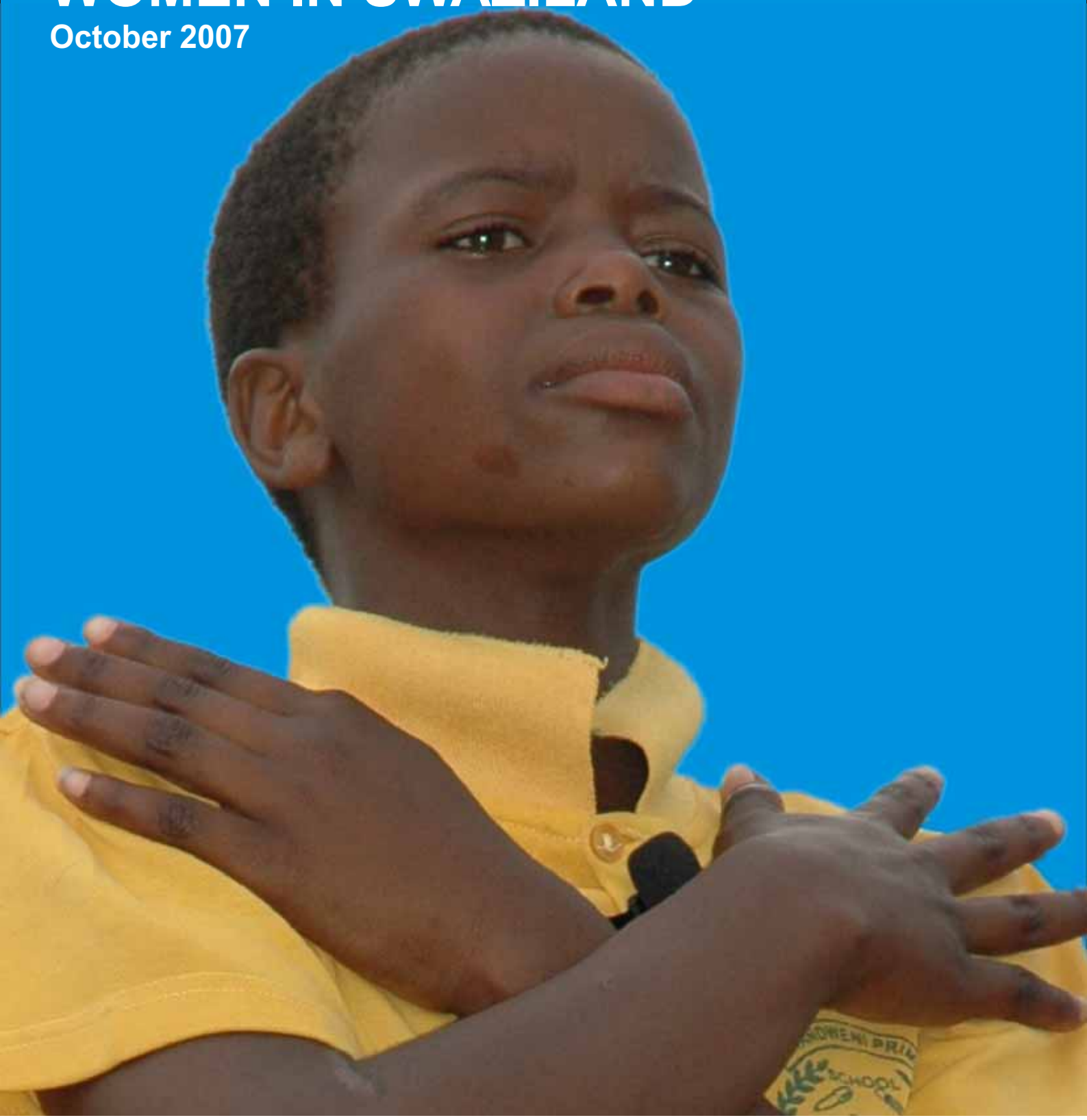
A NATIONAL STUDY ON VIOLENCE AGAINST CHILDREN AND YOUNG WOMEN IN SWAZILAND

October 2007



For every child
Health, Education, Equality, Protection
ADVANCE HUMANITY

unicef

CONTENTS

CREDITS

Report Prepared By
Avid Reza, Matthew Breiding, Curtis Blanton, James A. Mercy, Linda L. Dahlberg, Mark Anderson, Sapna Bamrah

Project Coordinator
Jama Gulaid, Representative, UNICEF, Swaziland

Operational Coordinator
Zodwa Dlamini-Mthethwa, Monitoring and Evaluation Officer, UNICEF, Swaziland

Principal Investigators
Avid Reza, Medical Epidemiologist, CDC, Atlanta
Matthew Breiding, Behavioral Scientist, CDC, Atlanta

Data Manager
Sapna Bamrah, Medical Epidemiologist, CDC, Atlanta

Statistician
Curtis Blanton, Statistician, CDC, Atlanta

Technical Support
James A. Mercy, Special Advisor for Strategic Directions, Division of Violence Prevention, CDC, Atlanta.
Linda L. Dahlberg, Associate Director for Science, Division of Violence Prevention, CDC, Atlanta.
Mark Anderson, Team Leader, International Emergency and Refugee Health Branch, CDC, Atlanta.
Tom Simon, Deputy Associate Director for Science, Division of Violence Prevention, CDC, Atlanta.
Xiangming Fang, Economist, CDC, Atlanta.
Michele Lynberg, Epidemiologist, CDC, Atlanta.
Kathleen Basile, Team Leader, Division of Violence Prevention, CDC, Atlanta.

Operational Support
Nonhlanhla Hleta-Nkambule, Communication Officer, UNICEF, Swaziland.
Yuko Kusamichi, Assistant Programme Officer, UNICEF, Swaziland.
Tizie Maphalala, Education Project Officer, UNICEF, Swaziland.

Field Team Supervisors

Khetsiwe Dlamini
Makhosazana Mabuza

Field Team Leaders

Fikile Dlamini
Delisile Khanyile
Nomfaneleko Khumalo
Zanele Maphalala
Busisiwe Matse
Buyile Mavimbela
Delisile Sibandze
Noncedo Tshabalala

Interviewers

Gabsile Dlamini
Pretty Dlamini
Nombulelo Dlamini
Nomvula Dlamini
Fikile Gama
Bindza Ginindza
Neliswa Hlongwane
Gcinile Hlophe
Andile Khanyile
Nobuhle Langwenya
Fiona Macedo
Queeneth Maseko
Siphiwe Masuku
Sivuyiso Maziya
Helen Mgadula
Dumsile Mhlanga
Alice Mkhonta
Sibongile Mlotsa
Nqobile Mthethwa
Lobesutfu Ngcamphalala
Dumile Nkambule
Sgcinile Nxumalo
Nontokozo Nyatsi
Khayelihle Seyama
Lomagugu Shabangu
Jabulile Shongwe
Nomcebo Shongwe
Nonhlanhla Sibandze
Qondile Sibiya
Sithembile Sibiya
Nomkhosi Sikhondze
Jabu Vilane
Njabuliso Zondi

Data Entry

Bethusile Khumalo
Mabandla Mziyako

Transport Officers

Mbongeni Bhembe
Ntuthuko Dlamini
Thokozani Gina
Khuzwayo Mabuza
Thembumenzi Mkhatshwa
Patrick Shongwe
Lucky Simelane
David Soko

COLLABORATING AGENCIES AND ORGANIZATIONS

Ministries

Ministry of Health	-	Eric Maziya, Maria Dlamini
Ministry of Education	-	Dineo Vilakazi
Ministry of Justice	-	Nompumelelo Lukhele

Central Statistic Office

Rachel Masuku,
Amos Zwane

Royal Swaziland Police

Lekina Magagula

Local Non-Governmental Organizations

Swaziland Action Group Against Abuse	-	Nonhlanhla Dlamini
Save the Children	-	Nomzamo Dlamini, Timothy Masuku
World Vision	-	Gideon Gwebu

National Emergency Response Council on HIV and AIDS

Sanelisiwe Tsel

United Nations Agencies

United Nations Population Fund	-	Aisha Camara-Drammeh
World Health Organization	-	Edward Maganu
Joint United Nations Programme on HIV/AIDS	-	Helen Odido

Acknowledgements

The Swaziland United Nations Children's Fund and the Centers for Disease Control and Prevention gratefully acknowledge with thanks the contributions of the various agencies, organizations, and individuals whose dedication, support and expertise made this survey possible.

We extend our deepest appreciation to all survey participants who were willing to trust the field team members and openly share their experience of violence in the hopes that this information would ultimately help to prevent violence. Further, special recognition is due to all the field team members who not only gained the skills necessary to implement a survey of this magnitude but also took great care in interviewing children and youth on the sensitive topic of violence and always placed the privacy and safety of the participants first. A list of all field team members can be found above.

The report also benefited from the contributions of a number of other people. In particular, acknowledgement is made to Rachel Jewkes, whose expertise in conducting studies on sexual violence in South Africa was invaluable to the development of the survey instrument and training protocol. Thanks are also due to the following: Basia Tomczyk, for providing input in the development of the training protocol as well as the human subjects issues related to conducting research on the topic of sexual violence in international settings; Lynn Jenkins and Susan Settergren, for providing input on the survey instrument and protocol; George Bicego and Peter Vranken, for providing input on the survey protocol, taking into consideration the cultural context of Swaziland; Kristin Becknell, for conducting the background literature search for this report.

This survey was funded by the Swaziland United Nations Children's Fund. Swaziland Action Group Against Abuse and the Swaziland United Nations Children's Fund provided the operational support necessary to implement the survey.

Executive Summary

Background

Violence against children is a significant global health and human rights problem, and a growing concern in sub-Saharan Africa. The problem of violence against children spans geographical boundaries, culture, race, class, and religion. It can be expressed in the form of physical or sexual assault or abuse, psychological or emotional abuse, and deprivation or neglect. Violence against children is a profound violation of human rights and has devastating short- and long-term mental and physical health consequences.

This report focuses primarily on sexual violence against female children. According to the World Report on Violence and Health, sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[1] Existing research shows that sexual violence is a major health problem throughout the world. Although nationally representative studies on child sexual violence are limited in sub-Saharan Africa, available data show that sexual violence against children is an important problem in the region.

Sexual violence is preventable. However, in order to develop and implement effective prevention strategies, timely and more complete data are needed. To the best of our knowledge, this survey provides, for the first time, national population based estimates that describe the magnitude and nature of the problem of violence experienced by female children in Swaziland. The objectives of this survey were to (1) describe the epidemiologic patterns of sexual violence and other forms of violence; (2) identify potential risk and protective factors for sexual violence; (3) assess the knowledge and utilization of health services available for victims of sexual violence and other forms of violence; (4) identify areas for further research; (5) raise awareness about violence as an important health problem; and (6) make recommendations on improving and enhancing interventions to better identify, treat and prevent sexual violence against children and its health-related consequences. This report will address all of the above listed objectives, with the exception of identifying risk and protective factors for sexual violence and areas for future research which will be presented in future publications.

Methodology

A 40 cluster by 48 national household survey was conducted in Swaziland from May 15 to June 16, 2007. A statistically valid sample size was calculated based on available data from prior surveys conducted in South Africa. In the first stage, enumeration areas (EA) (n=40) were selected with probability of selection proportional to size. In the second stage, we selected a systematic sample of households (n=48) with a random start in each EA, yielding a total of 1920 households nationally. A questionnaire was administered to one randomly selected eligible female 13-24 years of age in the selected household.

Main Findings

The results of this study indicate that violence against female children is highly prevalent in Swaziland. Approximately 1 in 3 females experienced some form of sexual violence as a child; nearly 1 in 4 females experienced physical violence as a child; and approximately 3 in 10 females experienced emotional abuse as a child.

Boyfriends and husbands were the most frequent perpetrators of sexual violence; male relatives (other than the victims' father) were the most frequent perpetrators of physical violence; and female relatives were the most frequent perpetrators of emotional abuse. Incidents of sexual violence most frequently occurred in the home, either the home of the respondent or the home of a friend, relative or neighbor.

It was found that over half of all incidents of child sexual violence were not reported to anyone, and less than 1 in 7 incidents resulted in a female seeking help from available services. Females indicated the primary reason for not reporting sexual violence was that they were not aware that what they had experienced was abuse. Many females also reported a fear of abandonment if they told anyone about the violence they had experienced. These numbers suggest a lack of understanding of what sexual violence is and how and where to report such incidents. In regard to physical violence, in only 1 out of 5 cases did females seek help from available services, despite the fact that nearly 1 in 4 resulted in injury that was serious enough to consult a doctor.

Main Recommendations

The results of this descriptive analysis have significant implications for focusing immediate and future prevention and response programs. Partnerships among government agencies in public health and education, non-governmental organizations that address these and related issues, and international organizations with technical expertise will be critical in developing a credible response to this problem. We offer several short, medium and long-term recommendations for moving forward in the prevention of violence against children in Swaziland. Some of these include the following:

- Broadly share the results of this survey with the people of Swaziland
- Identify a lead agency to coordinate prevention and response to violence against children
- Integrate efforts to address violence against children into existing infrastructure for addressing related health issues such as HIV/AIDS and reproductive health
- Develop a national plan to prevent violence against children in Swaziland
- Work to increase the human and operational capacity of government agencies and NGOs to address this problem by hiring more technical staff, developing monitoring and evaluation mechanisms, and increasing coordination among organizations addressing the problem.

BACKGROUND

Violence against children is a significant global health and human rights problem, and a growing concern in sub-Saharan Africa. It spans across boundaries of geography, culture, race, class, and religion. Violence against children can be expressed in the form of physical or sexual assault or abuse, psychological or emotional abuse, and deprivation or neglect.[1] These events occur in many different settings, including in the home and family, schools, healthcare and justice systems, workplaces and community.[2] Although perpetrators include strangers, most of these violent acts are committed by people who are part of the child's immediate environment, such as parents and the extended family, spouses, boyfriends and girlfriends, teachers, schoolmates, and employers.[2] Violence against children is a profound violation of human rights and has devastating short- and long-term mental and physical health consequences. The following examples provide some idea of the range and extent of violence against children throughout the world. The World Health Organization (WHO) estimated that approximately 53,000 child deaths in 2002 were homicides.[2] Although exposure to violence can result in a child's death, the magnitude of nonfatal violent events and their consequences are potentially far greater.[2,3,4,5] For example, in the Global School-based Student Health Survey carried out in a range of developing countries, between 20% and 65% of school-aged children reported having been verbally or physically bullied in school during the previous 30 days.[2] Limited research has shown that in some countries nearly half of children report they have been hit, kicked, or beaten by their parents.[6] Moreover, WHO estimated that 150 million girls and 73 million boys under 18 have experienced sexual violence involving physical contact.[7]

This report focuses primarily on sexual violence against female children. According to the World Report on Violence and Health, sexual violence is defined as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[5] Available research shows that sexual violence is a major health problem throughout the world. One-third of adolescent girls report their first sexual experience as being forced and nearly one in four women has experienced sexual violence in their lifetime.[5] Available data from Africa show that the percentage of females aged 16 years and older who report having been sexually assaulted in the previous 5 years range from 0.8% in Botswana to 4.5% in Uganda.[5] Peer-reviewed research on sexual violence against children in sub-Saharan Africa is limited.[8] Even the studies that have been conducted, however, are generally not nationally representative; samples are predominantly clinical or comprised of University students.[8] However, these studies are important in that they show that child sexual violence is an important problem in sub-Saharan Africa. One nationally representative study conducted in 1998 in South Africa showed that 1.6% of women reported they had been raped before the age of 15 years.[9] The consequences of sexual violence are broad and substantial. Some of the more common consequences include pregnancy and gynecological complications, HIV infection and other sexually transmitted diseases; mental health problems; and social ostracization.[5]

This report presents findings from the first nationally representative survey of sexual violence against children in Swaziland. Swaziland, a landlocked country between South Africa and Mozambique, is one of the smallest countries in mainland Africa. A former British protectorate, Swaziland gained its independence in September

1968. The majority of the population is ethnic Swazi. Traditionally Swazis have been subsistence farmers and herders, but some now work in the growing urban formal economy. Christianity in Swaziland is sometimes mixed with traditional beliefs and practices. The country's official languages are Siswati and English.

The need for a population-based survey to describe the magnitude and nature of sexual violence against children in Swaziland was based on limited data indicating that this is a major health problem. These data came from a few school-based studies. For example, the Swaziland 2003 Global School-Based Student Health Survey showed that 9.8% of female students between the ages of 13-15 years reported having ever been physically forced to have sexual intercourse.[10] The lifetime prevalence of forced sexual intercourse among female students 16 years and older was 21.1%. Other school based surveys confirm high levels of sexual violence against children. A study of all forms of child abuse among children attending select primary and secondary schools in Swaziland revealed that approximately 40% of this population experienced some form of child abuse during their lifetime.[11] The most common abuse reported by children was physical abuse (49.5%), followed by sexual abuse (19.2%). Further, the findings of this study indicated that students between the ages of 10 and 15 years were most vulnerable to child abuse. Lastly, a study of patterns of sexual behavior among secondary school students in Swaziland showed that 13% of the students described their first sexual experience as being coerced.[12]

These previous studies of sexual violence against children in Swaziland suffer from several limitations. First, since not all children attend school, these school-based studies are not representative of all children in Swaziland. It is estimated that approximately 9.4% of children of primary school age do not attend primary school.[13] Moreover, children who do not attend school or who drop out of school may be at highest risk for sexual violence. Second, these studies were descriptive and, therefore, not designed to identify risk and protective factors for sexual violence. These limitations restrict their usefulness for informing prevention efforts.

In response to concerns regarding sexual violence against children and the need for quality data that is nationally representative, Swaziland United Nations Children's Fund (UNICEF) requested technical assistance from the Centers for Disease Control and Prevention (CDC). CDC was asked to provide technical assistance in conducting a national survey to study the epidemiologic patterns of, and potential risk factors for, sexual violence against children, for the purposes of program and policy development. The lack of sufficient and reliable health data contributes to the inability of the various ministries, agencies and organizations interested in preventing sexual violence to make informed programmatic and policy decisions. One way to address the gap in health information on sexual violence against children is to collect nationally representative data through scientifically validated survey techniques. It is critical to obtain population based information on sexual violence for several reasons. First, little is known about the problem of sexual violence against children and decisions are based on limited data. In order to determine health priorities, population based data can provide decision makers with an overview of the magnitude and nature of the health problem that is occurring at a national level and be used to mobilize action. In the absence of good prevalence estimates the tendency in many countries is to believe that childhood sexual violence is not a problem.[14] Further, progress towards prevention cannot be monitored without reliable population based baseline and follow-up data. Population based data can also be used to identify potential risk and protective factors for sexual violence in order to develop effective prevention strategies. Lastly, since sexual violence is a potential route of transmission for HIV/AIDS, one of the leading causes of death in Swaziland, the prevention of sexual violence could also potentially contribute to its prevention.

Sexual violence is preventable. However, in order to develop and implement effective prevention strategies, timely and more complete data are needed. This survey provides, for the first time, national population based estimates that describe the magnitude and nature of the problem of violence experienced by female children in Swaziland. The objectives of this survey were to (1) describe the epidemiologic patterns of sexual violence and other forms of violence; (2) identify potential risk and protective factors for sexual violence; (3) assess the knowledge and utilization of health services available for victims of sexual violence and other forms of violence; (4) identify areas for further research; (5) raise awareness about violence as an important health problem; and (6) make recommendations on improving and enhancing interventions to better identify, treat and prevent sexual violence against children and its health-related consequences. This report will address all of the above listed objectives, with the exception of identifying risk and protective factors for sexual violence and areas for future research which will be presented in future publications.

METHODS

A 40 cluster by 48 household survey was conducted in Swaziland from May 15 to June 16, 2007.

Rationale for Focus on Females 13-24 Years Old: Since interviewing younger children would be both practically and ethically inappropriate, we decided the best approach would be to ask older children and youth about their childhood experiences. This approach is limited in that it may not accurately reflect the experiences of very young children, but it provides a reasonable approach given these barriers. Further, we decided to focus on females in this survey for two key reasons. First and foremost, females are the most common victims of childhood sexual violence, the primary focus of this survey.[1] Second, given that sexual violence is much less prevalent among male children the sample size needed to develop stable (reliable) prevalence estimates for male children would have substantially increased the cost of data collection, exceeding the budget available for the study. The decision to exclusively examine sexual violence directed toward female children should not be taken to mean that male children do not also suffer from sexual violence. The impact of sexual violence as well as other forms of violence on male children should be closely examined in subsequent studies in Swaziland.

Background Preparation: Key stakeholders identified by UNICEF provided input into the development of the survey protocol and instrument. These stakeholders included (1) relevant ministries such as the Ministry of Education, Ministry of Health and Social Welfare, and Ministry of Justice; (2) service providers such as the Swaziland Action Group Against Abuse (SWAGAA), Save the Children, the Social Welfare Department housed in the Ministry of Health and Social Welfare, and the Royal Swazi Police; and (3) other experts on sexual violence, including key informants in Swaziland as well as sexual violence researchers in South Africa. Meetings with key stakeholders and informants helped to inform the survey instrument and procedures, taking into consideration the local cultural context. In addition, these discussions helped to foster ownership of the survey and build local capacity to address the problem of sexual violence. Lastly, meetings with service providers were important for developing the referral process described below.

Pilot Test: Prior to implementation of this national household survey, we conducted a pilot. We randomly selected one village using the sampling frame described below. Next, we followed the procedures for 2nd stage sampling as described in the section on study design and selected a systematic sample of 48 households with a random start. In each household we randomly selected one female between the ages of 13-24 years. By following the same procedures as described for the study, the pilot helped to improve the questionnaire as well as the survey process, including but not limited to second stage sampling, approaching households, consent process, and the referral process.

Sample Size Calculation: Assuming a design effect of 2, we estimated that a sample size of 1024 households was needed to achieve a +/- 1.9% precision around an estimated prevalence of forced sexual violence against female youth of 5%[15] with a 95% confidence interval (CI). In Swaziland, approximately 68% of households have a female household member aged 13-24 years.[16] In order to account for this we, therefore, increased the estimated household sample size to 1505. In addition, the final estimated sample size needed for this level of precision was adjusted to 1881 households to account for a potential 20% non-response rate due to refusals and unavailability.

Study Design: We conducted a national household survey using a two-stage (40x48) cluster sample survey design. In the first stage, we selected a sample of enumeration areas (n=40) with probability of selection proportional to size (PPS). An enumeration area is a geographical subdivision of the country determined by the census department. In the second stage, we selected a systematic sample of households (n=48) in each of the enumeration areas with a random start, yielding a total of 1920 households nationally, which is more than what was estimated to be required (n=1881) in order to obtain the necessary precision for this study (*See Sample Size Calculations*). A household was defined as a person or group of persons who may be related (family) or unrelated or both who live together and share meals. Therefore, polygamous families who live and eat together were considered as one household. In each household we then selected one female between the ages of 13-24 years. When there was more than one eligible female per household, the interviewers made a list of all eligible females and then randomly selected one participant using the Kish Method (Appendix C). Once the interviewer and participant ensured privacy, the questionnaire was administered to the selected female after providing verbal consent (Appendix A, B). If the selected female was not available at the time of the survey, the survey team attempted to identify a time when she would be present. If the selected female was not found after two additional attempts, the household was skipped and not replaced regardless of whether or not there were other eligible female household members present. In cases where household members were not found after a total of three visits to the household or the household did not have an eligible female, the household was also skipped and not replaced.

Participation in the survey was voluntary. The survey was also confidential such that no personal identifiers were collected. Therefore, participants could not be linked to the data once they completed the interview. World Health Organization guidelines on ethics and safety in studies on violence against women, as described elsewhere,[17] were adhered to in this survey.[18,19] The Centers for Disease Control and Prevention's Institutional Review Board, which protects the rights and welfare of human research subjects, approved the study.

Sampling Frame: The sampling frame for this study was compiled by the Central Statistics Office (CSO) of Swaziland for the national population census in 1997. The list contains (1) enumeration areas (EAs); (2) names of the **Inkhundla**, Major Areas and Minor Areas that each EA is located in; and (3) the total population in each EA. Each EA is also given a code, similar to zip codes/postal codes, and are part of a data management system that provides unique reference codes to thousands of locations in Swaziland. This list was considered to be the most reliable and recent source of population estimates for Swaziland available at the time of the survey. Although the 2007 national census was conducted immediately prior to our survey, this sampling frame was not yet publicly available. As such, we relied on the 1997 census to randomly select 40 EAs based on PPS. Once we selected the 40 EAs, CSO updated the census information for these select areas using the 2007 census data.

Questionnaire Development: The questionnaire was developed using primarily standardized and previously tested survey tools (Appendix C). These survey tools included the Demographic and Health Survey (DHS), HIV/AIDS/STD Behavioral Surveillance Surveys (BSS), Child Sexual Assault (CSA) Survey, Youth Risk Behavior Survey (YRBS), and Longitudinal Studies of Child Abuse and Neglect (LONGSCAN). In addition, the questionnaire and the survey protocol itself were developed in consultation with key informants from Swaziland who were familiar with the problem of violence against children as well as the cultural context. Further, the questionnaire was revised based on feedback from the pilot. The questionnaire included the following topics: demographics; parental relations; family and community support; school experiences; sexual behavior and practices; HIV/AIDS; physical,

emotional and sexual violence; and utilization of and barriers to health services.

The following background characteristics of the study participants were assessed: age, socioeconomic status, marital status, ethnicity, religion, education and living situation. The sexual behavior and HIV/AIDS components utilized questions from both DHS and BSS. These questions were divided among the following topics: sexual behavior; condom use; and voluntary HIV/AIDS counseling and testing.

The assessment of physical, emotional and sexual violence was primarily based on questions utilized previously in DHS and CSA. A number of questions assessing physical violence and emotional abuse, including lifetime prevalence, were included in the survey. Questions assessing sexual violence examined types of sexual violence experienced, the settings where sexual violence occurred, and the relationship between the victim and perpetrator. This information was collected on the first and most recent incidents of sexual violence, which allowed for the calculation of lifetime and 12-month prevalence. In addition, we developed several questions assessing potential risk and protective factors, based on interviews with key informants and previous study results. Some of the questions on risk and protective factors were based on DHS, YRBS and LONGSCAN. We also asked questions regarding the negative health consequences and service seeking behavior related to these events. Definitions of the key terms used in this survey are described below.

The survey was administered in SiSwati. The questionnaire was translated from English into SiSwati and then back-translated into English. The translation was reviewed and revised by survey team members who were fluent in both SiSwati and English during the training for the pilot. The translations were further revised based on feedback from the pilot.

Key Definitions:
Child: anyone who is under 18 years of age.

Sexual violence: "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work."[5] In this survey we specifically asked about the following different forms of sexual violence:

- *Forced intercourse* in which a man or boy physically forced the respondent to have sexual intercourse against her will.
- *Coerced intercourse* in which a man or boy persuaded or pressured the respondent to have sexual intercourse against her will. In other words, the respondent gave in to sexual intercourse with a man or boy because she felt overwhelmed by continual arguments and pressure.
- *Attempted unwanted intercourse* in which a man or boy tried to make the respondent have sexual intercourse when she did not want to, but he did not succeed in doing so.
- *Unwanted touching of respondent* in which a man or boy touched the respondent against her will in a sexual way, such as unwanted touching, kissing, grabbing, or fondling, but he did not try to force her to have sexual intercourse.
- *Unwanted touching of perpetrator* in which a man or boy forced the respondent to touch his private parts against her will, but he did not force her to have sexual intercourse.

Emotional abuse: emotional ill treatment such as name calling or saying mean things that resulted in the respondent feeling scared or made to feel really bad.

Physical violence: physical act of violence such as being kicked, bitten, slapped, hit with a fist, or threatened with a weapon, such as a knife, stick, or a gun, regardless of whether or not it resulted in obvious physical or mental injury.

Sexual intercourse: sexual act involving vaginal or anal intercourse.

Data Quality, Control, Entry and Analysis: Team leaders reviewed every questionnaire for completeness and accuracy before leaving the interview location in an effort to minimize errors and missing data. Interviewers were sent back to collect missing information and to clarify information that appeared erroneous. In addition, the field supervisor randomly selected 10% of completed questionnaires from each EA and reviewed them for completeness and accuracy. Mistakes were brought to the attention of team leaders so that errors could be addressed with the teams and avoided in the future. Data were entered into Epi Info (version 3.3.2). There were no unique identifiers in the database that could be easily linked to a participant. Survey participants were each assigned a unique identification number based on their EA and household numbers. This project number was for study purposes only and could not be linked to an individual household. We undertook 20% double-data entry of the completed questionnaires. The percent data entry error for all fields was only .3%. Discrepancies were investigated and resolved by reviewing the questionnaire and correcting the erroneous data entry record to reflect the interviewer response. Given the percent data entry error was less than 1%, we determined that double data entry of all questionnaires was not necessary. SAS (version 9.1.3) was used for data management and SAS-callable SUDAAN (version 9.01) was used for analysis to take into account weighting of the variables and the complex sample design. All results were calculated using sampling weights so that they are nationally representative. The stability of the prevalence estimates was determined using the analytic guidelines for the U.S. National Health and Nutrition Examination Survey.[30] For proportions >0.25 and <0.75, a coefficient of variation (defined as the standard error divide by the proportion times 100) greater than 30% was considered unstable. For uncommon (proportion <=0.25) or very common (proportion >=0.75) events, an estimate was unstable if the sample size times the proportion (for uncommon events), or the sample size times one minus the proportion (for common events), was less than 8 times the calculated design effect (defined as the sampling variance due to the complex sample design divided by sampling variance from a simple random sample). The unstable estimates are considered to have a large sampling error around the estimated proportion due to either a small sample size or the cluster sample design. Any estimate that was found unstable was noted in the text or table.

Survey Team and Training: The eight survey teams consisted of 6 persons per team: one team leader responsible for providing direct supervision of the overall survey implementation in the field as well as selecting households using second stage sampling, introducing the survey to the household members, checking the questionnaires for completeness and accuracy, and ensuring interviewers followed appropriate procedures for offering referrals; four interviewers (with the exception of one team which had five interviewers) responsible for selecting the eligible female, obtaining consent, conducting the interview, insuring privacy and confidentiality, and offering a referral; and one driver. In addition, we employed one administrative supervisor and one field supervisor, each with considerable experience conducting surveys. These supervisors provided oversight and coordinated the activities of all teams. Team leaders were responsible for reporting their activities to the supervisors. Team members were identified by UNICEF. To help facilitate trust and understanding, all team members (with the exception of drivers) working on this project were female health workers or other female members of the community who were fluent in both English and the local language, SiSwati, and who were familiar with the culture in Swaziland. Additional selection criteria were based on age, education level, job experience and performance, and the area where they

lived and worked. As an additional precaution to ensure confidentiality and trust, team composition and assignments were such that team members were not designated to administer the survey in a village/town where they were likely to know any of the respondents.

Training sessions were held for 5 days by CDC and UNICEF staff to develop standardized, accurate, sensitive and safe techniques for implementing the survey. The training sessions covered the following topics: (1) background on the purpose of the study and on data collection and design; (2) a participatory review of the questionnaire and interview techniques; (3) role plays and field practice of approaching households and administering the questionnaire; (4) sampling procedures and assignment of sampling areas; (5) procedures for and importance of maintaining confidentiality; (6) two step process for obtaining consent from participants (Appendix A, B); (7) sensitivity towards participants; (8) protecting privacy of participants; (9) referral services and procedures; (10) identification and response to adverse effects; (11) discussions about interviewers' attitudes and beliefs towards sexual violence; (12) interviewer safety as well as referral services and procedures for the interviewers; and (13) human subjects research protection.

Referral Process: Survey teams were instructed not to provide any counseling. Instead, interviewers offered a list of local services and sources of support (Appendix D) to *all* study participants. In order to ensure that the nature of the survey was not revealed to non-participants, the list of services included services not associated with violence (e.g., TB, malaria, HIV/AIDS). Interviewers were instructed to indicate which organizations and agencies provide services for sexual violence, as well as other forms of violence, so that participants clearly understood where to obtain the necessary services.

In addition, if a participant became upset during the interview, the interviewer offered to place the participant in direct contact with a counseling service, either Swaziland Action Group Against Abuse (SWAGAA) or Save the Children, depending on the region where the participant lived. Further, for all participants who reported experiencing any form of abuse in the past 12 months, interviewers offered to place the participant in direct contact with the aforementioned counseling services (SWAGAA or Save the Children). If a participant indicated that they would like a direct referral, the interviewers asked permission to obtain their contact information, including their name and a safe way in which a counselor could find them. It is important to note that the interviewers did not give any of the information shared during the interview to the service provider. Further, the contact information was recorded on a separate form which was not connected with the interview (Appendix E). The form was provided to the administrative supervisor who gave each form directly to the service provider, such that the survey teams would have no documents identifying any of the study participants. SWAGAA and Save the Children then worked with the participants to determine the best and most appropriate services needed, as well as determine which organization(s) would best provide the needed service.

RESULTS

Sample Characteristics

Response Rate: All of the 40 EAs were accessible. However, in two of the EAs, less than 48 households were present because of the small size of the communities. The total number of households visited was 1900. As expected, sixty-eight percent (n = 1292) of the 1900 households selected had an eligible female. Information was collected from 1244 of the 1292 eligible females, for an overall response rate of 96.3%. Non-response was due to unavailability and refusals. Only 14 (1.1 %) of the selected females refused to participate in the survey.

Demographics: Among females between the ages of 13 and 24 years, 46.4% (95% CI, 42.4-50.4) were 13-17 years old (Table 1). The majority of females (85.1%; 95% CI, 71.6-92.9) lived in rural communities. Most females considered themselves Zionist (41.1%; 95% CI, 35.7-46.6) or Protestant (52.7%; 95% CI, 47.2-58.1). Approximately 9.7 % (95% CI, 7.1-13.1) were married. Among 13-17 year old females, 9.9% (95% CI, 7.7-12.5) were orphans, whose parents have both died.

Education: Approximately 97.5% (95% CI, 95.8-98.5) of 13-24 years old females have ever attended primary or secondary school. Eighty-one percent (95% CI, 75.5-86.4) of 13-17 year old females were enrolled in school. Among the 18.4% (96% CI, 13.6-24.5) of females 13-17 years old who were not attending school, the majority reported that they stopped attending school because they could not afford going to school (Table 2). The next most common reason for failure to attend school was pregnancy. Approximately 17.4% (95% CI, 10.9-26.6) stopped attending school because they became pregnant.

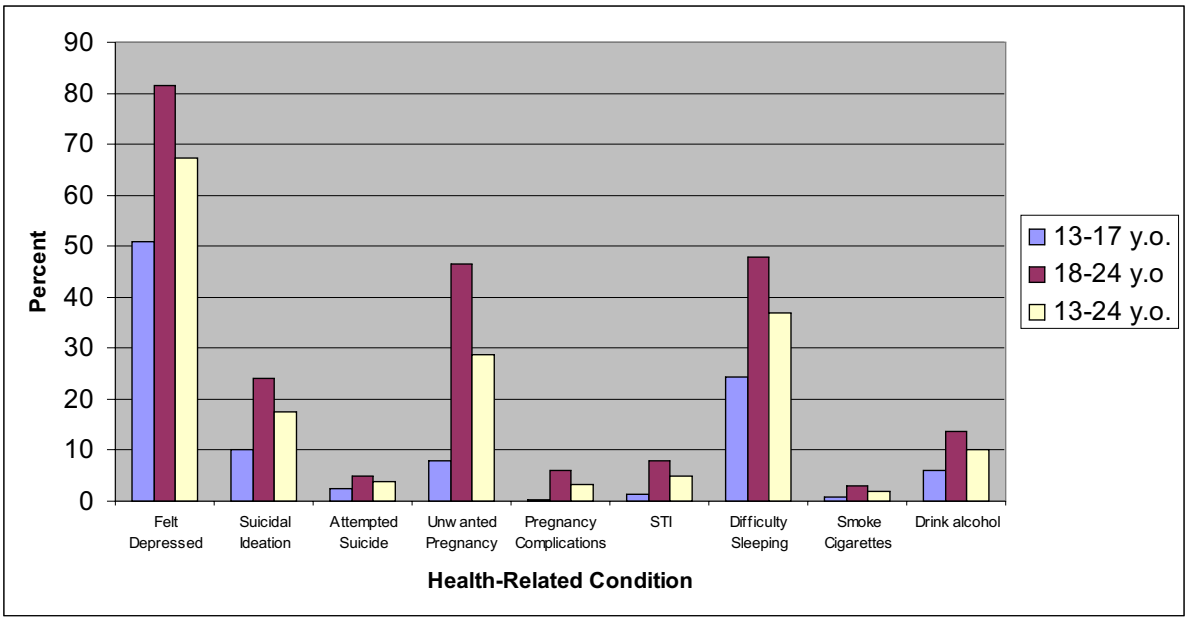
As expected, the majority of 18-24 year old females were not enrolled in school. Among the 78.2% (95% CI, 73.1-82.5) of 18-24 year old females who were not attending school, only 20.3% (95% CI, 15.4-26.2) indicated that they stopped attending school because they completed their education (Table 2). The majority reported that they stopped attending school because they could not afford going to school. Pregnancy also was one of the more common reasons for failure to attend school. Approximately 15.8% (95% CI, 12.5-19.7) of 18-24 year old females stopped attending school because they became pregnant.

Lifetime Experience of Health-Related Conditions and Behaviors: Overall, the majority of 13-24 year old females (67.4%; 95% CI, 62.7-71.8) reported feeling depressed at some point in their lifetime (Table 3, Figure 1). Further, 17.6% (95% CI, 14.9-20.7) reported ever having thoughts of suicide. About 3.8% (95% CI, 2.7-5.3) reported a prior suicide attempt. Approximately 51.0% (95% CI, 45.1-56.9) of all 13-17 year old females reported ever feeling depressed and 10.1% (95% CI, 7.8-13.0) indicated ever having suicidal ideation.

Some of the other leading health-related conditions among females 13-24 years of age included difficulty sleeping (37.0%, 95% CI: 33.1-41.1) and unwanted pregnancy (28.7%, 95% CI: 25.8-31.7). Nearly half of all females 18-24 years old report having experienced difficulty sleeping and having had an unwanted pregnancy. Among 13-17 years old females, 24.4% (95% CI, 20.4-29.1) reported difficulty sleeping and 7.9% (95% CI, 5.6-11.0) indicated having had an unwanted pregnancy.

Approximately 32.4% (95% CI, 28.3-36.7) of 13-24 year old females reported being tested for HIV. Among those tested, 86.9% (95% CI, 81.9-90.7) received their test results. Among those who received their test results, 12.2% (95% CI, 8.5-17.1) were told by a healthcare provider that they were HIV positive.

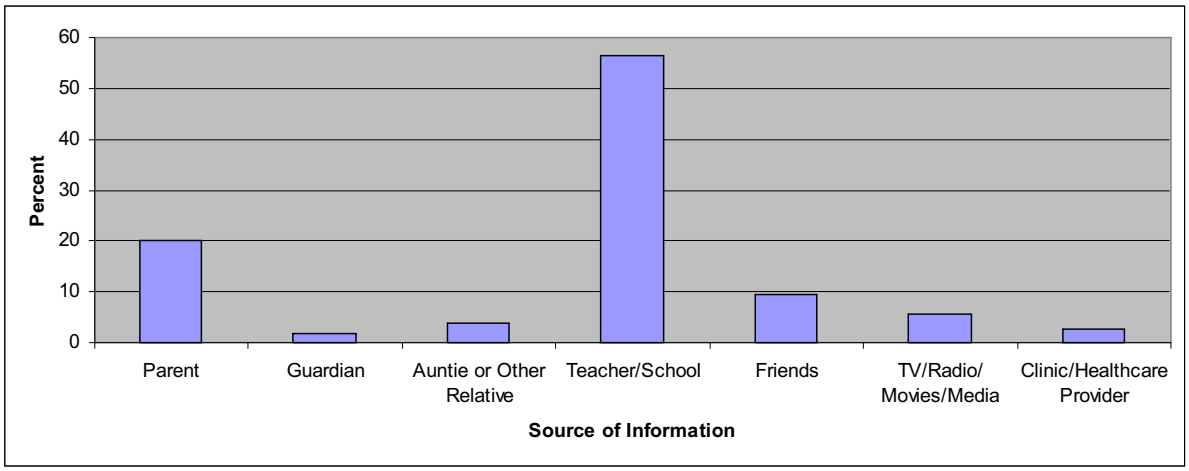
Figure 1. Self-Reports of the Lifetime Experience of Health-Related Conditions and Behaviors Among Females 13-24 Years - Swaziland 2007



Sexual Behavior and Practices

Knowledge about Sexual Behavior: The majority of 13-24 year old females (56%; 95% CI, 53.2-60.0) indicated that they obtained *most* of their information about sex while growing up from teachers or schools (Table 4, Figure 2). The next most common source of information was from parents, 20.2% (95% CI, 17.2-23.5). Although the majority of females did not report that their parents or guardian were the *primary* source of information regarding sex while they were growing up, 50.9% (95% CI, 47.7-54.1) reported that they had discussed sex with a parent or guardian. The majority of 13-24 year old females reported discussing HIV/AIDS, condoms, abstinence, sexual violence and safe sex with a parent or guardian (Table 5). The most common topic related to sexual behavior and practices discussed was abstinence (95.6%; 95% CI, 93.1-97.2).

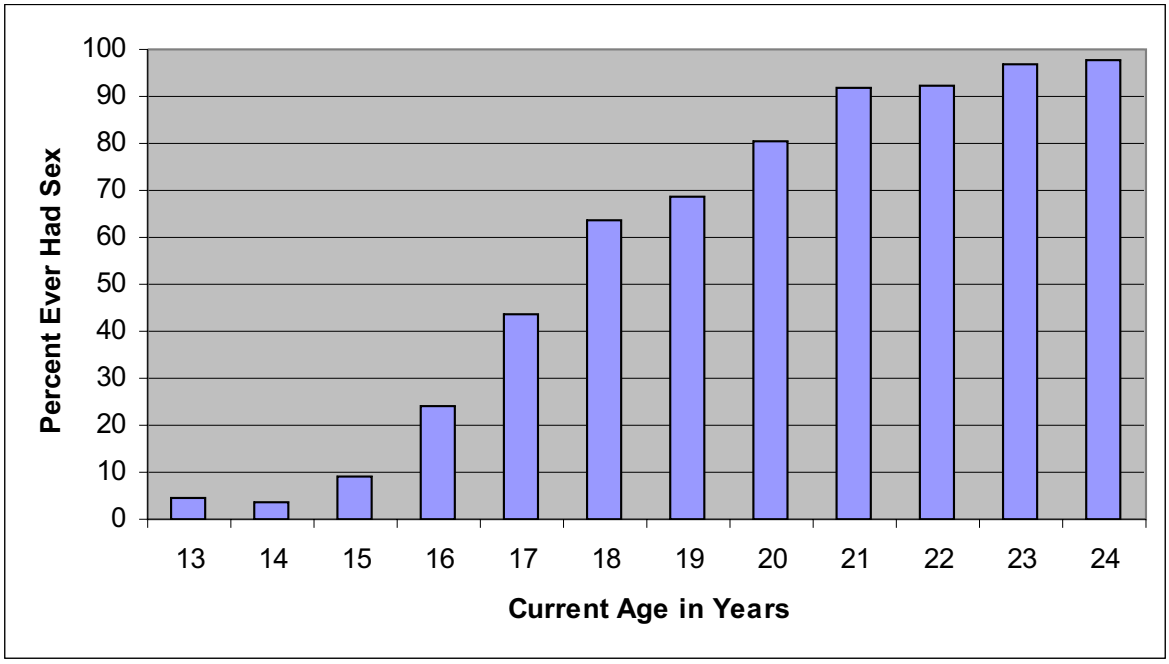
Figure 2. Primary Source of Information about Sex While Growing Up as Reported by Females 13-24 Years - Swaziland 2007



Social and Cultural Norms Regarding Sexual Behavior: The majority of females 13-24 years old felt *very* comfortable saying no to a boyfriend or husband, respected male adult in the family, male teacher, or respected male adult from the community who wanted to have sex (Table 6). Although females 13-24 years old felt *very* comfortable saying no to the male figures listed above, they felt least comfortable saying no to a boyfriend or husband.

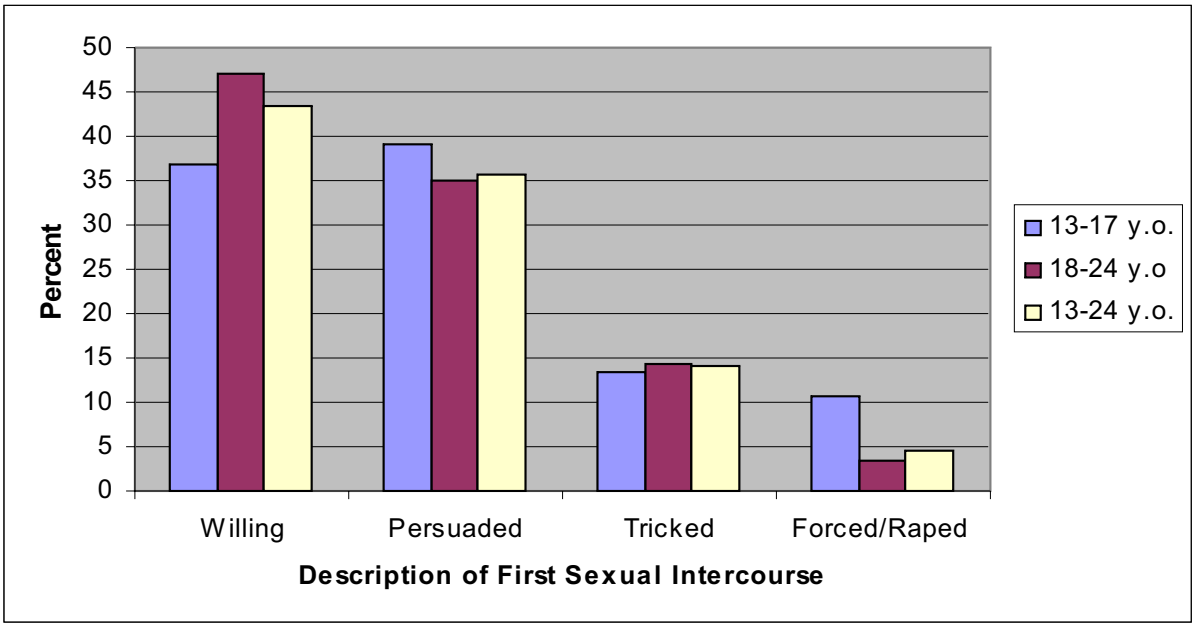
First Sexual Intercourse: Among 13-17 year old females, 17.1% (95% CI, 13.1-22.0) reported ever having sexual intercourse. Among 18-24 year old females, 81.7% (95% CI, 77.7-85.2) reported ever having sexual intercourse. The percentage of females who reported ever having sexual intercourse is plotted by age in Figure 3. The reported median age of first sexual intercourse among females 13-24 years old was 17.9 years.

Figure 3. Percent of Females 13-24 Who Ever Had Sexual Intercourse, by Age - Swaziland, 2007



Approximately 43.5% (95% CI, 37.9-53.4) of 13-24 year old females described their first sexual experience as being willing (Table 7, Figure 4). Over a third (36.8%; 95% CI, 23.7-52.2) of 13-17 year old females and nearly half of females 18-24 years old described their first sexual experience as being willing (Table 7). The remaining females reported they had been persuaded, tricked, or forced/raped during their first sexual experience. Approximately 4.6% (95% CI, 3.0-7.0) of 13-24 year old females described their first sexual experience as being forced/raped. Females within the 13-17 year age group reported the highest percent of rape (10.6%; 95% CI, 5.3-20.1) for their first sexual experience. About 94.6% (95% CI, 91.9-96.5) indicated that their first sexual intercourse was with a boyfriend or husband (Table 8). The majority of females 13-24 years old also reported that their first sexual experience was with someone older than themselves. Approximately 37.8% (95% CI, 32.8-43.0) reported that their first sexual intercourse was with someone less than five years older while 40.0% (95% CI, 33.7-46.6) were 5-10 years older and 9.1% (95% CI, 6.8-12.1) were more than 10 years older. Condoms were used by 52.8% (95% CI, 45.8-59.7) of females 13-24 years old during the first sexual intercourse.

Figure 4. Description of First Sexual Intercourse By Age Among Females 13-24 Years of Age - Swaziland 2007



Exchange of Money, Gifts, Favors and Other Items for Sex: The majority of females 13-24 years old reported that they had never been *offered* money, gifts, favors, or other items for sex. About 1.9% (95% CI, 1.2-3.0) reported that a teacher or principal ever *offered* money, gifts, food, shelter, or better grades in exchange for sex. Approximately 7.6% (95% CI, 5.5-10.4) reported that someone other than a teacher or principal ever *offered* money, gifts, food, or shelter in exchange for sex. Also, the majority of females 13-24 years old reported that they have never had sex with someone in hopes of receiving money, gifts, favors, or other items for sex. Less than 1% reported that they had sex with a teacher or principal because they *hoped to receive* money, gifts, food, shelter, or better grades. Approximately 1.9% (95% CI, 1.3-2.8) reported that they had sex with someone other than a teacher or principal because they *hoped to receive* money, gifts, food, or shelter. Among the latter group, 71.3% (95% CI, 50.9-85.6) indicated that they had sex with a boyfriend in exchange for the items listed.

Sexual Violence Prevalence

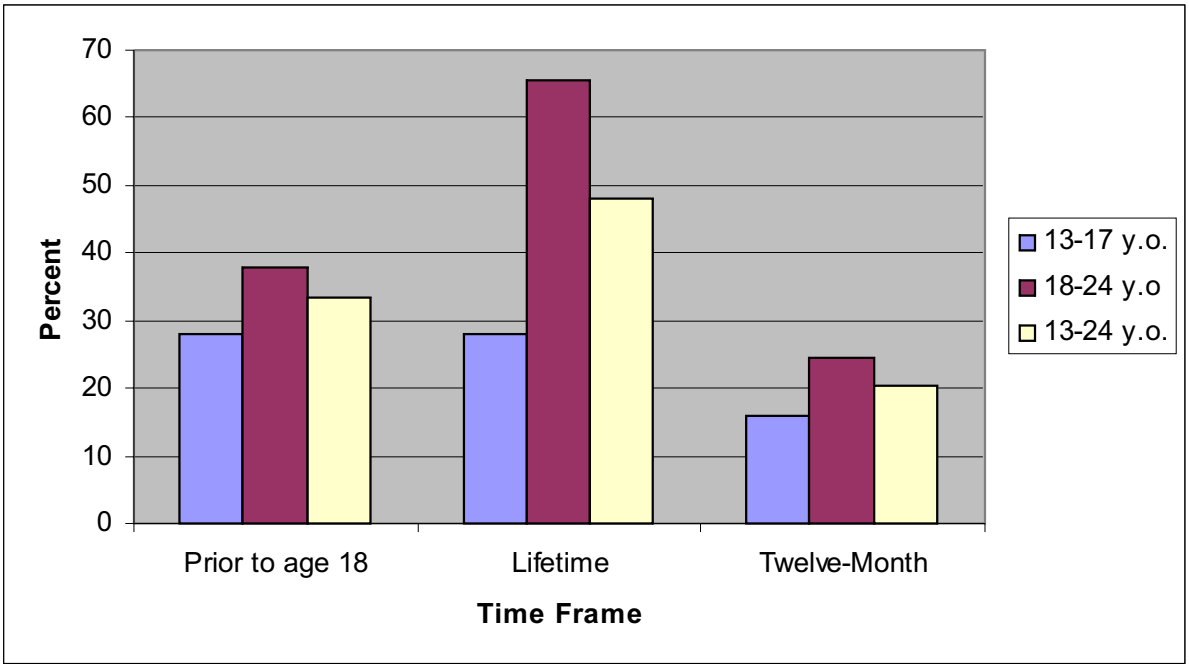
Prevalence of Sexual Violence Experienced Prior to Age 18: Overall, 33.3% (95% CI, 29.9-36.8) of females reported that they had experienced some form of sexual violence prior to age 18 (Table 9, Figure 5). Among 13-17 year old females, the prevalence of any sexual violence prior to age 18 was 28.0% (95% CI, 23.6-33.0) and 37.8% (95% CI, 33.1-42.6) among those 18-24 years old. Overall, the prevalence of forced intercourse prior to age 18 was 4.9% (95% CI, 3.7-6.6), the prevalence of coerced intercourse prior to age 18 was 9.1% (95% CI, 7.0-11.8), and the prevalence of attempted unwanted intercourse prior to age 18 was 18.8% (95% CI, 16.5-21.3). Among females 13-17 years old the prevalence of forced intercourse was 2.3% (95% CI, 1.3-4.1), the prevalence of coerced intercourse was 5.7% (95% CI, 3.4-9.2), and the prevalence of attempted unwanted intercourse was 16.8% (95% CI, 13.4-20.9). Among females 18-24 the prevalence of forced intercourse prior to age 18 was 7.2% (95% CI, 5.0-10.3), the prevalence of coerced intercourse prior to age 18 was 12.1% (95% CI, 9.3-15.5), and the prevalence of attempted unwanted intercourse prior to age 18 was 20.5% (95% CI, 17.0-24.4).

Among females experiencing any sexual violence prior to age 18, approximately 44.1% (95% CI, 38.3-50.1) reported one incident in their lifetime, while 55.9% (49.9-61.7) reported two or more incidents in their lifetime.

Lifetime Prevalence of Sexual Violence: Overall, 48.2% (95% CI, 43.8-52.7) of females reported that they had experienced some form of sexual violence in their lifetime (Table 10,Figure 5). Among 13-17 year old females, prevalence estimates for lifetime sexual violence are the same as those described in the above paragraph describing sexual violence prior to age 18. Among 18-24 year old females the prevalence of any lifetime sexual violence was 65.7% (95% CI, 59.5-71.4). The lifetime prevalence of forced intercourse for 18-24 year old females was 10.7% (95% CI, 8.0-14.0), the lifetime prevalence of coerced intercourse was 28.2% (95% CI, 22.3-35.0), and the lifetime prevalence of attempted unwanted intercourse was 36.2% (95% CI, 30.9-41.8).

Prevalence of Sexual Violence in the Preceding 12 Months: Overall, 20.5% (95% CI, 17.5-23.9) of females reported that they had experienced some form of sexual violence in the preceding 12 months (Table 11, Figure 5). Among 13-17 year olds females the prevalence of any sexual violence in the preceding 12 months was 16.0% (95% CI, 12.7-20.1), as compared to 24.4% (95% CI, 20.0-29.4) among those 18-24 years old. Overall, the prevalence of forced intercourse in the preceding 12 months was 2.1% (95% CI, 1.2-3.5), the prevalence of coerced intercourse in the preceding 12 months was 5.2% (95% CI, 3.6-7.5), and the prevalence of attempted unwanted intercourse in the preceding 12 months was 10.2% (95% CI, 8.3-12.4). The prevalence of forced intercourse in the preceding 12 months was 1.0% (95% CI, 0.4-2.2) for 13-17 year old females and 3.0% (95% CI, 1.6-5.7) for 18-24 year old females. Approximately 3.3% (95% CI, 1.7-6.1) of 13-17 year old females experienced coerced intercourse in the past 12 months while the prevalence of coerced intercourse in the preceding 12 months among females 18-24 years old was 6.9% (95% CI, 4.6-10.3). Finally, 8.0% (95% CI, 5.8-11.1) of 13-17 year old females experienced attempted unwanted intercourse in the past 12 months while the prevalence of attempted unwanted intercourse in the preceding 12 months among females 18-24 years old was 12.0% (95% CI, 9.0-15.9)

Figure 5. Prevalence of Sexual Violence Among Females 13-24 Years - Swaziland 2007



[1]Interpret with caution as these values are unstable (unreliable).

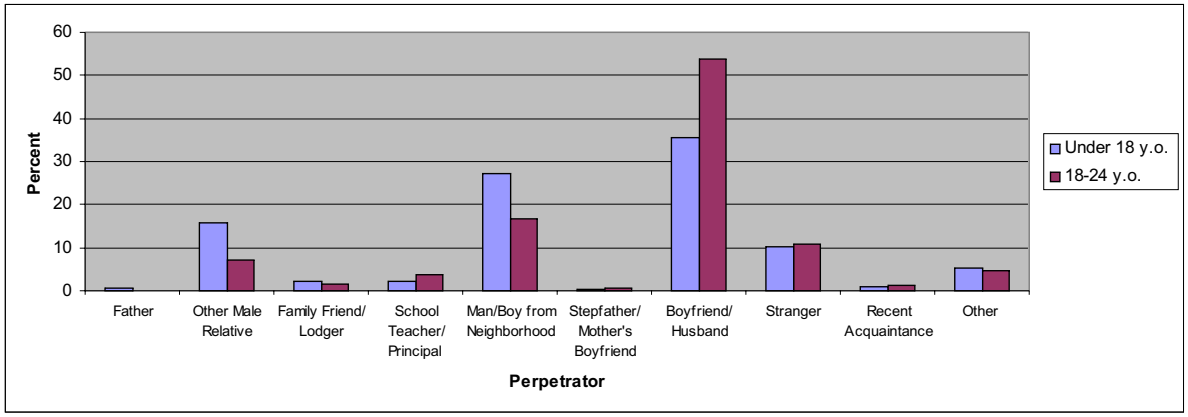
Sexual Violence Circumstances

The survey collected circumstance information on 13-24 year old females' first and most recent incidents of sexual violence. Among those who reported at least one incident of sexual violence prior to age 18, 70.3% (95% CI 62.9-76.8) reported one or two incidents in their lifetime while the remaining 29.7% (95% CI 23.2-37.1) reported 3 or more incidents. This means that circumstance information was collected on all incidents of sexual violence for 70.3% of 13-24 year old females who experienced at least one incident of sexual violence prior to age 18. For 29.7% of 13-24 year old females who experienced at least one incident of sexual violence we collected circumstance information on two of the incidents they experienced.

Age: Among incidents of sexual violence that occurred prior to age 18, 8.5% (95% CI, 6.5-11.0) occurred when the females were under 13 years of age and 91.5% (95% CI, 89.0-93.5) occurred when females were 13-17 years of age.

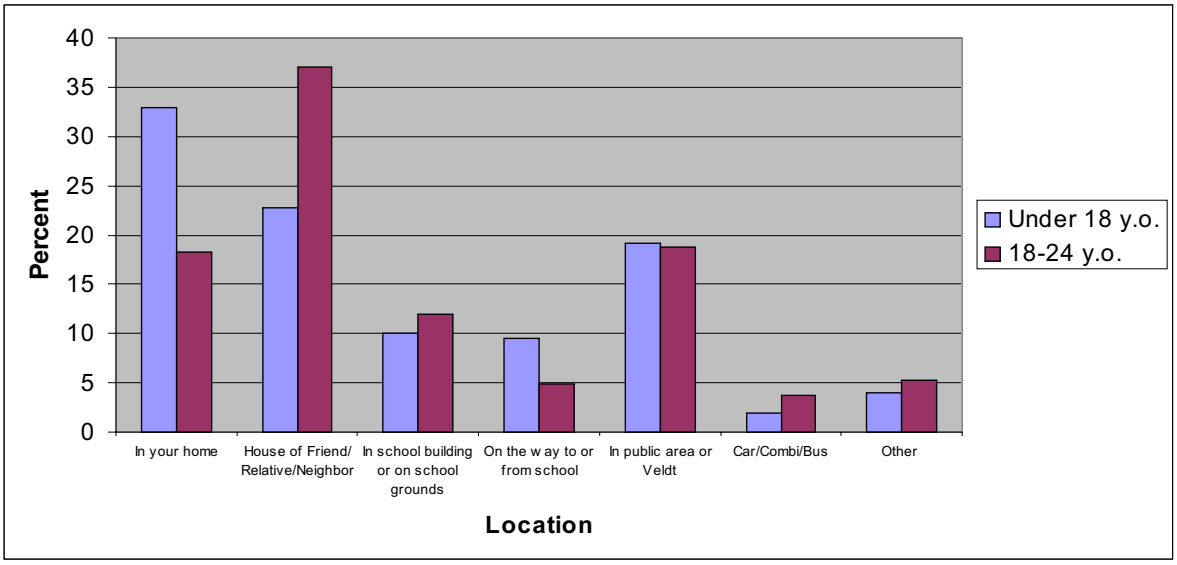
Perpetrator: Among incidents of sexual violence that occurred prior to age 18, 35.6% (95% CI, 30.0-41.6) were perpetrated by a husband or boyfriend, 27.1% (95% CI, 23.1-31.5) were perpetrated by a man/boy from the victim's neighborhood, 15.7% (95% CI, 11.2-21.6) were perpetrated by a male relative other than a father, stepfather or husband, and 10.1% (95% CI, 7.5-13.4) were perpetrated by a stranger (Table 12, Figure 6). Among incidents of sexual violence that occurred at ages 18-24, 53.8% (95% CI, 44.3-63.1) were perpetrated by a husband or boyfriend, 16.6% (95% CI, 11.1-24.0) were perpetrated by a man/boy from the victim's neighborhood, and 10.9% (95% CI, 7.2-16.0) were perpetrated by a stranger.

Figure 6. Perpetrators of Sexual Violence, by Age when Incident Occurred -- Swaziland, 2007



Location: Among incidents of sexual violence that occurred prior to age 18, 32.9% (95% CI, 25.6-41.1) occurred in females' own home, 22.8% (95% CI, 18.1-28.2) occurred in the house of a friend, relative, or neighbor, 19.1% (95% CI, 15.6-23.1) occurred in a public area or veldt (a field or an open area of land, typically in southern Africa), 10.0% (95% CI, 7.7-12.9) occurred in a school building or on school grounds, and 9.5% (95% CI, 7.2-12.3) occurred on the way to or from school Table 13, Figure 7). Among incidents of sexual violence that occurred at ages 18-24, 37.0% (95% CI, 28.3-46.7) occurred in the house of a friend, relative, or neighbor, 18.8% (95% CI, 13.2-26.0) occurred in a public area or veldt, 18.3% (95% CI, 10.9-29.1) occurred in females' own home, and 12.0% (95% CI, 6.4-21.5) occurred in a school building or on school grounds.

Figure 7. Location of Sexual Violence by Age when Incident Occurred -- Swaziland, 2007



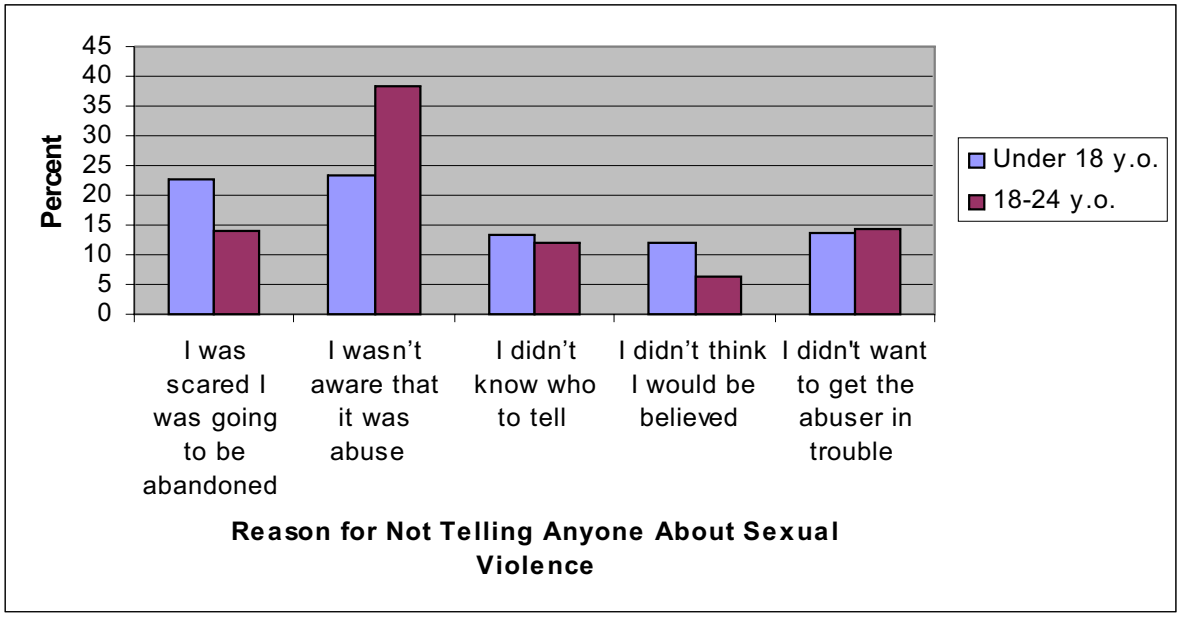
Drug and Alcohol Use: Among incidents of sexual violence that occurred prior to age 18, females reported that they had used drugs or alcohol prior to the incident in only 2 out of 704 incidents. Females reported that the perpetrator had used drugs or alcohol prior to 27.7% (95% CI, 20.2-36.8) of the incidents. Among incidents of sexual violence that occurred at ages 18-24 females reported that they had used drugs or alcohol prior to the incident in only 2 out of 180 incidents. Females reported that the perpetrator had used drugs or alcohol prior to 19.3% (95% CI, 12.4-28.8) of the incidents.

Reporting of Sexual Violence: Among incidents of sexual violence that occurred prior to age 18, 48.0% (95% CI, 40.8-55.2) of females reported that they had told someone about the event. Among incidents that were reported to anyone, approximately 8.4% (95% CI, 4.6-14.9) of incidents were reported to the police, 37.8% (95% CI, 26.4-50.7) of incidents were reported to a relative other than a parent, 29.1% (95% CI, 23.4-35.6) were reported to mothers, 17.0% (95% CI, 11.8-23.7) were reported to a friend, 9.2% (95% CI, 5.9-14.1) were reported to a teacher or principal, and 6.6% (95% CI, 3.7-11.4) were reported to fathers (Table 14). Among incidents of sexual violence that occurred between ages 18-24, 39.1% (95% CI, 29.8-49.2) of females reported that they had told someone about the event. Among incidents that were reported to anyone, approximately 3.9% (95% CI, 1.1-12.9) of incidents were reported to the police, 29.4% (95% CI, 17.6-44.9) of incidents were reported to mothers and 25.0% (95% CI, 14.4-39.6) were reported to a relative other than a parent.

Among incidents of sexual violence that occurred prior to age 18, 23.3% (95% CI, 16.3-32.0) of females who did not report the incident to anyone indicated that the primary reason they did not discuss the incident was because “I wasn't aware that it was abuse” (Table 15, Figure 8). Other reasons given for not discussing sexual violence with anyone: 22.6% (95% CI, 15.6-31.5) were “scared I was going to be abandoned,” 13.7% (95% CI, 9.2-19.9) “didn't want to get the abuser in trouble,” 13.5% (95% CI, 9.1-19.6) “didn't know who to tell,” 12.1% (95% CI, 8.1-17.6) “didn't think I would be believed.” Among incidents of sexual violence that occurred between ages 18-24, 38.5% (95% CI, 25-54.1) of females who did not report the incident to anyone indicated that their reluctance to discuss the incident was because “I wasn't aware that it was abuse.” Other reasons for not discussing sexual violence: in 14.0% (95% CI, 7.7-24.0) of incidents respondents were “scared I was

[1]Interpret with caution as these values are unstable (unreliable).

Figure 8. Primary Reason for Not Reporting Sexual Violence Among those who did not Report, by Age when Incident Occurred -- Swaziland, 2007



going to be abandoned," in 14.4% (95% CI, 8.6-23.3) of incidents respondents "didn't want to get the abuser in trouble," in 11.9% (95% CI, 6.5-20.9) of incidents respondents "didn't know who to tell," and in 6.2% (95% CI, 2.8-13.2) of incidents respondents "didn't think I would be believed."

Services Utilized: Among incidents of sexual violence that occurred prior to age 18, females reported that they utilized services following 13.6% (95% CI 10.6-17.4) of the incidents. Specifically, counseling was utilized following 7.0% (95% CI, 4.8-10.0) of incidents (Table 16). Females also reported that they utilized the police following 3.0% (95% CI, 1.9-4.8) of incidents and utilized a clinic/hospital following 2.1% (95% CI, 1.0-4.2) of incidents. Among incidents of sexual violence that occurred between ages 18-24, females reported that they utilized services following 13.5% (95% CI, 8.5-20.8) of the incidents. Counseling was the most utilized service, following 6.4% (95% CI, 3.6-11.0) of reported incidents.

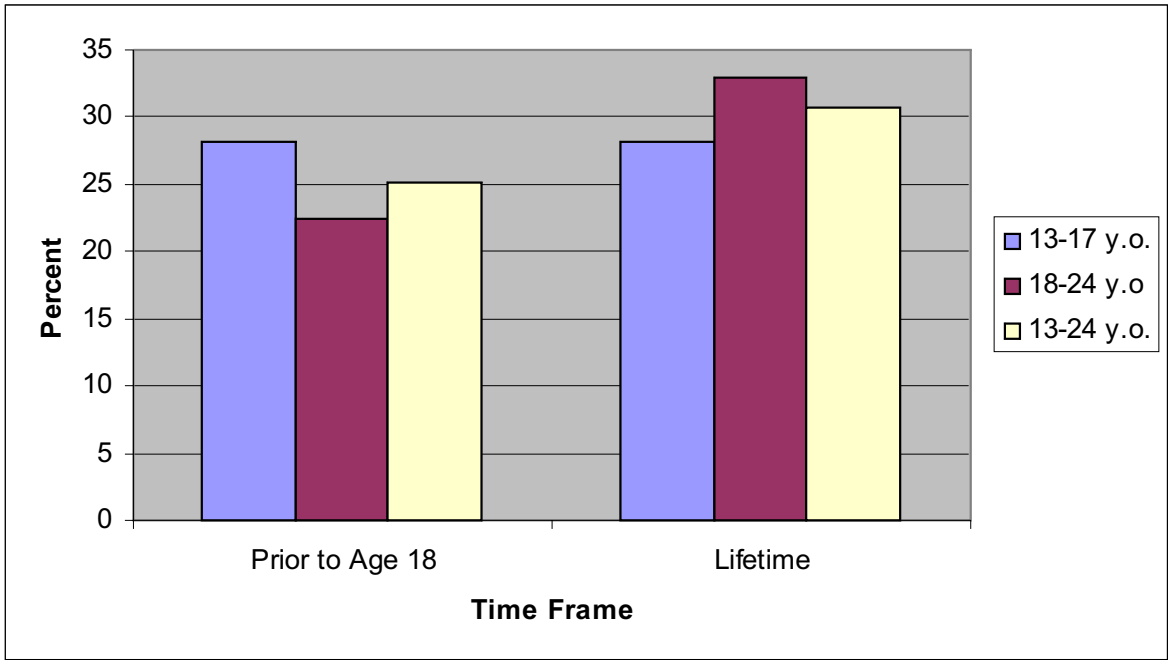
The majority of females who experienced sexual violence indicated that they would have liked help from services that they felt were not available to them. Among incidents of sexual violence that occurred prior to age 18, 62.3% (95% CI, 56.2-68.1) of females reported they would have liked to have had some form of help. Females experiencing sexual violence prior to age 18 desired help from a shelter or safe house following 57.4% (95% CI, 48.1-66.2) of incidents and desired help from a clinic or hospital following 27.3% (95% CI, 20.5-35.4) of incidents. Among incidents of sexual violence that occurred at ages 18 to 24, 54.2% (95% CI, 46.7-61.5) of females reported they would have liked to have had some form of help. Females experiencing sexual violence at ages 18 to 24 desired help from a shelter or safe house following 69.5% (95% CI, 59.7-77.7) of incidents and desired help from a clinic or hospital following 20.4% (95% CI, 12.9-30.7) of incidents.

Physical Violence Prevalence

Prevalence of Physical Violence Prior to Age 18: Overall, 25.1% (95% CI 22.0-28.4) of females reported that they had experienced some physical violence by an adult prior to age 18 (Table 17, Figure 9). Among 13-17 year old females the prevalence of physical violence by an adult prior to age 18 was 28.1% (95% CI 23.6-33.0), as compared to 22.4% (95% CI 18.7-26.7) among those 18-24 years old.

Lifetime Prevalence of Physical Violence: Overall, 30.7% (95% CI 27.0-34.6) of females reported that they had experienced physical violence by an adult in their lifetime (Table 17, Figure 9). Among 13-17 year old females, prevalence estimates for lifetime physical violence are the same as those in the above paragraph describing physical violence prior to age 18. Among 18-24 year old females the prevalence of physical violence by an adult was 32.9% (95% CI 28.1-38.1).

Figure 9. Physical Violence Experienced by Females 13-24 Years, Swaziland, 2007



Physical Violence Circumstances

Perpetrator: For physical violence that first occurred prior to age 18, 26.9% (95% CI, 21.2-33.5) were perpetrated by a male relative other than a father, stepfather or husband, 17.8% (95% CI, 13.0-23.9) by mothers, 17.5% (95% CI 12.5-23.9) by fathers, and 17.0% (95% CI, 12.2-23.1) by a female other than a mother or stepmother (Table 18). For physical violence that first occurred between the ages of 18 and 24 years, 44.6% (95% CI, 32.0-57.8) of perpetrators were a boyfriend or husband, and 14.2% (95% CI, 7.9-24.3) of perpetrators were a male relative other than a father, stepfather or husband.

Frequency: For physical violence that occurred prior to age 18, 35.0% (95% CI 29.4-41.0) of perpetrators were described as being violent "once", 27.0% (95% CI, 22.1-32.6) of perpetrators were physically violent a "few" times, and 38.0% (95% CI, 31.8-44.7) were violent "many" times. For physical violence that first occurred between the ages of 18 and 24 years, 49.8% (95% CI, 37.1-62.5) of perpetrators were described as being violent "once."

Age: For physical violence that first occurred prior to age 18, 39.7% (95% CI, 34.4-45.2) of the reported physical violence occurred prior to females turning 13 years of age, while 60.3% (95% CI 54.8-65.6) of the reported physical violence occurred when females were 13-17 years old.

Injury: For physical violence that first occurred prior to age 18, 27.1% (95% CI, 22.8-31.9) of the perpetrators caused injury that required consultation with a doctor. For physical violence that first occurred between the ages of 18 and 24 years, 28.5% (95% CI, 23.6-33.8) of the perpetrators caused injury that required consultation with a doctor.

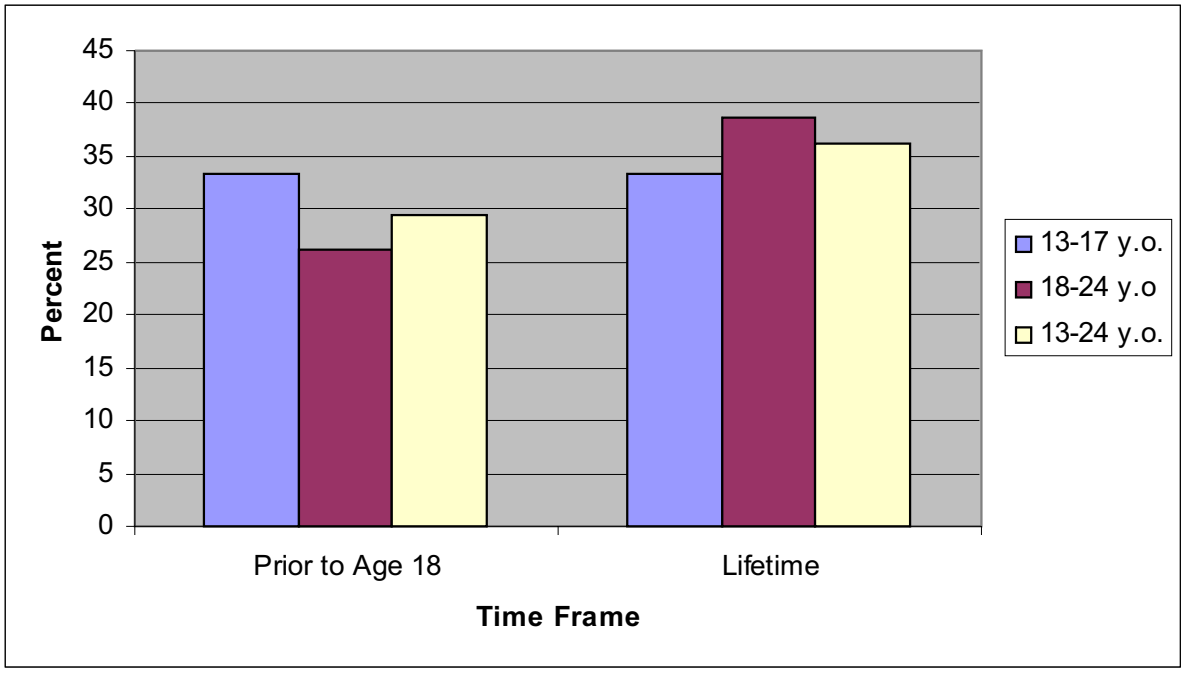
Help-seeking: Among females who first experienced physical violence prior to age 18, 22.2% (95% CI, 17.2-28.1) sought help from services of any kind. A clinic or hospital (40.8%; 95% CI, 28.2-54.8) was most often consulted, followed by the Royal Swazi Police (14 out of 72 who sought help). Among females who first experienced physical violence between the ages of 18 and 24 years, 27.5% (95% CI, 17.6-40.3) sought help from services of any kind. A clinic or hospital was the most frequent provider consulted (10 out of 22 who sought help).

Prevalence of Emotional Abuse

Prevalence of Emotional Abuse Prior to Age 18: Overall, 29.5% (95% CI, 26.7-32.4) of females 13-24 years old reported that they had experienced emotional abuse by an adult prior to age 18 (Table 19, Figure 10). Among 13-17 year old females the prevalence of emotional abuse by an adult prior to age 18 was 33.3% (95% CI, 28.6-38.4), as compared to 26.2% (95% CI, 22.1-30.7) among those 18-24 years old.

Lifetime Prevalence of Emotional Abuse: Overall, 36.2% (95% CI, 32.5-40.0) of females 13-24 years old reported that they had experienced emotional abuse by an adult in their lifetime (Table 19, Figure 10). Among 13-17 year old females, prevalence estimates for lifetime emotional abuse are the same as those in the above paragraph describing emotional abuse prior to age 18. Among 18-24 year old females the prevalence of emotional abuse by an adult was 38.7% (95% CI, 33.5-44.2).

Figure 10. Emotional Abuse Experienced by Females 13-24 Years, Swaziland, 2007



Emotional Abuse Circumstances

Perpetrator: For emotional abuse that first occurred prior to age 18, 29.3% (95% CI, 24.5-34.6) were perpetrated by a female relative other than a mother or stepmother, 24.2% (95% CI 19.9-29.0) by a male relative other than a father, stepfather or husband, 11.5% (95% CI 8.6-15.2) by a mother, and 10.9% (95% CI, 7.9-15.0) by a father (Table 20). For emotional abuse that first occurred between the ages of 18 and 24 years, 34.3% (95% CI, 25-44.9) were perpetrated by a female relative other than a mother or stepmother, 16.5% (95% CI 10.1-26.0) by a male relative other than a father, stepfather or husband, 13.1% (95% CI 7.2-22.5) by a father, and 10.0% (95% CI, 4.7-20.0) by a mother.

Frequency: For emotional abuse that first occurred prior to age 18, 13.1% (95% CI, 9.0-18.8) indicated that the abuse had occurred "once", 26.6% (95% CI, 21.3-32.6) indicated that it had occurred a "few" times, and 60.3% (95% CI, 52.3-67.7) indicated "many" times. For emotional abuse that first occurred between the ages of 18 and 24 years, 26.7% (95% CI 19.7-35.2) indicated that the abuse had occurred "once," while 57.1% (95% CI, 43.6-69.7) indicated that the abuse had occurred "many" times.

Age: For emotional abuse that first occurred prior to age 18, 42.3% (95% CI, 36.4-48.6) of the reported perpetrators began the emotional abuse prior to females turning 13 years of age, while 60.3% (95% CI, 54.8-65.6) of the reported perpetrators first engaged in emotional abuse when females were 13-17 years old.

Services

The majority of females 13-24 years old have heard about organizations and agencies that address the problem of violence against children and women in Swaziland (Table 21). Approximately 94.2% (95% CI, 92.4-95.6) of females have heard about Swaziland Action Group Against Abuse (SWAGAA). The majority of females also have heard about Save the Children, the Social Welfare Department which is housed in the Ministry of Health and Social Welfare, and LL (Shoulder to Cry On). The Domestic Violence and Child Protection Unit which is housed in the Royal Swaziland Police and a Hotline Service which is provided by SWAGAA and the Ministry of Education are less familiar to most females 13-24 years old.

DISCUSSION

This study documents that violence against children is a serious problem in Swaziland as it is in many other parts of the world. This study also documents many of the circumstances and conditions under which this violence tends to occur. These patterns provide important clues as to how to target and organize prevention strategies and policies.

Perhaps most importantly, the results of this study indicate that violence against female children is highly prevalent in Swaziland: approximately 1 in 3 females experienced some form of sexual violence as a child; 1 in 4 females experienced physical violence as a child; and nearly 3 in 10 females experienced emotional abuse as a child. Focusing on sexual violence, approximately 5% of females experienced forced intercourse and approximately 9% experience coerced intercourse before their 18th birthday. The only prior nationally-representative study of childhood sexual violence in sub-Saharan Africa was conducted in 1998.[9] This study found that 1.6% of South African females aged 15-49 had experienced forced or coerced intercourse prior to age 15. However, the differing age threshold (15 vs. 18) and differing age of study participants (13-24 vs. 15-49) make direct comparisons difficult.

While violence occurring in childhood is the focus of this report, it is important to note that the risk of violence continues into young adulthood. Among 18-24 year old females in Swaziland, nearly 2 in 3 had experienced some form of sexual violence in their lifetime. Given the documented consequences of exposure to violence, both among children and young adults, the magnitude of this problem is cause for great concern. Decades of research in the neurobiological, behavioral, and social sciences indicates, quite conclusively, that childhood exposure to violence can impact the development of the brain and subsequent vulnerability to a broad range of mental and physical health problems, ranging from anxiety disorders and depression to cardiovascular disease and diabetes.[20-22] Reducing the prevalence of violence against children in Swaziland is, therefore, likely to reduce the incidence and costs of future mental and physical health problems in the population, including the incidence and costs of HIV.

This study collected information on the perpetrators of violence against female children. It was found that sexual violence was most commonly perpetrated by boyfriends and husbands, men and boys from the victim's neighborhood, and male relatives. For physical violence, the most common perpetrators were male relatives other than the victim's father, victims' mothers and other female relatives. Finally, for emotional abuse, the most likely perpetrators were female relatives, male relatives, and victims' mothers. Among all three types of violence examined, male relations were involved in significant numbers. This finding is quite similar to that found in many other cultures, particularly for sexual violence.[5] The prevention of male perpetration of violence against female children should be an important focus of prevention efforts.

The study also examined the most common locations in which violence against female children occurs. It was found that sexual violence is most likely to occur in the home, either the home of the respondent or the home of a friend, relative or neighbor. Sexual violence also occurs in significant numbers in public areas or the veldt, on the way to or from school, and in school buildings or on school grounds. The large numbers of sexual violence incidents occurring in the home underscores the hidden nature of sexual violence, and presents one of the largest challenges in preventing sexual violence in Swaziland. This finding is quite similar to that found in many other cultures. The majority of sexual violence

in other cultures has been reported to occur in the home of the victim or the abuser as well.[5] In addition, the rural nature of much of Swaziland may also contribute to keeping the problem of sexual violence hidden.

We found that over half of all incidents of child sexual violence were not reported to anyone, and less than 1 in 7 incidents resulted in a female seeking help from available services. Females indicated the primary reason for not reporting sexual violence was that they weren't aware that what they had experienced was abuse. Many females also reported a fear of abandonment if they told anyone about the violence they had experienced. These numbers suggest a lack of understanding of what sexual violence is and how and where to report such incidents. In regard to physical violence, in only 1 out of 5 cases did females seek help from available services, despite the fact that nearly 1 in 4 resulted in injury that was serious enough to consult a doctor. These numbers suggest a gap in the need for services and females' comfort in seeking those services. When asked, the majority of female victims of sexual violence as a child reported they would have liked help in the form of a shelter or safe house.

In addition to asking about the experience of childhood violence our study also examined some aspects of sexual behavior among 13-24 year old females, as well as how females obtained information about sex. Nearly 1 in 6 females 13-17 years old, and over 4 in 5 females 18-24 years old, had engaged in sexual intercourse. Among 13-17 year old females, 10.6% described their first sexual experience as either “forced” or “raped.” At least one previous study examined this same question in the KZN province of South Africa.[23] Among 14-18 year old Black African females, they found that 6.0% of orphans and 8.7% of non-orphans described their first sexual experience as either “forced” or “raped.” Among 18-24 year old females in our study, approximately 3.5% described their first sexual experience similarly. Our results indicated that teachers are the primary source in providing information about sex to 13-24 year old females. Parents and friends were also important sources of information about sex, but in much smaller numbers than teachers. This finding indicates that teachers may be key partners in programming that promotes sexual health, particularly in efforts to prevent childhood sexual violence.

The strengths and limitations of this survey must be taken into consideration in reviewing the results. The survey has a few important strengths. Based on a review of the literature and to the best of our knowledge, this study is only the second study to provide nationally-representative estimates of childhood sexual violence in sub-Saharan Africa. In addition, interviewers obtained a very high response rate among eligible participants. We were concerned that a household study might miss a significant number of females in this age group who were currently attending school; however, the results indicate that interviewers were able to survey a significant percentage of females currently attending school. Each of these study strengths provides confidence that the sample surveyed was truly representative of 13-24 year old females in Swaziland. One final strength of the study is the depth of information that was collected, particularly on sexual violence circumstances. Large-scale health surveys, which have often been used to collect information on sexual violence, typically ask only a few questions about each health condition. The significant number of questions we asked about sexual violence allows us to better understand the details of these events, and will allow for more complex analyses in the future.

The findings of the study were restricted by several limitations. First, we only collected information about the first and last incident of sexual violence experienced by each female participant. If a female experienced more than two incidents of sexual violence, the circumstance information surrounding these additional incidents was not collected. However, 7 in 10 females who reported sexual violence prior to age 18 indicated that they had experienced either

one or two incidents, leading us to conclude that we captured information on the majority of sexual violence incidents. Further, we are likely to have underestimated the true prevalence of violence against female children for several reasons. First, past research in the U.S. has suggested that it is not uncommon for adult survivors of child sexual abuse to have no memory of that abuse.[24] Females who were younger at the time of abuse and who were abused by someone they knew were more likely to have no recall of abuse. Second, some females may be less likely to disclose an incident if the perpetrator is known to them. Third, we estimated the prevalence of violence among children under 18 years based, in part, on respondents who were 13-17 years old and had not yet reached their 18th birthday.

The data from this survey will permit us to examine many other important questions that go beyond the scope of this report. For example, we will be examining in more detail the extent to which victims of violence are more likely then non-victims to experience physical and mental health consequences. In addition we will be using the data to identify risk and protective factors for violence against children. We will also be able to address many specific questions of importance such as whether orphan status puts females at greater risk and, if so, why.[23] These subsequent analyses will increase the utility of these data for guiding the development of prevention programs and strategies.

CONCLUSION

Violence against children erodes the strong foundation that children need for leading healthy and productive lives. Exposure to violence during childhood can influence subsequent vulnerability to a broad range of mental and physical health problems, ranging from anxiety disorders and depression to cardiovascular disease and diabetes.[20-22] It can damage the emotional, cognitive, and physical development of children and, thereby, impact economic development by degrading the contribution of affected children to the human capital of their community and country. Sexual violence is perhaps the most insidious form of violence against children. The shame and denial associated with it contributes to a culture of silence in which neither children or adults speak about it or know what to do when confronted with it.[2]

The 2006 United Nation's Secretary General's Study of Violence Against Children documents the full range and scale of this problem on a global level.[2] It's a problem that affects every country and region of the world, but the full range and impact of this problem on health and development is only now becoming visible. Violence against children is both a public health problem and a human rights problem. The obligation for all States to work toward the elimination of violence against children is recognized by the Convention on the Rights of the Child. Efforts to prevent violence, therefore, uphold the right of each child to his or her human dignity and physical integrity.

This survey represents a critical step in addressing the problem of violence against children in Swaziland by providing basic information on the magnitude and characteristics of the problem. Without a clear description of a problem it is difficult to know if and how to respond to it. The results of this survey will help the people of Swaziland to continue their efforts to break the silence around violence against children and establish a stronger foundation for prevention. This survey builds on important work that is already being undertaken in Swaziland to address this problem by the government agencies and nongovernmental organizations that have cooperated in conducting the survey.

The prevention of violence against children in Swaziland can be strengthened by drawing upon evidence-based and promising prevention strategies and policies from other parts of the world. One of the primary findings of this report is that about three quarters of the perpetrators of sexual violence against female children and youth are husbands and boyfriends, men and boys from the victim's neighborhood, or male relatives. These are all people that are either partners of the victim or well known to the victim. This pattern may reflect cultural norms that influence relationships between males and females as well as the vulnerability of female children to victimization. Given that sexual violence and intimate partner violence may have common roots, promising work to prevent intimate partner violence in other African countries can potentially be adapted to prevent sexual violence involving females and their partners in Swaziland. For example, in South Africa, Stepping Stones, which is primarily an HIV prevention program, aims to improve sexual health through building stronger, more gender equitable relationships with better communication and less violence between partners.[25] A randomized controlled trial of the program found that in addition to reducing HIV infection the men in the program disclosed lower rates of perpetrating severe intimate partner violence at 12 and 24 months post intervention.[26]

This survey found that parents were commonly involved in physical violence against female children. A common approach to this type of violence around the world has been to establish parenting programs that focus on improving skills in

family management, problem-solving and discipline as well as providing support for parents who are under stress. Parenting programs are increasingly being used in middle- and low-income countries around the world.[2] For example, in South Africa, the Parent Centre in Cape Town provides parent support groups, training for parents in child development and effective discipline, home visitation services, and training for professionals who work with children.[27]

Another important finding of this survey is that the teachers and schools are by far the most important source of information regarding sexuality for female children. In the U.S. promising school-based strategies for preventing one source of sexual violence (i.e., dating violence) may also potentially be adapted and applied to the problem of sexual violence involving female adolescents in Swaziland. For example, Safe Dates is a school-based adolescent dating violence prevention program that seeks to reduce violence by changing dating violence norms, gender-role norms and improving conflict management skills.[28] In a randomized trial, Safe Dates was found to significantly reduce the perpetration of sexual as well as physical violence in dating relationships. Another educational approach being used in the U.S. that may complement more intensive programs such as Safe Dates is called Choose Respect. Choose Respect is a social marketing program designed to help adolescents form healthy relationships to prevent dating abuse before it starts.[29] This program is designed to motivate adolescents to challenge harmful beliefs about dating abuse and take steps to form respectful relationships.

The association of violence against children with other problems, such as HIV/AIDS, mental health, and reproductive health, has important implications for the development of prevention programs and policies. These associations suggest that it may be possible to integrate approaches to preventing aspects of violence against children with programs addressing these other pressing public health issues. This program integration can build upon common underlying risk factors. The Stepping Stones program, referred to above, is a great example of an effort to integrate intimate partner violence and HIV prevention by addressing common underlying factors such as sexual health, gender equity, and communication skills. In addition, since only a limited public health infrastructure exists for addressing violence against children it makes sense to build on, where possible and appropriate, more well established prevention infrastructure supporting surveillance, prevention programs, and health communication activities.

Preventing violence against children in Swaziland is complicated by the influence of poverty and social changes that increase the vulnerability of children (e.g., high rates of HIV/AIDS, increasing number of orphans). The impact of this problem, however, threatens the economic and social development of Swaziland by compromising the healthy development of its children. The findings from this survey can be used to develop prevention programs and policies and thereby contribute to a healthier future for the people of Swaziland.

RECOMMENDATIONS

The results of this descriptive analysis have significant implications for focusing immediate and future prevention and response programs. Partnerships among government agencies in public health, education and justice, non-governmental organizations that address these and related issues, and international organizations with technical expertise will be critical in developing a credible response to this problem. We offer the following recommendations in response to the initial results of this survey:

Immediate

- Broadly share the results of this survey with the people of Swaziland
- Identify a lead agency to coordinate prevention and response to violence against children
- Integrate efforts to address violence against children into existing infrastructure for addressing related health issues such as HIV/AIDS and reproductive health
- Continue to analyze these survey data to uncover epidemiologic patterns, risk and protective factors that can inform prevention strategies and public policies

Medium Term

- Develop a national plan to prevent violence against children in Swaziland
- Identify and implement evidence-based and promising prevention strategies for violence against children, in particular, programs that have shown promise in other African countries with similar circumstances
- Develop and implement a public information campaign directed at older children and youth that explains exactly what sexual violence is and where to go for information and help
- Increase capacity for providing safe shelter and counseling for child victims of violence
- Educate parents and other adults about the problem of violence against children and ways to protect their children from it and to recognize the signs of abuse if it has already occurred
- Integrate sexual violence prevention messages into school-based programs addressing sexuality, reproductive health, and social development
- Strengthen and expand appropriate legal protections for children and legal consequences for perpetrators
- Continue to educate police and other public safety officials about the problem and how to respond to it in sensitive and effective ways

Long Term

- Work to increase the human and operational capacity of government agencies and NGOs to address this problem by hiring more technical staff, developing monitoring and evaluation mechanisms, and increasing coordination among organizations addressing the problem
- Undertake future surveys to monitor the problem of violence against children and to assess progress in reducing the problem
- Undertake future surveys to better understand the problem of violence against male children
- Develop an injury surveillance system to track long-term trends in this problem
- Develop communication strategies that counter social norms that support violence against children
- Share the experience and capacity developed in Swaziland with other countries in sub-Saharan Africa to raise awareness about the problem of violence against children and the approaches used to address it

These recommendations should be considered in light of the culture of Swaziland as well as current activities and programs focused on prevention of violence against children that are already on the ground. In formulating these recommendations we recognize that our cultural distance and lack of direct knowledge about current activities may limit the applicability of some of what we recommend. Nevertheless, the results of this survey offer a great opportunity to build a strategy for protecting children from violence and, thereby, create a more secure future for the people of Swaziland.

TABLES

Table 1. Demographic Information of Females 13-24 Years of Age – Swaziland, 2007

	Results (n = 1244)		
	n	**WTD%***	**WTD (95% CI)**
Age			
13 – 17 years	575	46.4	(42.4-50.4)
18 – 24 years	669	53.6	(49.6-57.6)
Community Setting			
Urban	201	14.9	(7.1-28.4)
Rural	1043	85.1	(71.6-92.9)
Orphan Status			
Among 13-17 y.o.			
Biological Mother Died	111	19.8	(16.6-23.6)
Biological Father Died	173	29.3	(24.1-35.0)
Both Biological Parents Died	52	9.9	(7.7-12.5)
Among 18-24 y.o.			
Biological Mother Died	150	22.3	(19.4-25.4)
Biological Father Died	242	36.7	(32.7-40.9)
Both Biological Parents Died	75	11.6	(9.3-14.4)
Marital Status			
Married	127	9.7	(7.1-13.1)
Not Married	1112	90.3	(86.9-92.9)
Religion			
Zionist	499	41.1	(35.7-46.6)
Catholic	71	5.4	(3.4-8.6)
Protestant	661	52.7	(47.2-58.1)
Other	13	0.8**	(0.4-1.6)**
Socioeconomic Status Indicators			
Household Ever Goes Hungry			
Often	148	12.4	(9.2-16.5)
Sometimes	557	46.4	(42.4-50.3)
Seldom	166	13.2	(10.3-16.7)
Never	371	28.1	(23.4-33.3)
Type of Toilet Facility in Household			
Flush Toilet (own)	101	7.8	(4.3-13.6)
Flush Toilet (shared)	36	2.6	(1.6-4.4)
Pit Latrine	925	75.3	(67.6-81.7)
No Facility/Bush/Field	179	14.3	(8.9-22)
Other	1	0.1	(0-0.4)
Primary Source for Cooking			
Electricity	165	11.9	(8.2-16.9)
Gas	196	14.4	(10.0-20.2)
Paraffin	30	1.8**	(0.8-4.2)**
Wood	839	71.1	(61.0-79.4)
Other	12	0.8**	(0.4-1.9)**

*WTD = weighted results

**Interpret with caution as these values are unstable (unreliable).

Table 2. Reason for Not Currently Attending Primary or Secondary School by Age Among Females 13-17 Years of Age – Swaziland 2007

	Age of Respondent 13-17 Years Results (n = 112)			Age of Respondent 18-24 Years Results (n = 505)		
	n	**WTD%***	**WTD (95% CI)**	**n**	**WTD%**	**WTD (95% CI)**
Completed School	6	4.7**	(1.8-11.6)**	97	20.3	(15.4-26.2)
Got Pregnant	16	17.4	(10.9-26.6)	75	15.8	(12.5-19.7)
Could Not Pay for School	80	69.2	(60-77.1)	290	55.3	(49.3-61.2)
Other	10	8.7	(4.9-15.1)	43	8.6	(6.2-11.8)

*WTD = weighted results
**Interpret with caution as these values are unstable (unreliable).

Table 3. Self-Reports of the Lifetime Experience of Health-Related Conditions and Behaviors By Age Among Females 13-24 Years – Swaziland, 2007

	Age of Respondent 13-17 Years Results (n = 573)			Age of Respondent 18-24 Years Results (n = 669)			All Respondents 13-24 Years Results (n = 1242)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**
Felt Depressed	289	51	(45.1-56.9)	553	81.6	(76.5-85.8)	842	67.4	(62.7-71.8)
Suicidal Ideation	60	10.1	(7.8-13.0)	181	24	(19.6-29.0)	241	17.6	(14.9-20.7)
Attempted Suicide	15	2.4	(1.4-4.3)	40	5	(3.5-7.1)	55	3.8	(2.7-5.3)
Unwanted Pregnancy	43	7.9	(5.6-11.0)	320	46.6	(42.5-50.7)	363	28.7	(25.8-31.7)
Pregnancy Complications or Miscarriages	3	0.4**	(0.1-1.1)**	41	6	(4.3-8.4)	44	3.4	(2.4-4.8)
Sexually Transmitted Diseases	7	1.3**	(0.6-3.1)**	53	7.9	(5.9-10.4)	60	4.8	(3.7-6.3)
Difficulty Sleeping	141	24.4	(20.4-29.1)	332	47.8	(42.5-53.2)	473	37	(33.1-41.1)
Smoke Cigarettes	5	0.9**	(0.3-2.4)**	23	3	(1.9-4.8)	28	2	(1.2-3.4)
Drink alcohol[?]	32	6.1	(4.0-9.3)	97	13.7	(10.5-17.7)	129	10.2	(8.0-12.9)
	Results (n = 45)			Results (n = 302)			Results (n = 347)		
HIV[??]	4	12.8**	(4.5-1.4)**	40	12.1	(8.1-17.6)	44	12.2	(8.5-17.1)

*WTD = weighted results
[?] Ever drink alcohol other than a few sips.
[??] Percent refers to females who tested positive for HIV among those who tested for HIV and received their test results from a healthcare provider.
**Interpret with caution as these values are unstable (unreliable).

Table 4. Primary Source of Information about Sex While Growing Up as Reported By Females 13-24 Years of Age – Swaziland, 2007

	Results (n = 1237)		
	n	**WTD %***	**WTD (95% CI)**
Parent	245	20.2	(17.2-23.5)
Guardian	22	1.7	(1.1-2.5)
Auntie or Other Relative	49	3.7	(2.7-4.9)
Teacher/School	693	56.6	(53.2-60)
Friends	122	9.6	(7.9-11.6)
TV/Radio/Movies/Media	70	5.7	(4.3-7.4)
Clinic/Healthcare Provider	36	2.6	(1.6-4.1)

*WTD = weighted results

Table 5. Specific Topics Related to Sexual Behavior and Practices Females 13-24 Years of Age Reported Discussing with a Parent or Guardian – Swaziland, 2007

	Results (n = 635)		
	n	**WTD %***	**WTD (95% CI)**
HIV/AIDS	531	84.4	(80.8-87.5)
Condoms	415	65.9	(61.8-69.8)
Abstinence	606	95.6	(93.1-97.2)
Sexual Violence	462	72.6	(68.4-76.4)
Safe Sex	417	65.8	(60.1-71.1)

*WTD = weighted results

Table 6. Comfort Level of Females 13-24 Years for Saying "No" to a Male Who Wanted to Have Sex? by Age and Male Figures– Swaziland, 2007

	Age of Respondent 13-17 Years			Age of Respondent 18-24 Years			All Respondents 13-24 Years		
	Results (n = 573)			Results (n = 667)			Results (n = 1240)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**
Very comfortable saying no to boyfriend or husband	501	87.4	(83.8-90.4)	517	78.0	(73.4-82.1)	1018	82.4	(79.3-85.1)
Very comfortable saying no to respected male adult in family[?]	514	90.1	(86.4-92.9)	634	94.8	(91.9-96.7)	1148	92.6	(89.6-94.8)
Very comfortable saying no to male teacher	519	90.2	(85.5-93.4)	622	93.1	(90.4-95.1)	1141	91.7	(89-93.8)
Very comfortable saying no to respected male adult from community[??]	508	88.5	(85.2-91.1)	628	94.1	(90.9-96.2)	1136	91.5	(89-93.4)

? Sex refers to vaginal or anal intercourse.
* WTD = weighted results
[?] Respected male adult in family, other than husband.
[??] Respected male adult from community, other than teacher.

Table 7. Description of First Sexual Intercourse[?] By Age Among Females 13-24 Years of Age – Swaziland, 2007

	Age of Respondent 13-17 Years			Age of Respondent 18-24 Years			All Respondents 13-24 Years		
	Results (n = 95)			Results (n = 551)			Results (n = 646)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**
Willing	43	36.8	(23.7-52.2)	260	47.1	(39.5-54.9)	303	43.5	(37.9-53.4)
Persuaded	31	39.2	(25.4-55.0)	195	35	(27.5-43.3)	226	35.7	(28.3-43.8)
Tricked	11	13.4	(7.4-23.0)	75	14.4	(10.5-19.4)	86	14.2	(10.6-18.9)
Forced/Raped	10	10.6	(5.3-20.1)	21	3.5	(2.1-5.8)	31	4.6	(3.0-7.0)

[?] Sexual intercourse refers to vaginal or anal intercourse. Response choices provided to respondents as part of standard question.
*WTD = weighted results

Table 8. Relationship to Person With Whom Females 13-24 Years of Age Had First Sexual Intercourse By Age – Swaziland, 2007

	All Respondents 13-24 Years Results (n = 646)		
	n	**WTD%***	**WTD (95% CI)**
Boyfriend/Husband	618	94.6	(91.9-96.5)
Relative other than Husband[?]	12	1.9	(1-3.6)
Man/Boy from Neighborhood	11	2.3**	(1.1-5.1)**
Stranger	4	0.4**	(0.2-1.1)**
Other	3	0.6**	(0.2-2.2)**

*WTD = weighted results

[?] Relative other than husband includes father, stepfather, brother, or any other male relative.

**Interpret with caution as these values are unstable (unreliable).

Table 9. Sexual Violence Prior to Age 18 by Age Among Females13 -24 Years of Age – Swaziland, 2007

	Age of Respondent 13-17 Years[?] Results (n = 573)			Age of Respondent 18-24 Years Results (n = 669)			All Respondents 13-24 Years Results (n = 1242)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**	**n**	**WTD %**	**WTD (95% CI)**
Any Sexual Violence	160	28.0	(23.6-33.0)	259	37.8	(33.1-42.6)	419	33.3	(29.9-36.8)
Forced Intercourse	14	2.3	(1.3-4.1)	45	7.2	(5.0-10.3)	59	4.9	(3.7-6.6)
Coerced Intercourse	26	5.7	(3.4-9.2)	92	12.1	(9.3-15.5)	118	9.1	(7.0-11.8)
Attempted Unwanted Intercourse	98	16.8	(13.4-20.9)	134	20.5	(17.0-24.4)	232	18.8	(16.5-21.3)
Unwanted Touching of Respondent	81	14.0	(10.8-17.9)	98	14.1	(11.3-17.5)	179	14.1	(11.9-16.6)
Forced Touching of Perpetrator	6	1.2**	(0.5-2.7)**	12	1.5	(0.8-2.8)	18	1.3	(0.8-2.2)

[?] Prior to age 18 estimates among females 13-17 years of age is same as lifetime prevalence of sexual violence among 13-17 year olds.

*WTD = weighted results

**Interpret with caution as these values are unstable (unreliable).

Table 10. Lifetime Prevalence of Sexual Violence Among Females 13 -24 Years by Age Group, Swaziland, 2007

	Age of Respondent 13-17 Years Results (n = 573)			Age of Respondent 18-24 Years Results (n = 669)			All Respondents 13-24 Years Results (n = 1242)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %***	**WTD (95% CI)**	**n**	**WTD %***	**WTD (95% CI)**
Any Sexual Violence	160	28.0	(23.6-33.0)	443	65.7	(59.5-71.4)	603	48.2	(43.8-52.7)
Forced Intercourse	14	2.3	(1.3-4.1)	68	10.7	(8.0-14.0)	82	6.8	(5.3-8.6)
Coerced Intercourse	26	5.7	(3.4-9.2)	191	28.2	(22.3-35.0)	217	17.8	(14.1-22.2)
Attempted Unwanted Intercourse	98	16.8	(13.4-20.9)	244	36.2	(30.9-41.8)	342	27.2	(23.9-30.9)
Unwanted Touching of Respondent	81	14.0	(10.8-17.9)	221	32.2	(27.6-37.2)	302	23.8	(20.5-27.3)
Forced Touching of Perpetrator	6	1.2**	(0.5-2.7)**	33	4.8	(3.4-6.8)	39	3.1	(2.2-4.4)

*WTD = weighted results

**Interpret with caution as these values are unstable (unreliable).

Table 11. 12-Month Prevalence of Sexual Violence Among Females 13-24 Years by Age Group, Swaziland, 2007

	Age of Respondent 13-17 Years Results (n = 573)			Age of Respondent 18-24 Years Results (n = 669)			All Respondents 13-24 Years Results (n = 1242)		
	n	**WTD %***	**WTD (95% CI)**	**n**	**WTD %***	**WTD (95% CI)**	**n**	**WTD %***	**WTD (95% CI)**
Any Sexual Violence	92	16.0	(12.7-20.1)	175	24.4	(20.0-29.4)	267	20.5	(17.5-23.9)
Forced Intercourse	6	1.0**	(0.4-2.2)**	16	3.0	(1.6-5.7)	22	2.1	(1.2-3.5)
Coerced Intercourse	15	3.3	(1.7-6.1)	46	6.9	(4.6-10.3)	61	5.2	(3.6-7.5)
Attempted Unwanted Intercourse	45	8.0	(5.8-11.1)	81	12.0	(9.0-15.9)	126	10.2	(8.3-12.4)
Unwanted Touching of Respondent	46	7.4	(5.4-10.0)	83	10.7	(8.4-13.6)	129	9.2	(7.5-11.2)
Forced Touching of Respondent	3	0.6**	(0.2-2.0)**	15	2.1	(1.2-3.7)	18	1.4	(0.9-2.2)

*WTD = weighted results
**Interpret with caution as these values are unstable (unreliable).

Table 12. Perpetrators of Sexual Violence, by Age when Incident Occurred -- Swaziland, 2007

	Under 18 when Incident Occurred Results (n = 701)			18-24 y.o. when Incident Occurred Results (n = 182)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
Father	3	0.6**	(0.1-2.2)**	0	0	?
Other Male Relative[?]	98	15.7	(11.2-21.6)	12	7.2**	(3.2-15.0)**
Family Friend/Lodger	13	2.1**	(1-4.5)**	2	1.5**	(0.2-10.3)**
School Teacher/Principal	19	2.1	(1.2-3.7)	4	3.8**	(0.7-17.4)**
Man/Boy from Neighborhood	197	27.1	(23.1-31.5)	30	16.6	(11.1-24)
Stepfather/Mother's Boyfriend	2	0.4**	(0-2.9)**	1	0.7**	(0.1-5.5)**
Boyfriend/Husband	245	35.6	(30-41.6)	99	53.8	(44.3-63.1)
Stranger	79	10.1	(7.5-13.4)	25	10.9	(7.2-16)
Recent Acquaintance	8	1.0**	(0.3-2.8)**	2	1.1**	(0.2-4.9)**
Other	37	5.2	(3.4-8.1)	7	4.5**	(2.1-9.5)**

*WTD = weighted results
[?] Other male relative not including father, stepfather or husband
**Interpret with caution as these values are unstable (unreliable).

Table 13. Location of Sexual Violence, by Age when Incident Occurred -- Swaziland, 2007

	Under 18 when Incident Occurred Results (n = 704)			18-24 y.o. when Incident Occurred Results (n = 182)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
In your home	193	32.9	(25.6-41.1)	31	18.3	(10.9-29.1)
House of Friend/Relative/Neighbor	174	22.8	(18.1-28.2)	61	37.0	(28.3-46.7)
In the school building or on school grounds	70	10	(7.7-12.9)	20	12.0	(6.4-21.5)
On the way to or from school	75	9.5	(7.2-12.3)	10	4.9	(2.5-9.3)
In public area or Veldt	147	19.1	(15.6-23.1)	39	18.8	(13.2-26.0)
Car/Combi/Bus	12	1.9	(1.0-3.6)	9	3.7	(1.8-7.3)
Other	33	4	(2.3-6.9)	12	5.3	(2.6-10.4)

*WTD = weighted results

Table 14. Persons Told About Sexual Violence Among Incidents of Sexual Violence that were Reported, by Age when Incident Occurred[?] -- Swaziland, 2007

	Under 18 when Incident Occurred Results (n = 333)			18-24 y.o. when Incident Occurred Results (n = 69)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
Mother	104	29.1	(23.4-35.6)	21	29.4	(17.6-44.9)
Father	25	6.6	(3.7-11.4)	1	1.0**	(0.1-7.4)**
Other Relative	117	37.8	(26.4-50.7)	20	25.0	(14.4-39.6)
Friend	57	17.0	(11.8-23.7)	17	23.2	(12.6-38.7)
Teacher/Principal	27	9.2	(5.9-14.1)	9	19.2**	(8.2-38.7)**
Health Care Provider	0	0	?	0	0	?
Counselor	1	0.2**	(0-1.5)**	0	0	?
Police	31	8.4	(4.6-14.9)	4	3.9**	(1.1-12.9)**
Other	11	3.2**	(1.5-6.5)**	3	2.9**	(0.9-9.3)**

*WTD = weighted results

? Person may have reported to more than one person.

**Interpret with caution as these values are unstable (unreliable).

Table 15. Primary Reason for Not Telling Anyone About Sexual Violence Among Incidents of Sexual Violence that were not Reported, by Age when Incident Occurred -- Swaziland, 2007

	Under 18 when Incident Occurred Results (n = 371)			18-24 y.o. when Incident Occurred Results (n = 113)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
I was scared I was going to be abandoned	71	22.6	(15.6-31.5)	15	14.0	(7.7-24)
Financially dependent upon the abuser	9	3.2**	(1.1-8.5)**	2	1.2**	(0.3-4.6)**
I wasn't aware that it was abuse	92	23.3	(16.3-32)	40	38.5	(25-54.1)
I didn't know who to tell	56	13.5	(9.1-19.6)	14	11.9	(6.5-20.9)
I didn't think I would be believed	50	12.1	(8.1-17.6)	10	6.2**	(2.8-13.2)**
I didn't want to embarrass my family	16	4.3	(2.2-8.3)	5	4.9**	(2-11.6)**
The abuser threatened to hurt me or my family	8	2.3**	(0.8-6.2)**	2	1.3**	(0.3-5.2)**
I was given money or gifts not to tell anyone	3	0.6**	(0.1-2.6)**	2	1.2**	(0.3-4.4)**
I didn't want to get the abuser in trouble	47	13.7	(9.2-19.9)	15	14.4	(8.6-23.1)
Other	32	7.3	(4.2-12.6)	13	10.5**	(5.2-20.1)**

*WTD = weighted results

**Interpret with caution as these values are unstable (unreliable).

Table 16. Services Utilized Following Incidence of Sexual Violence, by Age when Incident Occurred -- Swaziland, 2007

	Under 18 when Incident Occurred Results (n = 705)			18-24 y.o. when Incident Occurred Results (n = 182)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
Shelter/Safe House	0	0	?	1	0.4**	(0.1-2.7)**
Counseling	56	7.0	(4.8-10)	14	6.4	(3.6-11)
Social Worker	5	0.8**	(0.2-2.4)**	0	0	?
Police	23	3	(1.9-4.8)	2	0.7	(0.2-3.1)
Clinic/Hospital	18	2.1	(1-4.2)	2	1.1**	(0.3-4.8)**
Traditional Healer	0	0	?	0	0	?
Hotline	0	0	?	0	0	?
Church	2	0.3**	(0.1-1.2)**	3	1.1**	(0.4-3.6)**
Community Organizations	3	0.5**	(0.1-2.5)**	0	0	?
Other	3	0.4**	(0.1-1.2)**	3	2.7**	(0.7-9.5)**

*WTD = weighted results
**Interpret with caution as these values are unstable (unreliable).

Table 17. Physical Violence* Experienced by Females 13-24 Years, Swaziland, 2007

	Age of Respondent 13-17 Years Weighted Results (n = 571)			Age of Respondent 18-24 Years Weighted Results (n = 663)			All Respondents 13-24 Years Weighted Results (n = 1234)		
	n	**%**	**(95% CI)**	**n**	**%**	**(95% CI)**	**n**	**%**	**(95% CI)**
Prior to Age 18	156	28.1	(23.6-33.0)	158	22.4	(18.7-26.7)	314	25.1	(22.0-28.4)
Lifetime	#	#	#	222	32.9	(28.1-38.1)	378	30.7	(27.0-34.6)

* Has any adult ever kicked, bitten, slapped, hit you with a fist, threatened you with a weapon, such as a knife, stick, or a gun, or thrown something at you?
# Lifetime estimates for the 13-17 year old age group are the same as those for estimates of physical violence occurring prior to age 18.

Table 18. Perpetrators of Physical Violence, by Age when Violence Began -- Swaziland, 2007

	Under 18 when Violence Began Results (n = 350)			18-24 y.o. when Violence Began Results (n = 71)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
Boyfriend/Husband	12	3.3**	(1.6-6.6)**	32	44.6	(32-57.8)
Father	61	17.5	(12.5-23.9)	6	11.3**	(4.7-24.8)**
Other male relative[?]	94	26.9	(21.2-33.5)	13	14.2	(7.9-24.3)
Mother	67	17.8	(13-23.9)	1	1.7**	(0.2-10.5)**
Other female relative[??]	60	17.0	(12.2-23.1)	1	2.7**	(0.3-17.9)**
Stepfather/Mother's boyfriend	5	1.4**	(0.6-3.4)**	0	0	?
Stepmother/Father's girlfriend	9	2.6**	(1.3-5.4)**	1	1.8**	(0.2-11.9)**
Teacher/Principal	19	6.7	(3.9-11.4)	3	2.6**	(0.8-8.4)**
Other	23	6.8	(4.5-10.3)	14	21.2**	(12.1-34.3)**

*WTD = weighted results
[?] Other male relative not including father, stepfather or husband.
[??] Other female relative not including mother or stepmother.
**Interpret with caution as these values are unstable (unreliable).

Table 19. Emotional Abuse* Experienced by Females 13-24 Years, Swaziland, 2007

	Age of Respondent 13-17 Years Weighted Results (n = 557)			Age of Respondent 18-24 Years Weighted Results (n = 655)			All Respondents 13-24 Years Weighted Results (n = 1212)		
	n	**%**	**(95% CI)**	**n**	**%**	**(95% CI)**	**n**	**%**	**(95% CI)**
Prior to Age 18	184	33.3	(28.6-38.4)	186	26.2	(22.1-30.7)	370	29.5	(26.7-32.4)
Lifetime	#	#	#	267	38.7	(33.5-44.2)	451	36.2	(32.5-40.0)

* When you were growing up, did any adults scare you or make you feel really bad because they called you names, said mean things to you, or said they didn't want you?
# Lifetime estimates for the 13-17 year old age group are the same as those for estimates of emotional abuse occurring prior to age 18.

Table 20. Perpetrators of Emotional Abuse, by Age when Abuse Began -- Swaziland, 2007

	Under 18 when Violence Began Results (n = 401)			18-24 y.o. when Violence Began Results (n = 87)		
	n	WTD %*	WTD (95%CI)	n	WTD %*	WTD (95%CI)
Boyfriend/Husband	5	1.3**	(0.5-3.6)**	6	7.7**	(3.3-17.1)**
Father	41	10.9	(7.9-15)	11	13.1	(7.2-22.5)
Other Male Relative[?]	87	24.2	(19.9-29)	17	16.5	(10.1-26)
Mother	52	11.5	(8.6-15.2)	10	10.0	(4.7-20)
Other female relative[??]	126	29.3	(24.5-34.6)	28	34.3	(25-44.9)
Stepfather/Mother's boyfriend	4	0.7**	(0.3-2)**	1	0.7**	(0.1-5.3)**
Stepmother/Father's girlfriend	27	7.3	(4.6-11.2)	3	2.3**	(0.7-7)**
Teacher/Principal	13	3.1	(1.7-5.6)	0	0	?
Other	46	11.7	(8.1-16.6)	11	15.4	(8.3-26.8)

*WTD = weighted results
[?] Other male relative not including father, stepfather or husband.
[??] Other female relative not including mother or stepmother.
**Interpret with caution as these values are unstable (unreliable).

Table 21. Organizations and Agencies Involved in Preventing or Addressing Violence Against Children and Women that Females 13 -24 Years Old Have Heard About – Swaziland 2007

	All Respondents 13-24 Years Results (n = 1240)		
	n	**WTD%***	**WTD (95% CI)**
Swaziland Action Group Against Abuse (SWAGGA)	1166	94.2	(92.4-95.6)
Social Welfare Department[?]	748	60.2	(55.3-64.8)
Save the Children	949	76.6	(72.1-80.5)
Hotline[??]	550	45.1	(38.8-51.6)
Domestic Violence and Child Protection Unit[???]	490	39.3	(34.7-44.1)
LL (Shoulder to Cry On)	731	58.6	(52.8-64.1)

*WTD = weighted results
[?] The Social Welfare Department is housed in the Ministry of Health and Social Welfare.
[??] A hotline service is provided by SWAGAA and the Ministry of Education. We did not distinguish between the different service providers.
[???] The Domestic Violence and Child Protection Unit is housed in the Royal Swaziland Police.

REFERENCES

1. Dahlberg LL, Krug EG. Violence a global public health problem. In *World Report on Violence and Health.* Krug EG, Dahlberg LL, Mercy JA, Zwi AB, and Lozano R, Eds.; World Health Organization: Geneva, 2002; 3-59.

2. Pinheiro PS. World Report on Violence Against Children. Geneva: United Nations, 2006.

3. Mercy JA, Butchart A, Farrington D, and Cerda M. Youth Violence. In *World Report on Violence and Health.* Krug EG, Dahlberg LL, Mercy JA, Zwi AB, and Lozano R, Eds.; World Health Organization: Geneva, 2002; 23-56.

4. Runyan D, Wattam C, Ikeda R, Hassan F, and Ramiro L. Child abuse and neglect by parents and other caregivers. In *World Report on Violence and Health.* Krug EG, Dahlberg LL, Mercy JA, Zwi AB, and Lozano R, Eds.; World Health Organization: Geneva, 2002; 57-86.

5. Jewkes R, Sen P, and Garcia-Moreno C. Sexual Violence. In *World Report on Violence and Health.* Krug EG, Dahlberg LL, Mercy JA, Zwi AB, and Lozano R, Eds.; World Health Organization: Geneva, 2002; 147-182.

6. Hahm HC, Guterman NB. The emerging problem of physical child abuse in South Korea. *Child Maltreatment.* 2001; 6:169179.

7. World Health Organization. Global estimates of Health Consequences Due to Violence Against Children. Background paper to the UN Secretary General's Study on Violence Against Children. Geneva: WHO, 2006.

8. Lalor K. *Child sexual abuse in sub-Saharan Africa: a literature review.* Child Abuse and Neglect. 2004; 28: 439-460.

9. Jewkes R, Levin J, Mbananga N, and Bradshaw D. Rape of girls in South Africa. Lancet. 2002; 359: 319-20.

10. Centers for Disease Control and Prevention and World Health Organization. *Swaziland Global School-Based Student Health Survey Questionnaire*. 2003. Available at http://www.cdc.gov/gshs/ .

11. Kanduza A, Mamba T, Ndlangamandla S, Vilakazi L, and Zungu H. *A study of abuse amongst school going children in Swaziland*. 2003.

12. Buseh AG. *Patterns of sexual behavior among secondary school students in Swaziland, southern Africa*. Culture,Health & Sexuality. 2004; 6(4): 335-367.

13. Central Statistics Office. *Swaziland Multiple Indicator Cluster Survey (MICS)*. Government of Swaziland: Mbabane, 2000; 11-12.

14. Finkelhor D. The international epidemiology of child sexual abuse. *Child Abuse & Neglect* 1994; 18: 409-17.

15. Estimate based on data available from the *1998 South Africa Demographic and Health Survey (DHS)*. There are no reliable national estimates in Swaziland for females 13-24 years of age. Given the geographic proximity and some cultural similarities between South Africa and Swaziland, we relied on data from South Africa on the prevalence of forced sexual violence Against women (available for women 15-24 years). Available at: Http://www.measuredhs.com/aboutsurveys/search/metadata.cfm?surv_id=113&ctry_id=55&SrvyTp=country

16. Estimates and assumptions based on data and methodology from the *2000 Swaziland Multiple Indicator Cluster Survey (MICS)*.

17. Matthew Breiding, Avid Reza, Curtis Blanton, Michele Lynberg, James A. Mercy, Mark Anderson. *Sexual Violence against Children: Retrospective Self Reports from 13 - 24 Year Old Females (CDC IRB Protocol #5092).* Centers for Disease Control and Prevention: Atlanta, 2007.

18. Department of Gender and Women's Health, World Health Organization. *Putting Women First: Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. World Health Organization: Geneva, 2001.

19. Department of Gender and Women's Health, World Health Organization. *Training on "Putting Women First" Ethical and Safety Recommendations for Research on Domestic Violence Against Women*. World Health Organization: Geneva, 2006. Available at www.gfmer.ch/Medical_education_En/PGC_RH_2006/pdf/Putting_Women_First_Jansen_2006.pdf

20. National Research Council and Institute of Medicine. From Neurons to Neighborhoods: The Science of Early Childhood Development. Committee on Integrating the Science of Early Childhood Development. Shonkoff JP, Phillips DA (eds.). Board on Children, Youth, and Families, Commission on Behavioral and Social Sciences and Education. Washington, D.C.: National Academy Press, 2000.

21. Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, Koss MP, Marks, JS. The relationship of adult health status to childhood abuse and household dysfunction. *American Journal of Preventive Medicine*, 1998;14:245258.

22. Kendall-Tackett KA Treating the lifetime health effects of childhood victimization. Civic Research Institute, Inc.: Kingston, NJ, 2003.

23. Thurman TR, Brown L, Richter L, Maharaj P, Magnani R. Sexual risk behavior among South African adolescents: Is orphan status a factor? *AIDS Behav* 2006; 10: 627-635.

24. Williams LM. Recall of childhood trauma: A prospective study of women's memories of child sexual abuse. Journal of Consulting and Clinical Psychology 1994;62(6):1167-1176.

25. Jewkes R, Nduna M, Jama PN. Stepping Stones, South African Adaptation. Second Edition. Pretoria: Medical Research Council, 2002.

26. Jewkes R, Nduna M, Levin J, Jama N, Dunkle K, Khuzwayo N, Koss M, Puren A, Wood K, Duvvury N. A cluster randomized controlled trial to determine the effectiveness of Stepping Stones in Preventing HIV infections and promoting safer sexual behavior amongst youth in the rural Eastern Cape, South Africa: Trial design, methods, and baseline findings. Tropical Medicine and International Health 2006;11:3-16.

27. Butchart A, HendricksG. The Parent Centre. In Butchart A (Ed.) Behind the Mask: Getting to Grips with Crime and Violence in South Africa. Pretoria: HSRC Publishers, 2000.

28. Foshee VA, Baumen KE, Ennett ST, Suchindran C, Benefield T, Linder GF. Assessing the effects of the dating violence prevention program "Safe Dates" using random coefficient regression modeling. Prevention Science 2005;6(3):245-258.

29. Choose Respect. Retrieved September 6, 2007 from http://www.chooserespect.org.

30. Analytic and Reporting Guidelines: The Third National Health and Nutrition Examination Survey, NHANES III (1988-94), October, 1996, National Center for Health Statistics,Centers for Disease Control and Prevention

Appendix A

Initial Information Form

Hello, my name is _____. I am one of the interviewers of a national survey supported by UNICEF. We are conducting a survey in Swaziland to learn about girl's and young women's health and life experiences. We are only interviewing girls and young women who are between 13 and 24 years old.

We are doing this survey to learn more about the health needs of this population. The findings from this study may help to make the health programs for girls and young women in Swaziland better. The findings from this survey may also help us find ways to decrease health problems among Swazi girls and young women.

Your participation is **completely voluntary** but your experiences could be very helpful to other females in Swaziland.

We would appreciate if you give us some time to talk with you.

Is now a good time to talk?

It is very important that we talk in private. Is this a good place to hold the interview or is there somewhere else that you would like to go?

Note whether respondent agrees to DISCUSS THE STUDY FURTHER:

[ ] Does not agree to DISCUSS STUDY FURTHER. Thank participant for her time and end.

[ ] agrees to DISCUSS STUDY FURTHER.

Name of Staff Member Obtaining Agreement to Provide Additional Information:_____

Signature:_____ Date:_____

Appendix B

Consent Form-Survey

Introduction
We are a group from the United Nations Children's Fund (UNICEF). We are doing a survey to learn about girl's and young women's health and life experiences in Swaziland.

Purpose of the Study
The findings from this survey may help to make the health programs for this population in Swaziland better. The findings from this survey may also help us find ways to decrease health problems among Swazi girls and young women.

Procedures
Your village and household have been chosen at random from a list of villages and households. This number is not linked to you for any other reason except that it helped us to choose households. If you agree to participate in this survey, we will ask you about your family, school, and community relationships. In addition we will be asking about your sexual activity, HIV and your experiences with all forms of violence. We would appreciate if you could give us some time to ask you these questions.

Risks
There is minimal risk to participating in this survey. Some of the questions in the survey ask about your health and your family. We will also ask you several questions about whether anyone has tried to have sex with you when you did not want to. Answering questions like this can be difficult. If the questions are upsetting or difficult for you to answer, we can stop the interview at any time or we can skip those questions. If you do not want to answer a question, just skip it and we will go to the next question. There are no right or wrong answers.

Benefits
You will not get anything, such as money for being in this survey. You may benefit from being in the study by learning more about services available for those who have experienced violence.

Questions or Concerns
There are people you can contact if you have any questions or concerns. If you have questions about participating in the survey, you can ask members of the survey team.

Confidentiality
The records of this survey will be private. Only the people who are doing the survey will be able to look at the answers you give to the questions. Nothing that is sent back to UNICEF will have your name on it or any other details that someone could look at and know that it was about you. Any information you share with us is confidential and will not be shared with anyone.

Participation is your choice. There will be no change in the health care that you get. There will be no effect on your family. Only those people who are doing the survey will know whether you are in the survey. You have the right not to be in this survey or to stop being in the survey at any time.

Do you have any questions?
Are you willing to be in this survey?

Yes___ No___

Name of Staff Member Obtaining Verbal Consent:
_____

Signature of Staff Member Obtaining Verbal Consent:
_____ Date: ___/___/__

Appendix C

(WHEN MORE THAN 1 FEMALE 13-24 YEARS IN HOUSEHOLD)

b b 0 U U U b G U G	
Eligible Female	AGE OF ELIGIBLE FEMALE
1	
2	
3	
4	
5	
6	
7	
8	
Then, in this household there are _____females living between 13 to 24 years old?	1. Number of eligible female(s) ???? **IF "0" WRITE "0" AND CONTINUE WITH THE NEXT HOUSEHOLD**

G G								
G U' U	U G () U							
					5	**6**	**7**	**8**
0	1	2	2	4	3	6	5	4
	1	1	3	1	4	1	6	5
	1	2	1	2	5	2	7	6
	1	1	2	3	1	3	1	7
	1	2	3	4	2	4	2	8
5	1	1	1	1	3	5	3	1
6	1	2	2	2	4	6	4	2
7	1	1	3	3	5	1	5	3
8	1	2	1	4	1	2	6	4
9	1	1	2	1	2	3	7	5

For more information:
Contact the Communication Section
UNICEF Swaziland
Tel: +268 407 1000
Fax: +268 404 5282
Website: www.unicef.org/swaziland

unicef