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Preventing Sexual Violence and HIV in Children

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Abstract

Background—Evidence linking violence against women and HIV has grown, including on the cycle of violence and the links between violence against children and women. To create an effective response to the HIV epidemic, it is key to prevent sexual violence against children and intimate partner violence (IPV) against adolescent girls.

Methods—Authors analyzed data from national household surveys on violence against children undertaken by governments in Swaziland, Tanzania, Kenya, and Zimbabwe, with support of the Together for Girls initiative, as well as an analysis of evidence on effective programmes.

Results—Data show that sexual and physical violence in childhood are linked to negative health outcomes, including increased sexual risk taking (eg, inconsistent condom use and increased number of sexual partners), and that girls begin experiencing IPV (emotional, physical, and sexual) during adolescence. Evidence on effective programmes addressing childhood sexual violence is growing. Key interventions focus on increasing knowledge among children and caregivers by addressing attitudes and practices around violence, including dating relationships. Programmes also seek to build awareness of services available for children who experience violence.

Discussion—Findings include incorporating attention to children into HIV and violence programmes directed to adults; increased coordination and leveraging of resources between these programmes; test transferability of programmes in low- and middle-income countries; and invest in data collection and robust evaluations of interventions to prevent sexual violence and IPV among children.

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Conclusions—This article contributes to a growing body of evidence on the prevention of sexual violence and HIV in children.

Keywords

violence against children; sexual abuse and exploitation; intimate partner violence; HIV prevention

LINKS BETWEEN SEXUAL VIOLENCE, INTIMATE PARTNER VIOLENCE, AND HIV OUTCOMES

Addressing violence against women and gender equality were identified by UNAIDS in the AIDS Investment Framework as critical for an effective response to the HIV epidemic (children are defined as girls and boys from birth to their 18th birthday as defined by the Convention on the Rights of the Child).[1] The link between sexual and physical violence against women and girls and HIV acquisition is well supported, with evidence across multiple studies demonstrating associations that are strong, largely consistent, graded, and biologically plausible.[2–5] A systematic review and meta-analysis of studies across different HIV epidemic settings shows that intimate partner violence (IPV) poses a 1.52-fold increase in risk of HIV among women.[6] Analysis of data from a longitudinal HIV study (from 2001 to 2009) in Uganda shows that women (aged 15–49 years) who had experienced IPV (physical and/or sexual and/or verbal) were 1.55 times more likely to subsequently acquire HIV than those who had never experienced it. The study estimated that 22% of new HIV infections could be attributed to IPV.[7] In a longitudinal study in South Africa, young women (aged 15–24 years) who reported multiple episodes of IPV were 1.51 times more likely to acquire HIV compared with women with 1 or no episodes of IPV. Women who scored low on a self-reported gender equity scale were 1.51 times more likely to subsequently acquire HIV compared with all other women. The study estimated that 12% of new HIV infections could be attributed to IPV.[3] In a cross-sectional study of 28,000 married women (aged 15–49 years) in India, those who had experienced both physical and sexual violence from intimate partners were nearly 4 times more likely to be HIV positive than those who had experienced no violence.[8,9]

Although studies showing a link between violence against women and HIV include populations aged 15–49 years, most research does not present adolescent-specific findings, and data on younger children are generally unavailable. However, we do know that like violence against women, violence against children is pervasive. Girls, especially as they enter adolescence, are particularly vulnerable to sexual violence, including by strangers and intimate partners, due to their age and gender.[10] In a global meta-analysis of child sexual abuse studies, it was estimated that worldwide, about 18% of girls and 7% of boys are exposed to sexual abuse during childhood.[11] Sexual violence occurs in many settings, including those where children should be safe and nurtured—at home, en route to and from and in schools, in their immediate communities, or in situations of displacement.[10]

Children’s vulnerability to sexual and physical violence is further exacerbated when additional factors of social tolerance of violence, exclusion, and discrimination intersect, such as those based on race, ethnicity, disability, and socioeconomic status. Vulnerability

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increases with limited educational and employment opportunities for girls, family disintegration, and weak legal and policy frameworks and enforcement, resulting in impunity to perpetrate violence and inadequate protection of children.[10]

Experiencing physical or sexual violence as a child is not isolated from other forms of violence experienced across the lifespan. It may co-occur with or contribute as a risk factor to other forms of violence, including sexual violence and IPV.[12] For example, exposure to violence during childhood can increase the risk of experiencing or perpetrating violence later in life.[13,14] In an assessment of reproductive health surveys in 6 countries in Latin America and the Caribbean, it was found that the proportion of women ever married or in a union that reported physical or sexual violence by a partner was more than twice as high for women who had experienced sexual or physical abuse in childhood as those who had not.[15]

According to a recent summary of evidence prepared by the World Health Organization,[5] the relationship between violence against women (in particular sexual violence and any form of IPV) and HIV can be explained through:

- Direct pathways: becoming infected with HIV as a result of rape.
- Indirect pathways: this includes a variety of consequences related to experiencing violence that then lead to HIV infection. These include: (1) psychological distress (eg, depression, anxiety, alcohol, and drug use); (2) increased likelihood of engaging in risk-taking behaviors that are associated with HIV (eg, transactional sex, early sexual initiation, having multiple sexual partners, or unprotected anal sex); (3) reduced access to HIV services and information (eg, due to stigma, limited knowledge, fear, or repercussion); (4) reduced protective factors (eg, reduced condom use, lack of power in negotiating sex, and condom use); and (5) clustering of risk among men who perpetrate violence (eg, multiple and concurrent partners, less condom use, and increased alcohol abuse).
- Common risk factors: certain risk factors, such as gender inequality, underlie both HIV transmission and sexual violence and IPV. Evidence suggests that multiple factors, operating at different levels, are associated with women's risk of IPV and HIV. For example, studies suggest that women who are exposed to violence in childhood (eg, witnessing parental violence, experiencing childhood abuse) or those who make an early sexual debut (often coerced) are at increased risk of both IPV and HIV later in life.[16–20]
- Violence as a result of HIV: This includes any kind of violence that results from being HIV infected (eg, disclosing one's status to a partner and experiencing violence as a result).

Regardless of the pathway, addressing sexual violence and any form of IPV against women has important implications for HIV prevention, treatment, care, and support. Emerging evidence indicates that similar pathways exist between sexual and/or IPV against children and HIV outcomes, and that violence against children and violence against women are

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linked. The next section in this article seeks to outline these links using recent data from 4 countries.

MEASURING THE PROBLEM: SEXUAL VIOLENCE AND IPV START EARLY IN LIFE

Findings that a substantial proportion of girls and boys are exposed to sexual violence are emerging from the Violence Against Children Survey (VACS)—a national household survey undertaken by governments in 9 countries and continuing in others, with support of partners of the Together for Girls initiative.[21] Data from the VACSs reveal that approximately 27%–38% of females had experienced sexual violence before age 18 years, and well over half of them had experienced more than 1 incident. Between 24% and 53% of females reported that their first sexual intercourse before the age of 18 was unwanted.[22–25]

While women and girls are most affected by sexual violence, boys are also vulnerable. This is clearly shown by the VACS data—between 7% and 18% of males reported that their first sexual intercourse before the age of 18 was unwanted, and approximately 9%–18% of males reported having experienced sexual violence before the age of 18.[23–25] In addition to suffering from physical, mental health, and social consequences, data suggest that for some boys, the experience of childhood sexual abuse increases the risk that they will perpetrate violence later in life (Figs. 1, 2).[26]

Furthermore, the VACS data confirm what has already been demonstrated in a variety of studies: most of the violence against women and girls is perpetrated by someone close to them, or someone whom they trust, such as a family member or intimate partner.[10] For example, the VACS data demonstrate that for a large proportion of girls, their first experience of sexual violence before the age of 18 was perpetrated by an intimate partner. VACS data show that 42.7% of boys in Kenya, and 26.7% of boys in Zimbabwe also reported that their first experience of sexual violence before the age of 18 was perpetrated by an intimate partner.[24,25] Secondary analyses is underway to better understand the characteristics of perpetrators (eg, sex, age), and further research is needed to understand the relation between experiencing IPV and HIV risk for boys and men (Fig. 3).

The VACS data also indicate an association between exposure to sexual violence and engaging in HIV risk behaviors. In Tanzania, the act of engaging in sex with 2 or more partners in the previous 12 months was significantly higher ($P < 0.05$) among females and males aged 19–24 years with a history of childhood sexual violence than those without. Infrequent or no condom use in the previous 12 months was significantly more common among females and males aged 19–24 years with a history of childhood sexual violence than those without ($P < 0.05$) (Figs. 4, 5).[23]

Worldwide, evidence shows that children are often vulnerable to multiple forms of violence. The VACS data confirm this. Over 80% of Tanzanian girls and boys who experienced sexual violence as a child also experienced physical violence, and more than 4 in 10 females and 1 in 2 males also experienced emotional violence.[23] Additionally, many children witness violence in their homes. Each year, it is estimated that between 133 million and 275 million

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children witness episodes of violent behavior between their parents.[10] However, much of the violence experienced by children is hidden as children and their families do not report it to official authorities or service providers due to stigma, discrimination, lack of trust in authorities, and availability of reporting mechanisms and services.[10]

Data from the VACS show that for low- and middle-income countries (LMICs), disclosure rates are particularly low. For example, in Zimbabwe, among 18–24 year-olds, only about 3% of females and slightly above 2% of males who experienced sexual violence as a child received professional help.[25] In Swaziland, over 60% of females reporting having experienced sexual violence indicated that they would have liked help, but felt services were not available.[27] Discrimination and stigma, combined with limited access to services, result in a cascade of poor care: few children disclose abuse, fewer still seek services and report to the authorities, virtually no children actually receive services and perpetrators rarely suffer consequences.

PREVENTING AND RESPONDING TO SEXUAL VIOLENCE AND IPV AMONG CHILDREN: EXISTING EVIDENCE FOR EFFECTIVE PROGRAMMING

Over the past 2 decades, important progress has been made in protecting children from different forms of violence. With the entry into force of the Convention on the Rights of the Child and its Optional Protocols,[28–30] and the recommendations of the World Report on Violence Against Children,[10] a solid normative framework and road map for action is in place.

The growing recognition of this problem at the international level is reflected in national political agendas. In 2013, approximately 90 countries responding to a global survey, reported having a legal prohibition on violence against children and sexual exploitation.[31] Legal reform with awareness campaigns have proved effective in changing attitudes and practices, although this is a long-term process. For example, in Sweden, corporal punishment of children was banned in 1979, and in combination with a national education campaign, support for corporal punishment among parents decreased from over 50% to barely 10% over a 40-year period. The number of preschool aged children who are hit by caregivers has fallen from over 90% to about 10% in the same time frame.[32] Legal and policy reform has been one of the key government actions in the response to the VACS findings. For example, in Swaziland, following the VAC study, a Children's Policy was adopted in 2009, and the Child Protection and Welfare Act has entered into force.[33,34]

In 2013, more than 80 countries also reported having policies in place to address violence, as compared with only 16 countries in 2006.[31] All countries which have published the VACS results have developed, or are in the process of developing multisectorial action plans to improve prevention and response services. In Tanzania, the 3-year Multi-Sector National Plan of Action to Prevent and Respond to Violence Against Children launched in 2013, sets out priority, budgeted actions with social welfare, justice, interior, planning, finance, health and education sectors, civil society, and religious communities. The Tanzania National AIDS Programs are included in the plan with a number of important actions in both prevention and response. Actions range from ensuring that HIV and AIDS prevention, care, and treatment

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programs target children who experience violence; incorporating attention to VACS in the national HIV/AIDS research agenda and national surveys, and conducting campaigns for VACS prevention in regions with high HIV prevalence.[35]

A recent evidence review of preventative responses to child sexual abuse and exploitation found that social mobilization and education programmes to change attitudes are most common. The review found that these programmes have an impact on attitudes, knowledge and behaviors, yet evidence is not available on their impact on decline in rates of sexual abuse and exploitation.[36]

The initiatives showing promising results have been embedded within broader efforts focusing on HIV prevention and are also challenging gender norms and attitudes contributing to gender-based violence (GBV) and HIV.[18,36] *Stepping Stones* and *Program H/M* are 2 life skills education programmes aiming to improve sexual health and prevent HIV by addressing gender inequality between men and women. Men participating in these programmes have shown greater acceptance of responsibility for domestic work, improved relationships with intimate partners, and lower rates of sexual and physical violence in intimate partner relationships.[18,36–39] While the programmes have been implemented in diverse contexts such as Africa, Asia, Latin America, and Europe, the interventions focus on challenging norms and attitudes among older adolescents, young adults, and adults. It would be important to explore whether these programmes may also be effective in challenging gender norms and attitudes toward children, leading to reduced rates of violence perpetration and victimization, and ultimately, to reduced sexual risk behaviors and HIV acquisition.

Mass media campaigns and “edutainment” programmes, using radio and television programming combined with community mobilization strategies have proven successful in catalyzing dialog at the community level around gender norms, sexuality, HIV, and GBV.[18,36] *Soul City*, which uses television, print booklets, and radio to confront issues of violence and HIV in South Africa and other African countries, has shifted knowledge, individual attitudes, and beliefs, but a reduction in actual rates of domestic violence has not been possible to establish.[18,36,39,40] *Soul Buddyz*, which is an adaptation for children aged 8–14 years focusing on children’s well-being through provision of health information and skills in relation to HIV and sexuality, has been successful in mobilizing children as agents of change in their own lives and that of the community.[41] In Nicaragua, the edutainment programme *Somos Diferentes, Somos Iguales* and *Entre Amigas*, which used television, radio, community-based activities, and training for young people, increased knowledge and fostered dialog among adolescents, particularly girls, around sensitive topics such as violence, HIV prevention, sexual and reproductive rights, homosexuality, and gender equality.[18,42] It is important to review lessons learned from these programmes and conduct more rigorous evaluations to determine whether they also contribute to a decline in rates of violence.

Various prevention programmes have been delivered in schools targeting children. *Child sexual abuse prevention programmes* teach children life skills around safety, protection, boundaries, and where to turn for help. Although some of these programmes show promising results, primarily in high-income countries, evidence of impact on decline in rates

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of sexual abuse varies, and is scant for LMICs.[36] *Sexual and reproductive health education programmes* aim to increase children' s knowledge around sexuality, sexual and reproductive health, HIV, risk and protective behaviors, and gender norms. Programmes have increased knowledge and improved attitudes around these issues, but the results on sexual and reproductive behaviors have been mixed.[36,43]

The school-based programmes that have yielded promising results are *dating violence prevention programmes. Safe Dates* and *Fourth R* are 2 programmes implemented in the United States and Canada, which target middle- and high-school students with the aim to challenge social norms and other factors contributing to IPV, and to increase students' help-seeking behaviors. *Fourth R* has shown a reduction in physical violence and *Safe Dates* a reduction in physical, psychological, and sexual violence, but their effectiveness is yet to be proven in LMICs.[36,44,45] Although schools can be environments where children are exposed to violence, girls who stay in school, especially secondary school, are less likely to acquire HIV, become pregnant or marry early.[46,47] It is important to continue to evaluate the impact of the different types of school-based programmes to determine cost effectiveness and applicability in different contexts. Measures for reaching out-of-school children also need to be explored.

Prevention programmes targeting vulnerable families and parents (eg, disadvantaged, at risk or adolescent parents) with the aim to reduce abuse—such as home visitation programmes and parenting education programmes—have shown positive outcomes in improving parent's child-rearing skills and preventing child maltreatment, mainly in high-income countries. Outcomes in relation to other forms of abuse, including sexual abuse and domestic violence, are unknown and need to be further explored.[36] Relevance to LMICs also need to be further tested. One programme specifically addressing child sexual abuse and GBV is the *Parents/ Families Matters! Program* implemented in the United States and tested in 8 African countries. This is a community-based intervention for parents of 9–12 year-olds that promotes positive parenting practices and effective parent-child communication around issues such as sex, sexuality, HIV prevention, violence, and sexual abuse. Parents participating in this programme significantly increased their knowledge, skills, comfort, and confidence in communication with their adolescents about sexuality and sexual risk reduction.[48] It is critical to continue to measure the effectiveness of this and similar programmes, including possible impact on rates of violence and HIV acquisition, including in different contexts, such as Africa where it is currently in operation.

Improved socioeconomic status is recognized as another effective means to decrease risk factors associated with sexual violence perpetration and victimization and HIV acquisition. Economic empowerment programmes for women and girls, such as micro credit schemes, have yielded positive results with respect to women's and girls' empowerment, reduction in IPV and risk behaviors such as teen pregnancy and early marriage.[49] For example, in South Africa, the IMAGE program, which added a gender and HIV training programme to an existing microfinance initiative, reduced partner violence by 51% over 2 years.[50] This study also suggested that micro finance programmes alone are not effective, but need to be accompanied by efforts to empower women and address gender norms. Conditional cash transfer programmes for girls in Malawi have shown promising results for reducing HIV

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incidence, teen pregnancy, and sexual activity, and improving school attendance—but impact on violence was not evaluated and the evidence on cash transfer programmes impact on violence is mixed.[5,51]

KEY NEXT STEPS

It is clear from the evidence that tackling violence against women and children, particularly sexual violence and IPV, is central to an effective HIV response. The evidence also points to the importance of addressing the cycle of violence early on, in childhood and adolescence, to prevent future victimization and/or perpetration of violence.

Making these linkages is key to capitalize on the many synergies between the early childhood, social welfare, HIV, gender, justice, health, and related sectors. To further strengthen these synergies and ensure an effective response to HIV and violence prevention, key next steps from this review include:

1. Modifying effective programmes focused on adults and young people to also include attention to children: Some of the most effective programmes at addressing sexual violence and IPV are embedded into broader efforts to prevent HIV by addressing gender norms—including norms around violence. Although most of these social mobilization and education efforts have largely targeted young adults and adults, these programmes to challenge gender norms and attitudes among children need to be tested along with the effects on both violence perpetration and victimization.

2. Increased coordination and leveraging of resources: synergies between HIV and child protection programmes are increasingly being explored not only in relation to violence prevention but also in relation to sexual and reproductive health, HIV prevention, treatment, care, and support. By working together, child health, HIV, and child protection programmes can avoid duplication of efforts and maximize impact. For example, it is critical to expand the existing training of health and community workers to improve violence and HIV screening and services.

3. Piloting effective programmes for children to test transferability to LMICs: although the evidence base for effective interventions is scant, this is particularly true in LMICs. Effective approaches developed and evaluated in high-income countries should be implemented and evaluated in LMICs to assess applicability and transferability of interventions from one context to another. For example, school-based programmes specifically targeting adolescents, such as teen dating violence prevention programmes, show particularly promising results in high-income countries. Education programmes targeting parents with young adolescents have also been effective in improving communication between parents and children in high-income countries but the evidence elsewhere on impact is pending.

4. Monitoring and evaluation: research is urgently needed to determine effectiveness of existing programmes and efforts in LMICs. This includes establishing clear indicators to track progress in both HIV and violence

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prevention and programming for children, evaluation of prevention programmes, costing of interventions, and tracking the impact of legislation and policies to prevent and protect children from violence. Greater attention is also needed to assess the economic implications of violence experienced by children, including sexual violence and IPV, both in the short and long term.

Childhood and adolescence offer a unique opportunity to change norms, behaviors, and attitudes related to sexual violence and IPV. Interrupting the cycle of violence early on can lead to a variety of positive health and social outcomes—including those related to HIV prevention, treatment, care, and support.

This article reflects the current state of knowledge and programme experience in this critical area of work—and although important progress has been achieved, much remains to be done, in particular, on building a stronger evidence base and evaluating and reporting on progress to create a robust set of policies and interventions. Given the harm that violence causes to children and society, this is an essential task for the international development community.

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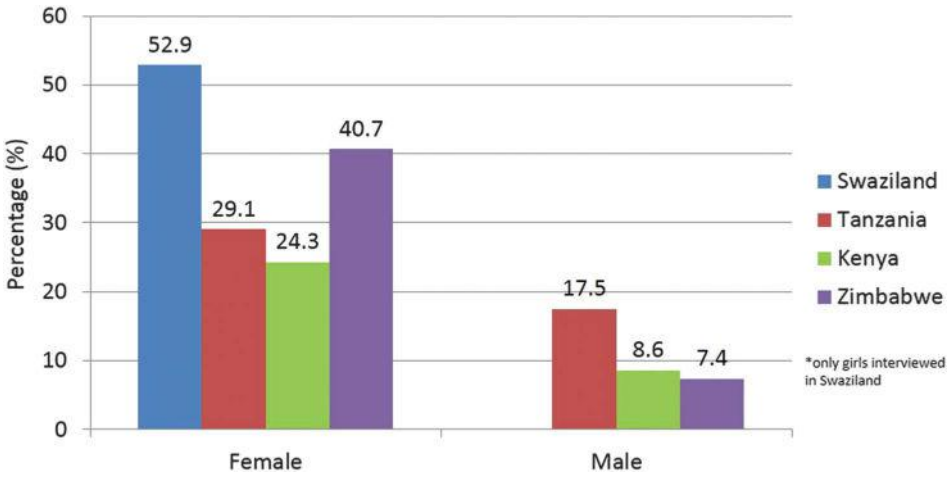

FIGURE 1.

Unwanted first sexual intercourse before age 18 reported by females and males aged 18–24 years in 4 VACS country sites.[22–25]

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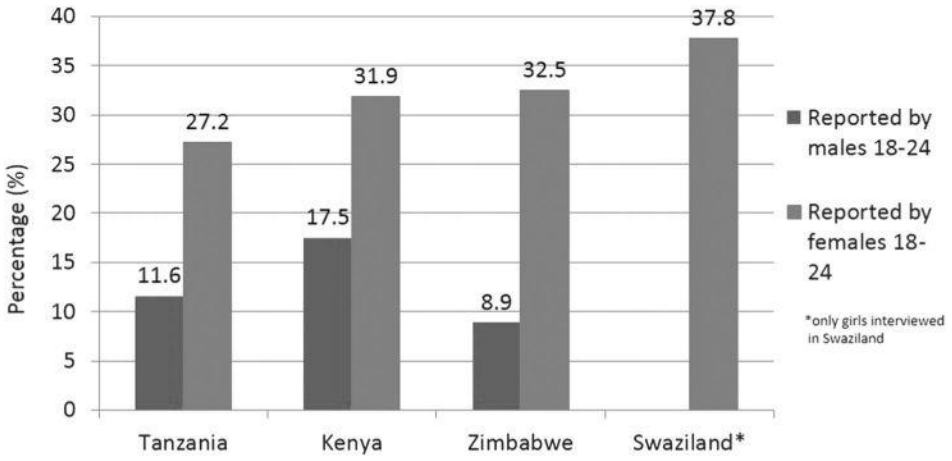

FIGURE 2.

Percentage of individuals who experienced sexual violence before age 18 in 4 VACS country sites.[22–25]

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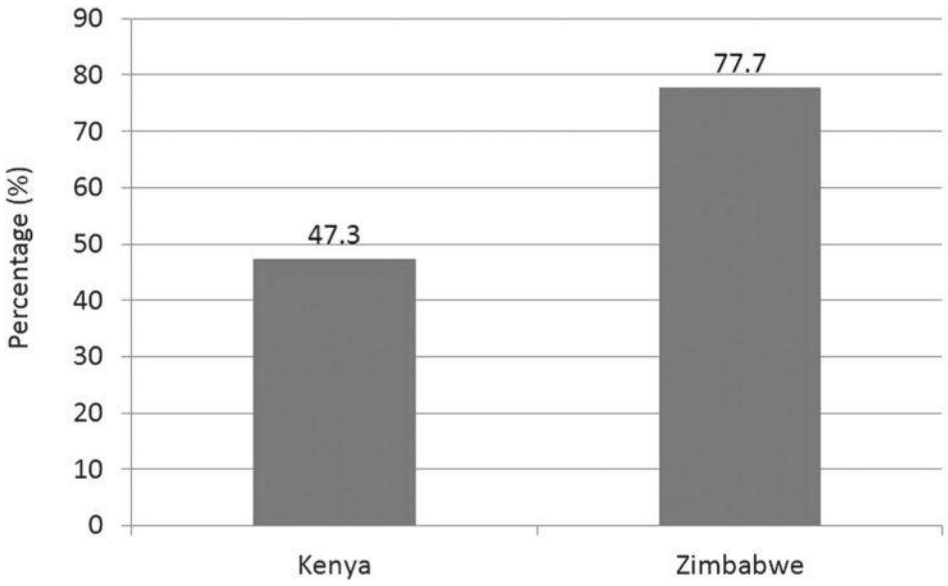

FIGURE 3.

Percentage of females in Kenya and Zimbabwe reporting first sexual violence incident before age 18 was perpetrated by a boyfriend/partner.[24,25]

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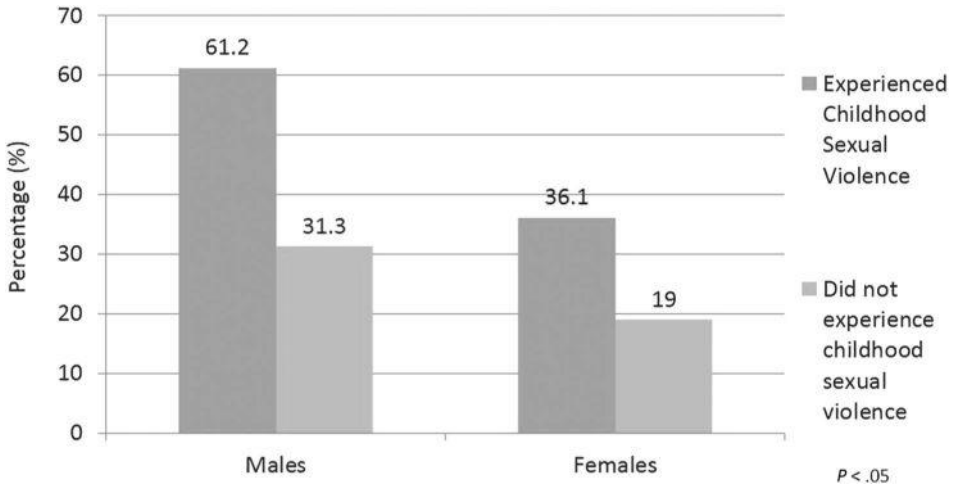

FIGURE 4.

Percentage of individuals in Tanzania who reported multiple sex partners in the previous 12 months, 19–24 year-olds who had ever had sex.[23]

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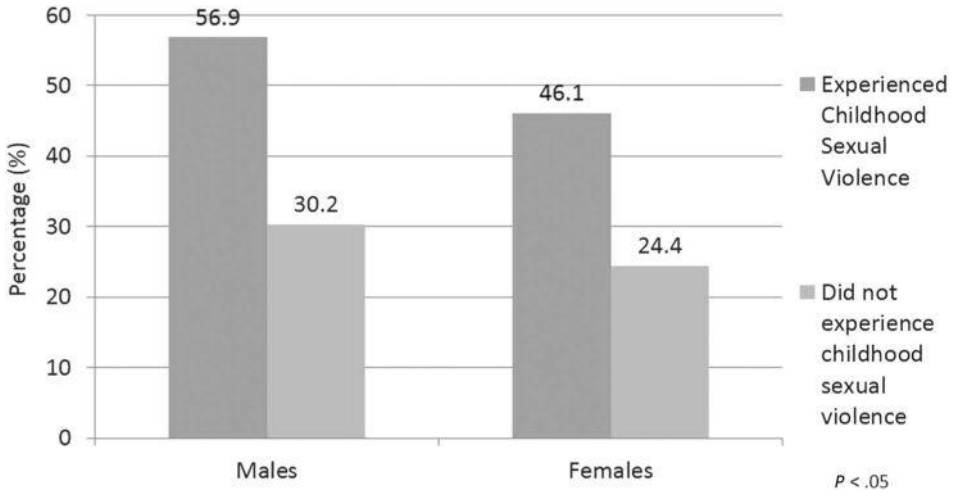

FIGURE 5.

Percentage of individuals in Tanzania who reported no or infrequent condom use in the previous 12 months, 19–24 year-olds who had ever had sex.[23]