SEXUAL VIOLENCE AGAINST CHILDREN IN MALAWI:

UNDERSTANDING PROTECTIVE FACTORS AND GENDER NORMS AIMED AT REDUCING VICTIMIZATION

by

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(Under the Direction of Nathan Hansen, PhD)

ABSTRACT

Background: Violence against children is a profound violation of human rights that spans across cultures, races, economic positions and geographical borders in both developed and developing countries. The most recent global estimates conducted by the World Health Organization (WHO) indicated that 150 million girls and 73 million boys under the age of 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact (WHO, 2006). The primary purpose of this dissertation is to better understand individual, familial and social causes that influence or hinder act(s) of sexual violence experienced in childhood by examining the protective factors and gender norms that are correlated with victimization.

Objective: This study examined associations between protective factors, gender norms and sexual violence by addressing the specific variables associated with placing a population (i.e. socioeconomic status, age and sex) at higher-risk. This information may inform and guide the development of strategies set to strengthen actions protecting children from sexual violence before it occurs.

Methods: The study design is based on secondary analysis of *Violence against Children Survey* (VACS) data previously collected in Malawi. Bivariate and multivariate logistic regression were employed to assess the links between protective factors, attitudes/beliefs of children and experiencing sexual violence.

Results: Among females, study findings determined that closeness of/with father, feeling safe in the community and never witnessing parental abuse and protection from sexual violence were protective factors from experiencing sexual violence. For males, findings indicated that positive friendships, perceived safety in the community and never witnessing spousal abuse were protective factors against exposure to sexual violence. Results also confirmed that certain gender norms are associated with the risk of sexual violence in childhood. For females, socioeconomic status was associated with sexual violence. Also, there were more significant associations between attitudes and believes in gender-based violence, intimate partner violence and perceptions of sexual relationships and having experienced sexual violence than among male respondents. These findings imply that further research and interventions should align with verifying gender norms while addressing key ethical tensions between cultural values and the factors that may cause social unbalances.

INDEX WORDS: Sexual violence against children, protective factors, gender norms, gender-based violence

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TABLE OF CONTENTS

Page

CHAPTER 1

INTRODUCTION

The Nature and Magnitude of Violence against Children

Violence against children is a profound violation of human rights that spans across cultures, races, economic positions and geographical borders in both developed and developing countries. In general, *violence against children* is categorized as physical, emotional and/or sexual. It can occur in the home, at school, during work, in care and justice systems and among community settings (Pinheiro, 2006). It is roughly estimated that between 500 million and 1.5 billion children endure some form of violence each year (United Nations [UN], 2013). The consequences of such violence can result in devastating short and long term mental, physical and economic consequences for the survivors, their families and society as a whole, compromising a child's entitlement to development and threatening their survival. Nations of sub-Saharan Africa, in particular, have among the highest rates of violence against children in the world. In fact, "reports of violence across Africa are so frequent it has now become accepted as an inevitable part of life" (World Health Organization [WHO], 2010, p. 1).

The true magnitude of *sexual violence against children* in sub-Saharan Africa in particular, remains unknown due to cultural fears and stigmas, mistrust in authorities, lack of services and underdeveloped social justice systems (Lalor, 2008; WHO, 2010). The most recent global estimates conducted by the World Health Organization (WHO) indicated that 150 million girls and 73 million boys under the age of 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact (WHO, 2006). Though the nature and

consequences of sexual violence against children differ from country to country in Africa, rates are among the highest reported in the world (Department of Social Development [DSD], Department of Women, Children and People with Disabilities & UNICEF, 2012; Jewkes, Sen & Garcia-Moreno, 2002). Studies in Africa indicate that "one-third of girls report their first sexual experience as being forced and nearly one in four women has experienced sexual violence in their lifetime" (Reza et al., 2007, p. 9). It has also been found that 40% of child survivors are girls under the age of 18, and one in six cases are under the age of 12 years (Jewkes, Abrahams & Mathews, 2009). Although little is known about the prevalence of sexual abuse among young males in Africa, research indicates that "1 in 10 men in adulthood report having been sexually abused by other men" (Mathews, Loots, Silweyiya & Jewkes, 2012, p. 84).

The Public Health Consequences

Violence against children is a major public health crisis. The United Nations (UN) Committee on the Rights of the Child (CRC) reports the most common consequences of physical, emotional and/or sexual violence against children are linked with cognitive impairment and failure to thrive causing greater susceptibility to injury, infectious diseases, mental health issues and other long-term chronic health conditions (Santos, 2013). In addition, child survivors of violence face the physical and emotional scars that may weaken their ability to prosper in adulthood to create healthy families and contribute to sound communities.

Sexual violence experienced in childhood can result in severe short and long term health and emotional conditions, manifesting immediately and/or in the years following assault. Conditions such as sexually transmitted infections, unintended pregnancies, obstetric and reproductive health issues, heart disease, depression and/or increased risk of suicide are some of the negative health outcomes resulting from sexual violence experienced in childhood (Dahlberg

& Krug, 2002; Millet, Kohl, Jonson-Reid, Drake, & Petra, 2013). In addition, a host of co-morbidities can be associated with sexual violence as physical and emotional traumas and limited access to immediate emergency healthcare often exacerbates consequences experienced by one incident alone.

Taxing already strained legal and social welfare services, sexual violence against children also results in a host of devastating outcomes as well as social and economic costs associated with reduced human capital and productivity, long-term medical care, social ostracism and/or placement of child victims in care (WHO, 2006). Additionally, these crimes against children may lead to further victimization in adulthood, violent relationships and/or risky sexual behaviors.

The impact of sexual violence on HIV infection is especially alarming in countries with fragile infrastructures lacking adequate care and treatment programs. Although the majority of HIV-infected children acquire the virus from their HIV-infected mothers pre/post-natal or through breastfeeding, HIV infection in female adolescents has a strong correlation with sexual violence experienced in childhood (Sommarin, C., Kilbane, T., Mercy, J., Moloney-Kitts, M. & Ligiero, D.P., 2014). In fact, recent evidence suggests that HIV infection rates in Africa are now most prevalent among adolescent female populations, and is strongly correlated with gender-based sexual violence[1] (20 to 25 percent of HIV infections among young adolescents in South Africa) (Jewkes, 2013; UNAIDS, 2014). Children may be exposed to and infected with HIV directly from a perpetrator, or indirectly due to the consequences of sexual assault that may later

[1] In 1993, the UN Declaration on the Elimination of Violence against Women offered the first official definition of the term "gender-based violence", which is used by the WHO today as any act of "violence that results in, or is likely to result in, physical, **sexual** or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" (UN General Assembly, A/RES/48/104, 2003).

lead to HIV infection (i.e. early and risky-sexual behaviors, non-disclosure due to fear and stigmatization and other health inequalities) (WHO & UNAIDS, 2013). Furthermore, children who witness intimate partner violence[1], are coerced into sex or marriage at a young age are also at-risk for HIV for similar reasons (i.e. early onset of sex, high-risk behaviors, etc.) (Moore, Awusabo-Asare, Madise, Langba & Kumi-Kyereme, 2007; Roman & Frantz, 2013).

General Research Purpose

The primary purpose of this dissertation is to better understand individual, familial and social causes that influence or hinder act(s) of sexual violence experienced in childhood. This dissertation conducted two separate studies employing quantitative analysis designed to:

(1) Examine direct and moderating associations between protective factors and sexual violence (victimization). Results from these analyses may help programs aimed at violence prevention gain a better understanding of which factors are more highly linked with victimization and which factors are more protective. Therefore, study outcomes may inform and guide the development of strategies to strengthen certain individual, familial and/or community interventions aimed at protecting children from sexual violence before it occurs. This new knowledge may also contribute to national advancements in effective prioritization of resources for response actions needed to combat the negative health consequences resulting from sexual violence.

(2) Explore associations between gender norms (attitudes and beliefs) among males and females who have experienced sexual violence in childhood to determine which factors are related to sexual victimization. Gender norms are highly correlated with social determinants of health and influence health behaviors. To this end, it is important to understand which ideals may be linked

[1] IPV is defined as "physical violence, **sexual violence**, stalking and psychological aggression by a current or former intimate partner" (Breiding, Basile, Smith, Black, & Mahendra, p. 11, 2015).

to sexual violence and which beliefs may reveal any imbalances - that may result in victimization. Furthermore, how males and females think differently about issues related to abuse and sexuality may expose levels of individual tolerance and social constructs of behavior linked to victimization. This analysis identifies if beliefs concerning gender-based violence, sexual relationships and/or intimate-partner violence are associated with placing a child at higher-risk for sexual violence taking into consideration socioeconomic status.

History and Limitations of the Research

Few studies have directly examined sexual violence against children in Africa as cases are often undisclosed, hidden and under-investigated. Even less known are the protective factors among families, communities and the larger society that can buffer or mitigate the risk of violence. Furthermore, research on gender norms investigating both male and female attitudes and beliefs about violence and sexual relationships are also largely underexplored in this region of the world (Small & Nikolva, 2015; Scott et al., 2013).

Studies typically highlight efforts that address actions against violence as more reactive than proactive; strategies to protect children tend to be disjointed and non-collaborative, and insufficient resources are allocated to measure the problem. Thus in 2006, the United Nations Secretary attempted to address research limitations by launching a worldwide study to determine the scale and causes of violence against children (Pinheiro , 2006). This three-year study resulted in a global response intending to augment resources for increased participatory research efforts for public action to prevent violence against children, especially sexual violence. In follow up, *The Global Survey on Violence against Children (2013),* reconfirmed that nations must prioritize prevention efforts on violence against children by addressing the underlying causes and translating them into preventive actions on multiple social-ecological levels (UN,

2013); thus reinforcing holistic and integrated approaches for prevention efforts. However, these studies did not fully identify systematic approaches needed to understand factors influencing child victimization and the more immediate response for survivors and their families; nor were these studies adequately linked to the advancement of the Millennium and/or Sustainable Development Goals,[1] "despite the fact that high levels of violence seriously undermine the possibility of achieving any of the goals" (WHO, 2010, p. 4; UN, 2000).

To address the need for more comprehensive and standardized studies measuring the true nature and magnitude of violence against children, the U.S. government, in partnership with other national governments and Together for Girls, initiated the *Violence Against Children Surveys* (VACS). VACS are the first nationally representative household surveys investigating physical, emotional and sexual violence against female and male children (CDC, 2013). More specifically, VACS estimate the "national prevalence of sexual, physical and emotional violence against children; identify potential risk and protective factors for violence against children; identify health and social outcomes of violence against children; and, assess knowledge and utilization of services available for children who have experienced violence as well as barriers to accessing such services" (CDC, 2013, p.13). Currently, VACS have been conducted in thirteen countries globally, with eight more in progress. Previous to VACS, studies in low-income countries examining violence against children have been non-generalizable or unpublished, causing significant gaps in evidence needed for planning, response and prevention efforts (Lalor, 2003; Lalor, 2004; Speth, 2009). Data obtained from VACS were used for this dissertation.

[1] The Millennium Development Goals set in the year 2000 were a blueprint and universal commitment to 8 goals and subsequent action plans to reduce poverty, hunger and disease among the world's poorest populations. When the goals ended in 2015, countries adopted a new set of sustainability goals established to "end poverty, protect the planet, and ensure prosperity for all as part of a new sustainable development agenda. Each goal has specific targets to be achieved over the next 15 years" (UN, 2015).

Research Significance and Public Health Impact

This research is significant because it addresses specific demographic factors and norms that may protect or modify the risk of sexual violence. Current VACS analyses do not report on the different protective factors or gender norms that may be associated with sexual victimization. Thus, the analyses conducted in these studies were derived from the comprehensive VACS datasets that would otherwise not be applied or fully analyzed.

Although research on sexual violence against children in Africa has not been widely investigated, studies in other regions of the world have conclusively established that one incident alone may result in multiple morbidities possibly due to limited healthcare access and availability (Lalor, 2008; WHO, 2010). Therefore, without integrative research investigating factors that can influence victimization, current response services are ineffective, leaving children vulnerable to a host of additional long-term negative health outcomes (Senn, Carey, Vanable, Coury-Doniger & Urban, 2006). Furthermore, risk factors have been extensively and more rigorously studied than protective factors; thus, it is critical to investigate protective factors that may directly modify the risk of violence, and help us to better understand resiliency and/or factors that are not necessarily associated with risk factors. To stop these consequences taxing social and health care systems, we must start with understanding the factors associated with protecting children from victimization in order to effectively prioritize interventions and more comprehensive services for survivors and their families.

Dissertation Format

This dissertation consists of two separate research papers; the first examining protective factors that may predict or have an effect modification on sexual violence and the second to investigate specific gender attitudes/beliefs that may be associated with victimization.

Below are the research questions, specific aims and hypotheses that reflect the general purpose of the dissertation according to each research paper. Overall, this dissertation seeks to address two primary research questions:

RQ1: What protective factors are associated with preventing sexual violence in childhood?

RQ 2: What gender attitudes and beliefs (gender norms) are associated with either protection or risk of sexual violence experienced in childhood?

Research Paper #1

Overall research questions (for paper #1)

RQ1: Are the proposed factors associated with protecting children from sexual violence (victimization)?

RQ2: Will the sex of the respondent moderate the strength of the associations between (1) positive parental relationships, (2) positive supportive friendships, (3) never witnessing violence in the home, and/or (4) feeling trust and safety in the community and protection from sexual violence?

RQ3: Will age or sex moderate the strength of the associations between (1) positive parental relationships, (2) positive supportive friendships, (3) never witnessing violence in the home and/or (4) feeling trust and safety in the community and protection from sexual violence?

RQ4: Are there any other interactions among the protective factors in their association with the prevention of sexual violence? For example, are the following moderating factors in protecting children from sexual violence: (1) perceived safety in the community, (2) perceived trust in the community, and (3) never witnessing violence in the community?

Specific Aim #1: Examine protective factors that are directly associated with the prevention of sexual violence experienced in childhood (victimization).

Hypotheses for Specific Aim #1:

H1.1: A strong sense of relationship with parents will be positively associated with protection from sexual violence.

H1.2: Children who have a friend to talk to about important things will be more protected from sexual violence than those who do not feel they have a close friend to talk to.

H1.3: Perceived safety and trust in the community will be protective factors against sexual violence.

H1.4: Having never witnessed violence before age 18 will be a protective factor against childhood sexual violence.

Specific Aim #2: Examine protective factors that differentially modify the observed effect of one protective factor with the prevention of sexual violence experienced in childhood (effect modification).

Hypothesis for Specific Aim #2:

H2.1: Gender and sex will interact (to positively influence) the causal effects of (1) parental relationships, (2) perceived trust and safety in the community, and (3) witnessing violence - on protecting a child from sexual violence.

Research Paper #2

Overall research questions (for paper #2)

RQ1: Are different gender attitudes/beliefs associated with protecting children from sexual violence (victimization)?

RQ2: Is socioeconomic status associated with experiencing sexual violence and is this linked to gender norms and protection or risk of sexual violence in childhood?

RQ3: Will gender and age moderate the strength of the associations between (1) tolerance and gender-based violence, (2) intimate partner violence, and/or (3) sexual relationships and protection from sexual violence?

Specific Aim: Examine gender attitudes/beliefs towards tolerance and gender-based violence, intimate-partner violence and sexual relationships and that are directly associated with the risk of sexual violence experienced in childhood (victimization).

Hypotheses for Specific Aim:

H1.1: Attitudes/beliefs against gender-based violence will be positively associated with protection from sexual violence.

H1:2: Attitudes/beliefs against intimate partner violence will be positively associated with protection from sexual violence.

H1.3: Attitudes/beliefs in negative sexual relations (i.e. men need to have sex with other women, even if they have good relationships with their wives) will be a risk factor for sexual violence.

H1:4: Respondents with a lower economic status (i.e. no electricity or car) and negative attitudes/beliefs about gender-based violence, intimate partner violence and sexual relationships are more likely to experienced sexual violence.

Study Designs

The study designs for the two papers presented in this dissertation are based on secondary analysis of *Violence against Children Survey* (VACS) data previously collected in Malawi (detailed in Appendix A). Led by the U.S. Centers for Disease Control and Prevention (CDC), in partnership with UNICEF and national ministries, a standardized VACS study design and descriptive quantitative methods for analysis and reporting was implemented to ensure

consistency with global indicators for violence against children. Analyzing the VACS variables of most interest to the global community involved an analytical approach including a description of weighted frequencies and percentages to obtain parameter estimates from the data along with 95% confidence intervals (CDC, 2013).

The purpose of both papers is to investigate the protective factors and gender norms (both categorical variables) that may have an impact on sexual violence. Chapters 3 and 4 of this dissertation include the manuscripts of each paper. Descriptions of the analytic strategies demonstrate the use of bivariate and multivariate analysis to help determine the existence of relationships between the independent variables and outcomes (i.e. protective factors and risk of sexual violence in study #1, and gender norms (attitudes/beliefs) and victimization in study #2). Whereas any effect modifications examined (characterized statistically as an interaction) helped determine if the level of a third factor changes the association (magnitude) of the effect of the primary exposure on the outcome (main effects).

Each paper examines both females and males according to two separate age groups (13-17 and 18-24).[1] The datasets used for this dissertation are based on a total of 2,162 interviews conducted in Malawi in 2013 consisting of 1,029 females (84.4% response rate) and 1,113 males (83.4% response rate) (MoGCDSW et al., 2014). For the studies conducted in this dissertation, data was stratified for each age group (i.e. 13-17 and 18-24) to help with interpretation of findings; the 13-17 age group yielded information on events occurring only within the 12 months prior to the interview to show current prevalence and patterns of sexual violence, and the 18-24 age group responses were based on experiences prior to age 18 years to show lifetime

[1] Respondent responses were placed into one of the two age groups (13-17 or 18-24) according to his/her age at the time the data was collected.

prevalence. In addition, examining the data according to age groups (i.e. 13-17 and 18-24) also helped to control for confounders when examining other variables (for example witnessing violence and gender norms towards gender-based violence), thereby making it easier to detect and interpret relationships between the independent and dependent variables. Different statistical models were employed to yield to most accurate quantitative findings (described in each manuscript and detailed in appendix C).

Ethical Considerations

The *Violence against Children Survey* in Malawi was independently reviewed and approved by the U.S Centers for Disease Control and Prevention Institutional Review Board (IRB) and the Malawian National Commission for Science and Technology Ethical Review Board. Participants aged 18-24 who were eligible for the study provided written informed consent. Participants 15–17 years provided assent and received consent from parents, and those under 17 living on their own or heading households were eligible for enrollment as emancipated minors.

When conducting research on sexual violence against children, implementation of rigorous ethical guidelines are critical. These guidelines help to minimize the risk of potential harm to participants, researchers and others, and ensure that risks are outweighed by benefits. Unfortunately, there is a serious disparity in internationally recognized or agreed upon ethical standards and guidelines for violence against children research (Finklehor, Hamby, Turner & Walsh, 2012). Thus, researchers are limited by the lack of resources to help guide and address ethical considerations different to that of more traditional research involving child respondents; the ethical responsibility is to ensure the research does no harm (Graham, Powell, Taylor, Anderson & Fitzgerald, 2013). There is some evidence that adolescents and young adults are

willing to talk about their experiences of abuse under a supportive structure; however, researchers must be prepared to address any challenges or dilemmas resulting in any strong emotional responses. In the context of this dissertation, assurances were warranted that data collection was obtained in the most ethically sound method as possible. In addition, findings presented in each manuscript (chapters 3 and 4) were carefully constructed to meet realistic capacities for intervention development and construed to prevent misinterpretation of blaming the innocent victim of these wrongdoings. To this end, the studies in this dissertation employed evidence-based standards with a pragmatic approach to data analysis, interpretation and reporting.

The Global Context of Violence against Children

For both papers, it is essential to understand the background and context of violence experienced in childhood, and to convey the deficiencies in evidence-based research in Africa. Guided by the research questions and hypotheses above, chapter 2 of this dissertation systematically explores the literature and details the gaps examining the links between the protective factors and victimization. Further reviews examine the attitudes/beliefs of children towards violence against women (gender-based violence), intimate partner violence and sexual relationships. Lastly, I felt it was also important to note perceptions of disclosure and how they relate to other help-seeking behaviors that may impact the effectiveness of interventions and services for child survivors of sexual violence in sub-Saharan Africa.

CHAPTER 2

LITERATURE REVIEW

This chapter examines several topics associated with violence against children in sub-Saharan Africa with a special emphasis on factors contributing to or preventing victimization of sexual abuse. The chapter also includes a systematic review of existing studies conducted in this region to understand the constructs associated with sexual violence against children in the context of African cultures, beliefs and norms. In addition, a deeper concentration about sexual violence against children in the nation of Malawi is highlighted to provide background and cultural context for the studies conducted in this dissertation. Thus, an exhaustive review of studies in countries outside of the sub-Saharan Africa region is beyond the scope of this chapter.

This chapter has five main sections. The first section defines the different types of childhood violence and how they may be interrelated. The second section covers the theoretical frameworks associated with risk and protective factors and gender norms. The third section provides an overview of the prevalence and health outcomes resulting from childhood sexual violence, with a special focus on the country of Malawi. The fourth section examines the factors associated with protecting children from violence and gender-norms that may be associated with victimization. This section also describes the impact that perceptions of sexual violence can have on the different types of interventions (services) offered in Malawi. The last section describes the challenges and ethical considerations associated with researching violence against children.

Violence against Children in Africa

Physical, Emotional and Sexual Violence in sub-Saharan Africa

As mentioned, *violence against children* is generally divided into three forms: physical, emotional and sexual. The differences between these forms of violence may be distinguishable from the perspective of clinical presentation, perpetrator intent and treatment; however, the existence of one form of violence is typically coupled with another. For example, an act of physical violence can be as emotionally shattering as it is physically traumatizing as consequences associated with betrayal from a trusted caregiver may be as devastating as the physical injuries incurred (Wolfe & McGree, 1991). Sexual abuse in particular is typically accompanied by both physical and emotional traumatization.

Since children can be subjected to more than one form of abuse at a time, it is important to address the relationships among each type of violence. Studies have found that correlations between physical, emotional and sexual violence have several similarities among long and short-term health consequences, risk and protective factors, settings, social and economic costs, revictimization and threat of harm (ISPCAN, 2003). The Violence Against Children Survey (VACS) conducted in Tanzania, for example, found that sexual violence experienced by females and males (aged 13-24) was often coupled with physical and emotional violence (UNICEF Tanzania, CDC & Muhimbili University of Health and Allied Services, 2011). Similarly, VACS conducted in Kenya revealed that "13% of females and 9% of males experienced all three types of violence during childhood" (UNICEF Kenya, CDC & Kenya National Bureau of Statistics, 2012, "Executive Summary," para. 3). Understanding how different types of violence overlap provides insight into the multiple risks associated with simultaneous occurrence of abuse, and

risk(s) associated with violent acts at different points in time. This information is essential to the coordination of protection and response networks.

Defining Key Terms

In an effort to articulate meaning and implication of violent acts against children, it is essential to describe the terminology most commonly used in examining violence in the sub-Saharan African region. Defining violence against children in this context, however, is challenging because of the distinctions between what constitutes and contributes to each type of violence, but also the cultural differences in which violent acts occur. Unfortunately, definitions differ to some extent and remain subject to interpretation. Therefore, in an attempt to consolidate terminology used in research, policies and action in sub-Saharan Africa for this dissertation research, the following developments and "definitions" are considered.

The 1989 United Nations Convention on the Rights of the Child define *violence against children* as, "all forms of physical and mental violence, injury and abuse, neglect or negligent treatment, maltreatment or exploitation and sexual abuse." The term *child maltreatment* is commonly used to collectively describe all of these forms of child abuse. Finkelhor and Korbin (1988) provided one of the first definitions of abuse and neglect broad enough to be responsive to the differences in cultural values, norms, and beliefs as, "the portion of harm to children that results from human action that is proscribed, proximate and preventable" (Pierce & Bozalek, 2004, p. 818; Finkelhor & Korbin, 1988, p.4). Application of this definition suggests that not all maltreatment is also abuse, which may be interpreted and imparted differently from the perspective of African cultures (Pierce & Bozalek, 2004). Thus Korbin later indicated (1991) three aspects for framing their child maltreatment definition in regard to these differences (culturally): "(1) cultural differences in childrearing practices and beliefs, (2) idiosyncratic

departure from one's cultural continuum of acceptable behavior, and (3) societal harm to children" (p. 68). In 1999, the WHO Consultation on Child Abuse defined child maltreatment as:

> All forms of physical and/or emotional ill-treatment, sexual abuse, neglect or negligent treatment or commercial or other exploitation, resulting in actual or potential harm to the child's health, survival, development to dignity in the context of a relationship of responsibility, trust or power (p. 15).

Unfortunately, the absence of one unified definition has resulted in various interpretations of what child maltreatment means from country to country (i.e. what is, and what is not child maltreatment). A movement towards standardizing this definition would help to articulate not only meaning, but also the subsequent coordination aimed at protecting and responding to child maltreatment (Ehiri, 2009).

Globally, there is no standard definition for *sexual violence against children* specifically. Remaining consistent with definitions used for child sexual abuse in low-to-middle income countries, the WHO (1999) developed possibly the most commonly recommended definition:

> The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by the age of development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person (pp. 13-17).

These definitions (reflective of child maltreatment and sexual violence against children) will be observed and considered throughout the dissertation and subsequent research papers. As

defined, there are several additional forms and implications associated with sexual violence. The analyses in this dissertation explored the four types of sexual violence as reported in the VACS datasets to include: (1) unwanted sexual touching; (2) unwanted attempted sex (intercourse); (3) physically forced sex; and, (4) pressured sex (intercourse) before the age of 18 (Ministry of Gender, Children, Disability and Social Welfare [MoGCDSW], University of Malawi, UNICEF Malawi, & CDC, 2014).

Ecological Frameworks to Understanding Sexual Violence against Children

The *Global Survey on Violence against Children* (2013) conducted by the United Nations identified five settings that violence against children occurs worldwide. These five settings include: "the home and family; school and educational settings; care and justice institutions; the work place; and, the community" (UN, 2013, p. xv). The social ecological model is the most fundamental framework used to understand this framework and the complex "interplay" of protective and risk factors that contribute to sexual violence occurring in these different settings. These factors are not only represented on the levels of the victim, perpetrator and family, but also on the community and societal systems that may inadvertently tolerate these crimes while concurrently providing services to remedy negative health outcomes.

The social ecological framework also helps us better understand violence and the effect of potential prevention strategies by looking at the inclusion of risk and protective factors from different influences (factors) at different levels including: individual, relationship (familial), community, and societal (Jewkes et al, 2002). Incorporated into one ecological model, we can begin to address the factors that may increase or decrease a child's individual vulnerability to sexual violence, as well as examine the gender-based perspectives of the familial, community and societal risk factors (Wessells, 2009). For example, gender inequalities involve risk factors

for sexual violence against children through social constructs of hypermasculinity on the individual level and societal level as gender norms (WHO, 2014). On the other hand, "protective factors may lessen the likelihood of sexual violence victimization or perpetration by buffering against risk" such as a family's ability to identify and counter risk for violence and/or supportive school systems that provide awareness and education on violence and prevention (CDC, 2014, "Protective Factors for Perpetration," para. 1). Additionally, the social ecological model emphasizes that sexual violence prevention requires changing norms, climate and culture. It addresses how we can promote community and behavioral change by addressing child protection and development, which is critically dependent on a secure, protective environment (familial). Thus, the social ecological model helps to identify protective factors in order to design "cross-sectoral prevention programs by highlighting the links and interactions between different levels and factors" (WHO, 2014, p. 19).

Brofenbrenner's Ecological Systems

To further emphasize the risk and protective factors on the level of the child victim, Urie Brofenbrenner's ecological systems theory helps us understand "that individuals, including children, influence their social environments and that various contexts of the social environment influence each other as well as the individual" (DSD et al., 2012, p. 5). Protection and response requires detailed understanding of the factors that "influence" violence. To this end, Brofenbrenner describes four levels of influence to include the micro, meso, exo and macro systems. These levels can be used to describe how certain risk and protective factors of the individual child may be directly influenced by his/her environment (e.g. gender norms).

Starting with the micro-system, the child is "alongside those directly involved in his/her treatment and care" (Coetzee, Kagee, & Bland, 2015, p. 315). These interactions (in the micro-

system) are also examined in the meso-system. For example, families in general provide a protective environment for growth and security formed by its members. However, family environments are sometimes dangerous in the context of harsh disciplines, patriarchal masculinities, forced parental control and lack of child monitoring and supervision. Research has indicated that approximately 7-37% of females and 3-27% of males reported sexual acts of violence as a child; with up to 56% of girls, and 25% of boys reported a relative or step-parent as the perpetrator (Callender & Dartnall, 2010). Home may also be where gender-based inequalities are first experienced by children, since boys may be encouraged to be more aggressive and dominant and girls to be more passive and compliant (Pinheiro, 2006). Unfortunately, challenging violence in families is very difficult as there is reluctance to intervene in this "private" sphere. The shame, secrecy and denial associated with familial violence against children fosters silence – children are afraid of consequences and afraid to disclose and seek services. Thus, the persisting circle of violence and negative outcomes continue.

Risk factors for violence against children associated with the exo system (community level) also directly impact the child individually. Risk factors such as language barriers, educational opportunities and access to health may negatively impact a survivor's ability to disclose and seek healthcare. These influences may also result in social ostracism and stigmas that negatively impact health outcomes, growth and development.

Finally, the macro-system reflects the impacts of health inequities, differences in cultural and societal norms that tolerate sexual violence and the stigmas associated with violent acts of abuse (Coetzee et al., 2015). The negative effects of the macro-system may greatly reduce protection strategies aimed at providing essential clinical and/or psychosocial care to counter the negative health consequences of sexual violence.

Overview of Violence against Children in Malawi

Prevalence and Health Outcomes in Malawi

The children of Malawi face economic, social and health disparities making them vulnerable to a wide-range of public health issues including acts of violence. An estimated 45.1% of Malawi's population of 16 million is under the age of 14, which is a high percentage of children when compared to other African nations (MoGCDSW et al., 2014). Malawi's development indicators reflect economic and social instabilities with some of the highest rates of food insecurity and HIV prevalence in sub-Saharan Africa; factors that have potential to increase child vulnerabilities to violence such as early marriage, reduced educational opportunities and child labor. Furthermore, the World Bank reports that 84.3% of the overall Malawian population resides in rural areas and these families are among the poorest of the poor (2015). These socioeconomic and political instabilities combined with a large child population place Malawian children at high-risk for future impoverishment and long-term health issues.

Some epidemiological studies in Malawi have generated data indicating high rates of physical and sexual violence, but none have examined the nature of risk and protective factors and gender norms influencing sexual violence (MoGCDSW et al., 2014). One study, conducted by Chesshyre and Molyneux in 2009, investigated clinical presentation and HIV post-exposure prophylaxis (PEP) of children reporting to a Malawian hospital. The findings revealed that violence against children in Malawi, especially sexual abuse, was generally on the increase. In December 2014, results from the *Violence against Children Survey* (VACS) in Malawi were released as the first nationally representative data describing physical, sexual and emotional violence experienced among Malawian children (MoGCDSW et al., 2014). Until this time, prevalence of violence against children occurring among these populations has not been well

documented; nor had there been information collected detailing clinical or psychological service provision for children living in rural communities (Speth, 2009). Overall, VACS (2014) findings indicated that violence against children in Malawi is highly prevalent and that multiple incidents were common. More specifically, findings indicated that 21.8% of females and 14.8% of males (aged 18-24) experienced some form of sexual violence before the age of 18, and 68.4% and 74.4% of these young adults reported multiple incidents, respectively (MoGCDSW et al., p. 63). Among the same age group, 42.4% of females and 65.5% of males experienced some form of physical abuse (MoGCDSW, 2014, p. 83). Of those who experienced physical abuse in childhood, 78.8% of females and 88.2% of males reported multiple incidents. In addition, it was found that one in five females and nearly one in four males experienced emotional abuse in childhood with 84.8% - 86.2% of survivors reported multiple incidents, respectively (MoGCDSW, 2014, p. 104). These findings clearly indicate a high prevalence of physical, emotional and/or sexual violence and repeated offenses among Malawian children.

The associations between violence experienced in childhood and negative health outcomes in Malawi have been examined through VACS data collection and analysis. Findings in Malawi (2014) indicated high levels of mental health consequences among study participants that had experienced some form of violence in childhood within 30 days prior to participating in the study (p. 119). For example, findings suggested moderate to serious mental distress, substance abuse, "self-harm, suicidal ideation and suicidal attempts" were significantly higher among study participants that had experienced physical, sexual and/or emotional violence in childhood than those who did not experience violence (p. 118-132). Thirty-three percent of females (aged 18 to 24) reported pregnancies due to unwanted sexual intercourse (p. 132). Although rates of HIV infection resulting from sexual violence are not clear, HIV prevalence in

Malawi is ranked 9th in the world at 10.2% prevalence among the adult population (UNAIDS, 2014). This alone increases the risk for HIV infection among children who experience sexual violence.

Factors Associated with Sexual Violence against Children

Paper #1: Risk and Protective Factors

There are many commonalities in both risk and protective factors associated with violence against children throughout Africa. However, what is considered a protective factor in one setting may be contradicted by a risk factor in another. Protective factors instituted in the home setting, for example, may reduce the risk of violence at school, and schools may reinforce this through teaching and promoting the negative outcomes of violence. However, a school may also tolerate societal acceptability of sexual violence challenging the protective factor influenced at home. Exposure to multiple risk factors may overwhelm and outweigh any protective factors; therefore, it is important to consider the risk factors while determining the most influential protective factors in an effort to prevent violence from occurring in the first place. This section examines these factors in more detail to help rationalize why protective factors, as opposed to risk factors, were highlighted in this dissertation.

Protective factors reduce the risk of assault and/or perpetration through critical interventions aimed at increasing gender equity, strengthening family environments and augmenting service delivery (DSD et al., 2012). Reflective of risk factors, protective factors primarily highlighted in the literature involve: increased levels of educational security and life building skills (individual); secure attachment and supportive family environment and positive and warm parent-child relationship (parental/family); educational opportunities for awareness and understanding (community); and, access to health care and social services (societal) (WHO,

2010). More specifically, a few protective factors introspective of risk factors found among African cultures involve: cohesion, stability and monitoring in the family system; involvement in after school activities and respect associated with education; support in the communities honoring pro-social behaviors; and, availability of services supporting survivors (DSD et al., 2012, p. 11).

As primary risk factors for violence against children can be examined at home, in school, within the community and other societal settings, they can also be interrelated among these different ecological systems. According to the report conducted by DSD et al., (2012), the influence of poverty and other social determinants can promote unsupportive familial environments that may subject a child to costly risk factors such as family conflict, parental substance abuse and "hiding" incidents of violence from public visibility. This in turn may result in lack of services and access to healthcare. Furthermore, a recent study found that children in families affected by societal stigmas associated with HIV were at higher risk of physical and/or emotional abuse (poverty and disability as mediating factors) than families suffering from other chronic illnesses (Meinck, Cluver & Boyes, 2015). At school, gang activities may influence acts of violence among peers, whereas in the community, tolerance to violence may inspire children to accept and model violent behaviors seen in others. Unfortunately, many children living in care or justice systems are not protected by their environments as staff ratios are minimal and poorly trained leaving children are more vulnerable to physical and sexual violence due to the poor standards of these systems (DSD et al., 2012).

In conclusion, many may argue that protective factors are simply the "flip side" of risk factors; that both are measured by the same indicators. However, interpretation of risk in the context of this literature review represents the causes of sexual violence; while protective factors

are the constructs that modify the risk. More specifically, protective factors describe tangible influences that may directly moderate the risk of sexual violence (Fraser, Richman & Gilinsky, 1999).

Protective and Risk Factors in Malawi

Protective and risk factors for violence against children in Malawi are similar to those found in other sub-Saharan African countries. In Malawi, the majority of the population resides in rural communities, which results in fewer opportunities for education, increased child marriages and limited services to protect children against violence (Small, & Nivolova, 2015). Gender norms (attitudes and beliefs) among these societies may increase the risk of violence. Interestingly, VACS (2014) indicated that among study participants, approximately 42% of females reported it was "acceptable for a husband to beat his wife under one or more circumstances" and that 2 in 5 felt that "women should tolerate violence to keep the family together" (MoGCDSW, p. 147). These high rates of tolerance and witnessing of violence in the home may encourage both perpetration of violence and victimization (Wolak & Finkelhor, 1998). Furthermore, a study conducted in 1999 suggested "that men are socialized to believe that it is not normal for women to actively agree to sexual intercourse and that coercion is necessary" (Malawi Ministry of Health, 2005, p. 5). Also specific to Malawi are high levels of poverty and HIV that may result in children becoming orphaned or living on the streets; therefore, being more vulnerable to violence in general from the standpoint of survival (MoGCDSW, 2014).

Unfortunately, little is known about the specific protective factors for violence against children in Malawi. Prevalence reports (including VACS) suggest similar factors experienced on the individual, familial, community and societal levels of surrounding countries could be

applicable to factors associated with reducing the risk of violence against children in Malawi. Studies focused on HIV post-exposure prophylaxis (PEP) offered in one of the country's largest hospitals report a steady incline of children presenting for these services post-assault via police referrals; this is a possible indication that police and medical units are working more collaboratively to provide services for these children (Chesshyre & Molyneux, 2009). This could also indicate an increase in HIV awareness and PEP services, which could pose as a protective factor in this scenario.

Paper #2: Gender-Based Norms (attitudes/beliefs)

Values and traditions generate many of the attributes that influence attitudes and beliefs towards gender-related norms (DSD et al., 2012). Although gender norms are constantly evolving among generations, they remain grounded on societal expectations. For example, there may be a strong belief that women should tolerate violence to keep their families together, or the belief that men need to have sex with other women, or that parents need to physically beat their child for misbehavior. The impact of these expectations can leave harsh scars and influence negative behaviors on children rendering them vulnerable to gender inequalities. Thus in the context of the individual, family, relationships outside the home, and society, imbalances among gender-norms and inequalities can drive attitudes and beliefs in the wrong direction.

For sexual violence, gender inequality is considered one of the primary risk factors for victimization and perpetration (Sommarin et al., 2014). Children may be exposed to various gender inequalities such as intimate-partner violence (IPV), gender-based violence (GBV) and/or negative sexual relationships. The mere implications of these inequities can cause lifelong consequences on health and well-being as well as victimization (Roman & Frantz, 2013).

Therefore, instilling gender equity to our children may be one of the most powerful protective factors in reducing the risk of sexual violence against children (DSD et al., 2012).

It is important to recognize the gender-norms, attitudes and beliefs of children in order to understand the context of resiliency, vulnerability, tolerance and/or protection from violence. The following sections describe different types, prevalence and factors associated with three of the primary constructs reflective of gender norms: gender-based violence, intimate partner violence and sexual relationships.

Gender-based violence (GBV)

In 1993, the UN Declaration on the Elimination of Violence against Women offered the first official definition of the term "gender-based violence", which is used by the WHO today as any act of "violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life" (UN General Assembly, article one, 2003). In Africa, studies show that gender norms are traditionally driven by male dominant social beliefs and values. For the individual, education for boys may take precedence over girls, leaving girls with fewer economic opportunities and higher dependence on males. On the family level, traditions may place men in higher positions of power over women and children and promote hypermasculinity, which may in turn magnify brutality, aggression and sexuality. Males may also be expected to be less communicative than females, and females may be taught to communicate more passively; these styles of communication may cause conflict and confusion for healthy sexual relationships. Economic instability, limited police protection and lack of care and justice systems are community and societal factors that may also hinder gender equity and overall safety for children, especially female children.

Researchers have found that many children and adolescents experience their first sexual encounter as forced or coerced, and often perpetrated by peers (Pinheiro, 2006). In 2005, the WHO initiated a multi-country study examining the prevalence and patterns of violence against women. Findings suggested that 11% to 45% of women who had sex before the age of 15 reported the experience as forced, and women in general were more likely to experience their first sexual encounter as forced (before the age of 17) than those who engaged in sex at a later age (WHO, 2005). Furthermore, the VACS study conducted in Kenya indicated that 24% of females who experienced their first sexual encounter (before the age of 18) as either forced (17%), pressured, tricked or threatened (to engage); 8.6% of males experienced the same type of first sexual encounter (UNICEF Kenya, CDC and Kenya National Bureau, 2012). The same VACS conducted in Tanzania alarmingly found that 29% of first sex experiences among females was unwilling (17.5% among males) (UNICEF Tanzania, et al., 2011). In Malawi, VACS results indicated that 38% of female respondents who have engaged in sex reported their first sexual experience as forced; 11% of males experienced the same type of first sexual encounter (MoGCDSW, 2014). From the public health perspective, understanding the nature of first sexual intercourse is important because of possible links to negative health consequences and reproductive health issues in adulthood (Maharaj & Munthree, 2007).

Poverty, economic instabilities and socio-cultural attitudes/beliefs are key factors associated with gender-based violence (Jones, Presler-Marshall, Cooke & Akinrimisi, 2012). For example, poverty forces many children into child-labor and early marriage placing girls more at-risk for exposure to dangerous situations and loss of days spent in school. In Nigeria for example, reports indicate that the average age for girls to begin working is 10.5 years, and 28% of girls between the ages of 15 and 19 have been or are married (Okpukpara & Odurukwe, 2006;

Co-operation and Development, 2009). Further studies suggest that traditional institutions (i.e. patriarchy, gender-bias towards males), urbanization and industrialization are additional factors that contribute to higher rates of sexual victimization among girls (Aderinto, 2010). Overcrowded homes and strong patriarchy practices place females more at risk of sexual violence, especially those who are married at an earlier age, do not attend school and/or engage in child labor (Aderinto, 2010).

Intimate partner violence (IPV)

Intimate partner violence (IPV) is defined as "physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner)" (Breiding et al., p. 11, 2015). IPV may be perpetrated by a current or former partner or spouse and can occur among heterosexual or same-sex couples and does not require sexual intimacy (whereas "gender-based violence" focuses on violence against women in general).

Similar to gender-based violence, IPV has strong links to HIV transmission, at-risk sexual behaviors and reproductive health problems (Hindin, 2014; Kouyoumdjian, Findlay, Schwandt, & Calzavara, 2013). A study in Kenya reported that 15% of sexual violence against women was perpetrated by their current husbands (Hindkin, Kishor, & Ansara, 2008). It also is important to note that IPV may also result in death from severe injuries inflicted by brutal acts. A study conducted in South Africa indicated that a women is killed by an intimate partner every six hours (in South Africa) (Mathews et al., 2004). A related concern is the impact IPV may have on children. Children who witness IPV may incur devastating consequences. For example, girls may learn that it is normal for a male adult to beat his spouse leaving her vulnerable to high-risk relationships, and boys may become perpetrators of violence later in life (Seedat, M.,

Van Niekerk, A., Jewkes, R., Suffla, S. & Ratele, K., 2009). Furthermore, children exposed to IPV have a greater chance of engaging in high-risk behaviors including early sexual debut, unprotected sex and having multiple partners placing them at higher risk for HIV (Roman & Frantz, 2013; Small & Nikolova, 2015).

Also similar to the implications of gender-based violence, IPV may be influenced by family and/or societal pressure for females to marry young, which is less common for males (Pinheiro, 2006). Marriage before the age of 18 is common for many young girls in sub-Saharan Africa. "Approximately 40% of women aged 20-24 worldwide who have been married before the age of 18 live in sub-Saharan Africa" (Walker, p. 1, 2012). In Malawi, approximately 49% of females are married before the age of 18, which ranks 11th among the highest prevalence in Africa (with Niger ranking the highest at 75% followed by Chad and Mali at 72% and 71% respectively) (Walker, 2012).

Sexual relationships

Healthy intimate relationships among adolescents are important aspects of growth and development and play meaningful roles towards psychosocial well-being in adulthood (Gevers, Jewkes, Mathews, & Flisher, 2012). However, intimate relationships during adolescence that turn harmful or violent can result in physical and psychological consequences, including lifelong struggles to maintain healthy relationships.

Gender attitudes and beliefs (norms) in adolescence about intimate relationships, sexual intercourse, how one should behave sexually and sexual risk-taking typically differ among males and females. Because gender norms influence social determinants and health behaviors, gender-based action groups suggest the development and implementation of realistic interventions focusing on parenting skills, developing life skills in children and changing norms that tolerate

violence (MoGCDSW, 2014; Bisika, 2008). However, in the absence of a strong and healthy family and community support networks, children are left vulnerable to their own interpretations about intimate partner relationships, which may be exacerbated by peer influences and cultural stigmas associated with the topic of sex. Thus, the complex physical and psychological dynamics already playing into adolescent growth and development may intensify expectations about intimate partner relationships and sexual contact. Therefore, it is essential to understand attitudes and beliefs among children in adolescence about sexual relationships to determine how these factors may relate to or interact with violence.

Perceptions of Sexual Violence: Child, Parents and the Community

In order to begin considering effective interventions to combat sexual violence against children, it is critical to understand the perspectives of children, parents, the community and society as a whole. Children's perceptions of sexual violence are strongly associated with their comfort and ability to disclose an act(s) of violence. Researchers have consistently found that children did not feel there were opportunities for privacy and prompts to discuss their situation and that children also tended to preconceive negative reactions from others (Jensen, Gulbrandsen, Mossige, Reichelt & Tjersland, 2005; Hershkowitz, Lanes & Lamb, 2007). A child's willingness to disclose abuse to his/her parents promptly and spontaneously decreased when he/she expected negative reactions, especially when the abuse was more serious. A strong correlation between predicted and actual parental reactions suggested that the children anticipated their parents' likely reactions very well (Hershkowitz, Lanes & Lamb, 2007; Staller & Nelson-Gardell, 2005; Goodman-Brown, Edelstein, Goodman, Jones & Gordon, 2003). In instances when a child did disclose, it was under situations initiated by adult dialogue about child behaviors (i.e. what was bothering them) or when the theme of sexual abuse was mentioned.

This is somewhat consistent with the study (mentioned in the section on disclosure) where 43% of children who had disclosed sexual abuse did so under an "accidental" detection, most likely promoted by the observation and suspicion of an adult (Collings, Griffinths & Kumalo, 2005).

In line with these concerns (of children), another study conducted in South Africa set out to explore whether victims of child assault perceived any harm caused by service provision (Collings, 2011). Disturbingly, the study found various forms of secondary victimization resulting from these services. These forms of "revictimization" corresponded with: (1) not being believed, (2) not providing important information; (3) risk of further victimization was not adequately addressed; and (4) essential services were not available/provided. No children reported the medical or legal examination or court experience as harmful or distressing (Collings, 2011). However, the study found that responses to the criminal justice system were negative when children feared for their own safety resulting from the release of their alleged offender. Unfortunately these findings are solely based on police reports, limiting the representation of disclose patterns to a small percentage of the population (because under 12% of cases are reported to authorities).

Parental perceptions of sexual violence are critical to understanding how parents may influence help-seeking behaviors. A study conducted in southern Africa explored child sexual abuse by investigating the knowledge and perceptions of parents regarding this problem (Mathoma, Maripe-Perera, Khumalo, Mbayi & Seloilwe, 2006). Although respondents to this study demonstrated knowledge of child sexual abuse, there were differences in perceptions of what can predispose their children. For example, blame on both the parent and child were described as parental failure to educate or talk to their child about the issues and myths associated with sex, and the influences of Western culture on the ways in which children behave

(i.e. dressing, watching TV programs on sex, desire for material possessions). The study findings also indicated that parents felt poverty was an additional predisposing factor compelling girls into prostitution (Mathoma et al., 2006). Unfortunately, it is difficult to draw conclusions that parents outside of this study perceive sexual violence in a similar manner; however, it does identify the serious need for further research on the factors associated with parental perceptions and how this may impact protection and service provision.

Community perceptions may play an essential role in a child's ability to disclose, and also in the acceptability/tolerance of disclosure within the community where services are provided. Studies were conducted in Tanzania on community concerns and controversies over how child sexual abuse cases are handled and the perceptions and management of handling child sexual offense cases by key personnel responsible for dealing with sexual offenses (Kisanga, Nystrom, Hogan & Emmelin, 2010). Findings indicated that community perceptions included: (1) awareness, but inability to do anything; (2) lack of trust in the healthcare and legal systems; (3) decreased respect by society and parents for children's rights; (4) myths justifying sexual violence against children; and (5) disclosure threatened by fear of stigma and discrimination. Other factors that may encourage negative community perceptions involves the frustration with shortages of working tools, lack of transportation for investigation and financial deficits (Kisanga et al., 2010).

Challenges of Conducting Research on Child Survivors

In general, there are many methodological limitations in conducting violence against children research. Besides the differences in definitions of sexual violence (mentioned above), sample sizes and research designs used to conduct sexual violence against children research do not necessarily yield the most generalizable data. As with any sensitive and potentially

stigmatizing public health topic, researchers are aware and cautious of the methodological constraints and cultural boundaries associated with sexual violence against children research. The cultural and political sensitivities and violation of human rights associated with this issue may render societal vulnerability and distrust; thus sometimes interfering with the rigor advocated in research agendas set to measure and explore the effectiveness of interventions and prevention efforts. To this end, researchers are tasked with varying definitions and articulation of "sexual violence against children" to meet different standards of social acceptability, tolerance and observations on a nation to nation basis. In addition, sample sizes are subject to convenience and costs restricting generalizability and study findings are only accurate to the extent of participant disclosure (Pereda, Guilera, Forns & Gómez-Benito, 2009).

Aside from the significant limitations found in the literature, sexual violence against children is gaining worldwide attention as a serious global public health issue threatening the future of millions of children. At this point, conclusions are difficult to ascertain from the limited rigor and scarcity of studies and the quality of research. In addition to the need for augmenting more refined, well-designed research is the obligation to align and translate evidence to policy and practice. To this end, future research agendas should perhaps reconsider the theoretical drivers behind violence prevention and focus on efficacy and effective adaption of proven methods to scale up critical clinical and psychosocial intervention programs. (Please see Appendix A: *Approaches and Limitations of Secondary Data Analysis* for a more in-depth observation of study limitations with VACS data).

Benefiting from the rich and comprehensive data collected during the VACS studies in Malawi, we are able to fill some of the gaps in research and knowledge mentioned previously. The following chapters are manuscripts from research aimed to better understand what variables

are associated with sexual violence against children in Malawi, and to also recognize the complexities and knowledge gaps in this difficult and underexplored public health crisis.

CHAPTER 3

SEXUAL VIOLENCE AGAINST CHILDREN IN MALAWI: FACTORS ASSOCIATED WITH PROTECTING CHILDREN FROM VICTIMIZATION[1]

[1] O'Mara Sage, E., Kress, H., Hansen, N. (2016). *To be submitted to Child Abuse & Neglect*.

Title & Abstract

Sexual Violence against Children in Malawi: Factors Associated with Protecting Children from Victimization

Background: Prevalence of violence against children in sub-Saharan Africa is not well documented, and few studies have examined the cultural and community nature of factors that may protect children from sexual violence. To date, risk factors have been more extensively and rigorously studied than protective factors examining safety in homes, trust in the community and friendships; therefore, the purpose of this study was to examine critical protective factors that may directly modify, buffer or insulate the risk of sexual violence.

Objective: This study examined the direct and moderating associations between protective factors and sexual violence among Malawian children by addressing the specific variables associated with placing particular groups (i.e. age and sex) at higher-risk for violence. This information may inform and guide the development of strategies set to strengthen actions protecting children from sexual violence before it occurs.

Methods: The study design is based on secondary analysis of VACS data previously collected in Malawi. Data was stratified into age groups (13-17 and 18-24) and by sex to examine factors that may protect children from sexual violence. Analytical approaches included a bivariate approach of chi-squared tests of independence, multivariate logistic regression to assess the independent associations between protective factors and sexual violence.

Results: Among females, study findings determined that closeness of/with father, feeling safe in the community and never witnessing parental abuse and protection from sexual violence were protective factors from experiencing sexual violence. For males, findings indicated that positive friendships, perceived safety in the community and never witnessing spousal abuse were

protective factors against exposure to sexual violence. It is anticipated that the impact of these findings will provoke future research and activities aimed at preventing sexual violence before it happens.

Keywords

Sexual violence against children, protective factors, Malawi

Introduction

The nature and magnitude of sexual violence against children in Malawi

Sexual violence against children is a profound violation of human rights that spans across cultures, races, economic positions and geographical borders in both developed and developing countries. The true magnitude of sexual violence against children in sub-Saharan Africa remains unknown due to cultural fears, mistrust of authorities, lack of services and underdeveloped social justice systems (Lalor, 2008; WHO, 2010). Global estimates conducted by the World Health Organization (WHO) indicated that 150 million girls and 73 million boys under the age of 18 have experienced forced sexual intercourse or other forms of sexual violence involving physical contact (Pinheiro, 2006). Though the nature and consequences of sexual violence against children differ from country to country in Africa, rates are among the highest reported in the world (Department of Social Development [DSD], Department of Women, Children and People with Disabilities & UNICEF, 2012).

The children of Malawi, in particular, face economic, social and health disparities making them vulnerable to a wide-range of public health issues including acts of violence. An estimated 45.1% of Malawi's population of 16 million is under the age of 14, which is considered a high child population compared to other African nations (Ministry of Gender, Children, Disability and Social Welfare [MoGCDSW], Center for Social Research at the University of Malawi, UNICEF Malawi, & CDC, 2014). Malawi's development indicators reflect economic and social instabilities with some of the highest rates of food insecurity and HIV prevalence in sub-Saharan Africa (UNDP, 2015; World Bank, 2015a; UNAIDS, 2014); factors that have potential to increase child vulnerabilities to violence (MoGCDSW et al., 2014). Furthermore, the World Bank reports that 84.3% of the overall Malawian population resides in rural areas and these

families are among the poorest of the poor (2015a). These socioeconomic and political instabilities place Malawian children at high-risk for future impoverishment and long-term health issues.

The Global Survey on Violence against Children (2013), reconfirmed that nations must prioritize prevention efforts on violence against children by addressing the underlying causes and translating these factors into preventive actions on multiple levels (UN); thus, reinforcing holistic and integrated approaches for prevention efforts. Notwithstanding an essential movement in addressing violence against children, comprehensive and systematic approaches for identifying factors that may influence child victimization are needed.

To address the need for more comprehensive and standardized studies measuring the true nature and magnitude of violence against children in Malawi, the U.S. Centers for Disease Control and Prevention partnered with the Malawian government, UNICEF and Together for Girls to conduct the *Violence against Children Survey* (VACS). In December 2014, results from VACS provided the first nationally representative data describing physical, sexual and emotional violence experienced among Malawian children (MoGCDSW et al). Overall, VACS (2014) results indicated that violence against children in Malawi is highly prevalent and that multiple incidents were common. More specifically, findings indicate that 25.4% of females and 14.6% of males (aged 18-24) experienced some form of sexual violence before the age of 18, and 68.4% and 74.4% of these young adults reported multiple incidents, respectively (MoGCDSW et al., p. 63).

Protective and risk factors in Malawi

Without integrative research investigating factors that can influence victimization in Malawi, current response services are ineffective leaving children vulnerable to a host of

additional long-term negative health outcomes (Senn, Carey, Vanable, Coury-Doniger & Urban, 2006). In an effort to address the high burden of sexual violence described in the VACS report, it is critical to consider the similarities, differences and impact that risk and protective factors have on preventing violence from occurring in the first place. The World Health Organization (WHO), identifies risk factors as "any attribute, characteristic or exposure of an individual that increases the likelihood of developing a disease or injury", whereas protective factors in the context of violence "may lessen the likelihood of sexual violence victimization or perpetration by buffering against risk" (CDC, 2014, "Protective Factors for Perpetration"). Although both risk and protective factors are commonly mentioned in research addressing violence against children, risk factors have been more extensively and rigorously examined than protective factors (Plummer & Njuguna, 2009). Therefore, it is critical to investigate protective factors that may modify, buffer or insulate the risk of violence aimed at preventing these crimes. To stop these consequences from taxing social and health care systems, we must start with understanding the factors associated with protecting children from victimization in order to effectively prioritize interventions, policies and more comprehensive services for survivors and their families.

The social ecological framework for violence prevention allows a better understanding of violence and the effect of potential prevention strategies by looking at the inclusion of risk and protective factors from different influences at different levels: individual, relationship (familial), community, and societal factors (Jewkes, Sen, Garcia-Moreno, 2002). This fundamental framework is often used to understand the complex "interplay" of protective and risk factors that contribute to sexual violence occurring in these different settings. Although some studies have generated data indicating high rates of child maltreatment, none have examined the nature of risk and protective factors influencing sexual violence against children in Malawi (MoGCDSW et al.,

2014). To this end, the purpose of this study was to examine protective factors that are directly associated with and/or may modify the risk of sexual violence experienced in childhood based on the individual, family and community factors in order to suggest focused approaches to protect children.

Methods

Study Sample and Inclusion Criteria

This study uses Malawi's 2014 VACS data to examine specific protective factors associated with sexual violence against children. The VACS sampling strategy was based on a four-staged multi-cluster survey design incorporating a sampling frame based on the most recent census data available (CDC, 2013; MoGCDSW et al., 2014). Based on official geographical subdivisions/household units, the first phase of sampling employed calculating enumerations areas (EAs) out of the total (based on probability proportional to size of the EAs) to determine the primary sampling units (PSUs – 1,000 recommended). Households were selected by equal probability sampling and eligible respondents were randomly selected in each household (CDC, 2013; MoGCDSW et al., 2014). To protect confidentiality and decrease the possibility of interviewing both a victim and perpetrator in the same community, a split sample approach was conducted ensuring that female surveys were implemented in different EAs than the male surveys (Fan, Kress, Gupta, Wadonda-Kabondo, Shawa & Mercy, 2016). Analyzing the VACS variables most relevant to protective factors includes population-based, weighted frequencies and percentages to obtain parameter estimates from the data along with 95% confidence intervals

(CDC, 2013). A total of 2162 interviews were conducted to include 1029 females and 1133 males with a response rate of 83% for females and 84% for males (Fan et al., 2016).[6]

In this study, both female and male data was examined according to two separate age groups: 13 to 17 and 18 to 24. Stratifying age groups for this study generated retrospective information on both recent and lifetime exposure to violence and results are based on three different time periods to include: (1) estimates of sexual violence experienced over lifetime; (2) sexual violence experienced prior to age 18; and (3) exposure to sexual violence in the past 12 months leading up to the time of the interview. More specifically, the 13-17 age sub-group yielded data on events that had occurred in past 12 months prior to the interview; thus respondents in this age group are considered in childhood representing more "current patterns and contexts" of childhood violence (MoGCDSW, p. 42; CDC, 2013). Age sub-group 18-24 (adults) represents experiences of violence over a lifetime as respondents reported on acts of violence experienced up to the age of 18 (throughout childhood) and until the time of the interview; representing lifetime prevalence rates and associated factors. Stratifying age groups also helped control for confounders when examining protective factors, thereby making it easier to detect and interpret relationships between the predictor and outcome variables and to statistically examine any interaction effects.

Ethical approval

The Violence against Children Survey in Malawi was independently reviewed and approved by the U.S Centers for Disease Control and Prevention Institutional Review Board (IRB) and the Malawian National Commission for Science and Technology Ethical Review

[6] A detailed description of the survey and methodologies can be found in the national report: *Violence against young children and women in Malawi: Findings form a national survey, 2013*, can be found at *http://www.togetherforgirls.org*.

Board. Participants aged 18-24 who were eligible for the study provided written informed consent. Participants 15–17 years provided assent and received consent from parents, and those under 17 living on their own or heading households were eligible for enrollment as emancipated minors.

Outcome Variable

The dependent variables of interest focused on study respondents who had experienced sexual violence at least one time and those who never experienced sexual violence over lifetime and during the last 12 months. We compared and used the different forms of sexual violence as reported in the VACS datasets to include: (1) unwanted sexual touching; (2) unwanted attempted sex (did not succeed); (3) unwanted physically forced sex; and, (4) unwanted pressured sex[7] (MoGCDSW et al., 2014). Since the primary objective of this study was to find associations between protective factors and respondents who did not experience any type of sexual violence, we grouped all four forms of sexual violence (controlling for age) as "experienced at least one type of sexual violence". It is important to note that study respondents who had experienced at least one occurrence of sexual violence typically experienced multiple acts throughout their childhood.

Predictor Variables

Determining factors that may lead to or prevent sexual violence in childhood involved a close examination of variables reflecting the individual, relationships and the community in which they live. As protective and risk factors tend to be intertwined with one another and can

[7] Respondents who reported experiencing unwanted "pressured sex" also involves coercion. WHO's World Report on Violence (2002) describes coerced sex as involving "psychological intimidation, blackmail or other threats" that may occur "when the person aggressed is unable to give consent" (Krug, Dahlberg, Mercy, Zwi, & Lozano, p. 149).

be context dependent, we determined which variables would act as a predictor, a confounder or cause an interaction effect. To this end, the predictor (independent) variables used in this analysis represented parental support, friendships, perceived trust and safety in the community and witnessing violence in the home (see table 3.1).

Statistical Analysis

SPSS statistical package (version 21) was used in this analysis. We used sample counts to demonstrate the number of actual records the analysis was based on and estimated population percentages to reflect the extent of the measure/statistic in the population. We first used a bivariate approach (chi-squared tests of independence) to assess the existence of any relationships between the protective variables and exposure to sexual violence over lifetime (controlling for age group). Bonferroni correction was applied to all p-values to adjust for multiple comparisons. The primary purpose of conducting bivariate analyses was to explore the existence of relationships between the protective factors and outcome variable.

Studying human behaviors requires consideration of relationships among many factors; thus, multivariate logistic regression was an appropriate next step to test all bivariate associations and to explore associations of the response categories more in-depth. Based on the findings of the bivariate analysis, multivariate logistic regression analysis was conducted to generate odds ratios, 95% confidence intervals and p-values using age groups as the control variable. This method assessed independent associations between protective factors and sexual violence. -2 Log likelihood and Nagelkerke R Square were considered to compare models and Hosmer & Lemeshow was conducted to tests goodness of fit between the observed and predicted values. Further testing through linear regression was also conducted to determine that no multicollinearity for either the male and female analyses was present by requesting collinearity

diagnostics examining absolute values (Beta) > 0.9, tolerance values < 0.1, and variance inflation factors (VIF) > 5.

Finding different results between the male and female models for a given predictor would have indicated an interaction was present between gender and that predictor. To this end, a second logistic regression analysis was employed to identify interactions that may influence the direction or strength of the relationship between the predictor and outcomes variables (effect modifier). By developing separate models for sex and controlling for age group, there was no need to examine additional interactions between sex and age group or sex and any other variable because cell sizes were too small resulting in structural zeros. In addition, moderation effects considered age as the modifying factor to test any interactions between perceived trust and safety in the community and witnessing violence in the home and experiencing sexual violence.

Results

Table 3.2 compares sample percentages and weighted population estimates including percentages of those who experienced sexual violence according to sex and age group. Based on a sum of the original weights, the estimated female survey population = 1,658,528 and the estimated male survey population = 1,494,796. These estimates are consistent with Malawi's consensus data for 13-24 year olds (Malawi National Statistical Office, 2008).

Given that both bivariate and multivariate regression was conducted for this study, we first describe bivariate relationships that demonstrated an existence of associations between each predictor variable (protection factors) and the outcome (lifetime sexual violence). The second section shows findings resulting from the multivariate analysis.

Bivariate Relationships

This section focuses on the results from the set of hypotheses aimed at testing which protective factors are directly associated with the prevention of sexual violence experienced over the lifetime. The bivariate analysis was conducted to assure the existence of significant associations between the variables selected and the outcome since these relationships have not been previously explored; chi-square results are indicated.

Age and Sexual Violence

Among females, there were no significant relationships between the two age groups (13-17 and 18-24) and experiencing lifetime sexual violence. However, there was a relationship between male respondents aged 18-24 and experiencing sexual violence (x^2 (1) = 8.67, p = .003). We are able to conclude there is a relationship between sexual violence and older males. This is confirmed by the Fisher's Exact test (.003).

Closeness to Parents and Sexual Violence

Among both female age groups, there is no relationship between the level of closeness a respondent feels towards her mother and exposure to sexual violence; therefore, the level of closeness to a mother does not appear to be a protective factor against sexual violence. On the other hand, there was a relationship between females and closeness to father in both age groups, 13-17 and 18-24 ($p < .003$ and $p < .000$, respectively). Opposite to female respondents, the overall Pearson chi-square test for males found that there was a significant relationship between sexual violence and closeness to mother ($p < .000$). In particular, for male respondents in the age group 13-17, the p-value was .000. (However, for the older age group (18-24), there was not a significant association between closeness to mother and experiencing sexual violence. Similar

results for males were found among the younger age group and closeness to father ($p < .008$), but not among the older age (and closeness to father).

Witnessing Violence in the Home and Sexual Violence

Among female respondents 13-17, there is no significance between the amount of times witnessing a parent punch, kick or beat other parent, boyfriend or girlfriend and experiencing sexual violence. However, for the older female age group (18-24), chi-square found evidence that there is a relationship between the amount of times witnessing a parent punch, kick or beat other parent, boyfriend or girlfriend and experiencing at least 1 exposure to sexual violence ($x^2 (4) = 19.589$, $p < .001$). Furthermore, there is a relationship between the amount of times witnessing a parent punch, kick or beat a sibling and exposure to sexual violence among both age groups ($p < .000$). For males, there were significant relationships between sexual violence and witnessing a parent abuse a spouse (or boyfriend/girlfriend) and/or a sibling among both age groups. For the younger age group (13-17), the p-vales for witnessing parental abuse towards a spouse or sibling was .007 and .020, respectively). For the older age group (18-24), chi-square showed $p < .007$ and $p < .016$, respectively.

Close Friendships and Sexual Violence

In accordance with the literature, it was hypothesized that children who have a friend to talk to about important things will be more protected from sexual violence than those who do not feel they have a close friend to talk to (when controlling for age) (Finklehor, Ormrod & Turner, 2007; Folger & Wright, 2013). However, among both sexes and age groups, results were only significant for the older male age group (18-24). Total chi-square tests indicated a p-value of .020, but only 18-24 year old males showed a significant p-value of .028.

Perceived Safety and Trust in the Community and Sexual Violence

Among female respondents aged 13-17, perceived trust and safety in the community does not indicate a significant relationship for protection from sexual violence. However, there was significance between trust in community and exposure to sexual violence for females aged 18-24 (x^2 (4) = 21.3, $p < .000$). Interestingly for this same age group among female respondents (18-24), there was no significance between perceptions of feeling safe in the community and experiencing sexual violence. Male results indicated similar findings showing that the levels of trust and safety in the community is significant among the younger age group ($p < .009$ and .000, respectively), but is not significant among the older age group (18-24).

Multivariate Relationships

The next section provides further details resulting from binominal logistic regression employing a backward stepwise entry using the likelihood ratio method (tables 3.3 and 3.4). Significant indicators are compared against the protective variable held constant to describe the relationships between the protective factors and the prevention of sexual violence experienced over the lifetime, before 18 and within the last 12 months.

Age and Sexual Violence

Multivariate regression confirmed that being a male in age group 18-24 increases the chances of having experienced sexual violence by a factor of 1.4 ($p < .031$). This finding assumes that males may have not understood the indication of sexual violence at a younger age, are reluctant to disclose sexual violence or that they may tend to experience sexual violence later in life. For females in the lifetime category, age group is significant at the $p = .016$ level indicating that if the respondent is in the 18-24 age group (opposed to age group 13-17), the odds of experiencing sexual violence prior to age 18 is reduced by a factor of 0.7, or by 30%.

Closeness to Parents and Sexual Violence

Among both female age groups, there is no significant relationship or significant impact on the odds between closeness to mother and experiencing sexual violence; therefore, closeness to the mother does not appear to be a protective or risk factor for sexual violence. However, logistic regression analysis indicated there was a significant relationship between closeness to father and sexual violence ($p < .000$). More specifically, study respondents who felt they were "very close" or "close" to their father compared to those who responded to having no relationship had a decreased likelihood of experiencing sexual violence by approximately 57% (or a factor of .47 and .39, respectively) for 18-24 year olds. Similarly, females reporting sexual violence in the past 12 months were also at a decreased risk (of sexual violence) if they reported a "very close" or "close" relationship with their father comparted to those who reported having no relationship (by factors of .32 and .26 respectively, both with $p<.000$). These results suggest that closeness to the biological father could be a protective factor against experiencing sexual violence. Similar to the bi-variate finings in the previous section, multivariate logistic regression demonstrated no overall significance between reported closeness to mother and/or father and experiencing sexual violence among both male age groups.

Witnessing Violence in the Home and Sexual Violence

Among female respondents reporting on lifetime sexual violence, logistic regression analysis showed no significance between witnessing intimate partner violence and experiencing sexual violence. However, females who witnessed a parent beat a sibling at least "once" increased the odds of experiencing sexual violence before the age of 18 compared to females who had reported witnessing a sibling being beaten "many" times. On the contrary, males who reported "never" witnessing intimate partner violence in the home had a 55% decreased

likelihood of experiencing sexual violence than those who witnessed intimate partner violence "many" times; therefore, it may be assumed that not witnessing intimate partner violence is an important protective factor against sexual violence. Interestingly among males, there are no associations between witnessing a sibling being abused by a parent and sexual violence.

Close Friendships and Sexual Violence

Among both male age groups, there is no relationship or significant impact on the odds of confiding important information to a friend and experiencing sexual violence. It may be concluded that the amount of friendships a child has to confide important information to is not necessarily a protective factor for sexual violence. Interestingly for female respondents in the lifetime and last 12 month categories, those who reported that they talked to their fiends "a lot" about important things had a much higher likelihood of experiencing sexual violence than those who did not talk to their friends "at all" about important things ($p < .004$, OR: 2.29 and $p < .001$, OR: 3.66). These results may indicate that females may not be aware of what constitutes sexual violence if they do not confide in or talk to their peers; therefore, those who do not talk to friends may be at higher risk of not recognizing sexual violence.

Perceived Safety and Trust in the Community and Sexual Violence

Female findings suggested a relationship between perceived levels of safety (only) in the community and sexual violence. In particular, female respondents (18-24) who reported feeling "very safe" had a 55% less likelihood of experiencing sexual violence than those who reported that they feel "do not feel safe at all". Similar to females, males who responded feeling "very safe" in the reported sexual violence in the past 12 months and lifetime categories had a 79% and 54%, respectively, less chance of experiencing sexual violence in comparison to those who responded they felt "not safe at all" in their communities. Males also reported "some" trust in

the community had a 51% decreased likelihood of experiencing sexual violence in the past 12 months than those who reported they had "no trust at all" in the community.

Discussion

Protective factors in the home and family

Families in general provide a protective environment for growth and security for their members. Secure attachment, supportive family environment and positive and warm parent-child relationships are possibly the most significant factors protecting children from harm (WHO, 2010). "Protective factors may lessen the likelihood of sexual violence victimization or perpetration by buffering against risk" such as a family's ability to identify and counter risk against violence (CDC, 2014, "Protective Factors for Perpetration," para. 1). However, family environments are sometimes dangerous in the context of existing violence in the home, harsh discipline, patriarchal masculinities, forced parental control and lack of child monitoring and supervision. Therefore, a primary focus of this study was to examine the associations between sexual violence and protective factors associated with the family including closeness to parents and less violence in the home.

An important finding of this study involved the comparison of the level of closeness a respondent felt towards his/her biological mother and father. For example, the association between females who felt "very close" or "close" to their father (when compared to those who had no relationship) presented as a protective factor or buffer against experiencing sexual violence. Consequently, finding no relationship between a female's closeness to her mother is reflective of different studies suggesting the position of harmful traditions mothers may pose on their daughters at an early age, such as encouraging them into premarital sexual relationships and/or early marriage due to social constraints, low education and fewer opportunities for

females in general (Stephen & Palamuleni, 2013; Ankomah, 1996; Pinheiro, 2006). This result also seems consistent with findings indicating that approximately 49% of females in Malawi are married before the age of 18, which ranks 11th among the highest prevalence of child marriage in Africa (Walker, 2012). Males on the other hand, may experience less "protective" support from fathers, which is consistent with studies examining instituted gender-based norms encouraging males to be more dominant and aggressive and females to be more passive and compliant (Pinheiro, 2006).

Although there was no significance between witnessing intimate partner violence and sexual violence among females, those who witnessed acts of parental abuse towards a sibling had an increased likelihood of experiencing sexual violence. Contrary to these findings, there was an association between males who witnessed spousal abuse and sexual violence, but there was no relationship between witnessing parental abuse towards a sibling and experiencing sexual violence. These results may indicate that females are more vulnerable to sexual violence if other siblings are experiencing acts of parental abuse in the same household, which is consistent with higher prevalence of girls experiencing sexual violence than boys. Furthermore, males who "never" witnessed spousal abuse may be less tolerant to violent acts and consequently are more cognizant of deterring an act of violence than those who may be accustomed to witnessing this type of violence as a more common occurrence. It is not clear whether or not witnessing a sibling being beat by a parent among male respondents is a risk or protective factor for sexual violence.

Friendships

Studies have found that strong social networks can buffer long-term consequences resulting from child maltreatment, but few have examined if strong friendships help to protect

against child victimization (Folger & Wright, 2013). The UN's World Report on Violence against Children (2006) suggests that positive peer interactions are essential in developing a child's resiliency in reducing the likelihood of victimization, and that school systems can help build or influence positive social support – in forms of friendships. A study conducted in 2007 examining factors and consequences associated with adolescent re-victimization found that social networks and support (such as friendships) was associated with protection against victimization (Finklehor, Ormrod & Turner, 2007). As the majority of Malawi's population resides in rural communities with fewer resources and less economic stability, deficiencies in the quality of schools and social systems may discourage social and peer developments among younger school-aged children (World Bank, 2010b). Furthermore, approximately 21% of Malawi's children ages five to fourteen are engaged in child labor, which also limits time to develop peer bonds and social networks (U.S. Department of Labor, 2014). Future research should explore the degree to which friendships influence protective factors such as self-esteem and peer alliances that may build stronger self-resiliencies against victimization.

Interestingly, our findings suggest that females who felt they could talk to their friends "a lot" showed a higher likelihood of experiencing sexual violence than those who have no friends to talk with about important things. This finding may suggest that females may not recognize acts of sexual violence until comparing their experiences with those of friends.

Trust and Safety in the Community

Communities in general are subject to political and environmental insecurities driving social stressors and economic instabilities. In many low-resource settings, systems aimed at protecting children may lack financial and professional capacities resulting in low service provision aimed at reducing the consequences of sexual violence. Therefore, perceptions and

tolerance of violence in communities may impact feelings of trust and security among families and possibly influence children to accept and/or model violent behaviors. More pertinent to Malawi are high levels of poverty and HIV that may result in children becoming orphaned or living on the streets, leaving them more vulnerable to sexual violence in general from the standpoint of survival (Mandalazi, Banda & Umar, 2013).

Community perceptions may play an essential role in a child's resiliency or protection from violence. In Tanzania, studies have focused on community concerns and controversies over how child sexual abuse cases are perceived, managed and handled by key authorities (Kisanga, Nystrom, Hogan & Emmelin, 2010). Findings indicated that community perceptions involved: (1) awareness, but inability of to do anything; (2) lack of trust in the healthcare and legal systems; (3) decreased respect by society and parents for children's rights; (4) myths justifying sexual violence against a child; and (5) lack of disclosure due to fear of stigma and discrimination. Other factors associated with community perceptions about sexual violence against children further highlight shortages of resources necessary for investigators, lack of transportation for investigation and financial deficits (Kisanga et al., 2010).

Interestingly, our findings indicted that trust in the community was not associated with protection from sexual violence among females. However, both males and females who responded feeling of "very" or "somewhat" safe in their communities had a higher likelihood of not experiencing sexual violence in comparison to those who responded "not safe at all". These findings may indicate that feelings of "safety" may be linked to more distinct cultural norms and values that support and protect children from harm, such as positive religious ideals and strong intact societies supported by traditions that value children (Plummer, C. & Njuguna, W., 2009);

whereas level of "trust" may be associated with perceptions of social and economic insecurities and services needed to support those who have experienced violence.

Trust and Safety in the Community, Witnessing Violence and Sexual Violence

In the development of study hypotheses examining the associations between family and community factors and protection from sexual violence, it was posited that age groups would moderate the relationship between trust and safety in the community and witnessing violence with protection from sexual violence. In other words, exploring if age emerged as a moderating effect from the combined impact of community and witnessing factors on sexual violence while treating those who responded "don't know" or "declined" as missing values. Interestingly, we found that no findings focusing on females resulted in any moderating effects among age groups. However, for males, we found that not having trust (among both age groups) or feeling safe (among the older age group) in the community decreased the chances of experiencing sexual violence. Although contradictory of the multivariate result, this finding is important for two reasons. First, it establishes the need to further explore how these protective factors (not trusting or feeling safe) may indeed establish some level of resiliency for Malawian males. With limited studies focused on how communities and society build protective environments for children, it is important to understand the impact trust and safety have on the sociocultural dynamics of Malawian youth. As mentioned previously, the interpretation of trust and safety may have similar or very different meanings among a particular culture. Second, while the association between friendships and protection against violence among males is strong, we could assume that males trust alliances more than their community as males may witness more acts of violence outside of the home than females.

Limitations

There were limitations in this study that should be considered. The first limitation was conducting a secondary data analysis, which limits control of study features such as the study purpose, choice and method of data collection. Although these elements may inadvertently sway the research away from the original intent and reduce significance and add bias to the study, we were careful to select variables that were well defined in the literature and reflective of social ecological theories.

A second limitation was using cross-sectional data to measure attitudes that may not be well developed among the Malawian culture. Also, we did not consider all variables in the dataset on a bivariate basis; to do this would entail an extensive consideration of all other variables that may possibly lead to sexual violence in childhood. However, for the purpose of this study, we remained consistent with variables most reflective of the social ecological model.

Third, although studying protective factors may help us better understand what factors directly modify, buffer or insulate the risk of exposure to sexual violence, many view protective factors as the "flip side" of risk factors; that both are measured by the same indictors. To this end, we interpreted risk in the context of factors that lead to or cause sexual violence and protective as the constructs that modify the risk (e.g. positive family and friend relations, feeling safe in one's community, not being exposed to violent acts). More specifically, the protective factors used here may better describe tangible influences that may directly moderate the risk of sexual violence (Fraser, Richman & Gilinsky, 1999).

Fourth, the survey's sampling approach was complex. To get the most accurate standard errors would require using Complex Samples to take into account the sampling methodology and resulting weights. Given the smaller sample sizes considered for this study, we compensated for

this to a large extent by using adjusted weights that sum to the overall sample while retaining the relationship/proportionality between the case weights.

Conclusion

The purpose of the present study was to examine protective factors that may provide a buffer against the negative consequences of sexual violence. This study also compared these protective factors between males and females in order to observe similarities or differences that may be influenced by family, friends and the community. Unlike similarities found in research focused on risk factors, this study showed that protective factors differ considerably among males and females. With the exception of trust and safety in the community, all other variables had opposite significance when comparing male responses to female responses. It may be that these differing results may be associated with gender-based norms influenced by the family and community. Further, the discrepancies in the prevalence of sexual violence among females to males may make it difficult to compare, or there may be other resiliency factors that self-protect children from the devastating actions of perpetrators. Future studies should focus on variables that consider a longitudinal design in accordance with prevalence estimates for each time frame (lifetime, prior to age 18 and during the past 12 months). This may reveal more of the true nature of factors associated with sexual violence before these events occur.

Sexual violence against children is gaining worldwide attention as a global public health issue threatening the future of millions of children. Unfortunately, current recommendations and conclusions are difficult to ascertain and promote as a result of the limited rigor, scarcity and quality of existing research and programs in low-resource settings. In addition, prevalence and magnitude of sexual violence may be more extreme than what has been revealed in the VACS datasets alone. It is therefore hoped that future studies will focus on the protective drivers

behind violence prevention that may more realistically evoke the efficacy and effective adaption of proven methods to scale up critical intervention programs and workforce capacities.

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Table 3.1: Variables reflecting protective factors and response categories

Relationship to parents

1. Closeness to biological mother:
   very close, close, not close, no relationship, don't know/declined
2. Closeness to biological father:
   very close, close, not close, no relationship, don't know/declined

Friendships

1. Talk to friend about important things:
   a lot, a little, not very much, not at all, don't know/declined

Safety in community

1. Level of trust of people living in community:
   a lot, some, not too much, not at all, don't know/declined
2. Level of safety in community:
   very safe, somewhat safe, not safe at all

Witnessing violence

1. Times witnessing adult (spousal) abuse:
   never, once, few many, don't know/declined
2. Times witnessing parent abusing sibling:
   never, once, few, many, no siblings, don't know/declined

Table 3.2: Sample percentages and weighted population estimates by Age and Sex

Females (N=1029*)

		Weighted Population %			
Age Group	*N*	*Sample***	*Lifetime prevalence*	*Prevalence prior to 18 years*	*Past 12 months*
13-17	455	43.1	34.3	29.4	22.9
18-24	574	56.9	33.1	22.6	14.3

Weighted population percentage is the percentage after being weighted to reflect national estimates
*33.6% of all females experienced at least 1 type of sexual violence
**Experienced at least 1 type of sexual violence

Males (N=1134*)

		Weighted Population %			
Age Group	*N*	*Sample***	*Lifetime prevalence*	*Prevalence prior to 18 years*	*Past 12 months*
13-17	615	47.3	17.0	13.7	12.7
18-24	518	52.7	24.1	15.4	11.8

Weighted population percentage is the percentage after being weighted to reflect national estimates
*20.8% of all males experienced at least 1 type of sexual violence
**Experienced at least 1 type of sexual violence

Table 3.3: Multivariate relationships between protective factors and response categories among female respondents

		Females (N=1,029)					
		SV Lifetime[a]			*Past 12 Months*[b]		
Predictor Variables	Indicator Categories	*Sig.*	*OR*	*95% CI*	*Sig.*	*OR*	*95% CI*
Closeness to father	*Very close*	**.013**	**.47**	**[.26, .85}**	**.000**	**.32**	**[.17, .60]**
	Close	**.005**	**.39**	**[.21, .75]**	**.000**	**.26**	**[.12, .53]**
	Not close	.519	1.2	[.64, 2.4]	.538	.808	[.41, 1.59]
	No relationship (ref)	**.000**			**.000**		
Closeness to mother	*Very close*						
	Close						
	Not close						
	No relationship (ref)	NS			NS		
Talking to friends	*A lot*	**.004**	**2.3**	**[1.30, 4.02]**	**.001**	**3.7**	**[1.72, 7.78]**
	A little	.086	1.6	[.93, 2.84]	.121	1.8	[.86, 3.77]
	Not very much	.130	1.6	.[88, 2.85]	**.013**	**2.7**	**[1.23, 5.60]**
	Not at all (ref)	.027			**.002**		
Witness spousal abuse	*Never*	.303	.76	[.45, 1.28]			
	Once	.16	.61	[.31, 1.21]			
	Few	.40	1.3	[.69, 2.49]			
	Many (ref)	.079			NS		
Witness child abuse	*Never*	.516	1.2	[.68, 2.15]			
	Once	**.028**	**2.1**	**[1.08, 4.01]**			
	Few	.162	1.6	[.84, 2.93]			
	Many (ref)	.000			NS		
Trust in community	*A lot*						
	Some						
	Not too much						
	Not at all (ref)	NS			NS		
Safety in community	*Very safe*	**.002**	**.42**	**[.24, .72]**	**.000**	**.29**	**[.16, .54]**
	Somewhat safe	**.013**	**.50**	**[.29, .87]**	**.010**	**.46**	**[.25, .83]**
	Not safe at all (ref)	**.007**			**.000**		

[a]Nagelkerke R squared = .121; [b]Nagelkerke R squared = .124
NS = not significant in final step of backward stepwise (likelihood ratio) regression
Missing values include those who either did not know or declined to respond

Table 3.4: Multivariate relationships between protective factors and response categories among male respondents

		Males (N=1,133)					
		SV Lifetime[a]			*Past 12 Months*[b]		
Predictor Variables	Indicator Categories	*Sig.*	*OR*	*95% CI*	*Sig.*	*OR*	*95% CI*
Closeness to father	*Very close*				.833	.89	[.31, 2.55]
	Close				.786	.85	[.27, 2.70]
	Not close				.203	2.1	[.68, 6.16]
	No relationship (ref)	NS			.026		
Closeness to mother	*Very close*	.223	.27	[.03, 2.22]	.145	.189	[.02, 1.77]
	Close	.618	.58	[.07, 4.96]	.358	.343	[.035, 3.35]
	Not close	.761	.71	[.08, 6.38]	.693	.630	[.06, 6.24]
	No relationship (ref)	.000			.002		
Talking to friends	*A lot*	.815	1.1	[.50, 2.42]			
	A little	.880	.94	[.42, 2.11]			
	Not very much	.122	1.9	[.84, 4.46]			
	Not at all (ref)	.019			NS		
Witness spousal abuse	*Never*	**.005**	**.47**	**[.27, .80]**			
	Once	.880	1.1	[.56, 1.96]			
	Few	.106	.57	[.29, 1.13]			
	Many (ref)	**.001**			NS		
Witness child abuse	*Never*				.097	.58	[.30, 1.11]
	Once				.189	1.7	[.78, 3.47]
	Few				.406	.70	[.30, 1.62]
	Many (ref)	NS			.002		
Trust in community	*A lot*				.996	1.0	[.54, 1.85]
	Some				.036	.514	[.28, .96]
	Not too much				.086	.61	[.34, 1.07]
	Not at all (ref)	NS			.047		
Safety in community	*Very safe*	**.004**	**.49**	**[.30, .80]**	**.004**	**.39**	**[.21, .75]**
	Somewhat safe	.146	.71	[.44, 1.13]	.494	.82	[.47, 1.44]
	Not safe at all (ref)	**.029**			**.010**		

[a] Nagelkerke R squared = .093; [b] Nagelkerke R squared = .119
NS = not significant in final step of backward stepwise (likelihood ratio) regression
Missing values include those who either did not know or declined to respond

CHAPTER 4

SEXUAL VIOLENCE AGAINST CHILDREN IN MALAWI: GENDER-BASED NORMS ASSOCIATED WITH VICTIMIZATION[8]

[8] O'Mara Sage, E., Kress, H., Hansen, N. (2016). To be submitted to *Child Abuse & Neglect*.

Title & Abstract

Sexual Violence against Children in Malawi: Gender-Based Norms Associated with Victimization

Background: Gender norms influence health behaviors and are highly correlated with social determinants of health. Unfortunately, little is known about gender attitudes and beliefs regarding tolerance of violence, aggression towards women and intimate partner relationships among those who have experienced sexual violence in childhood. To this end, it is important to understand which norms may be linked to sexual violence and which beliefs may reveal any imbalances - that may result in victimization.

Objective: This study examined associations between gender norms and sexual violence by addressing the specific variables associated with placing a population (i.e. socioeconomic status, age and sex) at higher-risk for violence. This information may inform and guide the development of strategies set to strengthen actions protecting children from sexual violence before it occurs.

Methods: The study design is based on secondary analysis of Violence against Children Survey (VACS) data previously collected in Malawi. Bivariate and multivariate logistic regression were employed to assess the links between attitudes/beliefs of children and experiencing sexual violence.

Results: Results confirmed that certain gender norms are associated with the risk of sexual violence in childhood. For females, socioeconomic status was associated with sexual violence. Also, there were more significant associations between attitudes and believes in gender-based violence, intimate partner violence and perceptions of sexual relationships and having

experienced sexual violence than among male respondents. These findings imply that further research and interventions should align with verifying gender norms while addressing key ethical tensions between cultural values and the factors that may cause social unbalances.

Keywords

Sexual violence against children, gender norms, gender-based violence, intimate partner violence

Introduction

Although gender norms are constantly evolving among generations, they remain grounded in societal expectations set to influence behavior in accordance to male and female roles. For example, traditional roles of females typically focus more on domestic affairs as males are responsible for the economic stability of the household. These social norms, when unbalanced, may place males in positions of dominance resulting in general disparities that can effect health and well-being (Singh, Verma & Barker, 2013). Thus, gender inequalities are correlated with social determinants of health that essentially have an impact on a combination of effects reflective of "relative power, autonomy, poverty, and marginalization, within, and across, societies and cultures" (Phillips, p.4, 2005; Department of Social Development [DSD], Department of Women, Children and People with Disabilities & UNICEF, 2012). In the context of violence, gender norms can influence attitudes and beliefs in gender-based violence, intimate partner violence and perceptions of sexual relationships. These three constructs may be linked to risk, resiliency and/or protection from violence. However, exposure to negative expectations about gender roles, rights and responsibilities can have a lifelong impact on children rendering them vulnerable to gender inequalities and a host of negative health consequences.

Public health consequences of violence against children

Violence against children is a profound violation of human rights that spans across cultures, races, economic positions and geographical borders in all countries. In general, violence against children is categorized as physical, emotional and/or sexual. It can occur in the home, at school, during work, in care and justice systems and among community settings (Pinheiro, 2006). Gender inequality is considered one of the primary risk factors for victimization and perpetration of violence against children (Sommarin, Kilbane, Mercy,

Moloney-Kitts & Ligiero, 2014; Tharp et al; 2013). Children exposed to these disparities may be at higher-risk of experiencing violence resulting in lifelong struggles with health and well-being (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002; Roman & Frantz, 2013). The United Nations (UN) Committee on the Rights of the Child (CRC) reports the most common consequences of physical, emotional and/or sexual violence against children are linked with cognitive impairment and failure to thrive causing greater susceptibility to injury, infectious diseases, mental health issues and other long-term chronic health conditions (Santos, 2013; Felitti et al., 1998). In addition, child survivors of violence face physical and emotional scars that may weaken and interfere with their ability to prosper in creating healthy families and contributing to sound communities in adulthood.

Sexual violence experienced in childhood can also result in more severe short and long term health and emotional conditions, manifesting immediately and/or in the years following assault. Conditions such as sexually transmitted infections, unintended pregnancies, obstetric and reproductive health issues, heart disease, depression and/or increased risk of suicide are a few negative health outcomes of sexual violence experienced in childhood (Dahlberg & Krug, 2002; Kendall-Tackett, 2013; Millet, Kohl, Jonson-Reid, Drake, & Petra, 2013). Additional co-morbidities many also occur from the physical and emotional traumas experienced by sexual violence. These outcomes may further tax already strained legal and social welfare services, as well as social and economic costs associated with reduced human capital and productivity, long-term medical care, social ostracism and/or placement of child victims in care (WHO, 2006). Additionally, these crimes against children may lead to further victimization in adulthood, violent relationships and/or risky sexual behaviors (Jewkes, Sen & Garcia-Moreno, 2002; Sommarin et al., 2014).

The impact of sexual violence on HIV infection is especially alarming in countries with fragile infrastructures lacking adequate care and treatment programs. Although the majority of HIV-infected children acquire the virus from their HIV-infected mother pre/post-natal or through breastfeeding, HIV infection in female adolescents has a strong correlation with sexual violence experienced in childhood (Sommarin et al., 2014). Recent evidence suggests that HIV infection rates in Africa are now most prevalent among adolescent female populations and gender-based sexual violence, in particular, is associated with up to 25% of HIV infections among young adolescents in South Africa (Jewkes, 2013; UNAIDS, 2014). Children may be exposed to and infected with HIV directly from a perpetrator, or indirectly due to the consequences of sexual assault that may lead to HIV infection (i.e. early and risky-sexual behaviors, non-disclosure due to fear and stigmatization and other health inequalities) (WHO & UNAIDS, 2013). Furthermore, children who witness intimate partner violence and/or are coerced into sex or marriage at a young age are also at-risk for HIV for similar reasons (i.e. early onset of sex, high-risk behaviors, etc.) (Moore, Awusabo-Asare, Madise, Langba & Kumi-Kyereme, 2007; Roman & Frantz, 2013).

Existing research limitations

In 2006, the United Nations set out to address research limitations by launching a worldwide study to determine the scale and causes of violence against children (Pinheiro, 2006). Recommendations called for a global response to augment resources for participatory research and public action to prevent violence against children, especially sexual violence. Since release of this report, intervention studies have highlighted that actions against childhood violence are more reactive than proactive; strategies to protect children tend to be disorganized and non-

collaborative; and, insufficient resources have been allocated to measure the problem. In addition, factors that influence sexual violence against children in Africa still remain unclear.

Gender norms associated with violence and sexual relationships are even more underexplored in sub-Saharan Africa (Small & Nikolva, 2015; Scott et al., 2013). Although associations between gender norms and perpetration at the individual, relationship, community and societal levels have been consistently documented, few studies have focused on gender norms as factors that may contribute to the risk for sexual violence (Jewkes, Sen & Garcia-Moreno, 2002; Tharp et al., 2013). More specifically, little is known about gender attitudes and beliefs regarding tolerance of violence, aggression towards women and intimate partner relationships among those who have experienced sexual violence in childhood. This study examines how these attitudes and beliefs of both males and females may be related to sexual victimization experienced in childhood, and addresses the impact of socioeconomic status on these factors.

Sexual Violence against Children in Malawi

Few studies have directly examined the nature, attitudes and beliefs about sexual violence in Malawi as cases are often undisclosed, hidden and under-investigated. More recent findings from the Malawi *Violence against Children Survey* (VACS)[9] (2014) indicated that 21.8% of females and 14.8% of males (aged 18-24) experienced some form of sexual violence before the age of 18, and 68.4% and 74.4% of these young adults reported multiple incidents, respectively (Ministry of Gender, Children, Disability and Social Welfare [MoGCDSW], Center for Social

[9] The *Violence against Children Survey* (VACS) conducted in Malawi (2014) was the first nationally representative study examining the nature and prevalence of physical, emotional and **sexual violence** against children. VACS is a partnership between the U.S. Centers for Disease Control and Prevention, the Malawian government, UNICEF and Together for Girls (MoGCDSW et al., 2014), and has been implemented in 13 countries with 8 in progress (to date).

Research at the University of Malawi, UNICEF Malawi, & CDC p. 63). In addition, HIV prevalence in Malawi is ranked 9th in the world at 10.2% prevalence among the adult population (UNAIDS, 2014). Though rates of HIV infection resulting from violence are not clear, children who experience sexual violence may be at greater risk of HIV transmission due to obstetric traumas that may result from the physical injuries endured (Cook, Dickens, Syed, 2004).

VACS findings in Malawi also collected information about specific gender norms to better understand the nature of violence by examining attitudes and beliefs towards physical violence. Adapted from the Gender-Equitable Men Scale (GEMS), these gender-specific variables were designed to measure various aspects of violence, sexuality, and masculinities within the construct of gender norms. Findings in Malawi showed that 42% of female respondents reported it was "acceptable for a husband to beat his wife under one or more circumstances" and that two in five believed that "women should tolerate violence to keep the family together" (MoGCDSW, p. 147). These high rates of tolerance of violence in the home may encourage both perpetration of violence and result in victimization (Wolak & Finkelhor, 1998). A different study in Malawi suggested "that men are socialized to believe that it is not normal for women to actively agree to sexual intercourse and that coercion is necessary" (Malawi Ministry of Health, 2005, p. 5). Despite efforts to reduce gender inequalities, these findings further suggest unequal social status of women and girls increasing vulnerabilities and access to healthcare, education, political representation and control over resources (United Nations Development Programme, 2013).

Study Purpose

The purpose of this study is to explore the associations between gender norms (attitudes and beliefs) of VACS respondents to determine which factors are associated with sexual

victimization. More specifically, we seek to understand if beliefs concerning tolerance of gender-based violence, sexual relationships and/or intimate-partner violence are associated with placing a child at higher-risk for sexual violence. This study also examines if socioeconomic status may be linked to gender norms increasing the odds of experiencing violence (according to male and female respondents).

Methods

Study Sample and Inclusion Criteria

This study uses Malawi's 2014 Violence against Children Survey (VACS) data to examine specific gender norms (attitudes and beliefs) and the association of these norms to study participants who have experienced at least one exposure of sexual violence in childhood. Analyzing the VACS variables most relevant to gender-based norms involved analyses of population-based, weighted frequencies and percentages to obtain parameter estimates from the data along with 95% confidence intervals (CDC, 2013). A total of 2162 interviews were conducted to include 1029 females and 1133 males with a response rate of 83% for females and 84% for males (Fan et al., 2016).[10]

Both females and males were examined according to two separate age groups: 13 to 17 and 18 to 24. Stratifying age groups for this study generated retrospective information on recent and lifetime exposure to violence. Results are based on two different time periods to include estimates of sexual violence experienced over lifetime and exposure to sexual violence in the past 12 months leading up to the time of the interview. More specifically, the 13-17 age group

[10] A detailed description of the survey and methodologies can be found in the national report: *Violence against young children and women in Malawi: Findings form a national survey, 2013*, can be found at *http://www.togetherforgirls.org*.

yielded data on events that had occurred in past 12 months prior to the interview; thus respondents in this age group are considered to represent "current patterns and contexts" of childhood violence (MoGCDSW, p. 42; CDC, 2013). The 18-24 age group (adults) represented experiences of violence throughout their lifetime. Stratifying age groups also helped control for confounders when examining gender-norms factors, thereby making it easier to detect and interpret relationships between the predictor and outcome variables.

Ethical approval

The Violence against Children Survey in Malawi was independently reviewed and approved by the U.S Centers for Disease Control and Prevention Institutional Review Board (IRB) and the Malawian National Commission for Science and Technology Ethical Review Board. Participants aged 18-24 who were eligible for the study provided informed written informed consent. Parents provided consent for participants 15–17 years, who also provided assent to participate, and those under 17 living on their own or heading households were eligible for enrolment as emancipated minors.

Outcome Variable

The dependent variables of interest focused on study respondents who had experienced sexual violence at least one time and those who never experienced sexual violence in childhood. Sexual violence consisted of four types as reported in the VACS datasets including: (1) unwanted sexual touching; (2) unwanted attempted sex (did not succeed); (3) unwanted physically forced sex; and, (4) unwanted pressured[11] sex (MoGCDSW et al., 2014). Since the primary objective of this study was to find associations between gender norms and respondents

[11] Respondents who reported experiencing unwanted "pressured sex" may also be referred to as "coercion". WHO's World Report on Violence (2002) describes coerced sex as involving "psychological intimidation, blackmail or other threats" that may occur "when the person aggressed is unable to give consent" (Krug et al., p. 149).

who experienced any of these types of sexual violence during their "lifetime" or in the "past 12 months", we grouped all four types of SV (controlling for age groups) as "experienced at least one type of sexual violence". Table 4.1 examines the sample percentages and weighted population estimates by age (13-17 and 18-24) and sex (male and female).

Predictor Variables

Independent variables used in this study were categorized under four main constructs to include: socioeconomic status (SES), gender-based violence, partner violence and perceptions of sexual relationships. Based on the social ecological model, the purpose of creating these constructs helped to organize, explain and measure possible associations between variables representing socioeconomic status and certain gender norms and experiencing sexual violence (outcome). To this end, we first generated the variables needed to measure the associations between SES and sexual violence, and then analyzed how these variables influenced variables under the three other constructs reflecting gender norms and experiencing sexual violence.

Variables used to measure the levels of socioeconomic status (SES) were derived from the Malawi VACS household surveys. The Malawi VACS household survey is a short questionnaire investigating household demographics and levels of vulnerability of all children residing in the household, while also garnering the opportunity for consent (CDC, 2013). It was important to use these variables to examine if SES resulted in any significant associations with gender norms and the outcome. To add rigor and validity to the variables measuring SES, we transformed nine existing variables found in the Malawi VACS Household Surveys using variables found in the Simple Poverty Scorecard for Malawi[12] (Schreiner, 2015). We generated

[12] Based on verifiable data from the Integrated Household Survey in Malawi, the Simple Scorecard is used to accurately estimate a household's economic level and national poverty rates (Schreiner, 2015).

new variables in the Malawi VACS datasets by changing the values of the numeric variables according to the values in the Simple Poverty Scorecard for Malawi (recoding) (see table 4.2). This recoding process allowed us to define value labels[13] reducing inconsistencies between how variables were defined between the two surveys (the Malawi VACS Household Survey and the Simple Scorecard for Malawi). This process also provided a more accurate measurement of SES by grouping respondents into three tertiles to represent "low", "middle" and high" SES levels. We included these SES variables in the model as control variables so that the coefficients for gender norms accounted for the impact of these indicators.

The different independent variables were selected from the Malawi VACS dataset to reflect gender norms based on three categories representing attitudes and beliefs about: (1) tolerance of violence and gender-based violence, (2) intimate partner violence, and (3) perceptions of sexual relationships. Respondents were given the opportunity to respond to each question with a simple "yes", "no" or "don't know" response. Respondents could also decline to respond to the question. Descriptive analysis reported very low response rates to the "don't know/declined" category; these responses were treated as missing values in this study's analysis. Table 4.3 is a list of the different questions asked of study respondents for both age groups.

Terminology used to guide the variables

To understand the relationships between the predictor variables and the outcome (experienced sexual violence), it is important to describe categories of gender norms that the predictor variables represent. These categories (or constructs) were developed based on associations in current literature and other studies and in the context of the way in which the

[13] The labels were created to represent respondent SES levels. Each respondent was categorized according to a "lower" (tertile 1), a "middle" (tertile 2) and a "higher" (tertile 3) SES level.

questions were asked during data collection. For example, gender-based violence and intimate partner violence, although similar, were separate categories formed based on the questions referring to "women" and "wife". In an effort to articulate meaning and implication of these gender norms (attitudes and beliefs), it is essential to mention the terminology most commonly used in correlation with violence in the sub-Saharan African region. For this study, the following definitions for gender-based violence and intimate partner violence:

> Any act of violence that results in, or is likely to result in, physical, sexual or psychological harm or suffering to women, including threats of such acts, coercion or arbitrary deprivations of liberty, whether occurring in public or in private life (UN General Assembly, article one, 2003).

There are several definitions used to describe intimate partner violence. The most common understanding involves perpetration by a current or former partner or spouse (whereas "gender-based violence" focuses on violence against women in general). This study employs the following description:

> Intimate partner violence involves physical violence, sexual violence, stalking and psychological aggression (including coercive tactics) by a current or former intimate partner (i.e., spouse, boyfriend/girlfriend, dating partner, or ongoing sexual partner) (Breiding, Basile, Smith, Black, & Mahendra, p. 11, 2015).

Statistical Analysis

SPSS statistical version 21 package was used in this analysis. We used sample counts to demonstrate the number of actual records the analysis was based on and estimated population percentages to reflect the extent of the measure/statistic in the population. To test the first set of hypotheses, we explored associations between gender norms and sexual violence by examining

bivariate relationships. The purpose of this step was to determine the existence of any relationships between the independent variables (SES and gender norms) and exposure to sexual violence. Bonferroni correction was applied to all p-values to adjust for multiple comparisons.

To assess independent associations between economic status, gender norms and sexual violence, multivariate logistic regression analysis was conducted to generate odds ratios, 95% confidence intervals and p-values using age groups as the control variable. The purpose of conducting multi-variate logistic regression analysis was based on the nature of the dichotomous outcome. R-Square was considered to compare models and Hosmer & Lemeshow was conducted to tests goodness of fit between the observed and predicted values.

Results

Multivariate Relationships

This section provides details resulting from binominal logistic regressions examining socioeconomic status (table 4.4) and the three constructs representing gender norms among males (table 4.5) and females (table 4.6). The best model fit employed logistic regression with backward selection of variables using the Wald method (Wald's Z-statistic) to retain significant predictors in the model. Those variables with an F-to-remove value of > .10 (default value), given the other variables in the model were dropped.

Socioeconomic Status and Experiencing Sexual Violence

Overall, there was no significance between socioeconomic status and experiencing sexual violence among males. However, results for females indicated that SES has a significant effect on whether or not a female experienced sexual violence. Females aged 13-17 who fell within the "higher" SES tertile were at an increased risk of experiencing sexual violence by approximately

190% compared to those in the "lower" SES tertile. Table 4.3 shows the associations between SES and victimization among both males and females.

Tolerance of Gender-Based Violence and Experiencing Sexual Violence

Among 18-24 year old females, there was a significant impact on the odds of believing that "a woman should tolerate violence in order to keep her family together" and experiencing sexual violence. Results demonstrated that those who answered "yes" to this question as compared to those who answered "no", were more likely to experience some form of sexual violence by approximately 94%. Interestingly, there were no association among the younger females age group. Therefore, it may be assumed that the older female age group (18-24) who believe that a woman should tolerate violence to keep her family together are more likely to experience sexual violence than those who do not believe this norm to be true.

Intimate Partner Violence and Experiencing Sexual Violence

Male respondents in both age groups were at a 159% increased likelihood to experience sexual violence if they believed "it is right for a man to hit or beat his wife if she does not take care of the children". Among males aged 18-24, there was also an increased likelihood of sexual violence for those who responded "yes" to the belief that "it is right for a man to beat his wife if she goes out without telling him" by a factor of 2.25; interestingly however, 13-17 year old males and females who responded "yes" to this same question were at a 65% decreased likelihood of experiencing sexual violence compared to those who responded "no" to this question. Also among males, results did not indicate significant relationships between experiencing sexual violence and the belief that "it is right for a man to hit or beat his wife is she argues with him"; however, females aged 18-24 who agreed with this same question were at an increased likelihood to experience sexual violence (lifetime) by a factor of 3.5. Lastly, 13-17

year old males were at an increased likelihood to experience sexual violence if they responded "yes" to the belief that "it is right for a man to hit or beat his wife if she burns the food" by a factor of 3.3 (last 12 months) and a factor of 2.6 (lifetime). There were no significant associations between the belief that "it is right for a man to hit or beat his wife if she refuses to have sex with him" and sexual violence among female or male respondents.

Sexual Relationships and Experiencing Sexual Violence

Multi-variate analysis showed strong associations between male beliefs "that men, not women, should decide when to have sex". For 13-17 year old males, there was a 180% increased chance of experiencing sexual violence if they agreed with this statement. However, older male respondents (18-24) were approximately 47% less likely to experience sexual violence if they believed this to be true. Somewhat contrary to this finding among males ages 18-24 was that those who felt that "men need to have sex with other women, even if they have good relationships with their wives" were at an increased risk of experiencing sexual violence by approximately 113%. Lastly, males aged 13-17 years who reported "yes" to the belief that "women who carry condoms have a lot of sex with men" were 55% less likely to experience sexual violence than those who did not agree with this statement.

Conversely, females aged 18-24 were at a 38% decreased likelihood to experience sexual violence (lifetime) if they believed that "women who carry condoms have sex with a lot of men". However, female respondents aged 13-17 were more likely to experience sexual violence if they agreed "that men need to have sex with other women, even if they have a good relationship with their wives" by a factor of 3.2 (220%). Surprisingly, female respondents aged 18-24 years old were at a 60% decreased likelihood of experiencing sexual violence if they agreed with this same

question. Also among females aged 13-17 who experienced sexual violence was the belief "that men, not women, should decide when to have sex" by a factor of 2.3.

Discussion

Socioeconomic Status and Experiencing Sexual Violence

It was interesting to find no associations between male SES levels and experiencing sexual violence. However, younger females considered to have a "higher" SES level were at a much higher risk of experiencing sexual violence than those of the lower and middle status. These results may indicate that females in the higher SES may also have more education and training opportunities making them more vulnerable to perpetration within the schools and workforce systems.

Tolerance and Gender-Based Violence

Throughout Africa, gender equity is traditionally driven by social beliefs and values that place men in higher positions of power over women and children, promoting patriarchal masculinities and gender inequities (DSD et al., 2012). Thus, the home is where gender-based inequalities may be first experienced by children as boys may be encouraged to be more aggressive and dominant and girls to be more passive and compliant (Pinheiro, 2006). For the purpose of this study, it was important to observe the associations between norms reflective of tolerance and gender-based violence and sexual violence experienced in childhood in order to better understand if these gender norms could indeed be a risk factor for victimization.

One of the most important findings of this study is the significance between believing that "a woman should tolerate violence in order to keep her family together" and those who have experienced sexual violence in childhood (among females). This finding suggests an acceptance or impartiality of violence against women among females in Malawi, which seems consistent

with a recent study conducted Malawi examining attitudes of violence and risk for HIV, which indicated that "traditional Malawian culture considers wife beating normal" (Small & Nikolova, 2015, p. 661). This cultural acceptance is consistent with male dominant gender norms, social beliefs and values, which may influence higher levels of violence tolerance in the home (Pinheiro, 2006). It was interesting to find no significant associations among male and female respondents who had experienced sexual violence and the belief that it is "justifiable for men to hit women when the woman sleeps with someone else". Regardless, evidence suggesting that gender-based violence is a tolerable act is alarming and suggests that acts of violence in the household are normal and routine; perhaps because laws to protect women and children are not fully executed in these regions of the world (Kamwedo, 2010).

Intimate partner violence

The purpose of including gender norms reflective of intimate partner violence was to understand possible associations with sexual victimization. Similar to gender-based violence, intimate partner violence has strong links to HIV transmission, at-risk sexual behaviors and reproductive health problems (Hindin, 2014; Kouyoumdjian, Findlay, Schwandt, & Calzavara, 2013). A study conducted in Malawi found a high prevalence of women had experienced some form of intimate partner violence over a lifetime (13% emotional, 20% physical, 3% severe violence, and 13% sexual violence) (Bazargan-Hejazi, Mederios, Mohammed, Lin & Dalal, 2013). A related concern is the impact intimate partner violence may have on children. Children who witness intimate partner violence may incur devastating consequences. For example, girls may learn that it is normal for a male adult to beat his spouse leaving her vulnerable to high-risk relationships, and boys may become perpetrators of violence later in life (Seedat, M., Van Niekerk, A., Jewkes, R., Suffla, S. & Ratele, K., 2009). Furthermore, children exposed to

intimate partner violence have a greater chance of engaging in high-risk behaviors including early sexual debut, unprotected sex and having multiple partners placing them at higher risk for HIV (Roman & Frantz, 2013; Small & Nikolova, 2015).

Opposite to female beliefs, male respondents who agreed "that it is right for a man to hit or beat his wife if she does not take care of the children" was significantly correlated with experiences of sexual violence in the past 12 months. Males in the younger age group (13-17) also believed "that it is right for a man to hit or beat his wife if she burns the food". These findings are consistent with other studies examining similar gender norms and with studies focused on gender inequities and links to sexual violence in the family setting (Small & Nikolova, 2015; Scott et al, 2013). For example, studies show that women are responsible for the domestic workload including taking care of the children (Kamwendo, 2010). A breach in this responsibility may result in punishment such as physical or emotional violence, which in turn may impact children who witness these acts in the household.

Other interesting findings involved the differences in associations between age groups (that experienced SV in the last 12 months) and the belief "that it is right for a man to hit or beat his wife if she goes out without telling him". The older male age group were highly likely to agree with this norm and the younger male and female respondents were more likely to not agree. However, females were more likely to respond "yes" to the belief "that it is right for a man to hit or beat his wife if she argues with him". In Malawi, approximately 49% of females are married before the age of 18, which ranks 11th among the highest prevalence of child marriage in Africa (Walker, 2012). These findings seem to reflect the implications of family and/or societal pressure for females to marry young, and thus have the perceptions of intimate partner violence as a "normal" occurrence (Pinheiro, 2006).

Sexual relationships

Healthy intimate relationships among adolescents are important aspects of growth and development and play meaningful roles towards psychosocial well-being in adulthood (Gevers, Jewkes, Mathews, & Flisher, 2012). However, intimate relationships during adolescence that turn harmful or violent can result in physical and psychological consequences, including lifelong struggles to maintain healthy relationships.

We found unexpected associations among male respondents who had experienced some form of sexual violence and their beliefs regarding sexual relationships. For example, older males who experienced sexual violence were more likely to believe 'that men, not women, should decide when to have sex"; however, males were at more risk if they felt "that men need to have sex with other women, even if they have a good relationship with their wives".

Among younger female respondents (13-17 years of age who have experienced sexual violence during the past 12 month and throughout their lifetime), there was an increased likelihood of believing "that men need to have sex with other women, even if they have a good relationship with their wives" and "that men, not women, should decide when to have sex" (among those who experienced lifetime exposure). In the Malawi VACS findings, females in the 18-24 age group reported higher rates of perpetration by a romantic partner (e.g. boyfriend). For the younger age group, a classmate/schoolmate was found to be the most common perpetrator ((MoGCDSW, 2014). These findings may be correlated with the notion that children are left vulnerable to their own interpretations about intimate partner relationships, which may be exacerbated by peer influences and cultural stigmas associated with the topic of sex (Bisika, 2008, Kamwendo, 2010). Thus, the complex physical and psychological dynamics already

playing into adolescent growth and development may intensify expectations about intimate partner relationships and the role of sexual contact.

Lastly, 18-24 year old females who have experienced sexual violence are actually less likely to agree with the statement "women who carry condoms have a lot of sex with men". This finding possibly indicates increased sexual education resulting from HIV prevention activities in schools and communities may have influenced a general norm that women who carry condoms have sex with men.

Limitations

Studying gender norms in the context of violence entails a great amount of sensitivity, cultural interpretation and consideration of previous studies that address similar phenomena. Therefore, there are limitations to this study that might encourage further examination of the impact that gender-based attitudes and beliefs have on the outcome of violence. It is also important to note that the nature of cross-sectional data collection assumes the occurrence of sexual violence prior to the interview; consequently, the experience of sexual violence may influence gender norms, attitudes and beliefs. Also, responses were limited to the timing of the survey interviews. As such, our analytical approach examining relationships between gender norms and victimization could be applied with gender norms as the outcome. The following are additional limitations considered important to mention.

First, variable selection is one of the limitations of this study. Approaches to reducing potential bias in variable selection were taken into account through consideration of the complex "interplay" of gender norms that may contribute to sexual violence occurring on the individual, familial, relationship and societal levels. Different settings may influence gender norms; however, we choose to focus on family influences on gender inequities in this study, which

limited discussion to other levels of the ecological framework. Future studies could consider variable selection based on other societal influences considered relevant and salient by international partners in violence against children studies and programs. A second limitation is that secondary data analysis may inadvertently influence the researcher to sway away the original intent of the variables. It is important to ensure that future research questions are formulated in accordance with clear constructs focused on perceptions of different gender roles to assess any patterns associated with gender norms and the outcome of victimization.

Conclusion

The findings presented in this study confirm the existence of links between gender norms and violence experienced in childhood; however, it is critical to interpret gender norms in the sense of familial, community and societal influences on a child's attitudes and beliefs. For example, males who have stronger attitudes and beliefs suggestive of male dominance may have grown up in family and social situations that have imparted those beliefs and thus, increased the likelihood of experiencing sexual violence. Children who have witnessed intimate partner violence may believe these are normative sexual relationships, and may be more exposed to violence themselves in this environment.

Future studies could seek deeper meaning into what motivates tolerance of violence and how these norms may encourage lifetime victimization. For example, it would be interesting to examine other variables may have an effect moderation on victimization such as witnessing violence in the home, type of perpetration and marital status. Since most studies examining gender norms and violence conclude that gender and social inequalities are major risk factors for victimization, it may be worthwhile to also consider levels of economic instabilities and socio-cultural practices as key factors associated with gender norms and violence (Jones, Presler-

Marshall, Cooke & Akinrimisi, 2012). To this end, perhaps closer examination of traditional institutions, urbanization and industrialization will inform additional factors that contribute to higher rates of sexual victimization not previously explored.

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Tables

Table 4.1: Sample percentages and weighted population estimates by Age and Sex

Females (N=1029*)

			Weighted Population %		
Age Group	*N*	*Sample***	*Lifetime prevalence*	*Prevalence prior to 18 years*	*Past 12 months*
13-17	455	43.1	34.3	29.4	22.9
18-24	574	56.9	33.1	22.6	14.3

Weighted population percentage is the percentage after being weighted to reflect national estimates
*33.6% of all females experienced at least 1 type of sexual violence
**Experienced at least 1 type of sexual violence

Males (N=1134*)

			Weighted Population %		
Age Group	*N*	*Sample***	*Lifetime prevalence*	*Prevalence prior to 18 years*	*Past 12 months*
13-17	615	47.3	17.0	13.7	12.7
18-24	518	52.7	24.1	15.4	11.8

Weighted population percentage is the percentage after being weighted to reflect national estimates
*20.8% of all males experienced at least 1 type of sexual violence
**Experienced at least 1 type of sexual violence

Table 4.2: Factors from the survey used to represent socioeconomic status (based on the Simple Poverty Scorecard for Malawi (Schreiner, 2015)

1. Amount of members living in the household.
2. Most prominent materials used to construct the floor of the household dwelling.
3. Most prominent materials used to construct the walls of the household dwelling.
4. Most prominent materials used to construct the roof of the household dwelling.
5. Type of toilet used among household members.
6. The main source of lighting fuel used by the household.
7. Use of bed nets in the household.
8. Does the household won a table.
9. Does the household own a bed.

Table 4.3: Variables used to represent gender norms, attitudes and beliefs

Tolerance and Gender-Based Violence (GBV)

1. Belief that a women should tolerate violence to keep family together
2. It is justifiable for men to hit women when…..the woman sleeps with someone else
3. It is justifiable for men to hit women when…..the woman is nagging
4. It is justifiable for men to hit women when…..the woman is not treating them with respect

Intimate Partner Violence

1. Belief that it is right for a man to hit or beat his wife if…. she goes out without telling him
2. Belief that it is right for a man to hit or beat his wife if…..she does not take care of the children
3. Belief that it is right for a man to hit or beat his wife if…..if she argues with him
4. Belief that it is right for a man to hit or beat his wife if…..if she refuses to have sex with him
5. Belief that it is right for a man to hit or beat his wife if…..if she burns the food

Sexual Relationships

1. Belief that men, not women, should decide when to have sex
2. Belief that men need more sex than women
3. Belief that men need to have sex with other women, even if they have a good relationship with their wives
4. Belief that women who carry condoms have sex with a lot of men

Table 4.4: Socioeconomic status (SES) and victimization

Females (N=1029*)

		SV Lifetime			Past 12 Months		
Age Group	*SES*	*Sig.*	*Exp(B)*	*95% CI*	*Sig.*	*Exp(B)*	*95% CI*
13-17	Lower (ref)	.017			.023		
	Middle	.130	1.61	[.87, 2.97]	.976	.989	[.49, 2.01]
	High	.004	2.61	[1.35, 5.03]	.022	2.30	[1.13, 4.71]
18-24							
	Lower (ref)	.247			.121		
	Middle	.761	.907	[.49, 1.70]	.217	.736	[.45, 1.20]
	High	.109	.565	[.28, 1.14]	.402	1.234	[.76, 2.02]

Males (N=1134*)

		SV Lifetime			Past 12 Months		
Age Group	*SES*	*Sig.*	*Exp(B)*	*95% CI*	*Sig.*	*Exp(B)*	*95% CI*
13-17							
	Lower (ref)	.434			.746		
	Middle	.197	.668	[.62, 1.23]	.508	.789	[.39, 1.59]
	High	.572	.828	[.43, 1.59]	.530	.777	[.35, 1.71]
18-24							
	Lower (ref)	.695			.592		
	Middle	.651	.896	[.56, 1.45]	.894	1.05	[.54, 2.02]
	High	.641	1.13	[.68, 1.89]	.326	1.41	[.71, 2.80]

Table 4.5: Multivariate relationships between gender norms and victimization for male respondents

	Males ages 13-17 (N=615)				Males ages 18-24 (N=518)			
	SV Lifetime[a]		Past 12 Months[b]		SV Lifetime[c]		Last 12 Months[d]	
Predictor Variables	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*
Tolerance and Gender-Based Violence								
1. Belief that a women should tolerate violence to keep family together	1.43	[.81, 2.51]	1.66	[.85, 3.22]	1.49	[.95, 2.32]	1.10	[.60, 2.04]
2. It is justifiable for men to hit women when the woman sleeps with someone else	.716	[.38, 1.36]	.913	[.43, 1.92]	.88	[.53, 1.49]	1.12	[.56, 2.21]
3. It is justifiable for men to hit women when the woman is nagging	.613	[.26, 1.43]	.919	[.36, 2.37]	.80	[.33, 1.91]	1.65	[.60, 4.52]
4. It is justifiable for men to hit women when the woman is not treating them with respect	1.83	[.88, 3.81]	.894	[.38, 2.12]	1.11	[.47, 2.59]	1.9	[.72, 4.94]
Intimate Partner Violence								
Belief that it is right for a man to hit or beat his wife if she…								
1. goes out without telling him	.753	[.36, 1.59]	**.357***	**[.14, .93]**	.1.06	[.48, 2.33]	**2.25***	**[.95, 5.36]**
2. does not take care of the children	1.35	[.67, 2.69]	**2.54***	**[1.19, 5.43]**	**2.67****	**[1.3, 5.46]**	.88	[.35, 2.24]
3. argues with him	.609	[.26, 1.41]	.680	[.27, 1.72]	.96	[.32, 2.87]	1.24	[.34, 4.52]
4. refuses to have sex with him	1.16	[.54, 2.51]	1.15	[.49, 2.69]	.69	[.30, 1.61]	1.55	[.57, 4.18]
5. burns the food	**3.31****	**[1.46, 7.49]**	**2.60***	**[1.0, 6.54]**	.65	[.23, 1.85]	.365	[.01, 1.36]
Sexual Relationships								
1. Belief that men, not women, should decide when to have sex	**2.62****	**[1.43, 4.81]**	**3.09****	**[1.5, 6.35]**	**.56***	**[.35, .90]**	**.50***	**[.26, .96]**
2. Belief that men need more sex than women	1.16	[.640, 2.09]	1.55	[.78, 3.08]	.93	[.60, 1.45]	.76	[.42, 1.38]
3. Belief that men need to have sex with other women, even if they have a good relationship with their wives	.732	[.354, 1.51]	.83	[.37, 1.87]	**1.88****	**[1.1, 3.11]**	**3.37****	**[1.82, 6.27]**
4. Belief that women who carry condoms have sex with a lot of men	.590	[.325, 1.07]	**.447***	**[.22, .91]**	1.42	[.90, 2.25]	1.53	[.82, 2.89]

* p < .05; ** p < .01

[a] Nagelkerke R squared =.128 .; [b] Nagelkerke R squared = .171; [c] Nagelkerke R squared = .673; [d] Nagelkerke R squared = .120

Missing values include those who either did not know or declined to respond

Table 4.6: Multivariate relationships between gender norms and victimization for female respondents

	Females ages 13-17 (N=455)				Females ages 18-24 (N=574)			
	SV Lifetime[a]		Past 12 Months[b]		SV Lifetime[c]		Last 12 Months[d]	
Predictor Variables	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*	*OR*	*95% CI*
Tolerance and Gender-Based Violence								
1. Belief that a women should tolerate violence to keep family together	.84	[.46, 1.54]	1.22	[.63, 2.38]	**1.85****	**[1.20, 2.86]**	**2.09***	**[1.18, 3.68]**
2. It is justifiable for men to hit women when the woman sleeps with someone else	1.55	[.81, 2.95]	1.86	[.58, 2.42]	1.52	[.96, 2.4]	1.38	[.75, 2.53]
3. It is justifiable for men to hit women when the woman is nagging	.69	[.33, 1.46]	.568	[.24, 1.35]	1.63	[.94, 2.83]	.55	[.24, 1.24]
4. It is justifiable for men to hit women when the woman is not treating them with respect	1.10	[.55, 2.2]	.694	[.31, 1.54]	.66	[.36, 1.18]	1.13	[.51, 2.53]
Intimate Partner Violence								
Belief that it is right for a man to hit or beat his wife if she……								
1. goes out without telling him	.54	[.25, 1.19]	**.35***	**[.14, .89]**	.62	[.32, 1.21]	.46	[.15, 1.35]
2. does not take care of the children	1.03	[.48, 2.24]	1.6	[.67, 3.79]	1.09.	[.58, 2.06]	.55	[.21, 1.46]
3. argues with him	.81	[.33, 2.02]	.95	[.35, 2.56]	1.17	[.57, 2.38]	**3.45****	**[1.34, 8.89]**
4. refuses to have sex with him	.43	[.17, 1.12]	.66	[.24, 1.8]	.61	[.31, 1.22]	.33	[.11, 1.05]
5. burns the food	2.23	[.88, 5.68]	1.35	[.47, 3.86]	.57	[.28, 1.14]	1.08	[.40, 2.92]
Sexual Relationships								
1. Belief that men, not women, should decide when to have sex	**2.30****	**[1.24, 4.27]**	1.74	[.87, 3.47]	.72	[.47, 1.11]	.86	[.47, 1.58]
2. Belief that men need more sex than women	.802	[.41, 1.59]	.61	[.28, 1.34]	1.40	[.89, 2.21]	.97	[.53, 1.77]
3. Belief that men need to have sex with other women, even if they have a good relationship with their wives	**3.0****	**[1.52, 5.85]**	**3.37****	**[1.62, 6.99]**	.63	[.38, 1.04]	**.38***	**[.17, .85]**
4. Belief that women who carry condoms have sex with a lot of men	.63	[.33, 1.2]	1.42	[.68, 2.99]	**.62***	**[.40, .96]**	.65	[.37, 1.16]

* p < .05; ** p < .01

[a] Nagelkerke R squared = .169.; [b] Nagelkerke R squared = .211; [c] Nagelkerke R squared = .102; [d] Nagelkerke R squared = .149

Missing values include those who either did not know or declined to respond

CHAPTER 5

RESULTS AND RECOMMENDATIONS

Violence is Preventable

Studies have found that the correlations between physical, emotional and sexual violence have several similarities among long and short-term health consequences and risk and protective factors. As these forms of violence are inter-related, so are the interventions that prevent violence form occurring in the first place. The information presented in chapters 3 and 4 provided additional perspective on the nature of factors that may either protect or place children at higher risk of sexual violence. Recommendations posed in this chapter are reflective of these findings and could also be considered for all forms of violence.

In general, evidence-based strategies that focus on the prevention of violence may be applicable across health, social and educational sectors through collective and sustainable actions. The following section focuses on these systems and describes protective factors that may help reduce the risk of violence against children. The following section of this chapter describes evidence-based interventions to build strong gender-related norms. Lastly, although not necessarily a focus of chapters 3 and 4, it is important to address the realities of service provision and healthcare services for victims of child sexual abuse in Malawi. Recommendations presented in this chapter are applicable with certain modifications in consideration of limited resources, capacities and interest in low-to-middle income countries.

Protective Factors

Based on the findings described in chapter 3, protective factors can reduce or modify the risk of assault and/or perpetration through critical interventions encouraging secure attachment and supportive family environment and positive parent-child relationships, supportive friendships, and a sense of support and safety within the community. The development of safe and nurturing home environments between parents/guardians and the children under their care is a commonly cited strategy to reduce violence against children. Not only are strong and compassionate parenting skills associated with prevention of violence against children in the home, but are also key in preventing early displays of violent behaviors in children (Knerr, Garner, & Cluver, 2013; Pinheiro, 2006; Runyan, Wattam, Ikeda, Hassan & Ramiro, 2002). However, parenting interventions vary according to methods of delivery, and there are certain challenges that may impede implementation in countries such as Malawi. For example, home visitation programs are some of the most successful parenting programs in areas of low socioeconomic status (Hillis, Mercy, Saul, Gleckel, Adab &Kress, 2015; Santos, 2013). In these programs, trained personnel provide in-home support concerning child health, development, and care. However, it may be difficult to implement in certain communities lacking resources for trained educators or where cultural norms drive suspicion of programs focusing on families.

Another intervention involves parent training delivered in small groups in community settings with a primary objective to reduce violence. These educational training programs are considered psychosocial interventions in the context of community and societal strategies for managing sexual assault. A study underway in 8 African countries is based on a randomized control trial conducted in the U.S. to assess the effectiveness of a parent training program (Parents Matter!) about sexuality and sexual risk reduction (Miller, K.S., et al, 2011).

Preliminary findings from this study suggest that parents can enhance communication about sexual abuse after participating in a program about general parent-child communications on sexuality (Miller, K.S., et al, 2011). Using this study as a platform for parent-oriented psychosocial intervention, researchers are currently examining its adaption in Africa to help understand and promote child disclosure to sexual violence (Miller, K., Lasswell, S.M., Riley, D.B. & Poulsen, M.N., 2013). However, adaptation and feasibility (acceptance, implementation and practicality) of such programs may take years to explore.

Developing positive peer relationships and social skills are also important protective factors that can prevent violence. Through peer relationships, a child may learn how to manage coping, problem-solving and conflict resolution building both self-confidence and resiliency (MoGCDSW, 2014; Sabina & Banyard, 2015). Strong social skills and friendships are traditionally influenced by integrative and supportive educational systems, which can also protect children from violence by teaching life-skills so that children can learn to protect themselves and resist causing harm to others. Ensuring attendance to school not only increases a child's level of educational security, but is also critical to social development of friendships and security set to strengthen "constructive human behavior" (Pinheiro , 2006, p. 150). However, child labor, early marriage, transportation and other factors may limit a child's opportunity to attend school and develop important peer bonds in the community.

Gender Norms

Chapter 4 findings indicate that negative gender attitudes and beliefs have some association with victimization. These norms are not to be interpreted as the fault of the child, but of the environment in which acts of violence are tolerated and considered normal. Thus, programs and interventions aimed at challenging negative gender norms are often complex and

difficult, especially in settings where strong patriarchal traditions and limited resources interfere with healthcare access and protection.

The promotion of gender equity is also an important preventative approach to end violence against children. Awareness, sensitization and social-media campaigns, although common, have not been considered evidence-based as many are standalone efforts (Mercy et al., 2015). Together with improving parenting norms associated with harsh disciplinary actions, agencies must focus collaboratively to develop unified and consistent programs geared towards common messages and actions in respectful consideration of religious beliefs, cultural norms, political and economic conditions, and environmental factors. Examination of these factors will require intentional, ongoing, respectful partnerships with community members including religious and traditional leaders and existing institutions (Instituto Promundo, 2012). Such partnerships are essential for establishing the conditions on which trust can be built and strengthened over time. Furthermore, expectations and experiences of parenthood are embedded within longstanding and powerful cultural frameworks which are gendered, creating different expectations for men and women as to their appropriate parental roles and responsibilities. Further research and interventions should align with these parental and local norms while addressing key ethical tensions between cultural values and parenting that could not be ascertained through research studies alone.

Disclosure and Service-Seeking Behaviors

The World Health Organization reports that children typically delay disclosure of an abusive experience instead of telling someone immediately following the event (2003); therefore, greatly underestimating the extent of sexual violence against children in general (WHO, 2002). Children may have fearful tendencies associated with the actual situation, the perpetrator, a

forced secrecy and/or conviction that no one will believe their claim(s) and disclosure may be accidental or on purpose entailing a "process" rather than in just one event (WHO, 2003). Estimates of non-disclosure among African cultures can range from 33% to 95% in girls and 42% to 100% in boys (Collings, Griffiths & Kumalo, 2005; Collings, 1995; Finklehor, 1994; UNICEF Tanzania et al., 2011; Zimbabwe National Statistics Agency [ZNSA], United Nations Children's Fund and Collaborating Centre for Operational Research and Evaluation, 2011). Non-disclosure can have a direct impact on access to intervention services also leading to re-victimization (i.e. since the perpetrator is not identified).

VACS reports indicate that disclosure rates and help-seeking behaviors are particularly low. For example, in Malawi, although 61.2% of females aged 18-24 years who experienced sexual violence in childhood told someone about their abuse, only 9.6% sought help. Among females aged 13-17, 59.8% told someone and 3.1% actually received assistance. For males reporting on lifetime childhood exposure (18-24), 64.7% told someone and 5.9% received any help (MoGCDSW). In Zimbabwe, VACS findings indicated that only 3% of females and 2% of males who disclosed their abuse received services (ZNSA et al., 2011; Sommarin et al., 2014). Another study conducted in Malawi that indicated that 98% of children who disclosed an assault were females, and 75% of these cases represented the first and single episode. This evidence suggests that cases of repeated assaults do not necessarily seek services as commonly and are presumably non-disclosed - thus never reported (Mason & Kennedy, 2014).

Access to Services

Ideally, comprehensive intervention services typically involve a multidisciplinary approach of clinical, psychosocial, police and legal services for child victims of sexual abuse. Unfortunately, service providers are limited in their ability to offer (any) services to survivors of

sexual abuse due to lack of resources, trained professionals, protocols on how to assess needs, facilities, coordinated efforts and management of cases among professionals, etc. (Chomba, E., 2010; Lalor, K. & McElvaney, 2010). Services that do exist often struggle how to proceed with cases of child abuse. Although limited, researchers consistently remark on the urgent need for more research and actual response services for treatment and support as "evidence suggests that very few children have access to such specialized services to ameliorate the potential negative effects of abuse" (Abrahams & Mathews, 2008, p. 490). Only a handful of studies conducted in sub-Saharan Africa focus on clinical interventions for child victims of sexual violence as these facilities are uncommon. Some programs in Malawi have focused on provision of HIV PEP for children who have experienced sexual violence (including eligibility, adherence to the 28-day PEP treatment and follow-up HIV testing at 1, 3 and 6 months post-treatment). However, of those who qualify for the PEP therapy, adherence rates (for PEP therapy) and follow-up for testing are extremely low (Collings, 2005; Speight et al., 2006; Collings, S.J., Bugwandeen, S. R. & Wiles, W.A., 2008; Taylor-Smith, et al, 2012; Girgira, T., Tilahun, B. & Bacha, T., 2014). These studies, although limited, warrant more immediate strategies geared towards the provision of treatment facilities, trained clinical staff and research to determine the low rates of adherence to the PEP. Furthermore, psychosocial interventions focus on provision of different therapeutic techniques and strategies aimed to address the child's psychological state of safety, trauma and functional impairment caused by sexual abuse are also limited in Malawi.

Aside from the gaps in interventions responding to sexual violence against children, the issue is gaining worldwide attention as a global public health issue threatening the future of millions of children. At this point, conclusions are difficult to ascertain from the limited rigor, scarcity and quality of existing programs in African nations. In addition to the need for

augmenting more refined, well-designed research is the obligation to align and translate evidence to policy and practice. Therefore, future research and program agendas should consider the risk and protective drivers behind violence prevention and focus on efficacy and effective adaption of proven methods to scale up critical clinical, psychological and psychosocial intervention programs.

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APPENDIX A

VIOLENCE AGAINST CHILDREN SYURVEYS

As described in Chapter One of this prospectus, *Violence Against Children Surveys* (VACS) have been conducted in nations recognizing the critical need for nationally representative data to determine the magnitude and nature of violence against children (CDC, 2013; MoGCDSW et al., 2014). VACS are national household surveys that retrospectively investigate physical, emotional and sexual violence against female and male children. Specifically, these studies:

- Estimate national prevalence of sexual, physical and emotional violence against children;
- Identify potential risk and protective factors for violence against children;
- Identify health and social outcomes of violence against children; and,
- Assess knowledge and utilization of services available for children who have experienced violence as well as barriers to accessing such services (CDC, 2014, p.13).

To date, these studies have revealed high rates of childhood violence among these populations in eight countries including Malawi, Nigeria, Tanzania, Kenya, Swaziland, Zambia, Zimbabwe, Cambodia and Haiti.

Sampling

This section describes the sampling design and methods used in collecting study data in the field (i.e. Malawi). VACS surveys use a multi-cluster survey design (CDC, 2014; MoGCDSW et al., 2014). Sampling frames for each country were based on the most updated census data available. In the first phase of sampling, a certain amount of enumerations areas (EAs) (based on official geographical subdivisions/household units) were calculated out of the

total (based on probability proportional to size of the EAs) to determine the primary sampling units (PSUs – 1,000 recommended). Households were selected by equal probability sampling and eligible respondents were randomly selected in each household (CDC, 2013; MoGCDSW et al., 2014). In Malawi, for example, a split sample approach was conducted (survey for females implemented in different EAs to males) to protect confidentiality and eliminate the possibility of interviewing both a survivor and perpetrator in the same community.

Research interviewers for VACS data collection in Malawi were locally recruited and selected based on educational and practical backgrounds in health, social science and/or counseling with experience in confidential interviewing techniques. Interviewers participated in a comprehensive and intensive training program to ensure procedures, confidentiality, standards and accuracy were practiced and that sensitivities, safety and response plans were executed. Interviewers were also trained on provision of informed consent (based on WHO's ethical and safety guidelines), privacy, how to handle interruptions during data collection and how provide help according to a response plan in the event of immediate danger or if a survey respondent needed and wanted assistance (WHO, 2001; WHO, 2012). Before implementation of the national survey in each country, the survey was pilot tested for questionnaire assessment and for subsequent response plan testing. Male researchers interviewed male respondents and female researchers interviewed female respondents. Surveys were translated and applied to accommodate the natural language of respondents.

Individual country-level protocols were collaboratively developed for VACS research. Protocols included data sharing agreements, in which a country may or may not participate. These agreements stipulate terms and conditions of data collected as briefly described above (i.e. access, use, ownership, location, etc.). The intention of this dissertation is to use datasets while

practicing strict adherence to the agreements stipulated in the protocols and to involve CDC and country representatives. Authorizations for data used for this purpose will commenced with CDC leadership and involved all interested parties as deemed appropriate by the Division of Violence Prevention and CDC Malawi.

Survey Instrument

The core questionnaires used in collecting VACS data included a household questionnaire, a female respondent questionnaire (for ages 13-24 years) and a male respondent questionnaire (for ages 13-24 years). All surveys contain background characteristics to assess socio-economic status, education levels, age, occupational status and living environment(s) (CDC, 2013; MoGCDSW et al., 2014). More specifically, the household survey is a short questionnaire investigating household demographics and levels of vulnerability of all children residing in the household, while also garnering the opportunity for consent. The female and male surveys cover a wide-range of topics relevant to assessing: experiences, perpetration, protective and risk factors, and attitudes/beliefs associated with physical, emotional and/or sexual violence; parental relations; family, friends and community support; sexual behaviors and practices; service provision including utilization and barriers; help-seeking behaviors/disclosure; STI and HIV knowledge; and, survey participation (CDC, 2013, p.26). For households with more than one eligible respondent, the research interviewer randomly selected one respondent (utilizing the Kish Method) (CDC, 2013).

Development of the VACS questionnaire

To ensure reliability and validity, the development of VACS questionnaires employed methods of standardization and cognitive appropriateness. Questionnaires were developed and led by a team of CDC scientists and external subject-matter experts tasked with comparing

measures previously tested in other studies to ascertain valid usefulness and comparable interests. In addition, several international surveys informed the design of the VACS questionnaires. Survey questions on sexual behavior and HIV/STI knowledge specifically, were derived from items listed in the *Demographic and Health Survey* (DHS), the *Behavioral Risk Factor Surveillance System* and the *WHO Multi-Country Study on Women's Health and Domestic Violence against Women* (MoGCDSW et al., 2014). More extensive country-level reviews were incorporated into the planning process for each country. Modifications made to the survey during the planning process ensured each country's unique perspectives and procedures were incorporated into the design, surveys and protocols. These additional consultations and input were attained through engaging in-country stakeholders and key informants focused on violence against children programs and child protection.

Psychometric Properties (cognitive interviewing studies)

The common approach to investigating violence against children is to survey adolescents and young adults on events that may have occurred earlier in their childhood and/or recent past (i.e. retrospective data collection) (Pinherio, 2006; Zolotor et al., 2009). In general, methods for establishing psychometric properties from these types of retrospective surveys have yielded important findings for the field of violence against children research (Hamby & Finkelhor, 2001; Dunne et al., 2009; Hulme, 2007). In the context of VACS, methods measuring internal consistency and content validity are apparent and detailed in each study protocol. Further validation efforts have been taken with VACS questionnaires through additional review by local practitioners, authorities and researchers within the implementing VACS country.

Experts involved in the development of VACS instruments referenced 13 different international and violence survey tools, drawing questions and definitions from items previously

tested in the field. An important and insightful effort taken prior to VACS implementation involved cognitive interviewing studies on the core VACS questionnaire primarily to obtain essential information on the processes and performance of questions. More specifically, it was critical to investigate how well survey questions were understood by study respondents (according to the intent of the question) and their accuracy in providing accurate answers (NCHS, 2015). Cognitive testing on VACS questionnaires provided relevant and in-depth understanding of how each question operates, that the questions are truly capturing the intended experiences and circumstances, and the contribution of each measure to the research goals. To this end, testing was conducted in two diverse countries lending general, yet informative findings necessary for survey revisions (i.e. restructuring questions and sections of the survey) (CDC, 2013).

APPENDIX B

APPROACHES AND LIMITATIONS OF SECONDARY DATA ANALYSIS

In general, studies using secondary data analysis involve the examination of data already collected for a purpose(s) different to the original intent of the data collection. The purpose of this section is to address the strengths and challenges in conducting a secondary analysis using VACS data collected in Malawi that were not necessarily detailed in the manuscripts (chapters 3 and 4). A primary benefit of a secondary analysis using these particular datasets is the opportunity to conduct a more complex and insightful examination of the various factors influencing an array of negative health consequences resulting from physical, sexual and emotional violence among both boys and girls. As mentioned, studies (previous to VACS) examining violence against children have been limited or unpublished causing significant gaps in generalizable information necessary for planning, response and prevention efforts (Lalor, 2003; Lalor, 2004; Speth, 2009).

There are several pros and cons to using secondary data analyses that may imply both advantages and disadvantages to using VACS datasets for dissertation purposes. Weighing and assessing these differences carefully is a worthwhile effort to ensure relevant variables are closely examined and correctly analyzed. Furthermore, conducting high-quality secondary analysis from studies that have already proven impact (such as VACS) may further contribute to response strategies needed to protect children from the short and long term consequences of these acts of violence (Smith et al., 2011).

Completed partnership collaborations, study design, data collection and analysis are a few advantages to conducting a secondary analysis. With the recent reports of high HIV prevalence among adolescent females in sub-Saharan Africa, there is renewed interest in the risk factors and service provision efforts associated with childhood violence among these populations (UNAIDS, 2014). An advantage to using VACS data in a secondary analysis, for example, enables us to further examine the factors and outcomes that leave children vulnerable to a host of additional morbidities that may predispose them to other outcomes. To this end, we may more clearly be able to observe the individual and social causes hindering healthcare provision for child survivors of sexual abuse and their families (Senn, et al., 2006). The breadth of variables in these datasets provides numerous additional analytic opportunities to generate recommendations on strategies to protect, treat and prevent negative short and long-term health outcomes resulting from childhood violence.

In general, data generated on behalf of government collaborations may be of higher quality than smaller studies. VACS is a high-quality study due to its strong design, based on considerable experiences with data collection (Together for Girls, 2012). Also, an important purpose of VACS studies is to generate nationally representative findings of the target population, which involves data collection among large sample sizes; therefore, outcomes of the studies are more generalizable and yield greater external validity.

Secondary data analyses are generally more cost-effective and less time-consuming than other study designs. Prior to considering a research agenda, the establishment of global collaborations for data collection in a low-to-middle income country is essential and may take several years to foster. In addition, the scale of nationally representative research comes with a high price and actual study design, data collection and analysis can take several more years to

complete. Furthermore, it may prove unethical to overburden community members by asking them to participate in multiples studies when the same information has been previously collected.

The VACS datasets provide rich information not currently found among any studies conducted on violence against children in sub-Saharan Africa (Together for Girls, p. 28, 2012). Study design and primary data collection has already been completed saving time, money and other resources needed to collect this critical information.

There are, however, disadvantages to secondary data analysis. A disadvantage to secondary data analysis may be that study purpose, choice and method of data collection has already been determined and there is no control of these study features. Therefore, the data may not facilitate particular research questions or the data may have a completely different purpose to accommodate the original research agenda (McCaston, 2005). Data collection, in general, is performed to address a certain question generated by interest and/or need. Traditionally, research questions are the starting point "and primary determinant of the research design" (Maxwell, 2013, p.73). Beginning with the dataset and no thoughtful questions or measures may lead to "data dredging" (Smith et al., 2011, p .922). Already collected and analyzed secondary data may inadvertently influence the researcher to sway away the original intent of examining variables not previously analyzed; therefore, a disadvantage to using the VACS data in a secondary analysis may be the temptation to fit the data to a similar, but different question, moving away from the intent and measures of the secondary analysis potentially reducing significance and adding bias to the study.

Secondary data analysis based on larger sample sizes may lack the levels of evidence needed to focus on a single construct (McCaston, 2005). As mentioned, the breadth of the VACS variables provides many opportunities for a variety of interests. However, this may be a

disadvantage in measuring a few single constructs in any depth. To this end, single and/or subsets of variables will need to be carefully considered to reflect the defined constructs of the VACS study used in this dissertation to reduce possible issues with reliability and validity (Shadish et al., 2002). In addition, advanced practice of statistical analysis is necessary to perform complex and rigorous analysis beyond descriptive analysis already conducted on this data. Using the VACS datasets will involve levels of analytical capabilities that may require technical assistance and expertise.

Another disadvantage to using secondary data may involve insensitivities to the nature and meaning of the descriptive findings. As with any sensitive and potentially stigmatizing public health topic, researchers are aware and cautious of the methodological constraints and limitations in sexual violence against children research. The cultural and political sensitivities and violation of human rights associated with this issue may render societal vulnerability and distrust; thus sometimes interfering with the accuracy advocated in research agendas set to measure and explore the effectiveness of interventions and prevention efforts. To this end, researchers are tasked with varying definitions and articulation of "sexual violence against children" to meet different standards of social acceptability, tolerance and observations on a nation to nation basis. Not having been involved personally in data collection can place limitations on interpretation and inconsistencies in data analysis. In addition, data collection was performed by those inherent of these countries. Cultural differences and analysis from a (removed) American perspective may cause unintended oversight of important implications and correlations found in the data. Therefore, in-county co-authorships were sought to include the perspectives and cultural context as much as possible.

APPENDIX C

INDICATOR DEFINITIONS (SEXUAL VIOLENCE)

CDC, Division of Violence Prevention, Violence against Children and Youth Team, 2015

INDICATOR (SV)	DEFINITION
Sexual Abuse – any (last 12 months)	The percent of 13-17 year old respondents who reported any sexual abuse in last 12 months **Numerator:** *The number of respondents 13-17 years old who reported any sexual abuse in last 12 months* **Denominator:** *The total number of respondents 13-17 years old*
Sexual Abuse (childhood prevalence)	The percent of 18-24 year old respondents who reported any sexual abuse prior to age 18 **Numerator:** *The number of respondents 18-24 years old who reported any sexual abuse prior to 18* **Denominator:** *The total number of respondents 18-24 years old*
Unwanted sexual touching (last 12 months)	The percent of 13-17 year old respondents who reported any unwanted sexual touching in last 12 months **Numerator:** *The number of respondents 13-17 years old who reported any unwanted sexual touching in last 12 months* **Denominator:** *The total number of respondents 13-17 years old*
Unwanted attempted sex (last 12 months)	The percent of 13-17 year old respondents who reported any unwanted attempted sex in last 12 months **Numerator:** *The number of 13-17 year old respondents who reported any unwanted* attempted sex in last 12 months **Denominator:** *The total number of respondents 13-17 years old*
Physically forced or pressured sex (last 12 months)	The percent of 13-17 year old respondents who reported any physically forced or pressured sex in last 12 months **Numerator:** *The number of 13-17 year old respondents who reported any physically forced or pressured sex in last 12 months* **Denominator:** *The total number of respondents 13-17 years old*
Unwanted sexual touching (childhood prevalence)	The percent of 18-24 year old respondents who reported any unwanted sexual touching prior to age 18 **Numerator:** *The number of respondents 18-24 years old who reported any unwanted sexual touching prior to 18* **Denominator:** *The total number of respondents 18-24 years old*
Unwanted attempted sex (childhood prevalence)	The percent of 18-24 year old respondents who reported any unwanted attempted sex prior to age 18 **Numerator:** *The number of respondents 18-24 years old who reported any unwanted* attempted sex *prior to 18* **Denominator:** *The total number of respondents 18-24 years old*

Physically forced or pressured sex (childhood prevalence)	The percent of 18-24 year old respondents who reported any physically forced or pressured sex prior to age 18 **Numerator:** *The number of respondents 18-24 years old who reported any physically forced or pressured sex prior to 18* **Denominator:** *The total number of respondents 18-24 years old*
First sexual intercourse was unwanted	Percent of 13-17 year old respondents who reported their first experience of sexual intercourse was unwanted **Numerator:** *The number of 13-17 year old respondents who reported that for their first experience of sexual intercourse was unwanted* **Denominator:** *The total number of respondents 13-17 years old who reported ever having sexual intercourse*
First sexual intercourse, if prior to age 18, was unwanted	Percent of 18-24 year old respondents who reported their first experience of sexual intercourse was unwanted prior to age 18 **Numerator:** *The number of 18-24 year old respondents who reported that for their first experience of sexual intercourse prior to age 18 was unwanted* **Denominator:** *The total number of respondents 18-24 years old who reported ever having sexual intercourse prior to age 18*