

Review

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Review

No Safe Space: A Systematic Review of Violence Against Women and Girls Across Africa (ANULA-WP1)

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Abstract

Introduction: Violence against women and girls (VAWG) is a major public health and human rights issue in Africa, with prevalence consistently among the highest globally. According to WHO and UNFPA, one in three women worldwide experience violence in their lifetime, but in sub-Saharan Africa the burden is compounded by poverty, food insecurity, conflict, and weak health systems. Despite its scale, evidence is fragmented across countries and populations, often excluding vulnerable groups such as pregnant women, sex workers, healthcare workers, adolescents, and HIV-positive women. This review synthesises available data to provide a comprehensive understanding of the scope, determinants, outcomes, and interventions addressing VAWG in Africa. **Methods:** We conducted a systematic review in accordance with PRISMA 2020 guidelines. PubMed, Embase, Web of Science, Scopus, African Journals Online, WHO, UNFPA, and Demographic and Health Survey (DHS) repositories were searched (2000–2024). Eligible studies were conducted in African countries and reported prevalence, determinants, outcomes, or interventions for VAWG, including IPV, sexual violence, workplace violence, reproductive coercion, in-law abuse, or community-based violence. Data were extracted independently by two reviewers, appraised for quality, and synthesised using thematic, contextual, trend, and intersectional analyses. **Results:** Eighty studies from 22 African countries were included. Lifetime IPV ranged from 30–65%, pregnancy IPV 25–60%, childhood sexual abuse ~33%, workplace violence 30–62%, and >50% among sex workers. Determinants included alcohol use, poverty, food insecurity, conflict, and inequitable gender norms. Outcomes included maternal morbidity, depression, adverse birth outcomes, HIV/STI risk, and sexual dysfunction. Interventions such as SASA!, Indashyikirwa, CETA, and MAISHA reduced IPV and improved secondary outcomes. **Conclusion:** VAWG in Africa is pervasive, persistent, and particularly concentrated among marginalised groups. Integrated, trauma-informed, and equity-sensitive responses are urgently required to reduce its health and social consequences.

Keywords: violence against women; Africa; socio-cultural factors; economic abuse; legal systems; patriarchy; gender-based violence; systematic review

Background

Violence against women and girls (VAWG) is recognised globally as one of the most pressing public health and human rights challenges of our time. The United Nations describes VAWG as a “shadow pandemic” that undermines health, development, and gender equality, cutting across cultural, socioeconomic, and political contexts. The World Health Organization (WHO) estimates that one in three women worldwide have experienced physical and/or sexual violence in their lifetime, predominantly by an intimate partner [1]. The United Nations Population Fund (UNFPA) further highlights that VAWG has devastating intergenerational impacts, perpetuating cycles of poverty, ill-health, and social exclusion [2].

In Africa, the burden of VAWG is particularly acute. Regional estimates suggest that women and girls in sub-Saharan Africa experience some of the highest prevalence of intimate partner violence (IPV) globally, with lifetime exposure ranging from 33% to over 60% depending on context [1]. UNFPA and the African Union have underscored that VAWG intersects with broader challenges, including early and forced marriage, female genital mutilation/cutting (FGM/C), sexual exploitation in humanitarian settings, and economic disempowerment. Conflict and instability exacerbate these risks: according to the United Nations Office for the Coordination of Humanitarian Affairs (UNOCHA), women in fragile and conflict-affected states face disproportionately high levels of sexual and gender-based violence, often used as a weapon of war [3]. In countries affected by protracted crises—such as the Democratic Republic of Congo, South Sudan, and parts of the Sahel—weak governance and poor infrastructure mean survivors frequently lack access to justice, health care, and psychosocial support.

The public health consequences of VAWG in Africa are profound. WHO has documented links between IPV and maternal morbidity, depression, anxiety, suicide, unintended pregnancy, unsafe abortion, adverse birth outcomes, HIV infection, and chronic conditions such as cardiovascular disease [1]. The Joint United Nations Programme on HIV/AIDS (UNAIDS) has highlighted the particularly strong associations between VAWG and HIV acquisition, especially in southern Africa where young women remain at the epicentre of the epidemic. Beyond health, VAWG undermines women’s participation in education, employment, and political life, contributing to lost productivity and slowing progress towards the Sustainable Development Goals (SDGs), particularly SDG 3 (good health and wellbeing) and SDG 5 (gender equality) [4].

Despite increasing global attention, the African context presents unique structural drivers of violence. Poverty, food insecurity, gender-inequitable norms, polygamy, in-law dynamics, and patriarchal authority systems sustain high tolerance for violence. Weak health and legal infrastructures, combined with chronic underfunding, limit survivor-centred care and protection. In many settings, women’s economic dependency and lack of decision-making autonomy heighten their vulnerability, while limited data systems make it difficult to design targeted interventions. Conflict, displacement, and migration create conditions in which sexual violence, exploitation, and coercion thrive, yet accountability remains limited.

While national surveys such as the Demographic and Health Surveys (DHS) provide valuable estimates of IPV prevalence, they often focus narrowly on intimate partner dynamics and conceal the lived realities of marginalised populations. Groups such as pregnant women, female sex workers, healthcare workers, adolescents, HIV-positive women, and infertile women are either under-represented or excluded, despite being among those most affected. Furthermore, non-partner violence including workplace harassment, reproductive coercion, in-law abuse, and community-based sexual exploitation remains poorly documented. Evidence on interventions is also fragmented: although programmes such as SASA in Uganda, Indashyikirwa in Rwanda, and MAISHA in Tanzania demonstrate the potential of community mobilisation, couple-based training, and gender-transformative approaches, much of this evidence is concentrated in a few countries, leaving substantial regional gaps[5].

These gaps underscore the rationale for an evidence synthesis focused specifically on Africa. First, the high burden of VAWG in the region, coupled with overlapping crises of conflict, HIV, and poverty, demands a consolidated understanding of how violence manifests across diverse populations and contexts. Second, fragmented evidence prevents policymakers from distinguishing between broad national averages and concentrated vulnerabilities in hidden or high-risk groups. Third, there is an urgent

need to integrate epidemiological data with emerging intervention evidence, to guide health systems and policy frameworks towards effective, scalable, and context-sensitive solutions. Finally, synthesising evidence through a multi-layered lens encompassing thematic, contextual, temporal, and intersectional analysis offers a more nuanced understanding of the drivers, consequences, and protective factors shaping VAWG in Africa.

In response, this systematic review collates and critically appraises evidence from 78 studies across 22 African countries published between 2000 and 2024. By adopting four complementary analytic approaches, it provides the most comprehensive account to date of VAWG in Africa. This synthesis is intended to support clinicians, researchers, and policymakers in developing integrated, trauma-informed, and equity-sensitive strategies to reduce violence, strengthen health systems, and accelerate progress towards global commitments on gender equality and women's health.

Methods

Protocol and Reporting

This systematic review followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) 2020 guidelines. A review protocol was developed a priori, outlining the research questions, inclusion criteria, and planned analysis strategy.

Research Questions

The review aimed to:

1. Characterise the types of violence committed against women and girls in African countries.
2. Conduct a thematic and contextual synthesis of determinants and outcomes of such violence.
3. Provide a trend analysis across regions and populations over time.

Eligibility Criteria

Studies were eligible for inclusion if they were conducted in African countries and reported on violence against women and girls (VAWG), encompassing intimate partner violence (IPV), sexual violence (SV), workplace violence (WPV), reproductive coercion, in-law abuse, or community-based violence. Eligible studies employed quantitative, qualitative, or mixed-methods designs and were required to report on at least one of the following: prevalence, determinants, outcomes, or interventions related to VAWG. Exclusion criteria comprised editorials, opinion pieces, studies lacking primary data, and research conducted outside the African context.

Information Sources and Search Strategy

Electronic searches were conducted in PubMed, Embase, Web of Science, Scopus, African Journals Online (AJOL), and grey literature repositories (WHO, UNFPA, DHS reports). Search terms combined "violence", "women", "girls", "Africa", and country names, using Boolean operators. The search spanned 2000–2024.

Study Selection

Two reviewers independently screened titles, abstracts, and full texts. Disagreements were resolved by consensus or third-party adjudication. A PRISMA flow diagram documented the selection process.

Data Extraction

A structured form captured: author, year, country, population, setting, sample size, prevalence/type of violence, determinants, outcomes, and contextual notes (e.g., conflict, HIV, infertility, pregnancy, workplace -Table 1)

Table 1. Characteristics of the studies included in the systematic review.

ID	Author	Country	Study type	Methodology	Setting	Population	Age	Sample size	Findings/ Outcome	Outcome measure
1	Gonsalve, Kaplan & Paltiel[6]	South Africa	Mathematical model	Quantitative	Urban	N/A	N/A	N/A	Less sanitation facilities leads to major risk of sexual assault for women.	Census and statistics 2015,2016
2	Ashenafi et al.[7]	Eastern Ethiopia	Cross sectional	Quantitative	Rural& urban	Postpartum mothers	15–44 years	3015		WHO multi-country study questionnaire
3	B.T. Gashaw et al. [8]	Ethiopia	Cross sectional	Descriptive	Acute	Pregnant women	15–45 years	720	Among multiparous women, any lifetime emotional or physical abuse was associated with late ANC	The standardized and validated abuse assessment screening (AAS) tool

4	Yohannes et al. [9]	Ethiopia	Cross sectional	Quantitative	Acute	Pregnant women	18–50 years	299	Physical violence was reported as the commonest type of violence. Being illiterate, husband's alcohol consumption, husband history of arrest, occupation of husband were significantly associated with domestic violence against pregnant women.	A structured World Health Organization (WHO) multi-country study questionnaire
5	Azene, Yeshita & Mekonnen[10]	Ethiopia	Cross sectional	Quantitative	one referral hospital, three public health Centers, seven private clinics and 14 health posts, seven in rural and seven in urban areas	Pregnant women	Not mentioned	409	The prevalence of psychological, physical, and sexual violence was 29.1%, 21%, 19.8% respectively	A structured questionnaire

6	Berhanie et al.[11]	Ethiopia	Case control	Quantitative	Acute	Pregnant women	16-48 years	954	women who had been exposed to physical violence during pregnancy were five times more likely to experience low birth weight	Pre-tested structured questionnaire
7	Gebreslasie et al.[12]	Ethiopia	Cross sectional	Quantitative	Acute	Post- partum women	19-35 years	648	statistically significant association between exposure to intimate partner violence during pregnancy and still birth. Pregnant women who were exposed to intimate partner violence during pregnancy	A structured questionnaire
8	Lencha et al.[13]	Ethiopia	Cross sectional	Quantitative	Acute	Pregnant women	Not mentioned	612	Physical violence (20.3%), sexual violence (36.3%), psychological/emotional violence (33.0), controlling behavior violence (30.4%) and economic violence (27.0) were the type of IPV encountered by participants.	Pre-tested structured questionnaire
9	Fekadu et al.[14]	Ethiopia	Cross sectional	Quantitative	Acute	Pregnant women	18 to 49 years	450	Of the total pregnant women surveyed, 58.7% were victims of at least one form of domestic violence during	Pre-tested structured questionnaire

									pregnancy,	
10	Tadesse et al.[15]	Ethiopia	Case - control	Quantitative	Acute	Post- partum women		138 cases and 276 controls	Any IPV during pregnancy was significantly associated with PTB	IPV questionnaire was adopted and modified from the Ethiopian Demographic and Health Survey (21) and the WHO 2005 Multi-Country study
11	Mohammed Et al.[16]	Ethiopia	Cross sectional	Quantitative	Acute	Couples	18 to 42 years	210 male/female pairs	IPV is prevalent in Ethiopia where three out of four women reported having experienced one or more type of IPV.	self-reported questionnaires
12	Musa et al.[17]	Ethiopia	Cross sectional	Quantitative	Acute	Post- partum women	15–49 years	648	The prevalence of intimate partner violence during the most recent pregnancy was found to be 39.81%	interviewer-administered standardized questionnaire based on the World

										Health Organization Multi-Country Study on Women's Health and Domestic Violence against Women survey
13	Kouyoumdjian et al. [18]	Uganda	Cohort study	Quantitative	Community	Female participants who had at least one sexual partner	15 to 49 years	15081	Risk factors for IPV from childhood and early adulthood included sexual abuse in childhood or adolescence, earlier age at first sex, lower levels of education, and forced first sex.	Revised Conflict Tactics Scales
14	Mootz et al. [19]	Uganda	Survey	Quantitative	Community	Women	13 – 49 years	605	Most respondents (88.8%) experienced conflict-related violence.	Survey questions
15	Gibbs et al.[20]	South Africa	Cross sectional	Quantitative	Urban	Men and women	18-30 years	680 women and 677 men	Two third of women experienced physical or/and sexual IPV over past year.	WHO violence against women scale

16	Owusu Adjah and Agbemafla[21]	Ghana	Cross sectional (Secondary data analysis)	Quantitative	Community	Married women	16-49 years	2563	Of the 1524 ever married women in this study, 33.6% had ever experienced domestic violence (some form of sexual, physical or emotional violence) and 87% were currently married.	Household questionnaire
17	Abebe Abate et al.[22]	Ethiopia	Cross sectional	Quantitative	Community	Married pregnant women	15-49 years	282	The prevalence of intimate partner violence during recent pregnancy was 44.5%.	WHO multi-country study questionnaire
18	Fawole et al.[23]	Nigeria	Cross sectional	Quantitative	Schools	Students	10-21 years	640	At least one form of GBV was experienced by 89.1% of public and 84.8% private schools students	Self-administered questionnaire
19	Okenwa et al.[24]	Nigeria	Cross sectional	Quantitative	Acute	Women	15-49 years	934	The 1 year prevalence of IPV was 29%, with significant proportions reporting psychological (23%), physical (9%) and sexual (8%) abuse.	A structured questionnaire
20	Gust et al.[25]	Kenya	Cross sectional	Descriptive	Community	Women and girls		8003	Among 8003 participants, 11.6% reported physical violence by a sexual partner in the last 12 months	A survey

21	Kimani, Osero and Akunga[26]	Kenya	Cross sectional	Mixed	Shool	Adolescent girls	15–19 years.	301	Among the respondents, 33% were victims of sexual violence.	self-administered questionnaires
22	Fute et al. [27]	Ethiopia	Cross sectional	Quantitative	Community	Nurses	25–52 years.	660	The prevalence of workplace violence was 29.9%	A pre-tested and structured questionnaire
23	Feseha et al.[28]	Ethiopia	Cross sectional	Quantitative	Refugee camp	Refugee women	Not mentioned	422	The prevalence of physical violence in the last 12 months and lifetime were 107(25.5%) and 131(31.0%) respectively.	A pre-tested interviewer guided structured questionnaire
24	Matseke et al.[29]	South Africa	Randomised controlled trial	Descriptive	Community health centres	HIV-positive pregnant women	18 years or older	673	Overall, 56.3% reported having experienced either psychological or physical IPV.	The Edinburgh Postnatal Depression Scale 10 IPV was assessed using an adaptation of the Conflict

										Tactics Scale 18 HIV serostatus disclosure was assessed using an adapted version of the Disclosure Scale
25	Wandera et al.[30]	Uganda	Cross-sectional	Survey	Community	Women who were in a union	15-35+ year	1307	More than a quarter (27%) of women who were in a union in Uganda reported Initimate Partner Sexual Violence.	Shortened and modified version of the Conflict Tactics Scale
26	Lyons et al.[31]	Abidjan	Cross-sectional	Quantitati	Communi	Women (assigned female sex at birth, and engaged in sex work as a primary source of income)	18 years or older	466	Police refusal of protection was associated with physical and sexual violence	interviewer-administered questionnaires

27	H Stöckl et al.[32]	Tanzania	Cross-sectional	Quantitative	Acute	Pregnant women	15–49 years	2503	In total, 7% (n=88) of women in Dar es Salaam and 12% (n=147) of women in Mbeya reported having experienced violence during pregnancy.	Pretested questionnaire
28	Mahenge et al.[33]	Tanzania	Cross-sectional	Quantitative	Acute	1-9 months postpartum women	18-<36 years	500	18.8% experienced some physical and/or sexual violence during pregnancy.	Structured questionnaire
29	Selin et al.[34]	Soth Africa	Randomised control trial	Quantitative	Rural	Adolescent girls and young women	13-20 years	2,533	Nearly one quarter (19.5%, 95% CI = [18.0, 21.2]) of AGYW experienced any IPV ever (physical or sexual) by a partner.	Survey
30	M. C. Ezeanochie et al.[21]	Nigeria	Cross-sectional	Quantitative	Acute	HIV-positive women	21 - 43 years	305	Intimate partner violence was reported by 99 women, giving a prevalence of 32.5% .	semi-structured interviewer-administered questionnaire
31	Prabhu et al.[35]	Tanzania	Cross-sectional	Quantitative	HIV voluntary counseling and testing center	Women	18-<40 years	2436	432 (17.7%) reported IPV during their lifetime.	Standardised 44 item questionnaire

32	Delamou et al. [36]	Guinea	Cross-sectional	Quantitative	Acute	Women	15-49 years	232	213 (92%) experienced IPV in one form or another at some point in their lifetime.	IPV screening questionnaire
33	Gibbs et al. (2017)[37]	South Africa	Cross-sectional	Quantitative	Acute	Postpartum women	18- <35 years	275	Prevalence of past 12-month sexual and/or physical IPV was 10.55% (n = 29).	Structured questionnaires
34	Malan, Spedding and Sorsdahl[38]	Western Cape	Cross-sectional	Quantitative	Acute	Pregnant women	18 years or older	150	Lifetime and 12-month prevalence rates for any IPV were 44%.	Self-report measures Socio-demographics questionnaire WHO interpersonal violence questionnaire (IPVQ) Childhood trauma questionnaire (CTQ) Alcohol use disorder identification test (AUDIT)

										Exposure to community violence questionnaire The Edinburgh postnatal depression scale (EPDS)
35	Olufunmilayo and Abosede[39]	Nigeria	Cross-sectional	Analytical	Community	Female sex workers	22 - 30 years	283	Sexual violence was the commonest type (41.9%) of violence experienced, followed by economic (37.7%), physical violence (35.7%) and psychological (31.9%).	Semi-structured interviewer administered questionnaire and in-depth interview guide.
36	Alangea et al.[40]	Ghana	Randomised control trial	Descriptive exploratory	Community	Female	18 to 49 years	2000	Half of women (50.9%) had experienced IPV in their lifetime; with ever experience of sexual or physical IPV.	A structured quantitative survey
37	Reese et al.[41]	Tanzania	Secondary data analysis	Quantitative	Community	Women	15–49 years	10139	Approximately 1.5% (n =94) of women reported perpetrating isolated physical IPV	Domestic violence module

										(questionnaire)
38	Were et al.[42]	East and South Africa	Randomised control trial	Quantitative	Community	HIV serodiscordant couples	N/A	3408	IPV was reported at 2.7% of quarterly visits by HIV infected women.	Interview
39	Falb et al.[43]	West Africa	Secondary analysis	Quantitative	Rural	Women	N/A	981	Half of women reported lifetime physical or sexual IPV, and nearly 1 in 5 (18.6%) reported experiencing reproductive coercion.	Survey
40	Breiding et al.[44]	Swaziland	Survey	Quantitative	Community	Female	13 - 24 years	1244	The risk of experiencing sexual violence in childhood was significantly higher among respondents who reported having had no relationship with their biological mothers	Survey questionnaire
41	Negussie Deyessa et al.[45]	Ethiopia	Cross-sectional	Quantitative	rural and semi-urban	Married women	15–49 years	1994	Violence against women was more prevalent in rural communities.	A standardised WHO questionnaire

42	Yenealem et al.	Ethiopia	Cross-sectional	Quantitative	Acute	Health care workers	25-years<35	553	The prevalence of workplace violence was found to be 58.2%	Structured self administered questionnaire
43	Sisawo et al. [46]	Gambia	Cross-sectional	Mixed	Health administrative regions	Nurses	30> years	219	A sizable majority of respondents (62.1%) reported exposure to violence in the 12 months prior to the survey; exposure to verbal abuse, physical violence, and sexual harassment was 59.8%, 17.2%, and 10% respectively.	self-administered questionnaire
44	Murrayl et al.[47]	Zambia	Randomised control trial	Quantitative	Community	Couples	18-66 + years	123	112 clients reported active IPV	N/A
45	Hendrickson ZM, et al.[48]	Tanzania	Cross-sectional	Quantitative	Community	Female sex workers	18-55 years	496	Forty per cent of participants experienced recent physical or sexual violence, and 30% recently experienced severe physical or sexual violence.	WHO's Alcohol Use Disorders Identification Test assessment
46	Newman et al. [49]	Rwanda	Survey	Mixed	Community	Health workers	N/A	297	Thirty-nine percent of health workers had experienced some form of workplace violence in year prior to the study.	health workers survey, facility

										manager and key informant interviews, patient focus groups and a facility risk assessment inventory (NB: This article draws only from a subset of health worker survey, key informant and facility manager interview,
47	Alemie et al. [50]	Ethiopia	Cross-sectional	Quantitative	Acute	HIV positive women	19-<45 years	626	The overall prevalence of intimate partner violence against HIV positive women within the last 12 months was 64.2%	A pretested structured interviewer-administered questionnaire



48	Andarge and Shiferaw[51]	Ethiopia	Cross-sectional	Quantitative	Community	Married women	15-49 years	696	LifetimeandcurrentIPVwere62.4%and50%,respectively.	A pretested and structured questionnaire
49	Tsai et al.[52]	South Africa	Cohort	Longitudinal	Community	Pregnant women		1238	IPV intensity had a statistically significant association with depression symptom severity	Survey and Edinburgh Postnatal Depression Scale
50	Cao et al.[53]	Ghana	Randomised control trial	Quantitative	Community	Pregnant women	16< years	374	The IPV prevalence was in high sample with 84.8%	Ghana Demographic and Health Survey
51	Mutagoma et al.[54]	Rwanda	Cross-sectional survey	Quantitative	Community	Female sex workers	≥15 years	1978	- Violence prevalence: 18.1% raped/forced sex during sex work, 35.6% experienced physical violence.	Survey
52	Memiah et al.[55]	Kenya	Cross-sectional	Quantitative	Community	Women ever-partnered	aged 15–49 years,	3028	- Higher odds of IPV associated with: age 40–49 yrs, urban residence, being employed, poor wealth index, early sexual debut (<18), low education, partners aged >50 yrs, and attitudes justifying wife-beating.	Survey

53	R. Jewkes et al.[56]	South Africa	Cluster randomized control trial	Quantitative	Community	Young women and men, normally resident, able to consent	Intended : 16–23 years; Actual: 15–26 years	Baseline: 1,415 women & 1,367 men; Follow-up: 1,085 women & 985 men	- Main motivations: HIV testing, community benefit, smaller proportion for incentive (R20).	structured questionnaire
54	Ghoneim et al.[57]	Egypt	Cross-sectional	Quantitative	Community	Women	18–45 year	303	There was no significant difference between both groups in rates of exposure to violence (p-value 0.830). Primary infertility was a significant contributing factor in infertile women's exposure to violence (p-value 0.001)	Arabic validated NorVold Domestic Abuse Questionnaire

55	Z. Iliyasu et al.[58]	Nigeria	Cross-sectional	Quatitative	Acute	Women	range 18–45 years	373	<ul style="list-style-type: none"> - Prevalence of IPV in past year: 35.9% (95% CI 31.1–41.0). - Types: psychological (94%), sexual (82.8%), verbal (35.1%), physical (18.7%), economic (66.4%). - 25.4% experienced multiple forms of IPV. - Main perpetrators: spouses. 	CTS2 (Conflict Tactics Scale, revised).
56	A.P. Pack et al.[59]	Kenya	Cross-sectional	Quantitative	Community	Female sex workers	≥18 years (majority >24 years: 60.6%)	619	<ul style="list-style-type: none"> - Prevalence of IPV (last 30 days): 78.7%. - Perpetrators: both clients & non-paying partners. 	survey
57	M.C.Greene et al.[60]	14 Sub Saharan Africa	population-based cross-sectional survey (multilevel mixed-effects model)	Quantitative	Community	Women	15-49 years	86024	Prevalence of partner alcohol use and IPV ranged substantially across countries (3–62 and 11–60%, respectively).	Demographic and Health Surveys

58	Gebrezgi et al.[61]	Ethiopia	Cross-sectional	Mixed	Acute	Pregnant women	15->34	422	The prevalence of intimate partner physical violence in pregnancy was 20.6% (Interview, pretested semi-structured locally adapted questionnaire
59	Harvey et al.	Tanzania	Cluster randomized control trial	Mixed	Community	Women	Not mentioned	66	Baseline interviews with participants indicate a prevalence of physical and/or sexual IPV during the past 12 months of 27% (95% confidence interval: 24% to 29%)	Structured questionnaires, In depth interview guides
60	Mashaphu et al.[62]	South Africa	Cross-sectional	Quantitative	Community	serodiscordant couples	aged ≥18 year	30	Exposure to IPV differed significantly between men (28.6%) and women (89.3%) (proportional	Questionnaire
61	Belay and Menber[63]	Ethiopia	Cross-sectional	Quantitative	Acute	Married women	below the age 30 years old	119	Nearly half (46.4%) of the study participants were victims of at least one episodes of intimate partner violence in the recent pregnancy. Psychological	structured and pretested questionnaire

									violence 141 (44.2%) was the most common form of violence encountered followed by sexual violence 137 (42.9%).	
62	Abrahams et al.[64]	South Africa	RCT	Quantitative	Acute	Rape survivors	10 - >22 years	279	The follow-up rate for the control arm was 92.7% and 91.9% for the intervention arm.	Telephone call conversations
63	Vyas S.[65]	Tanzania	Demographic and Health Survey	Quantitative	Acute	Women	Mean age 29 years	9,304	In total, 3,868 (43.2%) women reported that they had experienced physical or sexual violence by a partner or non-partner	household questionnaire
64	Dunkle K, et al.[66]	Rwanda	RCT	Quantitative	Community	Couples	<25->35 years	828 women and 821 men	at endline, 815 women (98.4%) and 763 men (92.9%) in the intervention and 802 women (96.4%) and 773 men (93.1%) were available for intention- to- treat analysis	Adapted WHO violence against women instrument
65	Tchamo et al.	Mozambique	Population based analysis	Quantitative	Community	Stakeholders and population	Not mentioned	850,881 (Patients)	The economic cost of VAW in Maputo, Matola, Beira, and Nampula, for a time horizon of	Interviews

									4 years (2005–2008), was US\$1,473,828.7, with the health sector absorbing about 81% of the amount, justice 17%, and organizations working in the area of prevention with 2%.	
66	Merrill et al.[67]	Zambia	RCT	Quantitative	Acute	HIV-positive adolescents and young adults	15–24 years	272	prevalence of any violence victimization was 78.2%. Past-year prevalence was 72.0% among males and 74.5% among females.	survey
67	Ahinkorah et al. [68]	Sub saharan Africa	Survey	Quantitative	Community	Women	15–49	84,486	The odds of reporting ever experienced IPV was higher among women with decision-making capacity [AOR = 1.35; CI = 1.35–1.48].	survey
68	Ameh et al.[69]	Nigeria	Cross sectional	Quantitative	Acute	Infertile women	20-40+ years	233	41% women experienced domestic violence.	Questionnaire
69	N. Kyegombe et al. [70]	Uganda	RCT	Mixed	Community	women	15–49 years	419 men, 343 women	At follow-up, women in intervention communities were less likely to report past year experience of physical or sexual IPV than their control counterparts (aRR 0.68, 95% CI 0.16–1.39)	Interview guide and quantitative questionnaire

70	Gibson et al.[71]	Ethiopia	survey	Quantitative	Community	adults	18-26+ years	809	The survey shows that only 18% of people openly say wife-beating is acceptable, but indirect questions suggest about 28% support it.	population-based demographic survey
71	Dibaba et al.	Oromia	Cross sectional	Quantitative	Community	Female youth	15 to 424years	600	15.3% youth had experienced rape	Adapted from other studies
72	Chirwa ED. Et al.[40]	Ghana	RCT	Quantitative	Community	Adult men)	(≥18 years	2126	Lifetime IPV perpetration: 50% of men	Interview guide
73	Tadesse et al.	Ethiopia	Case control study	Quantitative	Acute	Mothers who gave birth before 37 completed weeks of gestation	15- ≥35 years	138 cases and 276 controls	the prevalence of any IPV during pregnancy was 44.8% among cases and 25% among controls.	IPV questionnaire was adopted and modified from the Ethiopian Demographic and Health Survey (21) and the WHO 2005 Multi-Country
74	M.R. Decker et al. [72]	Baltimore, Maryland,	survey	Quantitative	Community	Female Adolescents	15 - 19 Years	1,112	Among ever-partnered women, past-year IPV prevalence ranged from 10.2% in Shanghai	survey

		USA; New Delhi, India; Ibadan, Nigeria; Johannesburg, South Africa; and Shanghai, China							to 36.6% in Johannesburg. Lifetime non-partner sexual violence ranged from 1.2% in Shanghai to 12.6% in Johannesburg.	
75	Cockcroft et al.[73]	Botswana	Cross-sectional	Quantitative	Community	Young women	15–29 years	3,516	8% reported sexual violence	Interview guide
76	Nakku-Joloba et al.[74]	Uganda	N/A	Qualitative	Community	Male and female	25–44 years	54	Fourteen of 22 (63%) female participants reported that they sometimes experienced domestic violence. Male participant's knowledge of syphilis and their perception of their valued role as responsible fathers of an unborn baby facilitated return.	Interview guide
77	Christofides NJ, et al.[75]	South Africa	Cluster RCT	Quantitative	Community	male	18–40 years	2600	intervention expected to reduce men's perpetration of physical/sexual VAW and improve gender-equitable norms	audio computer-assisted self-interview questionnaire

78	Tulu C, et al.[76]	Ethiopia	Cross-sectional	Quantitative	Acute	Pregnant women	<20- >34 years	385	Overall prevalence of domestic violence during pregnancy: 24.5%. Factors significantly associated with domestic violence: partner alcohol consumption, unplanned pregnancy, and unwanted pregnancy	Questionnaire
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Risk of Bias Assessment

Quantitative studies were appraised using the AXIS tool for cross-sectional designs, CASP for qualitative studies, and RoB-2 for RCTs (Table 3 & 4).

Data Synthesis

Data from the included studies were synthesised using four complementary analytic approaches. First, a thematic analysis was conducted to categorise the forms of violence reported, their determinants, outcomes, and interventions. Findings were mapped against the WHO ecological model to capture risk and protective factors at the individual, relationship, community, and societal levels, ensuring comparability across heterogeneous study designs. Second, a contextual analysis was undertaken to situate evidence within specific population subgroups pregnant women, female sex workers, healthcare workers, adolescents, HIV-positive populations, infertile women, and women sampled through Demographic and Health Surveys (DHS) and across different African countries and regions. This enabled identification of population- and setting-specific vulnerabilities and protective factors. Third, a trend analysis was performed to assess temporal changes in prevalence and patterns of intimate partner violence (IPV) and other forms of violence against women and girls (VAWG). This drew on repeated DHS surveys, WHO multi-country data, and other longitudinal or nationally representative datasets to illustrate stability or shifts in prevalence across time and regions. Finally, an equity-focused intersectional analysis was applied to examine how overlapping structural inequalities including poverty, educational attainment, disability, HIV status, infertility, occupational role, pregnancy, and conflict exposure—intersect to exacerbate risk. This approach highlighted vulnerability clusters, demonstrated how compounded disadvantages amplify both exposure to and consequences of violence, and identified groups most likely to be left behind by universal interventions. Together, these four analytic layers provided a comprehensive synthesis that integrated thematic insights, contextual nuance, temporal patterns, and equity dimensions to inform policy and practice.

Results

Study Characteristics

A total of 78 studies conducted between 2000 and 2024 across 22 African countries were included, encompassing a mix of cross-sectional surveys (n=53), Demographic and Health Survey (DHS)-based analyses (n=9), randomised controlled trials (RCTs; n=7), longitudinal cohorts (n=5), and qualitative or mixed-methods studies (n=4). Sample sizes ranged from small clinic-based investigations of fewer than 200 participants to nationally representative DHS surveys exceeding 5,000 women. Populations studied included pregnant women (n=24), adolescents and young women (n=9), healthcare workers (n=7), female sex workers (n=6), HIV-positive individuals (n=9), infertile women (n=3), and community-based general female samples (n=20). Studies spanned diverse contexts including conflict-affected settings (e.g., Côte d'Ivoire, Uganda), HIV-prevalent communities (e.g., South Africa, Zambia, Ethiopia), and health service environments (e.g., Ethiopia, Rwanda, Gambia) (Lyons et al., 2018). Methodological quality varied, with most studies reporting validated IPV measures (e.g., WHO multi-country instrument, DHS modules), though recall bias, under-reporting, and facility-based sampling limited generalisability in some contexts.

Thematic Analysis

The thematic synthesis identified four dominant themes: forms of violence, determinants and risk factors, health and social outcomes, and protective factors and interventions (Table 2). Violence was consistently multi-faceted, spanning physical, sexual, psychological, economic, controlling behaviours, in-law violence, reproductive coercion, childhood sexual abuse, and workplace harassment. Determinants clustered at the individual (alcohol use, age, education, HIV status,

infertility, disability), relationship (partner control, polygamy, marital status, in-law dynamics), community (poverty, displacement, adolescent marriage, workplace conditions), and societal (gender-inequitable norms, conflict, patriarchal backlash) levels.

Table 2. Themes and sub-themes identified alongside of determinants and exposures.

Theme	Sub-themes	Determinants	Exposures	Evidence synthesis
Forms of violence	Physical, sexual, psychological, economic, reproductive coercion, in-law abuse, workplace harassment	–	WHO/DHS IPV items; workplace violence tools; reproductive coercion scales	IPV 30–65%; pregnancy IPV 25–60%; CSA ~33%; FSWs 50%+; WPV 30–62%
Determinants	Alcohol/substance use; poverty/food insecurity; low education; childhood trauma; partner control; infertility stigma; disability; conflict	Individual, relationship, community, societal (WHO ecological model)	Logistic regression, mediation analysis, DHS pooled regressions	Consistent drivers in >80% of studies; partner alcohol strongest predictor
Health and social outcomes	Maternal morbidity, depression,	–	EPDS, FSFI, birth outcomes,	IPV linked to depression

	anxiety, poor ANC use, adverse birth outcomes (preterm, LBW, stillbirth), HIV/STI risk, sexual dysfunction, workplace stress		ANC attendance, STI/HIV status	($\beta=1.04-1.54$), unintended pregnancy, poor adherence to PMTCT/PE P, low ANC uptake
Protective factors/interventi ons	Education, joint decision- making, social support, couple communication, gender- transformative curricula, psychotherapy, economic empowerment	Individual/relationship/com munity	SASA! cRCT; Indashyikir wa cRCT; CETA psychothera py RCT; MAISHA trial	Demonstrat ed reductions in IPV and improved co-benefits (mental health, food security, parenting)

Contextual Analysis

Contextual patterns were striking across subgroups. Pregnant women reported IPV prevalence exceeding 50% in Ethiopia, predominantly driven by partner alcohol use and women's economic dependency[77, 78]. Female sex workers in Rwanda and Kenya faced pervasive violence (>50%) from clients and brothel managers, often linked to HIV/STI risk. Healthcare workers in Rwanda, Ethiopia, and Gambia experienced 30–62% workplace violence, with nurses and midwives at highest risk due to frontline exposure and understaffing[79, 80]. Adolescents in South Africa reported escalating IPV with age, with prevalence rising from 11% at 13–14 years to 32% at 17–20 years[80]. HIV-positive women and youth in Ethiopia and Zambia experienced the highest reported burdens, with 60–78% multi-type violence, underscoring syndemic interactions between HIV and violence. Infertile women

in Nigeria and Egypt experienced IPV and in-law abuse rooted in reproductive stigma. In contrast, DHS-based national estimates in Nigeria, Ghana, and Kenya were lower (23–35%) but concealed subgroup vulnerabilities.

Trend Analysis

Temporal evidence from repeated DHS surveys and WHO multi-country studies showed persistent high prevalence of IPV across two decades, with no evidence of sustained declines. In Tanzania, physical IPV in pregnancy was ~7–12% in 2001–02 WHO surveys, yet multi-form IPV was ~48% in the 2015 DHS[81]. In Uganda, past-year IPV remained stable at ~30%, but reached >60% in conflict-affected districts. In Ethiopia, Oromia reported pregnancy IPV as high as 65%, contrasting with ~32% in Addis Ababa[9]. DHS data from Nigeria and Ghana remained stable (23–35%) between 2003 and 2018, while South Africa showed IPV prevalence consistently around 40% with syndemic clustering of HIV, poverty, and depression. Figure 1 is a multi-country trend figure (2000–2020) showing IPV prevalence from repeated DHS/WHO studies in Tanzania, Uganda, Ethiopia, Nigeria, Ghana, South Africa.

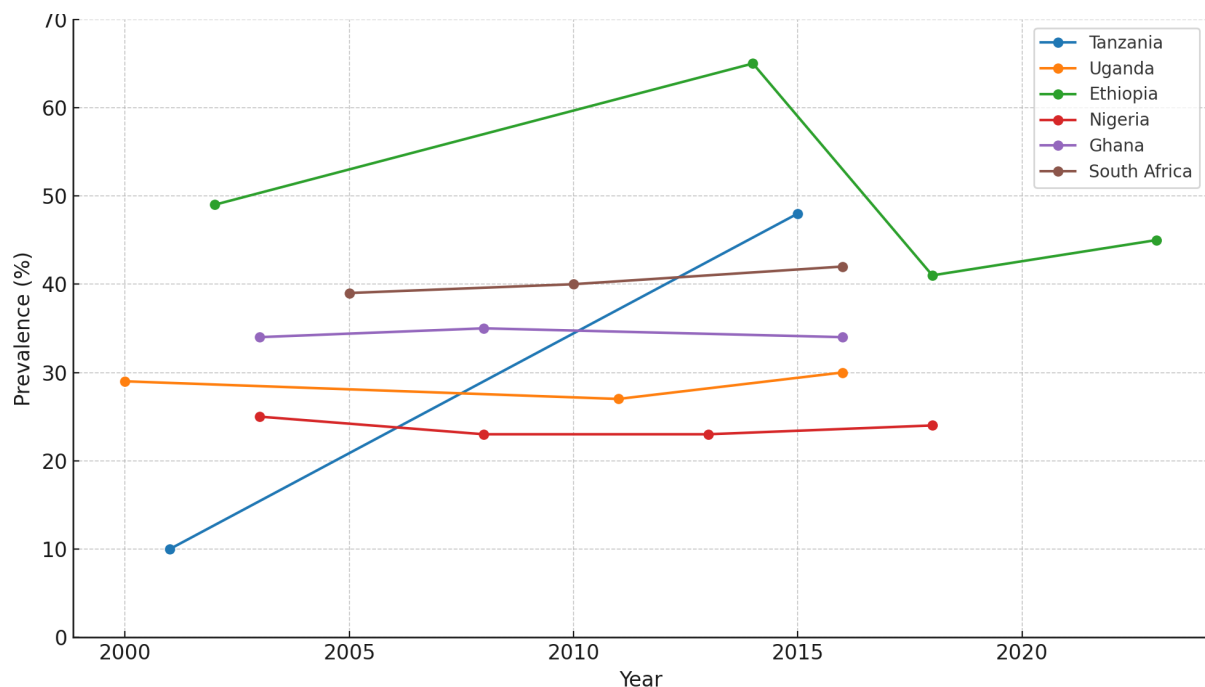


Figure 1. Multi-country trend figure (2000–2020).

Intersectional Analysis

An intersectional lens highlighted how overlapping disadvantages exacerbate risk. HIV-positive women and youth were among the most vulnerable, with IPV prevalence >60%, amplifying poor ART adherence and HIV transmission risks. Pregnant women living in poverty experienced intensified IPV, with food insecurity (AOR 6.59 in Ethiopia) emerging as one of the strongest predictors. Adolescents experiencing school dropout or early marriage faced escalating IPV, particularly in South Africa and Eswatini[82]. Healthcare workers, particularly nurses and midwives, bore a dual burden of workplace and domestic violence, with violence concentrated in under-resourced settings[83]. Conflict exposure increased IPV and in-law abuse in Côte d'Ivoire and Uganda, with odds ratios of 1.7–2.0 for women from conflict-affected households. Importantly, in DHS analyses, women with greater decision-making autonomy sometimes reported higher IPV risk, reflecting patriarchal backlash in transitional empowerment contexts[31].

Discussion

This systematic review provides comprehensive evidence that violence against women and girls (VAWG) in Africa is pervasive, multi-dimensional, and deeply rooted in structural inequalities. Across 80 studies from 22 countries, we found that lifetime intimate partner violence (IPV) affects between one-third and two-thirds of women, with particularly high prevalence among pregnant women, HIV-positive populations, female sex workers, and healthcare workers[83]. Violence was not limited to the home: in-law abuse, reproductive coercion, childhood sexual violence, and workplace harassment were also prominent. Determinants clustered across the WHO ecological model, including alcohol use, poverty, food insecurity, gender-inequitable norms, and conflict exposure. Importantly, interventions such as SASA!, Indashyikirwa, CETA, and MAISHA demonstrated that well-designed, gender-transformative or trauma-focused programmes can reduce violence and deliver co-benefits in mental health, child wellbeing, and economic security[70]. Collectively, these findings highlight that VAWG is not only an endemic social issue but also a public health emergency demanding systemic, multi-sectoral responses.

The implications of these findings are profound. Population-level surveys such as DHS tend to report prevalence between 23% and 35%, but subgroup analyses reveal much higher burdens in marginalised groups, aligning with literature from South Asia and Latin America where structural vulnerability predicts concentrated violence exposure. Our synthesis shows that pregnant women, HIV-positive individuals, adolescents, infertile women, sex workers, and healthcare workers all experience overlapping risks that are seldom captured in national averages. This divergence illustrates a major gap in existing research: current epidemiological monitoring frameworks under-report hidden, high-risk populations and under-measure non-partner violence such as workplace harassment and in-law abuse. Furthermore, while a small but growing number of intervention trials in Africa demonstrate reductions in IPV, these remain concentrated in a few countries (Uganda, Rwanda, South Africa, Tanzania), with little coverage elsewhere. There is limited longitudinal evidence on how violence trajectories evolve across the life course, and insufficient integration of equity-focused analyses in existing reviews.

Clinically, the findings underscore the urgent need for trauma-informed, integrated care pathways. IPV was consistently linked to maternal morbidity, depression, anxiety, unintended pregnancy, poor antenatal care uptake, preterm birth, low birth weight, HIV/STI risk, and even occupational attrition among healthcare workers. For pregnant and postpartum women, routine IPV enquiry during antenatal and reproductive health visits should be prioritised, alongside referral to trauma-based psychological support and linkage with economic and social protection services. For HIV-positive populations, integrating IPV screening into ART adherence and prevention of mother-to-child transmission (PMTCT) programmes is essential. Health systems must also recognise workplace violence as both a gender equity issue and a contributor to staff burnout, absenteeism, and poor patient outcomes. The clinical evidence is unequivocal: without addressing trauma and violence, gains in maternal, sexual, and reproductive health will remain constrained.

This paper makes several novel contributions. First, it combines thematic, contextual, trend, and intersectional analyses in a single synthesis, providing a uniquely multi-layered understanding of VAWG in Africa. Second, it extends beyond IPV to encompass often-overlooked forms of violence such as in-law abuse, reproductive coercion, workplace harassment, and the dual burden among healthcare workers demonstrating that women's experiences of violence are complex and extend across multiple spheres of life. Third, by applying an intersectional lens, this review identifies clusters of compounded vulnerability that are rarely captured in conventional epidemiological reports, offering direct guidance for targeted policy and programming. Finally, by integrating temporal trends with equity analysis, the review shows that while national averages have remained relatively stable, concentrated risks persist and are likely worsening in conflict and high HIV-prevalence settings. Taken together, these findings establish a new standard for evidence synthesis on VAWG in Africa and provide a roadmap for interventions and research that centre structural inequality, trauma, and resilience.

Strengths and limitations

This review has several notable strengths. It is, to our knowledge, the most comprehensive synthesis of violence against women and girls (VAWG) in Africa to date, drawing on 80 studies from 22 countries and spanning over two decades of evidence. By integrating four analytic lenses thematic, contextual, trend, and intersectional it provides a multidimensional understanding of both the scale and complexity of violence. The inclusion of diverse populations, such as pregnant women, sex workers, adolescents, healthcare workers, HIV-positive and infertile women, strengthens the relevance of the findings across different life stages and social contexts. Furthermore, the incorporation of intervention trials alongside epidemiological studies highlights not only the magnitude of the problem but also emerging solutions.

There are, however, limitations. Evidence was concentrated in East and Southern Africa, with relatively fewer studies from West and North Africa, limiting regional generalisability. Many studies relied on cross-sectional designs, precluding causal inference. Recall bias, under-reporting due to stigma, and the sensitivity of IPV questions may have underestimated true prevalence. Measurement variability, particularly in non-partner violence and reproductive coercion, restricted comparability. Finally, the synthesis, while robust, was largely descriptive; quantitative meta-analysis was precluded by heterogeneity in study designs, outcomes, and measures.

Conclusions

Violence against women and girls in Africa is widespread, multifaceted, and closely tied to structural inequalities, with particularly high burdens among pregnant women, HIV-positive populations, sex workers, adolescents, infertile women, and healthcare workers. The health consequences are profound, spanning maternal morbidity, mental health disorders, reproductive harm, and occupational stress. While evidence-based interventions such as community mobilisation, couples' curricula, and trauma-focused care show promise, coverage remains limited. Addressing VAWG requires integrated, trauma-informed, and equity-focused responses embedded within health systems, alongside.

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