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Disclosure of Sexual Violence Among Girls and Young Women Aged 13 to 24 Years: Results From the Violence Against Children Surveys in Nigeria and Malawi

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Abstract

Understanding factors that are associated with disclosure of sexual violence (SV) is important for the delivery of health services as well as developing strategies for prevention and response. The Violence Against Children Surveys were conducted in Malawi and Nigeria. We examined the prevalence of SV, help-seeking behaviors, and factors associated with disclosure among girls and young women aged 13 to 24. The self-reported prevalence of SV was similar in Nigeria (26%) and Malawi (27%). Among females who experienced SV, approximately one third (37%) in Nigeria and one half (55%) in Malawi ever disclosed their experience of SV. Females in Nigeria were significantly more likely to disclose to their parents (31.8%) than females in Malawi (9.5%). The most common reason for nondisclosure in Nigeria was not feeling a need or desire to tell anyone (34.9%) and in Malawi was embarrassment (29.3%). Very close relationships with one or both parents were significantly associated with disclosure among Nigerian females (odds ratio [OR] = 5.5, 95% confidence interval [CI] = [2.1, 14.6]) but were inversely associated with disclosure among Malawian females (OR = 0.05, 95% CI = [0.01, 0.33]). Reasons for nondisclosure of SV and factors associated with disclosure among females differ in the African nations studied. The stigma associated with shame of SV may prevent females from disclosing and thus receiving necessary support and health, social, and other services. This study demonstrates a need to reduce barriers for disclosure to improve the delivery of health, social, and other response services across African nations, as well as to develop culturally appropriate strategies for its response.

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Author Contributions

KHN, HK, and SAS conceptualized the paper and study design. KHN wrote the first draft of the manuscript and conducted the analyses. All authors contributed to the interpretation of the results and the review of the paper.

Declaration of Conflicting Interests

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Keywords

sexual violence; disclosure; girls; adults

Introduction

Sexual violence (SV) is associated with mental and physical health problems, such as anxiety, depression, unwanted pregnancy, cardiovascular disease, diabetes, and sexually transmitted diseases (Felitti et al., 1998; World Health Organization [WHO], 2013). Violence against children affects over a billion children globally (Hillis, Mercy, Amobi, & Kress, 2016). Recent studies on violence against children in African nations have found that more than 25% of females experience SV before the age of 18, but fewer than 1 out of 10 victims received services for such violence (Sumner et al., 2015). In addition to formal receipt of services, disclosure of SV to a parent, friend, or loved one is also low (Ministry of Gender, Children, Disability and Social Welfare of the Republic of Malawi, United Nations Children's Fund, The Center for Social Research at the University of Malawi, & Centers for Disease Control and Prevention, 2013; National Population Commission of Nigeria, UNICEF Nigeria, & Centers for Disease Control Prevention, 2016).

A meta-analysis of 217 studies on SV against children by Stoltenborgh, Van, Ijzendoorn, Euser, and Bakermans-Kranenburg (2011) suggested that cultural beliefs and values may contribute to the variability of childhood SV prevalence that is measured across countries and continents (Stoltenborgh et al., 2011). Globally, several studies have found that the highest prevalence of self-reported SV was in Africa (Finkelhor, 1994; Pereda, Guilera, Forns, & Gómez-Benito, 2009; Stoltenborgh et al., 2011), and noted cultural beliefs that may contribute to the normalization of such experiences, such as initiation rites, myths around avoiding and curing HIV/AIDS, and gender norms (Lalor, 2004; Townsend & Dawes, 2004). However, cultural factors, such as shame, embarrassment, beliefs about modesty and chastity, religious beliefs, and male dominance, may prevent children and families from disclosing such experiences (Fontes & Plummer, 2010). Local contextual factors may influence the prevalence of SV, its disclosure, and seeking help.

Females are more vulnerable to SV and its negative health outcomes. Females are more likely to experience intimate partner violence, rape, early or forced marriage, trafficking for the purposes of sexual exploitation and child labor, and genital mutilation/cutting (WHO, 2016). Females are also more likely to experience the physical effects of SV such as gynecological and reproductive health problems, unwanted pregnancy, vaginal bleeding or infection, chronic pelvic pain, and urinary tract infections (J. C. Campbell, 2002; Watts & Mayhew, 2004). In addition, feelings of shame and embarrassment are more likely to prevent females from disclosing incidents of SV (Ullman, Starzynski, Long, Mason, & Long, 2008). Even if females report incidents of SV, they are often not believed or blamed for the SV that they experienced (Ahrens, Campbell, Ternier-Thames, Wasco, & Sefl, 2007).

Improving SV disclosure is important for recovery from trauma and reducing psychological distress. SV may increase the risk of health problems such as anxiety, depression, difficulty trusting others, posttraumatic stress disorder (PTSD), and substance abuse (R. Campbell,

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Greeson, Bybee, & Raja, 2008). Disclosure has been linked to improved psychological and physical well-being for survivors (Jacques-Tiura, Tkatch, Abbey, & Wegner, 2010). One benefit of disclosure is social support, which has been shown in numerous studies to be associated with positive outcomes, such as positive life change and growth as well as reduced PTSD and depressive symptoms (Ahrens et al., 2007; Borja, Callahan, & Long, 2006).

Another benefit of disclosure may be the delivery of medical, psychological, and protective interventions. Receiving early health services after the experience of rape may potentially treat a range of gynecological and reproductive health problems, including HIV and other sexually transmitted infections (STIs), unwanted pregnancy, chronic pelvic pain, and urinary tract infections (J. C. Campbell, 2002; Watts & Mayhew, 2004). Those who experience SV may also need counseling and treatment for depression and posttraumatic stress disorder (J. C. Campbell, 2002; Watts & Mayhew, 2004). Finally, early, after-rape intervention could potentially prevent long-term chronic health conditions and high-risk behaviors such as drugs, alcohol, tobacco use, and unprotected sex (J. C.Campbell, 2002; Watts & Mayhew, 2004).

There have been no nationally representative studies in African nations to date that have examined disclosure among victims of SV and the reasons for nondisclosure among those who do not (Stoltenborgh et al., 2011). A better understanding of factors associated with nondisclosure of SV in children and young adults could contribute to the development of culturally appropriate strategies to increase reporting and health service utilization. As part of a global public health surveillance and research effort known as the Violence Against Children Surveys (VACS), this study sought to better understand disclosure of SV in Nigeria and Malawi.

Method

Measures

The VACS is a national population-based household survey of 13- to 24-year-old females and males, and is designed to measure sexual, physical, and emotional violence that occurred in childhood, as well as risk and protective factors and consequences of violence (Ministry of Gender, Children, Disability and Social Welfare of the Republic of Malawi, United Nations Children's Fund, The Center for Social Research at the University of Malawi, & Centers for Disease Control and Prevention, 2013; National Population Commission of Nigeria, UNICEF Nigeria, & Centers for Disease Control Prevention, 2016).

Experiences of childhood violence—Respondents were asked a series of questions related to sexual, physical, and emotional violence by any perpetrator. SV was defined as having ever experienced (a) unwanted sexual touching (e.g., touching in a sexual way, kissing, grabbing, or fondling), (b) attempted unwanted sexual intercourse (perpetrator attempted intercourse but penetration did not occur), (c) pressured intercourse (unwanted sex was completed through use of threats or nonphysical pressure), and (d) physically forced sex (unwanted intercourse completed through physical force) in their lifetime. Physical violence was defined as ever being slapped, pushed, hit with a fist, kicked, or whipped, or threatened

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with a weapon such as a gun or knife. Emotional violence was defined as ever being ridiculed and being made to feel unwanted or unloved. Each respondent received an ordinal score (0, 1, 2, or 3) depending on the total number of types of violence experienced (sexual, physical, or emotional). The precise phrasing of each question is available in the VACS questionnaires (https://www.cdc.gov/violenceprevention/childabuseandneglect/vacs/index.html).

Respondents who experienced SV were asked about the perpetrator of the first and most recent incident of SV. These perpetrators were categorized into one of six groups—family member, romantic partner/spouse, friend or neighbor, authority figure, classmate/schoolmate, or other (includes strangers and others who were not included in the other five categories). A dichotomous (0,1) variable was created for each perpetrator type.

Respondents were asked whether they had ever witnessed physical abuse in their home or community by the following questions: “How many times did you see or hear your parent punched, kicked, or get beaten up by your other parent, or their boyfriend or girlfriend?” “How many times did you see or hear a parent punch, kick, or beat your brothers or sisters?” and “Outside of your home and family environment, how many times did you see anyone get attacked?” Those who responded “at least once” to either of these questions were recoded as having witnessed physical violence.

Disclosure of and help seeking for SV—Respondents who experienced any SV were asked whether they told anyone about their experiences of SV, whether they knew of a place to receive help, and whether they sought help from a hospital/clinic, police station, helpline, social welfare, or legal office. Those who disclosed SV to someone were asked whom they told. Those who did not disclose were asked the reasons for not telling anyone, and those who did not seek help were asked their reasons for not seeking help.

Personal characteristics—Descriptive variables examined in the analyses were the respondent’s age and whether the respondent was orphaned prior to age 18 (one or both parents). Christian or Muslim religion was asked in Nigeria but not in Malawi because religious background in Malawi is relatively homogeneous and was not a key demographic question of interest for the Malawi survey.

Social relationships—Respondents were also asked about relationships with parents and friends. A variable was created for closeness with one or both parents by combining responses to the following questions: “How close do you feel to your biological father?” and “How close do you feel to your biological mother?” Responses were “very close,” “close,” “not close,” and “no relationship.” Respondents who answered “not close” or “no relationship” were combined into a “no relationship” category. Due to small sample size in multivariate analyses, close relationships with one or both parents were combined, and very close relationships with one or both parents were combined. To measure relationship with friends, respondents were asked “How much do you talk to friends about important things or personal matters?” Responses were “a lot,” “a little,” “not very much,” and “not at all.” Respondents who replied “a lot” were recoded as having close relationships with friends, “a

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little" or "not very much" as having some relationships with friends, and "not at all" as having no relationship with friends.

Procedure

Data for this study were collected in Malawi (2013) and Nigeria (2014) using a nationally representative cross-sectional household survey that used a three-stage sampling design to select 13- to 24-year-old females and males. In a three-stage sampling design, (a) geopolitical area units, called primary sampling units (PSUs), are selected from the latest population census data which is used as the basis of the sampling frame; (b) a complete list of all households within each selected area is constructed and a sample of households is randomly selected from each list; and (c) one individual is randomly selected from each selected household for interview. This type of design assumes that each selected survey-eligible individual can be linked to one, and only one, household in the country. The overall response rates were 93.7% in Nigeria and 84.4% in Malawi. The study was approved by the Centers for Disease Control and Prevention's (CDC) Institutional Review Board (IRB) as well as host nation IRBs.

A face-to-face structured questionnaire was administered by trained interviewers in the local language. Informed consent was given by respondents before the interview was conducted. The survey had two components: a short demographic interview with the head of household and a comprehensive interview with the respondent covering questions about sexual, physical, and emotional violence.

Data Analysis

Due to the higher prevalence of SV among females, analyses focused on girls and young women aged 13 to 24 years. Descriptive analyses examined the prevalence of childhood violence and various sociodemographic characteristics. Among those who experienced SV, help-seeking behaviors and associated reasons were calculated. Factors associated with disclosure of SV were assessed in a multivariate logistic regression model. Odds ratios (ORs) estimated via logistic regression were considered statistically significant at alpha <. 05. Analyses were performed in SAS 9.3 (SAS Institute Inc., Cary, North Carolina, USA) using SAS SURVEYFREQ and SURVEYLOGISTIC procedures to account for the complex survey design.

Data were weighted to be nationally representative. Weighting is a method used to account for the probability that each respondent came into the sample and the differential effects of nonresponse, and imperfect sampling frames that affect the composition of the sample. Final sample weights are calculated by (a) determining base weights to account for all steps of random selection that led to the sample of population members, (b) adjusting for nonresponse, and (c) further adjusting to calibrate the final set of adjusted weights to the distribution of the population.

Results

As shown in Table 1, a total of 1,766 females (M = 18.4, SE = 0.1) from Nigeria and 1,029 females (M = 18.3, SE =0.2) from Malawi aged 13 to 24 completed the survey and were

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included in analyses. The majority (69%) of females in both countries experienced some type of childhood violence in their life, which could include sexual, physical or emotional violence. In Nigeria, 39% of females experienced one type of violence, and 30% of females experienced two or more types of violence. Similarly, in Malawi, 36% of females experienced one type of violence, and 33% experienced two or more types of violence. More than one in four females experienced SV in Nigeria (26%) and Malawi (27%). The most common perpetrator of SV in Nigeria (37%) and Malawi (31%) was a romantic partner or spouse, followed by a friend or neighbor (37% and 28%, respectively). In addition, a majority of females in both countries witnessed physical violence in the home or community (Nigeria, 76%; Malawi, 60%).

Among females who experienced SV, Nigeria (n = 456) and Malawi (n = 256), a limited proportion ever told anyone about their SV experiences and the majority did not seek professional help. As presented in Table 2, approximately one third (37%) and one half of females (55%) who experienced SV in Nigeria and Malawi, respectively, told someone about their experience of SV. Only 1 in 7 females (14%) in Nigeria and 1 in 5 females (23%) in Malawi who experienced SV knew where to receive help, and only 4% of females in Nigeria and 9% of females in Malawi ever sought help for SV.

Females who did disclose experiences of SV most commonly told a friend or neighbor in Nigeria (37.5%) and Malawi (53.3%). Family members were the second largest group to whom females disclosed in Nigeria and Malawi. The prevalence of disclosure to parents was significantly lower in Malawi (9.5%) than in Nigeria (31.8%) ($p < .0001$). Conversely, almost 30% of females in Malawi disclosed to a sibling, as compared with only 13.7% of females in Nigeria. Embarrassment for self or family as a reason for nondisclosure was significantly higher among females in Malawi (29%) than females in Nigeria (10.1%) ($p < .0001$). The most common reason for not seeking help in Nigeria and Malawi was the belief that SV was not a problem (40% and 35%, respectively).

Different patterns of factors associated with disclosure emerged for Nigeria and Malawi as shown in Table 3. In Nigeria, religion, orphan status, relationships with parents, the number of types of violence experienced, and the type of perpetrator were significantly associated with disclosure. The odds of disclosure were higher among females who are Christian (OR = 2.5, 95% confidence interval [CI] = [1.2, 5.3]) compared with Muslim. In addition, the odds of disclosure were higher among females who had lost both parents prior to age 18 compared with females who had both parents living (OR = 5.9, 95% CI = [1.5, 23.6]). The level of closeness with parents was significantly associated with higher odds of disclosure compared with those who had no relationships with their parents (close: OR = 3.0, 95% CI = [1.1, 8.4]; very close: OR = 5.5, 95% CI = [2.1, 14.6]). Disclosure was also significantly associated with experiencing multiple types of violence. Females who experienced all three types of violence had higher odds of disclosure than among females who experienced only one type of violence (OR = 2.5, 95% CI = [1.1, 5.9]). Females were also significantly more likely to disclose if family members were the perpetrators of SV compared with perpetrators who were not family members (OR = 5.7, 95% CI = [2.0, 16.9]).

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In Malawi, very close relationships with parents and close relationships with friends were significantly associated with disclosure but in different directions. Females in Malawi who had very close relationships with one or both parents were less likely to disclose SV than females who had no relationship with their parents (OR = 0.05, 95% CI = [0.01, 0.33]). Females who had close relationships with friends were more likely to disclose SV than females who had no relationships with friends (OR = 4.8, 95% CI = [1.6, 13.9]). Other relationships were not significant.

Discussion

Our study in two African nations detected high rates of self-reported SV among girls and young women, yet low levels of disclosure of such violence, knowledge of where to seek help, and service seeking. Over a quarter of females experienced SV, but less than 5% of females in Nigeria and 10% of females in Malawi who experienced such violence sought help. This indicates that many females who experienced SV may not have received necessary health, social, and other services. One possible explanation for the low levels of disclosure in both countries is that relatively few girls and young women knew where to receive help (14% in Nigeria and 23% in Malawi). Despite high rates of SV, disclosure and service-seeking behaviors remain low for females in these African nations, which may prevent recovery and treatment.

The observed differences in disclosure patterns between Nigeria and Malawi suggest that social support and attitudes toward SV could play an important role in disclosure. For example, females in Nigeria were significantly more likely to disclose to their parents than females in Malawi. The stigma and shame from SV appeared to be the motivating factor for nondisclosure among Malawian females, which is further evident by the low levels of disclosure to parents and caregivers despite having a close relationship. Dispelling myths associated with SV and supporting victims is an important step in ending the cycle of SV in this population. Other significant differences in nondisclosure between Malawi and Nigeria may exist; however, our study was only able to capture the largest differences.

In both countries, cultural and religious beliefs appear to play a significant role in predicting disclosure. In Nigeria, where participants' religion was ascertained, females who identified as Christians were more likely to disclose than females who identified as Muslim. Studies have shown that Nigerian Muslim and Christian populations have different values, beliefs, and sexual behavior patterns (Barker & Rich, 1992; Makinwa-Adebusoye, 1992). While Nigerian Muslims have stricter rules on premarital sex and virginity, Nigerian Christians may have a more permissive attitude toward sex, which may contribute to higher disclosure rates (Agha, 2009). Cultural differences in expectations for virginity, modesty, and familial honor may influence disclosure (Amar, 2007). Studies in Malawi suggest that girls and women are expected to be chaste until marriage, and once married, monogamous. Thus, they may not be likely to disclose any experiences of sex outside of their marriage for fear of abandonment and poverty (Kathewera-Banda et al., 2005; Lindgren, Rankin, & Rankin, 2005).

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Experiencing multiple forms of violence also contributes significantly to disclosure rates. Females in Nigeria who experienced three types of abuse were more likely to disclose than someone who experienced only one or two types. Experiencing more than one type of violence, or polyvictimization, has been shown in numerous studies to be associated with negative mental and physical health outcomes (Finkelhor, Ormrod, & Turner, 2007; Le, Holton, Romero, & Fisher, 2016; Sabina & Straus, 2008; Simmons, Wijma, & Swahnberg, 2015). A recent meta-analysis found that 38.1% of children in low- and middle-income countries (eight were from Africa, four from South Asia, two from East Asia and Pacific region, one from South America, and one from Central America) experienced polyvictimization, which was associated with poor mental health, developmental problems, low cognitive development, increased health risk behaviors, and suicidal thoughts (Le et al., 2016). Polyvictimization was also found to be associated with posttraumatic stress disorder, depression, and anxiety, which may be caused by higher levels of humiliation, shame, sadness, hopelessness, and low self-esteem experienced by polyvictimized children and adolescents (Turner, Shattuck, Finkelhor, & Hamby, 2017). Experiencing more than one type of abuse increases risk of negative health outcomes, which studies have found to be conducive to disclosure (Le et al., 2016; Turner et al., 2017). There were also differences in disclosure based on the victim's relationship with the perpetrator in Nigeria. Perpetrators who were family members and those in the "other" category were significantly associated with higher disclosure than those who were not family members or in the "other" category. These results suggest that various factors that may reflect the context or impact of violence are associated with the likelihood of disclosure among girls and young women in these African nations.

This study is subject to several limitations. First, as a household survey, VACS does not include data on children living outside of family care (such as homeless or institutionalized children) who may be most vulnerable to violence victimization and who may have unique patterns of and barriers to disclosure. In addition, the current study is limited to only females and does not capture the prevalence of SV among males. Further studies among these subpopulations are important for understanding the whole picture of SV in some African nations. Second, the survey relied on retrospective self-reports of violence, which may be affected by recall bias, social desirability bias, fear of disclosure, or cultural factors. Self-reported experiences of SV are likely to underestimate the true prevalence of SV, further underscoring the importance of reducing barriers to disclosure (Fergusson, Horwood, & Woodward, 2000; Hardt & Rutter, 2004; Widom & Morris, 1997). Third, due to the low numbers of girls and young women who disclosed, there may be large variability in the CIs. Despite the variability, the ORs show that certain characteristics are significantly associated with disclosure, although the exact effect needs to be studied further. Finally, for survivors experiencing multiple types of SV, it was not possible to identify which incidents prompted disclosure.

The WHO and the CDC, along with other global partners, have developed a package of seven evidence-based strategies, called INSPIRE, that provides a framework for ending violence against children (WHO, 2016). Some of these strategies include strengthening norms and values that support nurturing and positive relationships for all children and young adults, creating positive parent–child relationships, and improving access to high-quality

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health services for all children who need them to reduce the long-term impact of violence (WHO, 2016). Some of these strategies may foster the positive environments that contribute to disclosure of SV, and provide access to services for victims.

Based on the INSPIRE strategies, several programs and policies can be implemented to prevent violence against children as well as support those who have been affected by violence. For example, as a result of the VACS, Malawi increased government investment in (a) training caregivers/parents on building safe, stable, and nurturing relationships with their children, (b) building life skills for children and youth, (c) increasing access to and awareness of child response services, and (d) developing policies and programs to address harmful gender norms (WHO, 2016). Successful, evidence-based programs in other African nations show promise for reducing SV. For example, the “No Means No” IMpower program in Kenya empowers adolescent girls by improving their self-esteem and teaching them self-defense to reduce their risk of SV (Sarnquist et al., 2014). An evaluation of the program demonstrated that the intervention group had a higher likelihood of disclosure of SV and a decrease in sexual assault rates. These programs suggest that implementing effective, evidence-based strategies is successful in changing local and national norms that contribute to the perpetration of SV among girls, which may also lead to increases in disclosure and self-esteem.

Violence against children has devastating consequences on not only the child but also families, communities, and society. Increasing disclosure about SV could provide opportunities to enhance supports, improve psychological and physical well-being, and may help in the recovery process. Furthermore, addressing the underlying barriers to help-seeking behaviors has the potential to help reduce the negative short- and long-term consequences of SV for survivors, and may help communities tailor specific interventions to reduce the cycle of SV perpetration.

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References

Agha S. Changes in the timing of sexual initiation among young Muslim and Christian women in Nigeria. Archives of Sexual Behavior. 2009; 38:899–908. DOI: 10.1007/s10508-008-9395-0 [PubMed: 18712467]

Ahrens CE, Campbell R, Ternier-Thames NK, Wasco SM, Sefl T. Deciding whom to tell: Expectations and outcomes of rape survivors' first disclosures. Psychology of Women Quarterly. 2007; 31:38–49. DOI: 10.1111/j.1471-6402.2007.00329.x

Amar AF. Understanding the veil: Non-stranger sexual assault of a Muslim woman. Journal of Forensic Nursing. 2007; 3:134–136. DOI: 10.1111/j.1939-3938.2007.tb00100.x [PubMed: 18027534]

Barker GK, Rich S. Influences on adolescent sexuality in Nigeria and Kenya: Findings from recent focus-group discussions. Studies in Family Planning. 1992; 23:199–210. DOI: 10.2307/1966728 [PubMed: 1523699]

Borja SE, Callahan JL, Long PJ. Positive and negative adjustment and social support of sexual assault survivors. Journal of Traumatic Stress. 2006; 19:905–914. DOI: 10.1002/jts.20169 [PubMed: 17195986]

Campbell JC. Health consequences of intimate partner violence. The Lancet. 2002; 359:1331–1336. DOI: 10.1016/S0140-6736(02)08336-8

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Campbell R, Greeson MR, Bybee D, Raja S. The co-occurrence of childhood sexual abuse, adult sexual assault, intimate partner violence, and sexual harassment: A mediational model of posttraumatic stress disorder and physical health outcomes. Journal of Consulting and Clinical Psychology. 2008; 76:194–207. DOI: 10.1037/0022-006x.76.2.194 [PubMed: 18377117]

Felitti VJ, Anda RF, Nordenberg D, Williamson DF, Spitz AM, Edwards V, … Marks JS. Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. American Journal of Preventive Medicine. 1998; 14:245–258. DOI: 10.1016/s0749-3797(98)00017-8 [PubMed: 9635069]

Fergusson DM, Horwood LJ, Woodward LJ. The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults. Psychological Medicine. 2000; 30(3):529–544. [PubMed: 10883709]

Finkelhor D. The international epidemiology of child sexual abuse. Child Abuse & Neglect. 1994; 18:409–417. DOI: 10.1016/0145-2134(94)90026-4 [PubMed: 8032971]

Finkelhor D, Ormrod RK, Turner HA. Polyvictimization and trauma in a national longitudinal cohort. Development and Psychopathology. 2007; 19:149–166. DOI: 10.1017/s0954579407070083 [PubMed: 17241488]

Fontes LA, Plummer C. Cultural issues in disclosures of child sexual abuse. Journal of Child Sexual Abuse. 2010; 19:491–518. DOI: 10.1080/10538712.2010.512520 [PubMed: 20924908]

Hardt J, Rutter M. Validity of adult retrospective reports of adverse childhood experiences: review of the evidence. Journal of Child Psychology and Psychiatry. 2004; 45(2):260–273. [PubMed: 14982240]

Hillis S, Mercy J, Amobi A, Kress H. Global prevalence of past-year violence against children: A systematic review and minimum estimates. Pediatrics. 2016; 137(3) Article e20154079. doi: 10.1542/peds.2015-4079

Jacques-Tiura AJ, Tkatch R, Abbey A, Wegner R. Disclosure of sexual assault: Characteristics and implications for posttraumatic stress symptoms among African American and Caucasian survivors. Journal of Trauma & Dissociation. 2010; 11:174–192. DOI: 10.1080/15299730903502938 [PubMed: 20373205]

Kathewera-Banda M, Gomile-Chidyaonga F, Hendriks S, Kachika T, Mitole Z, White S. Sexual violence and women's vulnerability to HIV transmission in Malawi: A rights issue. International Social Science Journal. 2005; 57(186):649–660. DOI: 10.1111/j.1468-2451.2005.00582.x

Lalor K. Child sexual abuse in sub-Saharan Africa: A literature review. Child Abuse & Neglect. 2004; 28:439–460. DOI: 10.1016/j.chiabu.2003.07.005 [PubMed: 15120925]

Le MT, Holton S, Romero L, Fisher J. Polyvictimization among children and adolescents in low- and lower-middle-income countries: A systematic review and meta-analysis. Trauma, Violence, & Abuse. 2016; Advance online publication. doi: 10.1177/1524838016659489

Lindgren T, Rankin SH, Rankin WW. Malawi women and HIV: Socio-cultural factors and barriers to prevention. Women & Health. 2005; 41:69–86. DOI: 10.1300/j013v41n01_05 [PubMed: 16048869]

Makinwa-Adebusoye P. Sexual behavior, reproductive knowledge and contraceptive use among young urban Nigerians. International Family Planning Perspectives. 1992; 18:66–70. DOI: 10.2307/2133396

Ministry of Gender, Children, Disability and Social Welfare of the Republic of Malawi, United Nations Children's Fund, The Center for Social Research at the University of Malawi, & Centers for Disease Control and PreventionViolence against children and young women Malawi—Findings from a National Survey 2013Lilongwe: Government of Malawi; 2014

National Population Commission of Nigeria, UNICEF Nigeria, & Centers for Disease Control PreventionViolence against children in Nigeria—Findings from a National Survey 2014Abuja, Nigeria: UNICEF; 2016

Pereda N, Guilera G, Forns M, Gómez-Benito J. The international epidemiology of child sexual abuse: A continuation of Finkelhor (1994). Child Abuse & Neglect. 2009; 33:331–342. DOI: 10.1016/j.chiabu.2008.07.007 [PubMed: 19477003]

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Sabina C, Straus MA. Polyvictimization by dating partners and mental health among U.S. college students. Violence and Victims. 2008; 23:667–682. DOI: 10.1891/0886-6708.23.6.667 [PubMed: 19069560]

Sarnquist C, Omondi B, Sinclair J, Gitau C, Paiva L, Mulinge M, Maldonado Y. Rape prevention through empowerment of adolescent girls (2014). Pediatrics. 2014; 133(5):e1226–e1232. DOI: 10.1542/peds.2013-3414d [PubMed: 24733880]

Simmons J, Wijma B, Swahnberg K. Lifetime co-occurrence of violence victimisation and symptoms of psychological ill health: A cross-sectional study of Swedish male and female clinical and population samples. BMC Public Health. 2015; 15(1) Article 979. doi: 10.1186/s12889-015-2311-3

Stoltenborgh M, Van Ijzendoorn MH, Euser EM, Bakermans-Kranenburg MJ. A global perspective on child sexual abuse: Meta-analysis of prevalence around the world. Child Maltreatment. 2011; 16:79–101. DOI: 10.1037/e516542013-024 [PubMed: 21511741]

Sumner SA, Mercy AA, Saul J, Motsa-Nzuza N, Kwesigabo G, Buluma R, Kilbane T. Prevalence of sexual violence against children and use of social services-seven countries, 2007–2013. Morbidity and Mortality Weekly Report. 2015; 64(21):565–569. [PubMed: 26042646]

TownsendL, , DawesA. Individual and contextual factors associated with the sexual abuse of children under 12: A review of recent literature. In: RichterLM, DawesA, , Higson-SmithC, editorsSexual abuse of young children in Southern AfricaHSRC Press; 20045594

Turner HA, Shattuck A, Finkelhor D, Hamby S. Effects of poly-victimization on adolescent social support, self-concept, and psychological distress. Journal of Interpersonal Violence. 2017; 32:755–780. DOI: 10.1177/0886260515586376

Ullman SE, Starzynski LL, Long SM, Mason GE, Long LM. Exploring the relationships of women's sexual assault disclosure, social reactions, and problem drinking. Journal of Interpersonal Violence. 2008; 23:1235–1257. DOI: 10.1177/0886260508314298 [PubMed: 18309039]

Watts C, Mayhew S. Reproductive health services and intimate partner violence: Shaping a pragmatic response in sub-Saharan Africa. International Family Planning Perspectives. 2004; 30:207–213. DOI: 10.1363/3020704 [PubMed: 15590387]

Widom CS, Morris S. Accuracy of adult recollections of childhood victimization, part 2: childhood sexual abuse. Psychological Assessment. 1997; 9(1):34.

World Health OrganizationGlobal and regional estimates of violence against women: Prevalence and health effects of intimate partner violence and non-partner sexual violenceGeneva, Switzerland: Author; 2013

World Health Organization. INSPIRE: Seven strategies for ending violence against children2016Retrieved from http://www.who.int/violence_injury_prevention/violence/inspire/en/

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Table 1

Background Characteristics, Social Relationships, and Experiences of Childhood Violence Among 13- to 24-Year-Old Females in Nigeria (n = 1,766) and Malawi (n = 1,029), Violence Against Children Surveys (VACS).

	Nigeria		Malawi	
Background Characteristics	**%**	**(95% CI)[a]**	**%**	**(95% CI)[a]**
Age group				
13–17	40.8	[37.7, 44.0]	43.1	[37.2, 49.0]
18–24	59.2	[56.0, 62.3]	56.9	[51.0, 62.8]
Religious affiliation				
Christian	51.9	[46.9, 56.9]	*b*	*b*
Muslim	48.1	[43.1, 53.1]	*b*	*b*
Orphan status prior to age 18				
Not an orphan	77.8	[75.1, 80.5]	70.2	[65.8, 74.6]
Lost one parent	19.4	[16.9, 21.9]	22.2	[17.4, 27.0]
Lost both parents	2.8	[1.9, 3.7]	7.6	[5.5, 9.8]
Social relationships				
Relationships with parents				
No relationship with parents	2.9	[1.9, 4.0]	2.4	[1.2, 3.7]
Close relationship with one parent	5.9	[4.7, 7.1]	7.0	[5.0, 9.0]
Close relationship with both parents	13.3	[11.0, 15.7]	7.1	[3.3, 11.0]
Very close relationship with one parent	37.0	[33.4, 40.6]	40.4	[36.6, 44.3]
Very close relationship with both parents	40.8	[36.6, 45.0]	43.0	[36.7, 49.3]
Relationships with friends				
No relationship with friends	35.9	[32.3, 39.5]	33.3	[28.7, 38.0]
Some relationship with friends	35.9	[32.9, 39.0]	36.5	[32.4, 40.6]
Close relationship with friends	28.2	[25.2, 31.1]	30.2	[24.4, 36.0]
Experiences of childhood violence				
Number of types of violence experienced				
0	31.4	[27.6, 35.2]	31.1	[26.9, 35.3]
1	39.3	[35.9, 42.6]	35.9	[32.9, 38.8]
2	21.8	[18.9, 24.6]	20.7	[15.4, 26.1]
3	7.6	[5.9, 9.3]	12.3	[8.3, 16.4]
Sexual violence				
Experienced any sexual violence	25.6	[22.6, 28.6]	27.2	[22.9, 31.5]
Perpetrator of sexual violence[c]				
Family member	7.6	[4.7, 10.6]	11.4	[5.6, 17.2]
Romantic partner/spouse	37.4	[31.2, 43.7]	30.8	[23.0, 38.6]
Friend or neighbor	37.0	[32.2, 41.8]	28.0	[18.1, 38.0]
Authority figure	5.6	[2.8, 8.5]	4.2	[1.1, 7.3]
Classmate/schoolmate	14.4	[10.6, 18.2]	21.9	[15.3, 28.5]
Other[d]	16.5	[12.6, 20.4]	13.1	[6.9, 19.3]
Ever witnessed physical violence in home or community				

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	Nigeria		Malawi	
Background Characteristics	**%**	**(95% CI)[a]**	**%**	**(95% CI)[a]**
No	24.1	[20.8, 27.3]	40.1	[35.0, 45.3]
Yes	75.9	[72.7, 79.2]	59.9	[54.7, 65.0]

Note. CI = confidence interval.

[a] Nationally representative weighted percentages.

[b] Question not asked in Malawi VACS.

[c] Among respondents who experienced sexual violence.

[d] "Other" includes everyone else who is not included in the other five categories, such as strangers.

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Table 2

Disclosure of and Service Seeking for Child Sexual Abuse and Related Factors Among 13- to 24-Year-Old Females Who Experienced SV in Childhood in Nigeria and Malawi, Violence Against Children Surveys (VACS).

	Nigeria (*n* = 456)		Malawi (*n* = 256)		
	%	95% CI [a]	%	95% CI [a]	Chi-Square *p* Value
Disclosure and help-seeking behaviors					
Ever told anyone about SV	36.5	[30.7, 42.4]	54.6	[40.9, 68.3]	.01
Knew of a place to receive help	13.9	[9.4, 18.4]	22.6	[17.3, 82.7]	.01
Ever sought help for SV	4.2	[2.1, 6.3]	8.7	[2.8, 14.7]	.07
Person told about SV[b]					
Parents	31.8	[22.5, 41.2]	9.5	[4.3, 14.7]	<.001
Sibling/relative	13.7	[6.5, 20.8]	28.9	[10.2, 47.6]	.08
Spouse/romantic partner	*c*	*c*	0	0	
Friend/neighbor	37.5	[27.8, 47.1]	53.3	[37.6, 68.9]	.09
Authority figure	4.6	[1.6, 7.5]	*c*	*c*	
Other	10.3	[4.8, 15.8]	*c*	*c*	
Reasons for not telling anyone[d]					
Did not know who to go to	4.5	[1.9, 7.1]	*c*	*c*	
Afraid of getting in trouble	30.3	[22.5, 38.2]	*c*	*c*	
Embarrassed for self/family	10.1	[5.4, 14.7]	29.3	[22.1, 36.5]	<.0001
Did not think it was a problem	15.5	[9.5, 21.6]	21.1	[7.0, 35.1]	.45
Did not need/want to tell anyone	34.9	[25.4, 44.4]	*c*	*c*	
Reasons for not seeking help[e]					
Did not know where to go	0		*c*	*c*	
Afraid of getting in trouble	*c*	*c*	*c*	*c*	
Embarrassed for self/family	*c*	*c*	*c*	*c*	
Did not think it was a problem	39.9	[22.0, 57.8]	35.0	[14.7, 55.2]	.70
Did not need/want services	30.3	[12.3, 48.3]	*c*	*c*	

Note. CI = confidence interval; SV = sexual violence.

[a] Nationally representative weighted percentages.

[b] Asked among those who disclosed.

[c] Suppressed due to unstable estimates (relative standard error (RSE) >40%).

[d] Asked among those who did not disclose.

[e] Asked among those who did not seek help.

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Table 3

Factors Associated With Disclosure of Sexual Violence[a] Among 13- to 24-Year-Old Females Who Experienced Sexual Violence, Violence Against Children Surveys (VACS).

	Nigeria		Malawi	
	aOR	**95% CI**	**aOR**	**95% CI**
Age group				
13–17	1.0 (ref)		1.0 (ref)	
18–24	1.2	[0.7, 2.1]	1.6	[0.7, 3.7]
Religion				
Christian	**2.5**	**[1.2, 5.3]**	*b*	*b*
Muslim	1.0 (ref)		*b*	*b*
Orphan status prior to age 18				
Not an orphan	1.0 (ref)		1.0 (ref)	
Lost one parent	0.6	[0.3, 1.0]	1.1	[0.4, 3.2]
Lost both parents	**5.9**	**[1.5, 23.6]**	1.5	[0.3, 6.9]
Relationships with parents				
No relationship with parents	1.0 (ref)		1.0 (ref)	
Close relationship with one or both parents	**3.0**	**[1.1, 8.4]**	0.18	[0.02, 1.87]
Very close relationship with one or both parents	**5.5**	**[2.1, 14.6]**	**0.05**	**[0.01, 0.33]**
Relationships with friends				
No relationship with friends	1.0 (ref)		1.0 (ref)	
Little relationship with friends	1.0	[0.6, 1.9]	1.5	[0.6, 3.8]
Close relationship with friends	1.0	[0.5, 1.9]	**4.8**	**[1.6, 13.9]**
Number of types of violence				
1	1.0 (ref)		1.0 (ref)	
2	1.6	[0.7, 3.6]	2.1	[0.7, 6.3]
3	**2.5**	**[1.1, 5.9]**	1.0	[0.4, 2.6]
Perpetrator[c] of sexual violence				
Family member	**5.7**	**[2.0, 16.9]**	3.5	[0.5, 25.9]
Romantic partner/spouse	0.8	[0.4, 1.7]	0.4	[0.1, 1.5]
Friend or neighbor	1.4	[0.7, 2.8]	2.2	[0.5, 9.8]
Authority figure	2.8	[0.8, 9.7]	2.7	[0.4, 16.3]
Classmate/schoolmate	1.0	[0.4, 2.6]	0.5	[0.1, 2.8]
Other[d]	**2.2**	**[1.1, 4.5]**	0.6	[0.2, 2.6]
Ever witnessed physical violence in home or community	1.6	[0.7, 3.4]	2.6	[1.0, 7.3]

Note. aOR = adjusted odds ratio; CI = confidence Interval. Boldface values indicates significance at $p < 0.05$.

[a] Among those who disclosed.

[b] Question not asked in Malawi VACS.

[c] A dichotomous (0,1) variable was created for each perpetrator type.

[d] Includes everyone else who is not included in the other five categories, such as strangers.