RATIONALE FOR AND HISTORY OF THE VIOLENCE AGAINST CHILDREN SURVEYS

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Division of Violence Prevention
National Center for Injury Prevention and Control
Centers for Disease Control and Prevention
Past Year Exposure to Selected Categories of Violence, NatSCEV, United States, 2008

- Any exposure: 60.6%
- Assault with no weapon or injury: 36.7%
- Assault with weapon or injury: 14.9%
- Sexual victimization: 6.1%
- Child maltreatment: 10.2%
- Dating violence*: 1.4%
- Witnessing family assault: 9.8%
- Witnessing community assault: 19.2%

* Figures for dating violence are only for children and adolescents 12 and older.
Violence Against Children Is Costly and Destructive

Health-Risk Behaviors
- Multiple & Concurrent Partners
- Unsafe Sexual Practices
- Smoking, Alcohol, Drugs
- Smoking, Alcohol, Drugs
- Unintended & Adolescent Pregnancy
- Fetal Death
- Pregnancy Complications

Maternal & Child Health
- Depression, Anxiety, PTSD
- Somatic Complaints
- Unwanted Pregnancy
- Social Ostracism
- Re-Victimization
- Diabetes
- Heart Disease
- STDs, Including HIV
- STDs, Including HIV
- Physical Injury
- Stroke
- Cancer
- Suicide
- Stroke

Disease & Injury

Mental Health Disease & Injury
Paths Leading From Violence Against Children to HIV

- Direct Transmission
- Compromised Negotiation
- Forcing Children Out of Homes
- HIV Risk Behaviors
Childhood adversity is strongly associated with all classes of mental health disorders at all life course stages across low, middle, and high-income countries.

Childhood adversities are powerful predictors of the onset and persistence of suicidal behaviors.

Eradication of adverse childhood experiences would reduce the burden of mental disorder by 30%.
Exposure to child maltreatment has been found to be associated with decreased telomere length in adults.

Exposure to intimate partner violence has been found to be associated with decreased telomere length.

Childhood adversity can have long-term epigenetic consequences which may be inherited by subsequent generations.
Violence Damages the Brain

Violence Against Children/Youth → Risk Behaviors And Conditions → Mental and Physical Health and Cognitive Development

Premature Aging

Infancy → Adulthood
The Strategic Importance of Preventing Violence Against Children

- Viable programmatic and policy options exist
- Influences many different health outcomes over the life course
- Substantial cumulative impact on health
- Addresses health disparities
- Influence other desirable outcomes (e.g., human capital formation)
- Scientifically grounded
- Politically feasible
A New Lever for Public Health
Violence Against Children Surveys (VACS)
CDC and UNICEF Initiated the VACS with the Swaziland and Tanzania Governments

- Motivated by an absence of data
- The link with between violence and HIV was also an important motivator
- Clear involvement of government and civil society from the outset
- Swaziland and Tanzania have both used the data to take action
Together for Girls: A Global Partnership

- Generate data to guide action
- Support governments in evidence-based prevention and response
- Mobilize action through advocacy and public awareness

- Centers for Disease Control and Prevention
- United Nations Children’s Fund
- President’s Emergency Plan for AIDS Relief
- The Joint United Nations Programme on HIV/AIDS
- United Nations Development Fund for Women
- United Nations Population Fund
- Becton, Dickinson and Company
- CDC Foundation
- Nduna Foundation
- Grupo ABC
Completed and Proposed Surveys of Violence Against Children

- Swaziland
- Kenya
- Tanzania
- Philippines
- Viet Nam
- Malaysia
- Haiti
- Uganda
- Rwanda
- Zambia
- Botswana
- Nigeria
- Zimbabwe
- Laos PDR
- Indonesia
- Papua New Guinea
- Rwanda
- Tanzania
- Malawi
- Swaziland
VACS Addresses Two Key Questions

How can we MEASURE the IMPACT of violence on children’s lives?

How can we foster POLITICAL AND PUBLIC ENGAGEMENT to reduce violence against children?
Purposes of the VACS

- Describe magnitude and nature of the problem
- Assess health consequences
- Identify potential risk and protective factors
- Assess utilization of services
- Help guide prevention programs and policies
Multi-Sectoral Task Forces

- UNICEF Country Office
- Government Ministries
- Local Non-Governmental Organizations
- Universities
- UN Agencies
  - e.g., UNFPA, UNAIDS, WHO
- USG In-country Offices
  - e.g., PEPFAR, USAID, CDC
Methods

- National household survey
- Three-stage cluster sample survey design
- Randomly select one eligible female or male aged 13-24 years in each household
- Swaziland – girls only; All subsequent surveys both girls and boys
- Surveys carried out by in-country institutions
- Extensive efforts to protect child respondents
Protecting Child Respondents

- Do not disclose full purpose of the study to anyone except respondents (health survey)
- Do not interview females and males in the same community
- Only one interview per household
- Minimize the percent of households visited per cluster
- Extensive interviewer training
- Conduct interviews in private and predefined procedure for handling interruptions
- Provide a list of services to every respondent
- Response plan for respondents who want help
Organization and Content of the Respondent Questionnaires

- Background of Respondent
- Gender Attitudes
- Safety
- Witnessing Physical Violence
- Physical Violence Victimization and Services
- Emotional Violence Victimization
- Sexual Behavior
- Sexual Exploitation
- Non-Contact Sexual Violence
- Sexual Abuse Victimization and Services
- Perpetration of Violence/Abuse/Exploitation
- Substance Abuse and Health Questions
- Responding to Sensitive Questions
- Closing Section
Prevalence of Sexual Violence Prior to Age 18 Reported by Females and Males 18-24 Years of Age in Five VACS Country Sites

Five Country Comparison

- **Swaziland**: 37.8
- **Tanzania**: Females - 27.2, Males - 11.6
- **Kenya**: Females - 31.9, Males - 17.5
- **Zimbabwe**: Females - 32.5, Males - 8.9
- **Haiti**: Females - 25.7, Males - 21.2

*Only girls interviewed in Swaziland*
Prevalence of Physical Violence By Adult Household Members or Authority Figures Prior to Age 18 Reported by Females and Males 18-24 Years of Age in Four VACS Country Sites

Four Country Comparison

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<th>Country</th>
<th>Females</th>
<th>Males</th>
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<tbody>
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<td>73.5</td>
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*Only girls interviewed in Swaziland*
Prevalence of Emotional Violence Prior to Age 18
Reported by Females and Males 18-24 Years of Age
in Four VACS Country Sites

Four Country Comparison

Tanzania | Kenya | Zimbabwe | Haiti

Females:
23.6 | 25.8 | 29 | 34.6
Males:
27.5 | 31.9 | 39.2 | 27.2

*Only girls interviewed in Swaziland
Association Between Childhood Sexual Violence and Selected Health Conditions, Females 13–24 Years Old, Swaziland, 2007

Adjusted odds ratio * Adjusted for age, community setting, SES, and orphan status

- HIV/STDs: 3.7
- Pregnancy Complications: 3.5
- Alcohol Use: 3.0
- Unwanted Pregnancy: 2.9
- Suicidal Ideation: 2.3
- Feeling Depressed: 2.3
- Attempted Suicide: 2.0
- Difficulty Sleeping: 1.8
- Cigarette Use: 1.2


SES, Socioeconomic status STDs, Sexually transmitted diseases
None or Infrequent Condom Use in the Previous 12 Months by Experiences of Childhood Sexual Violence - As Reported by 19-24 Year Olds Who Ever Had Sex, Tanzania 2009

Disclosure and Service Usage by Victims of Child Sexual Violence, Tanzania, 2009

- **Girls**
  - Told someone about sexual violence: 52.3%
  - Sought services for sexual violence: 22.0%
  - Received services for sexual violence: 13.0%

- **Boys**
  - Told someone about sexual violence: 31.4%
  - Sought services for sexual violence: 11.5%
  - Received services for sexual violence: 3.7%*

* Estimate is unstable

Prevalence of Sexual Violence Prior to Age 18 Reported by Females and Males 13-24 by Camp Status, Haiti, 2012

Any Sexual Violence Post Quake in Haiti

- Females: 34.7% (Camp) vs. 21.6% (Non-Camp)
- Males: 24.3% (Camp) vs. 19.6% (Non-Camp)
VACS Data as a Catalyst for Action

- Guides action
- Advocacy tool
- Breaks the silence
- Creates a new conversation
Protection for sexual offense victims in Swaziland

By Jabulile Phakathi

MBABANE, Swaziland, 30 December 2008 – In response to concern about the alarming rates of violence against children documented in a 2007 national study conducted by UNICEF and the US Centers for Disease Control, Swaziland has established its first Sexual Offences Unit for children and young people.

Swaziland’s Chief Justice, Richard Banda, cuts the ribbon to open the country’s first Sexual Offences Unit. Witnessing are (from left): Justice Monakgeng, UNICEF Representative Dr. Jama Gulaid and Ministry of Justice and Constitutional Affairs Principal Secretary Sicelo Dlamini.

Housed in the Magistrate’s Court, the unit has a child-friendly interview room, offices for five prosecutors and a resource centre for staff.
VACS Data as a Catalyst for Action in Swaziland

**Examples**
- National education campaign
- Weekly children’s radio program

**Examples**
- Every police station has trained officers
- First shelter established for survivors
- First counselling center established
- First child-friendly court established

**Examples**
- Sexual Offenses Bill
- Child Welfare Bill
- Gender, children’s and education policies strengthened
Tanzanian Multi-Sector Task Force: A National Response to Violence Against Children

- Comprehensive child protection response
  - Education
  - Social Welfare
  - Legal and Justice
  - Public Health
  - Community

- State and Civil Society Partnerships
- Local Government Service Delivery
- Public Awareness Campaign
Zimbabwe Protocol on Management of Sexual Abuse and Violence

Protocol on the Multi-Sectoral Management of Sexual Abuse and Violence in Zimbabwe

2012

Led by the Judicial Service Commission
Preventing Violence Against Children Changes the Paradigm

Moving from a Vision of Surviving
to
a Vision of Surviving and Thriving
For more information

Visit CDC’s National Center for Injury Prevention and Control web site:

www.cdc.gov/ncipc
The findings and conclusions of this presentation have not been formally disseminated by the Centers for Disease Control and Prevention and should not be construed to represent any agency determination or policy.