPV further elevating this risk. Ainamani et al. (2022) identified post-traumatic stress disorder (PTSD) as another important mental health consequence of childhood IPV exposure. In addition, Ibala, Seff, and Stark (2021) reported that childhood IPV exposure was associated with increased suicidal ideation among adolescent girls in Nigeria, Uganda, and Malawi.

Overall, the evidence consistently indicates that childhood exposure to IPV is associated with a range of adverse mental health outcomes, including psychological distress, depression, PTSD, and suicidal ideation, highlighting its persistent impact across the life course.

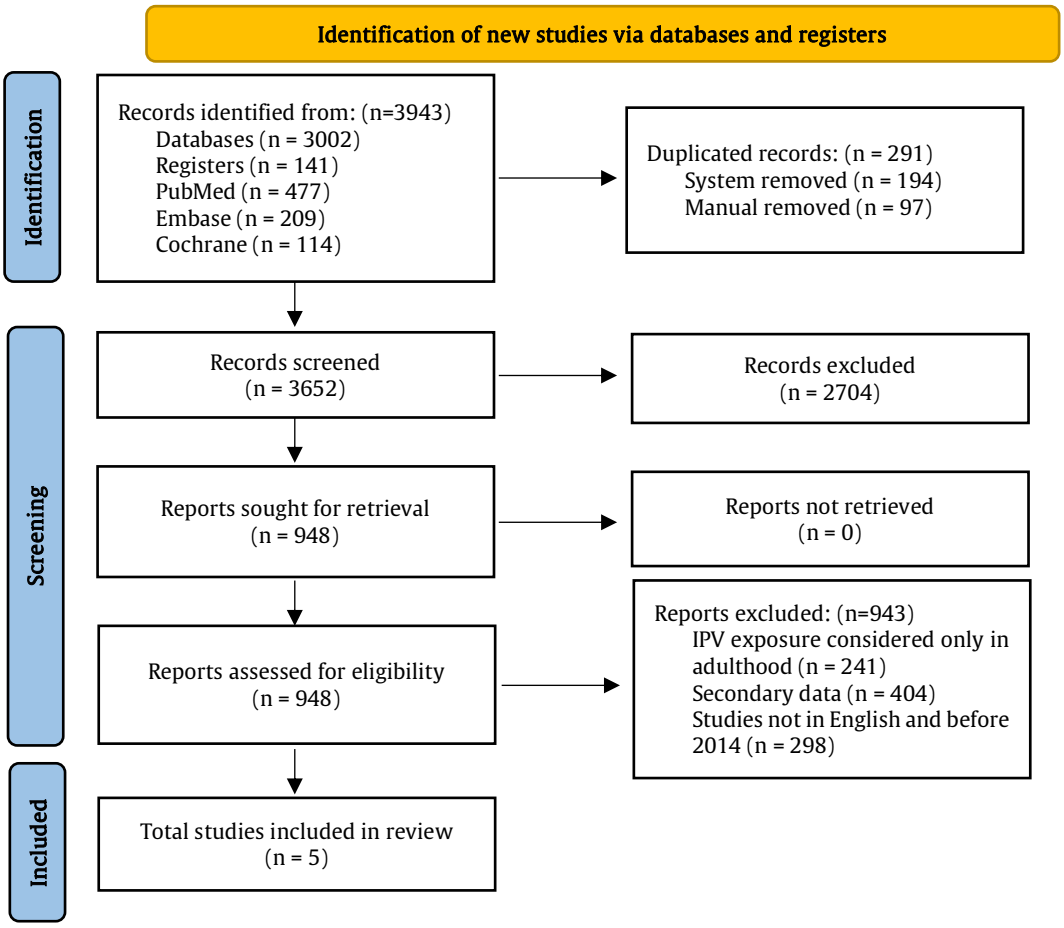

Figure 1: A PRISMA diagram

Factors Between Childhood IPV Exposure and Mental Health Outcomes

Several factors were identified between childhood IPV exposure and mental health outcomes, such as gender, age, marital status, and attitudinal acceptance of IPV. Evidence from sub-Saharan Africa suggests that gender is an important determinant of the mental health consequences of intimate partner violence (IPV). Studies in Malawi and Uganda found that women were more likely to experience depression and psychological distress, while a study in Zambia reported that males had a significantly lower risk of suicide than females (Kieselbach et al., 2021; Ainamani et al., 2022; Lee et al., 2022).

Age may moderate the relationship between childhood exposure to IPV and subsequent mental health outcomes (Hatcher et al., 2022; Lee et al., 2022). In particular, one study found that older age among individuals exposed to IPV was significantly associated with greater mental distress (Lee et al., 2022). Marital status has also been associated with mental health outcomes following exposure to IPV. Individuals who were currently married had lower odds of experiencing mental distress than those who had never married or were divorced, separated, or widowed (Lee et al., 2022).

Attitudinal acceptance of IPV has also been associated with mental health outcomes among individuals exposed to IPV. Acceptance of IPV was linked to lower odds of suicidal ideation and reduced symptoms of mental distress (Ibala, Seff, & Stark, 2021). Other factors reported to influence the relationship between childhood exposure to IPV and mental health outcomes include monthly income, educational

attainment, and employment status (Hatcher et al., 2022; Lee et al., 2022).

Quality appraisal

Across the five studies assessed using the NOS, scores ranged from 6 to 9 out of 10 points (Table 2). Lee et al. (2022) and Hatcher et al. (2022) scored highest at 9 points each, followed by Kieselbach et al. (2021) at 8 points, Ibala, Seff and Stark (2021) at 7 points, and Ainamani et al. (2022) scoring lowest at 6 points. Comparability and outcome domains were consistently strong across all five studies, with each scoring the maximum 2 points in both categories. Variation in total scores was therefore driven almost entirely by the selection domain, which ranged from 2 (Ainamani et al., 2022) to 5 (Lee et al., 2022; Hatcher et al., 2022).

The main methodological limitations noted across studies clustered around two recurring issues: First, reliance on self-report measures flagged in Kieselbach et al. (2021), Lee et al. (2022), and Hatcher et al. (2022), where outcomes (mental distress, suicide risk) were assessed via self-report or household interview rather than independent clinical assessment or record linkage. Second, sampling limitations. Ainamani et al. (2022) used convenience sampling from three schools targeting a pre-identified group of 232 maltreatment-affected children/adolescents, while Ibala, Seff, and Stark (2021) lacked a described or justified sample size calculation. Overall, all five included studies fell in the "good" range (7–9 points), except Ainamani et al. (2022), which was driven primarily by non-random, targeted sampling rather than by weaknesses in outcome measurement or comparability.

DISCUSSION

This mini-systematic review synthesised evidence from five studies conducted across five African countries examining childhood exposure to IPV or related childhood violence exposures and subsequent mental health outcomes. The most important finding of this review is not only the observed associations between violence exposure and psychological distress, depression, post-traumatic stress disorder (PTSD), and suicidal ideation, but also the extremely limited evidence base itself. Despite a broad search of the literature, only five eligible studies were identified, and all employed cross-sectional designs. This paucity of evidence substantially constrains the certainty, generalisability, and temporal interpretation of the observed associations. Accordingly, the findings should be interpreted as preliminary evidence from a small number of heterogeneous studies rather than as a comprehensive representation of childhood IPV exposure and mental health across the African continent.

The small number of eligible studies is particularly noteworthy because IPV and gender-based violence more broadly have been extensively documented in sub-Saharan Africa. For example, a previous systematic review and meta-analysis identified dozens of studies examining gender-based violence among women in the region, although most were cross-sectional and considerable heterogeneity existed in definitions, measurement, and study populations (Muluneh et al., 2020). The contrast suggests that the evidence gap identified in the present review is not necessarily attributable to an absence of IPV research in Africa in general; rather, there appears to be a much narrower evidence base specifically linking childhood exposure to IPV with subsequent mental health outcomes. Recent Africa-focused synthesis has similarly highlighted the need for prospective longitudinal research and culturally validated measures when investigating the consequences of childhood IPV exposure (Wadji et al., 2025).

Several factors may plausibly contribute to why so few directly relevant studies were identified. First, population-level surveillance of violence against children remains uneven. Although Violence Against Children Surveys (VACS) have substantially improved nationally representative data collection in several countries, systematic and repeated surveillance is still required to monitor exposure, outcomes, and the effects of prevention policies over time (Chiang et al., 2016). Second, IPV and other forms of gender-based violence are frequently underreported because disclosure may be constrained by stigma, shame, fear of retaliation, economic dependence, normalisation of violence, and limited confidence in formal support systems (Muluneh et al., 2020; Palermo et al., 2014). These factors may affect both routine surveillance and participation in research, potentially obscuring the true extent of childhood exposure and its consequences.

Third, studying long-term mental health consequences requires methodological and institutional resources that are not equally available across settings. Prospective cohort studies demand sustained funding, participant retention, repeated assessments, trained research personnel, and long-term institutional infrastructure. Mental health research capacity in sub-Saharan Africa has historically been constrained by limited research funding, shortages of trained researchers, restricted mentorship and career pathways, and insufficient institutional infrastructure (Chibanda et al., 2020). These structural constraints may partly explain why cross-sectional studies predominate in the present evidence base and why longitudinal studies directly examining childhood IPV exposure and later mental health remain scarce. This interpretation is consistent with recent recommendations for greater investment in prospective and African-led research on childhood IPV exposure (Wadji et al., 2025).

This evidence scarcity also has important policy implications. Policies and programmes addressing childhood IPV exposure and subsequent mental health needs require contextually relevant evidence regarding who is most vulnerable, which mechanisms connect exposure with later psychological outcomes, and which protective factors may interrupt these pathways. When evidence derives from only a small number of countries and predominantly cross-sectional studies, continent-wide policy assumptions risk extrapolating beyond what the available data can support. Strengthening national surveillance, harmonising measures of childhood violence and mental health, investing in longitudinal cohorts, and developing research capacity are therefore not merely academic priorities but essential components of evidence-informed child protection and mental health policy.

Childhood IPV Exposure

Within the five studies reviewed, exposure to IPV or related forms of childhood violence appeared substantial, although estimates differed considerably across populations and measurement approaches. Approximately one-third of respondents in Malawi, Nigeria, and Zambia reported witnessing IPV during childhood (Kieselbach et al., 2021; Lee et al., 2022), while high levels of childhood physical and sexual violence were reported among South African women (Hatcher et al., 2022).

Table 1 The characteristics of included studies

Author (Year)	Study design	Population	Sample size	IPV measurement	IPV type	Mental health outcomes	Study Findings
Ainamani et al., 2022	Cross-sectional study	children and adolescents between the ages of 8-18 in Uganda	N=232 (48% females, 52% males)	• Maltreatment and Abuse Chronology of Exposure Paediatric Version (Pedi MACE), specifically the subscale for witnessing parental intimate partner violence (IPV), consisting of four items.	Witnessing parental intimate partner violence	• Post-traumatic stress disorder (PTSD): assessed using the revised Child PTSD Symptoms Scale for DSM-5 Self-Report (CPSS-VSR). • Depression: assessed using the Center for Epidemiological Studies Depression Scale for Children (CES-DC).	• Participants who witnessed intimate partner violence (IPV) had more PTSD symptoms (M = 3.4, SD = 1.94, p = .001) and depression symptoms (M = 3.16, SD = 1.97, p < .001). • Witnessing intimate partner violence was a significant predictor of PTSD (OR = 1.48, 95%CI: 1.19-1.83, p < .001). • Witnessing intimate partner violence was also a significant predictor of depression (OR = 1.30, 95%CI: 1.08-1.57, p = .006).
Hatcher et al., 2022	Cross-sectional study	Adult women aged 18-86 years in South Africa	N=7276 women	Selected items from the WHO Multi-Country Study Instrument (4-item index)	Physical violence (hitting, kicking, threats or use of a weapon) and sexual violence (forced sex)	Depressive symptoms (screened using the Patient Health Questionnaire 2-item screener [PHQ-2])	Combined exposure to childhood abuse and past-year SIPV was significantly associated with increased odds of reporting elevated depressive symptoms (aOR=2.05, 95%CI:1.54-2.71, p < 0.001) after controlling for socio-economic markers and latent neighborhood characteristics.
Kieselbach et al., 2021	Cross-sectional study	Nationally representative samples of female and male youth aged 13–24 years in Cambodia*, Malawi, and Nigeria	• Malawi: N = 2,147 (1,029 females, 1,133 males) • Nigeria: N = 4,098 (1,766 females, 2,437 males)	Questions assessing how many times participants saw or heard a parent being punched, kicked, or beaten up by their other parent or partner (categorized as never, once, a few times, many times).	Physical violence (seeing or hearing acts of physical aggression such as punching, kicking, or beating)	Moderate to severe mental distress (assessing non-specific distress including anxiety and depression), measured using the 6-item Kessler K6 scale with a cut-off score of >=5	Witnessing IPV was significantly associated with higher odds of moderate to severe mental distress in Cambodia (OR = 2.73 for females; OR = 2.38 for males), Malawi (OR = 2.48 for females; OR = 1.66 for males), and Nigeria for males (OR = 2.12), but not for females in Nigeria (OR = 0.91).
Lee et al., 2022	Cross-sectional study	Youths aged 18-24 years in Zambia	N=1034 (50.6% female)	• Witnessed IPV: Assessed by asking whether respondents had seen or heard a parent punched, kicked, or beaten up by the other parent, or their boyfriend or girlfriend. Questions were derived from validated scales, including the Juvenile Victimisation Questionnaire. • Direct IPV (Physical Violence): Assessed as a perpetrator category (intimate partner) under physical violence	• Witnessed intimate partner violence • Experienced physical violence by an intimate partner	• Mental distress (past 30 days): Measured using the Kessler-6 Psychological Distress Scale. • Suicide risk (lifetime): Measured via self-report questions assessing whether respondents had ever thought about suicide or attempted suicide.	• Witnessing IPV was significantly associated with higher odds of mental distress (OR=1.5, 95% CI [1.1, 2.0]). • Witnessing IPV was not significantly associated with suicide risk in bivariate analysis (OR= 1.4, 95% CI [0.9, 2.1]) or in the adjusted model (aOR= 1.6, 95% CI [0.9, 3.0]).

Author (Year)	Study design	Population	Sample size	IPV measurement	IPV type	Mental health outcomes	Study Findings
				questions asking whether an intimate partner had punched, kicked, beaten with an object, choked, burned, or threatened/used a weapon.			
Ibala et al., (2021)	Cross-sectional study	Adolescent girls and young women aged 13–24 years in Nigeria, Malawi, and Uganda	N =5,954 (Nigeria: n = 1,766; Malawi: n = 1,029; Uganda: n = 3,159)	• Questions capturing physical IPV by a current or former partner • Questions capturing attitudinal acceptance (tolerance) of IPV across five specific scenarios (wife goes out without telling husband, neglects children, argues with him, refuses sex, or burns food)	Physical intimate partner violence	• Mental distress, measured by the Kessler 6 Scale (K6) • Suicide ideation, measured using the single-item question: "Have you ever thought about killing yourself?"	• Exposure to IPV was significantly associated with increased mental distress (lower K6 scores) across all three countries (Nigeria, Malawi, and Uganda). • IPV exposure was associated with higher odds of suicide ideation in Nigeria (aOR=9.18) and Uganda (aOR=4.36). • Among female survivors who had experienced IPV, expressing attitudinal acceptance of IPV was significantly associated with decreased mental distress in Nigeria (B=2.86) and Malawi (B = 4.38). • Among survivors of IPV in Nigeria, exhibiting attitudinal acceptance of IPV was associated with significantly lower odds of suicide ideation (aOR=0.24).

Table 2 Quality appraisal for included studies

Author (Year)	Selection	Comparability	Outcome	Total points (10)	Comments
Ainamani et al., 2022	2	2	2	6	Participants were gathered using convenience sampling from three schools and consisted of a targeted group of 232 children and adolescents with a known history of maltreatment as identified by social workers.
Hatcher et al., 2022	5	2	2	9	Overall findings are limited by reliance on self-reported outcome measures typical of cross-sectional household surveys, and by the lack of reported response rates.
Kieselbach et al., 2021	4	2	2	8	The research relies on a single dichotomized, self-reported item rather than on a standalone validated psychometric scale.
Lee et al., 2022	5	2	2	9	mental distress and suicide risk were assessed strictly through participant self-reports during household interviews rather than independent clinical assessments or medical record linkages.
Ibala, Seff and Stark, 2021	3	2	2	7	The study did not describe or justify a formal sample size calculation or power analysis within its methodology.

Among children from vulnerable family environments in Uganda, witnessing IPV against parents or other violence occurring within the family environment was also common (Ainamani et al., 2022). These findings should not be interpreted as estimating a single prevalence of childhood IPV across Africa because the included studies differed substantially in age ranges, sampling frames, exposure definitions, and instruments. Nevertheless, they are consistent with broader evidence indicating that violence against children and IPV remain important public health concerns in sub-Saharan Africa (Muluneh et al., 2020).

Variation in prevalence across the included studies may reflect genuine contextual differences as well as methodological factors. Sociocultural norms, family structures, gender relations, socioeconomic conditions, legal protections, willingness to disclose violence, and availability of support systems differ across countries and communities. At the same time, differences in recall periods, definitions of witnessing versus directly experiencing violence, age at assessment, and measurement instruments can substantially affect prevalence estimates. Underreporting is an additional concern because survivors may be reluctant to disclose violence, particularly in settings where violence is socially normalised or disclosure may have interpersonal or economic consequences (Muluneh et al., 2020; Palermo et al., 2014). These considerations reinforce the need for standardised and culturally validated measurement approaches rather than direct comparison of prevalence estimates obtained using substantially different methods.

Childhood IPV Exposure and Mental Health Impacts

The five included studies generally suggest an association between childhood IPV or related violence exposure and adverse mental health outcomes; however, the strength and statistical robustness of these associations varied across studies and analytical models. Kieselbach et al. (2021) reported that witnessing IPV during childhood was associated with increased odds of moderate-to-severe mental distress in several study populations, although the association was not significant among females in Nigeria. Hatcher et al. (2022) found that South African women exposed to childhood violence had greater odds of elevated depressive symptoms, particularly when childhood violence co-occurred with more recent IPV exposure. Among children and adolescents with histories of maltreatment in Uganda, witnessing parental IPV was associated with PTSD and depressive symptoms (Ainamani et al., 2022). Ibala et al. (2021) also reported associations between IPV exposure, psychological distress, and suicidal ideation among adolescent girls and young women in Nigeria, Uganda, and Malawi.

The findings of Lee et al. (2022) require particularly cautious interpretation. Although witnessing IPV was associated with greater psychological distress in bivariate analysis, the association did not remain statistically significant after adjustment for other adverse childhood experiences and relevant covariates. Likewise, witnessing IPV was not independently associated with suicide risk in the adjusted model. This distinction illustrates why conclusions from the present evidence base should not be framed as demonstrating a uniformly significant effect across all studies. Rather, childhood IPV exposure often occurs alongside other forms of adversity, and the independent contribution of any single exposure may change once co-occurring violence, socioeconomic conditions, and other childhood experiences are considered.

Nevertheless, the overall pattern is compatible with a substantially larger international literature. Longitudinal meta-analytic evidence indicates that exposure to IPV during childhood is prospectively associated with later internalising, externalising, and overall adjustment problems, with some associations becoming stronger across longer follow-up periods (Vu et al., 2016). A recent systematic review similarly identified depression, anxiety, PTSD, and other psychological difficulties among children exposed to IPV and emphasised heterogeneity according to age, gender, and developmental context (Asiedu & Baliki, 2025). These external findings provide important context for the five African studies, while also demonstrating the type of longitudinal evidence that remains largely unavailable for African populations.

These findings also support previous research showing that exposure to violence and IPV is associated with a broader spectrum of mental health disorders, including depression, PTSD, suicidal behaviour, anxiety disorders, and alcohol use disorders (Ahmadabadi et al., 2020; Sparrow et al., 2017; Tsai et al., 2016). Importantly, the evidence regarding alcohol use disorders derives from the broader external literature and not from the five studies included in the present review. Exposure to violence during critical developmental periods may disrupt emotional regulation, stress-response processes, perceived safety, and social development, increasing vulnerability to psychological difficulties throughout adolescence and adulthood. Furthermore, childhood adversities frequently cluster rather than occur in isolation; meta-analytic evidence indicates that cumulative exposure to multiple adverse childhood experiences is associated with substantially greater risks of poor mental and behavioural health outcomes (Hughes et al., 2017).

One notable finding was the absence of a significant association between witnessing IPV and mental distress among females in Nigeria reported by Kieselbach et al. (2021). This inconsistency cautions against assuming that exposure has identical consequences across gender and cultural settings. Cultural norms, the social meaning assigned to violence, differential exposure to co-occurring adversities, social support, resilience resources, and reporting behaviours may potentially contribute to heterogeneity. However, these mechanisms were not directly tested in the included studies and therefore remain hypotheses requiring empirical examination. Future research should incorporate appropriately powered tests of moderation and prospective measurement of potential protective factors rather than inferring these mechanisms from cross-sectional associations.

Lee et al. (2022) also reported associations between several adverse childhood experiences, including emotional and physical violence, and psychological distress or suicide-related outcomes. Interestingly, stronger friendship indicators were associated with greater mental distress in some analyses, contrasting with previous evidence suggesting that supportive social relationships generally protect against poor mental health (Heinze et al., 2018; Turner et al., 2017). This discrepancy may indicate that the quality, stability, and protective function of peer relationships are more important than simply their presence or quantity. In contrast, orphanhood was not independently associated with mental distress or suicide risk, differing from previous studies linking childhood adversity and disrupted caregiving environments with poorer mental health outcomes (Abdel Aziz & Vostanis, 2017; Shafiq et al., 2020; Shiferaw et al., 2018). Taken together, these findings indicate that childhood violence operates within broader interpersonal and socioeconomic

environments and should not be examined as an isolated exposure.

Factors Between Childhood IPV Exposure and Mental Health Outcomes

The reviewed evidence suggests that several individual and socioeconomic characteristics may be associated with variation in mental health outcomes among people exposed to IPV or other childhood violence. These included gender, age, marital status, education, employment, income, and attitudes toward IPV. However, because the included studies were cross-sectional and did not consistently conduct formal moderation or mediation analyses, these variables should be described primarily as associated factors rather than established moderators or mediators.

Gender-related differences were observed across several studies, although they were not entirely consistent. Female participants were more likely to report depression or psychological distress in some settings, whereas males showed lower suicide risk in particular analyses. International research also indicates that developmental stage and gender can shape the presentation of psychological difficulties following childhood exposure to IPV, although the direction and magnitude of such differences vary across studies (Asiedu & Baliki, 2025). These patterns indicate that future research should test gender and developmental stage prospectively and within specific cultural contexts rather than assuming universal sex differences.

One particularly interesting finding concerned attitudinal acceptance of IPV. Ibala et al. (2021) reported that among some IPV survivors, greater attitudinal acceptance of IPV was associated with lower psychological distress or lower odds of suicidal ideation. Although this may reflect psychological adaptation or reduced cognitive dissonance following prolonged exposure to violence (Eoh et al., 2019), it should not be interpreted as indicating that acceptance of violence is psychologically beneficial. Rather, the normalisation of violence may alter how experiences are appraised or disclosed while simultaneously discouraging recognition of abuse, disclosure, help-seeking, and engagement with formal services (Schomerus et al., 2021). Evidence from developing-country settings indicates that gender-based violence is substantially underreported to formal sources, reinforcing concerns that apparent adaptation may coexist with limited access to support (Palermo et al., 2014).

Consequently, prevention strategies should combine efforts to challenge social norms that tolerate IPV with accessible, culturally appropriate, and trauma-informed psychological support. Interventions should also consider the broader ecological context–including family relationships, socioeconomic vulnerability, school and community environments, gender norms, and access to services–rather than treating mental health consequences exclusively as individual-level problems.

Strengths and Limitations

This review provides a focused synthesis of the currently available literature concerning childhood exposure to IPV or closely related childhood violence experiences and mental health outcomes in African settings. Its main contribution is not the establishment of a definitive continent-wide estimate or causal relationship, but the identification of a substantial evidence gap. The fact that only five eligible studies were identified despite the major public health burden of IPV demonstrates how limited the directly relevant evidence remains. The review also brings together heterogeneous populations and outcomes, identifies recurring methodological weaknesses, and highlights priorities for future research, particularly longitudinal studies and more consistent measurement of exposure and mental health outcomes.

Nevertheless, several important limitations substantially constrain interpretation. First, only five studies were eligible for inclusion. Such a small evidence base prevents robust conclusions regarding consistency, effect magnitude, geographical patterns, or population differences and makes the synthesis particularly sensitive to the characteristics and methodological limitations of individual studies. Findings from these five studies therefore cannot be generalised to Africa as a whole. The limited geographical coverage is also important because the included countries represent only a small proportion of the continent's considerable sociocultural, linguistic, economic, political, and health-system diversity. This limitation is consistent with broader calls for geographically diverse and prospective research on childhood IPV exposure in Africa (Wadji et al., 2025).

Second, all included studies employed cross-sectional designs, which limit causal and temporal inference regarding the association between childhood IPV exposure and mental health outcomes (Caruana et al., 2015). Cross-sectional studies cannot adequately determine developmental trajectories or establish whether observed psychological outcomes persist, emerge, or change over time. This is especially important because longitudinal evidence from outside the African context demonstrates that associations between childhood IPV exposure and adjustment can evolve across developmental periods (Vu et al., 2016). Consequently, describing the observed outcomes as unequivocally "long-term consequences" should be done cautiously unless childhood exposure and subsequent mental health outcomes were clearly separated temporally.

Third, there was considerable population heterogeneity and a partial mismatch between the populations implied by the original review question and those actually represented in the included studies. Participants ranged from children and adolescents to young adults and adult women, meaning that the studies do not represent a single developmental population. Some mental health outcomes were measured while participants were still children or adolescents, whereas others were assessed retrospectively in adulthood. Consequently, evidence concerning "adult long-term mental health outcomes" is substantially more limited than might be inferred from the original framing of the review.

Fourth, the operationalisation of exposure was not uniform across studies. Some studies specifically assessed witnessing parental or caregiver IPV during childhood, whereas others incorporated broader childhood physical or sexual violence, direct IPV experiences, or combinations of childhood violence and more recent IPV. These constructs are related but not equivalent. This exposure mismatch complicates synthesis and limits the extent to which all findings can be attributed specifically to witnessing or being exposed to parental IPV during childhood. Future reviews should use a clearly prespecified operational definition that distinguishes witnessing parental IPV from direct child maltreatment, adolescent dating/IPV victimisation, and adult IPV exposure.

Fifth, several studies relied on retrospective self-reported exposure and self-reported mental health outcomes, introducing the possibility of recall, reporting, and common-method bias (Althubaiti, 2016). Disclosure of IPV may also be influenced by stigma, fear, social norms, and the perceived consequences of reporting, potentially

leading to underestimation or differential classification of exposure (Muluneh et al., 2020; Palermo et al., 2014). These concerns are particularly relevant when comparing prevalence and associations across socioculturally heterogeneous settings.

Sixth, substantial heterogeneity existed in the definitions of IPV, exposure periods, age ranges, mental health instruments, outcome thresholds, and analytical strategies. These differences, combined with the very small number of studies, precluded meaningful meta-analysis and required a narrative synthesis. The observed associations should therefore not be interpreted as representing a pooled or common effect across the five countries.

Finally, the paucity of studies may partly reflect broader structural limitations in violence surveillance and mental health research capacity rather than a lack of public health relevance. Nationally representative systems such as VACS have improved the availability of childhood violence data, but ongoing surveillance remains incomplete (Chiang et al., 2016). At the same time, limitations in funding, research infrastructure, specialist training, mentorship, and sustained research careers continue to constrain mental health research capacity in parts of sub-Saharan Africa (Chibanda et al., 2020). These gaps strengthen the case for long-term investment in African-led prospective cohorts, repeated population surveillance, culturally validated measurement tools, and multidisciplinary research linking child protection with mental health services.

CONCLUSION

The available evidence consistently demonstrates that childhood IPV exposure is associated with long-term adverse mental health outcomes, including psychological distress, depression, PTSD, and suicidal ideation. Although the current evidence base remains limited, the findings underscore childhood IPV as an important public health issue requiring coordinated prevention and intervention strategies. Trauma-informed mental health services, strengthened child protection systems, school- and community-based prevention programs, and caregiver training should be prioritised to mitigate the long-term psychological consequences of childhood IPV, especially for vulnerable populations. Future research should employ longitudinal designs, examine culturally specific protective and risk factors, and expand geographical coverage to better understand the mechanisms linking childhood IPV exposure to mental health across Africa.

DECLARATION

Ethics approval and consent to participate

Not applicable.

Consent for publication

Not applicable.

Availability of data and materials

All data generated or analysed during this systematic review are included in this published article and its supplementary materials. The search strategies and keywords used for the literature search, as well as the relevant extracted data and results, are provided within the article and supplementary files.

Conflicts of interest Statement

The authors declare no conflicts of interest–whether financial, personal, or professional–with any party that could potentially influence the objectivity or introduce bias into the findings of this study.

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Artificial Intelligence-Assisted Technology

The authors declare that no artificial intelligence (AI)-assisted technologies were utilized to analyze the data in this study. The use of AI-assisted technology was strictly limited to grammatical refinement and final text proofreading.

Authors' contributions

M.R.O. literature review process, analysing, writing–original draft, review and editing; C.L. conception, writing–review and editing; M.M. conception, writing–review and editing, and supervision.

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ADDITIONAL INFORMATION

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Table S1 Search strings for PubMed

Search number	Query	Sort By	Results
4	((#1) AND (#2)) AND (#3)	Most Recent	123
3	("intimate partner violence" or "spousal violence" or "relationship abuse" or "domestic violence" or "family violence" or "household abuse")	Most Recent	28,872
2	("anxiety" or "nervousness" or "depression" or "low mood" or "Post-Traumatic Stress Disorder" or "PTSD")	Most Recent	850,147
1	("childhood trauma" or "childhood distress" or "early-life trauma")	Most Recent	8,061