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BMJ Paediatrics Open

Global prevalence of childhood sexual violence from 20 countries using the Violence Against Children and Youth Surveys

Journal:	<i>BMJ Paediatrics Open</i>
Manuscript ID	bmjpo-2024-002497
Article Type:	Viewpoint
Date Submitted by the Author:	16-Jan-2024
Complete List of Authors:	Chiang, Laura; CDC, Division of Violence Prevention Miedema, Stephanie; CDC, Division of Violence Prevention Saul, Janet; US Department of State, Bureau of Global Health Security and Diplomacy Mercy, James; CDC, Division of Violence Prevention Brooks, Andrew; UNICEF Eastern and Southern Africa Regional Office Butchart, Alexander; World Health Organization, Prevention of Violence Unit Bachman, Gretchen; USAID Hegle, Jennifer; CDC, Division of Global HIV and TB Ligiero, Daniela; Together for Girls Logan, J.; CDC, Division of Global HIV and TB Masseti, Greta; CDC, National Center for Injury Prevention and Control
Keywords:	Child Abuse, Epidemiology, Statistics

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This work was supported with funding from the U. S. President's Emergency Plan for AIDS Relief (PEPFAR) and the views of the authors do not necessarily reflect those of the U. S. Government or Bureau of Global Health Security and Diplomacy/PEPFAR, the United States Agency for International Development, or the US Centers for Disease Control and Prevention

INTRODUCTION

Violence against children is a pervasive global public health and human rights issue, with one billion children experiencing at least one form of violence annually.¹ Extensive scientific literature shows childhood adversity, including sexual violence, to be directly and indirectly associated with a host of health and social consequences with a dose-response effect, consequential intergenerational impacts, and sizable economic ramifications.² There is a dearth of population data on the prevalence of childhood sexual violence as well as its antecedents and health and social outcomes, which has hampered violence prevention and child protection efforts globally and locally. Population data are critical, alongside administrative data systems and statistical definitions and classification schemes,³ for governments to adequately begin addressing violence against children. The absence of national prevalence data has resulted in limited information to guide national policies and prevention strategies, monitor trends, and evaluate prevention efforts. Globally, lack of data on the epidemiologic patterns of violence against children has resulted in deficient prioritization for preventing and responding to this critical problem.

Violence Against Children and Youth Surveys (VACS) collect comprehensive data on violence and have been implemented in over 23 countries in Africa, Asia, the Caribbean, Europe, and Latin America since 2007. VACS have also been repeated in three countries: Zimbabwe (2011; 2017), Kenya (2010; 2019), and Eswatini (2007; 2022). VACS provide extensive data on the prevalence and contexts of all forms of violence, including sexual violence, therefore allowing for targeted prevention and response efforts. VACS further provide the global research community with data to examine the epidemiologic patterns of childhood sexual violence across countries and regions. This article draws on VACS reports and empirical publications, to summarize and describe patterns in childhood sexual violence across countries that have completed VACS and shed light on the global prevalence of childhood sexual violence.

METHODS

VACS data from 20 countries was used to summarize the prevalence of childhood sexual violence from diverse regions of the world. Both estimates for countries that have repeated VACS are represented in this summary. VACS use a three-stage cluster randomized household sampling design to generate nationally representative estimates of violence against children.⁴ (Nguyen et al., 2016). Interviewer-administered surveys are conducted with male and female youth aged 13-24 years, who provide retrospective reports of lifetime experiences. A standard protocol ensures data comparability across countries and protections for participant safety and confidentiality. Participants in need of help with violence or other adversity are offered services and support.

VACS collects data on physical, emotional, and sexual violence, but this discussion is focused on sexual violence. VACS collect data on four types of sexual violence: 1) unwanted sexual touching; 2) attempted forced sex; 3) forced sex; and 4) pressured sex. Experiences of one or more of these types of sexual violence prior to the age of 18 is defined as any childhood sexual violence.

RESEARCH ETHICS APPROVAL STATEMENT

These studies were all approved by the CDC Institutional Review Board with the IRB ID of IORG0000112. Each country was also reviewed and approved by required local Institutional Review Boards or Ethical Review Committees as required and appropriate for each country.

RESULTS

Data from 20 countries across four continents highlight that childhood sexual violence is a sizable problem, with lifetime prevalence estimates ranging from 4.4% in Cambodia to 37.2% in Eswatini (2007) for females and from 1.1% in Zimbabwe (2017) to 21.2% in Haiti for males (Table S1, Figure S1). The prevalence of childhood sexual violence declined in the three countries where the VACS was repeated. In Eswatini, data were only collected from females in the first VACS therefore a prevalence comparison was only allowable for the female population. The Eswatini results showed that childhood sexual

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3 violence reduced from 32.5% in 2007 to 5.5% in 2022 (Table S1, Figure S1). In Zimbabwe, childhood
4 sexual violence reduced from 37.2% in 2011 to 9.1% in 2017 among girls; and reduced from 8.9% in
5 2011 to 1.1% in 2017 among boys (Table S1). In Kenya, the rate of childhood sexual violence reduced
6 from 31.9% in 2010 to 15.6% in 2018 among girls and reduced from 17.5% in 2010 to 6.4% in 2018
7 among boys (Table S1, Figure S1).
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10 Certain patterns also emerged with respect to contexts for childhood sexual violence. Common
11 perpetrators of childhood sexual violence are people known to the child: intimate partners, friends and
12 classmates, family, and neighbors (results available upon request). Further, childhood sexual violence
13 most often takes place in homes or school (results available upon request). Across all countries, VACS
14 find that many victims of childhood sexual violence do not disclose their experiences to anyone.
15 Disclosure of childhood sexual violence to anyone ranged from 13.8% (Lao PDR) to 72.9% (El Salvador)
16 among females, and from 17.3% (Zimbabwe 2017) to 64.7% (Malawi) among males. A smaller minority
17 of victims try to seek professional services (<0.1%-25.7% among females; <0.1%-32.6% among males)
18 and very few successfully receive any services for their experience/s (less than 5% in most of the
19 countries).
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22 DISCUSSION

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24 Results in this summary provide data from 24 published VACS reports from 20 countries, including three
25 countries that have repeated VACS. This summary provides insight into the global prevalence and
26 patterns of childhood sexual violence. VACS have raised awareness and improved understanding of
27 childhood sexual violence in many countries worldwide, and thereby catalyzed action. After data
28 collection and analysis, findings are disseminated to multi-sectoral partners within countries, including
29 relevant government ministries, civil society, and multi-lateral institutions. These partners provide
30 interpretive context to the results and identify prioritized actions to prevent and respond to childhood
31 sexual violence in a data to action process. Since 2016, *INSPIRE: Seven Strategies to End Violence Against*
32 *Children* (<https://www.who.int/publications/i/item/9789241565356>) has guided interpretation of VACS
33 results and their use in guiding data-driven efforts to address all forms of violence against children,
34 including sexual violence. INSPIRE has served as a framework to link prioritized indicators from VACS to
35 evidence-based prevention and response programs and policies for countries to consider introducing,
36 scaling up or evaluating, depending on their current national strategy.
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41 While VACS cannot tell us why childhood sexual violence declined in all three sub-Saharan African
42 countries that repeated the survey, we do know governments and stakeholders used survey results to
43 guide violence prevention programming and policy. For example, after the 2010 Kenya VACS, the
44 government instituted a new constitution which included articles explicitly protecting children from
45 violence and shortly after passed the Children's Act (2012) and Marriage Act (2014), both of which
46 further expanded legal protections (Annor et al, 2021).⁵ In addition, PEPFAR (The President's Emergency
47 Plan for AIDS Relief) and the Global Fund have made sizable contributions through HIV prevention
48 programming in each of these three countries and integrates violence prevention interventions and
49 post-violence care clinical services. A notable example is the DREAMS initiative that delivers a package
50 of evidence-based programs on key risk factors of HIV among adolescent girls and young women,
51 including sexual violence, and reaches approximately 2.9 million girls and young women each year.⁶
52 VACS data have also informed PEPFAR's investments in strengthening child protection systems through
53 its Orphans and Vulnerable Children programming. VACS results informed the establishment of a
54 national child protection management system in Kenya, the introduction of a child-friendly courtroom in
55 Eswatini, and the scale up of an evidence-based parenting intervention focused on reducing harsh
56 discipline throughout East and Southern Africa (Cluver et al, 2022).⁷
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It is important to consider the impact of UNICEF and WHO as key global health and child protection
leaders as they have expanded their attention to violence, as well as the targeted work of partners such
as Together for Girls who take a data driven focus specifically on childhood sexual violence elimination.
As VACS continue to be implemented globally, and particularly as it is repeated in countries, a clearer
picture may emerge on global trends in childhood sexual violence. Current results show: a pattern of
high prevalence; people who perpetrate are typically known and often trusted by their child victims; and
sexual violence frequently occurs in homes and schools where children should be safest. Further, few
victims of childhood sexual violence receive professional services. Patterns of VACS results continue to
demonstrate the gendered nature of sexual violence against girls and boys and highlight the need for
gender-informed interventions to reduce the risk and mitigate the consequences of childhood sexual
violence for all youth. Continued and regular population-level data collection, such as through VACS, is

critically important for countries to understand the burden, contexts, and consequences of violence against children and youth and to galvanize action.

This summary is subject to several limitations. First, VACS provide cross-sectional data or in countries that have repeated VACS, serial cross-sectional data. The surveys cannot provide information on why childhood sexual violence declined in those three countries where it has been repeated. Second, the VACS are adapted by key partners in each country and there is some variation in wording of questions between countries. Third, VACS are household surveys and do not collect data on children who are institutionalized or otherwise living outside family care. Complimentary research is needed globally and VACS countries to better understand and interpret patterns of childhood sexual violence, what is contributing to the observed reduction in prevalence and conduct research with youth not captured in a household survey who may be even more vulnerable to violence.

CONCLUSION

Sexual violence in childhood is a public health and human rights issue with long-term consequences across the lifetime of the affected individuals as well as consequential societal and economic impacts. VACS have documented the prevalence and epidemiologic patterns across more than 24 countries, providing governments and key child protection partners with critical data that can catalyze multi-sectoral action. The countries that have repeated VACS have seen marked improvement in prevalence of violence, demonstrating that violence is preventable, not inevitable. However, much more work remains, given the high prevalence rates still seen in many countries and to understand the reasons for the declining prevalence of childhood sexual violence that has been observed. Population level surveys with close attention to ethical and methodological rigor, such as VACS, are a critical tool to elucidate the problem and ignite action.

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Table S1. Prevalence, disclosure, and receipt of services of sexual violence before age 18, among 18-24-year-olds, Violence Against Children and Youth Surveys, 2007 - 2022

	Female				Male		
	Childhood sexual violence	Disclosure of childhood sexual violence [^]	Help-seeking for childhood sexual violence	Receipt of help for childhood sexual violence	Childhood sexual violence	Disclosure of childhood sexual violence	Help-seeking for childhood sexual violence
	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)
Eswatini- 2007	33.3 (32.7 - 41.6)	48.0 (40.8 – 55.2)	NA	13.6 (10.6 – 17.4)	-	-	-
Eswatini- 2022	5.5 (4.5-6.5)	66.3 (60.9 – 71.7) [□]	25.7 (20.8 – 30.6) [□]	23.1 (18.4 – 27.8) [□]	2.1 (0.7 – 3.4)*	48.4 (32.9 – 63.8) [□]	**
Kenya- 2010	31.9 (27.0-36.7)	45.9 (38.8 - 53.1)	6.8 (1.3 - 12.3)	3.4 (0.0 - 7.0)	17.5 (12.9-22.0)	35.8 (23.6 - 48.0)	2.1 (0.0 - 4.6)
Kenya- 2018	15.6 (12.5-18.7)	41.3 (31.0 - 51.6)	12.5 (7.4 - 17.7)	10.7 (5.8 - 15.7)	6.4 (2.8-10.0)	26.7 (9.8 - 43.6)*	3.2 (1.6 - 4.7)
Zimbabwe- 2011	32.5 (27.7 - 37.3)	51.8 [†]	4.3 [†]	2.7 [†]	8.9 (6.1 - 11.6)	45.1 [†]	2.4 [†]
Zimbabwe- 2017	9.1 (8.1–10.0)	60.8 (55.7 – 65.9)	17.1 (13.1-21.2)	14.3 (10.4 – 18.1)	1.1 (0.3–2.0)	17.3 (0.0 – 48.1)	**
Tanzania- 2009	26.7 (22.1 - 31.3)	52.3 (41.7 – 62.7) [□]	22.0 (16.0 – 29.5) [□]	13.0 (7.7 – 21.2) [□]	11.6 (8.0 - 15.2)	31.4 (21.8 – 42.8) [□]	11.5 (6.7 – 19.0)
Haiti- 2012	25.7 (21.8 - 29.6)	57.0 (48.3 – 65.7)	NP	NP	21.2 (17.1 - 25.3)	37.4 (28.1 – 46.7)	NP
Malawi- 2013	21.8 (17.7 - 25.9)	61.2 (51.3-71.2)	9.6 (0.0 – 23.5)	9.0 (0.0 – 22.8)	14.8 (10.2 - 19.5)	64.7 (50.7 – 78.7)	5.9 (0.0 – 11.0)
Cambodia- 2013	4.4 (2.5 - 6.3)	50.6 (32.4 – 68.9)	38.9 (19.4 – 58.4)	NA	5.6 (3.5 - 7.7)	20.6 (5.4 – 35.8)	5.7 (0.0 – 13.0)
Nigeria- 2014	24.8 (21.0 - 28.7)	38.3 (30.5 – 46.1)	5.0 (1.9 – 8.0)	3.5 (1.4 – 5.5)	10.8 (8.7 – 13.0)	26.9 (18.1 – 35.7)	2.6 (0.0 – 5.3)
Zambia- 2014	20.3 (16.4-24.3)	51.6 (41.3 – 62.0)	1.4 (0.0 – 3.2)	7.2 (0.0 – 16.8)	10.0 (6.9-13.0)	51.4 (38.2 – 64.6)	7.2 (0.0 – 16.0)
Lao PDR- 2014	7.3 (4.9-9.8)	13.8 (3.8 – 23.8)	<0.1***	<0.1***	12.0 (8.9-15.1)	46.8 (33.6 – 60.1)	32.6 (19.4 – 45.0)
Uganda- 2015	35.3 (30.4-40.2)	56.5 (49.7 – 63.3)	10.1 (5.5 – 14.6)	7.7 (3.7 – 11.6)	16.5 (14.2-18.7)	52.5 (44.4 – 60.6)	6.4 (3.3 – 9.6)
Botswana- 2016	9.3 (7.5-11.2)	67.8 (57.0 – 78.7)	21.0 (12.7- 29.2)	18.0 (10.2 – 25.9)	5.5 (3.8-7.2)	47.8 (30.6 – 65.0)	2.6 (0.0 – 7.4)
Honduras-2017	16.2 (14.0 - 18.5)	64.2 (57.3 - 71.1)	7.9 (4.1 - 11.6)	5.9 (2.7 - 9.0)	9.9 (8.2 - 11.6)	34.2 (25.8 - 42.6)	4.1 (0.0 - 9.0)
El Salvador- 2018	13.5 (9.5 - 17.5)	72.9 (61.4 - 84.4)	16.3 (7.8 - 24.7)	15.3 (7.6 - 22.9)	2.5 (1.1 - 4.0)	50.7 (29.2 - 72.1)	<0.1***
Colombia- 2018	17.8 (10.0 - 25.6)*	41.5 (23.6 - 59.4)*	7.6 (0.0 - 20.2)*	NA	6.6 (3.1 – 10.1)*	45.2 (25.5 - 64.9)*	1.1 (0.0 - 2.9)
Côte d’Ivoire-2018	6.1 (3.2-9.1)	46.3 (37.2-55.5)	1.0 (0.0 – 3.1)	<0.1***	3.0 (1.2-4.7)	45.7 (35.5-55.8)	2.6 (0.0 – 7.2)
Lesotho- 2018	14.5 (12.4-16.6)	39.3 (33.2 – 45.3)	11.4 (7.8 – 14.9)	8.0 (4.7 – 11.3)	5.0 (2.6-7.3)	23.2 (0.0 – 46.6)	<0.1***
Namibia- 2019	11.8 (9.6 - 14.0)	50.0 (41.9 - 58.2)	10.5 (7.2 - 13.9)	9.7 (6.5 - 12.9)	7.3 (4.7 - 9.9)	31.2 (22.6 - 39.8)	**
Moldova- 2019	14.4 (9.5 - 19.3)	37.1 (17.0 - 57.1)	4.9 (0.1 - 9.7)*	3.6 (0.0 - 7.9)*	5.3 (2.8 - 7.9)	18.0 (3.1 - 33.0)*	3.3 (0.0 - 8.7)
Mozambique- 2019	14.3 (10.8 - 17.8)	32.2 (25.3 - 39.1)	NP	NP	8.4 (5.8 - 11.0)	28.7 (17.1 - 40.3)	NP

NP = Results not published or publicly released

NA = Results not available

*RSE is >30% but less than or equal to 50%, results should be interpreted with caution

**RSE is >50% and estimate is suppressed.

*** When the prevalence of an indicator is zero percent (0.0%), those results are denoted as <0.1% and should be interpreted with caution. It cannot be assumed that the

[^] Disclosure of SV includes childhood and adult exposure to SV if the survivor experienced multiple forms of SV spanning the life course. This is a limitation of this measure.

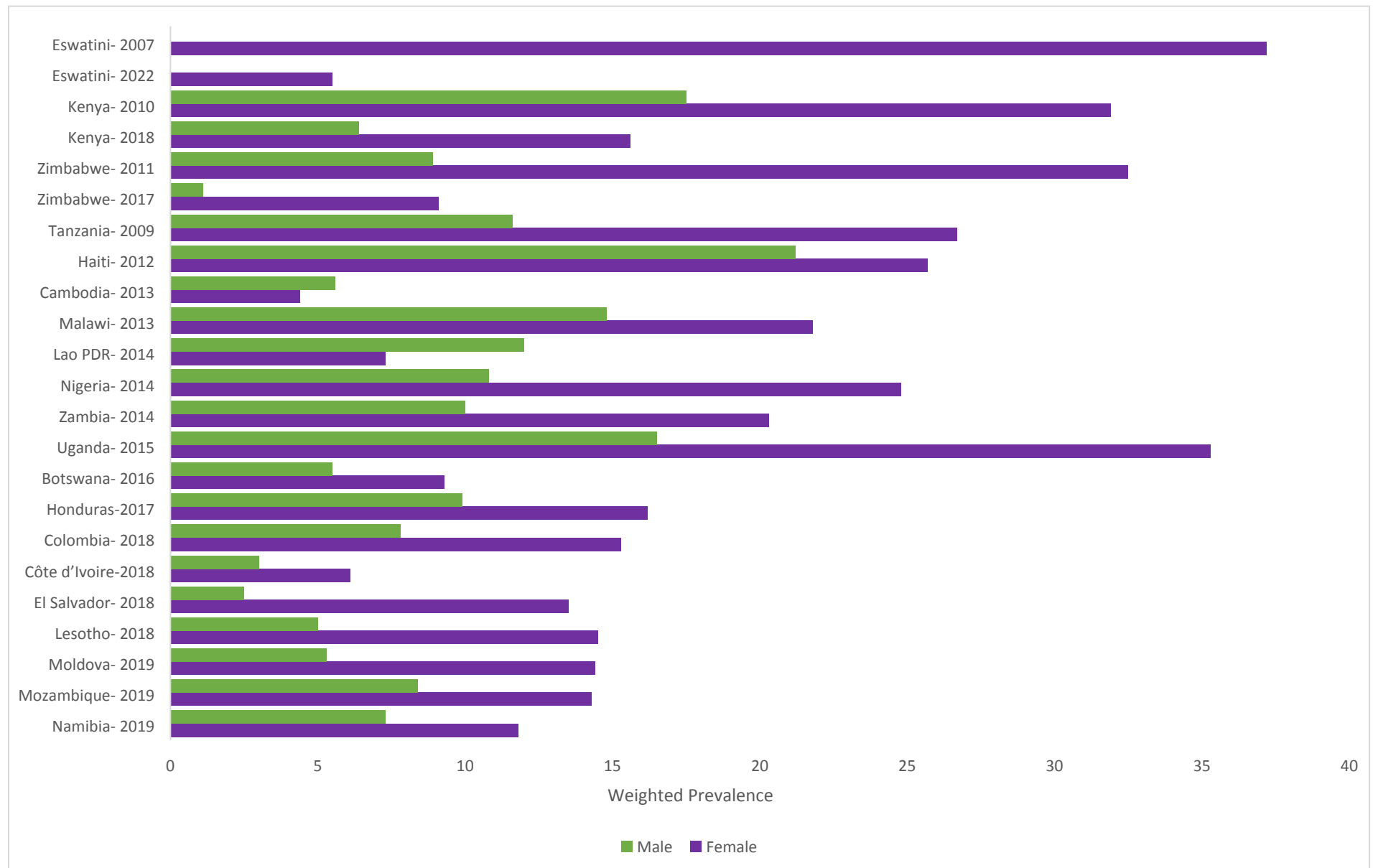
[□] Estimates are among 13–24-year-olds

† Confidence intervals are not reported in 2011 Zimbabwe public report
Data and reports can be accessed at www.togetherforgirls.org

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Figure S1. Weighted prevalence of sexual violence before age 18 among male and female youth 18-24-years-old, Violence Against Children and Youth Surveys, 2007 - 2022



BMJ Paediatrics Open

Successful Child Sexual Violence Prevention Efforts Start with Data: How the Violence Against Children Survey Helped Curb the Tide of Child Sexual Violence in 20 Countries

Journal:	<i>BMJ Paediatrics Open</i>
Manuscript ID	bmjpo-2024-002497.R1
Article Type:	Viewpoint
Date Submitted by the Author:	20-Feb-2024
Complete List of Authors:	Chiang, Laura; CDC, Division of Violence Prevention Miedema, Stephanie; CDC, Division of Violence Prevention Saul, Janet; US Department of State, Bureau of Global Health Security and Diplomacy Mercy, James; CDC, Division of Violence Prevention Brooks, Andrew; UNICEF Eastern and Southern Africa Regional Office Butchart, Alexander; World Health Organization, Prevention of Violence Unit Bachman, Gretchen; USAID Hegle, Jennifer; CDC, Division of Global HIV and TB Ligiero, Daniela; Together for Girls Logan, J.; CDC, Division of Global HIV and TB Masseti, Greta; CDC, National Center for Injury Prevention and Control
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8 *Health Security and Diplomacy/PEPFAR, the United States Agency for International Development, or the*
9 *US Centers for Disease Control and Prevention*

10
11 *Funding: This study did not receive any funding in any form*

12
13 *No competing interest*
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16 17 INTRODUCTION

18
19 Violence against children is a pervasive global public health and human rights issue, with one billion
20 children experiencing at least one form of violence annually [1]. Extensive scientific literature shows
21 childhood adversity, including sexual violence, to be directly and indirectly associated with a host of
22 health and social consequences with a dose-response effect, consequential intergenerational impacts,
23 and sizable economic ramifications [2]. There is a dearth of population data on the prevalence of
24 childhood sexual violence as well as its antecedents and health and social outcomes, which has
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50 METHODS

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VACS collects data on physical, emotional, and sexual violence, but this discussion is focused on sexual
violence. VACS collect data on four types of sexual violence: 1) unwanted sexual touching; 2) attempted
forced sex; 3) forced sex; and 4) pressured sex. Experiences of one or more of these types of sexual
violence prior to the age of 18 is defined as any childhood sexual violence.

RESEARCH ETHICS APPROVAL STATEMENT

These studies were all approved by the CDC Institutional Review Board with the IRB ID of IORG0000112.
Each country was also reviewed and approved by required local Institutional Review Boards or Ethical
Review Committees as required and appropriate for each country.

RESULTS

Data from 20 countries across four continents highlight that childhood sexual violence is a sizable problem, with lifetime prevalence estimates ranging from 4.4% in Cambodia to 37.2% in Eswatini (2007) for females and from 1.1% in Zimbabwe (2017) to 21.2% in Haiti for males (Table S1, Figure S1). The prevalence of childhood sexual violence declined in the three countries where the VACS was repeated. In Eswatini, data were only collected from females in the first VACS therefore a prevalence comparison was only allowable for the female population. The Eswatini results showed that childhood sexual violence reduced from 32.5% in 2007 to 5.5% in 2022 (Table S1, Figure S1). In Zimbabwe, childhood sexual violence reduced from 37.2% in 2011 to 9.1% in 2017 among girls; and reduced from 8.9% in 2011 to 1.1% in 2017 among boys (Table S1). In Kenya, the rate of childhood sexual violence reduced from 31.9% in 2010 to 15.6% in 2018 among girls and reduced from 17.5% in 2010 to 6.4% in 2018 among boys (Table S1, Figure S1).

Certain patterns also emerged with respect to contexts for childhood sexual violence. Common perpetrators of childhood sexual violence are people known to the child: intimate partners, friends and classmates, family, and neighbors (results available upon request). Further, childhood sexual violence most often takes place in homes or school (results available upon request). Across all countries, VACS find that many victims of childhood sexual violence do not disclose their experiences to anyone. Disclosure of childhood sexual violence to anyone ranged from 13.8% (Lao PDR) to 72.9% (El Salvador) among females, and from 17.3% (Zimbabwe 2017) to 64.7% (Malawi) among males. A smaller minority of victims try to seek professional services (<0.1%-25.7% among females; <0.1%-32.6% among males) and very few successfully receive any services for their experience/s (less than 5% in most of the countries).

DISCUSSION

Results in this summary provide data from 24 published VACS reports from 20 countries, including three countries that have repeated VACS. This summary provides insight into the global prevalence and patterns of childhood sexual violence. VACS have raised awareness and improved understanding of childhood sexual violence in many countries worldwide, and thereby catalyzed action. After data collection and analysis, findings are disseminated to multi-sectoral partners within countries, including relevant government ministries, civil society, and multi-lateral institutions. These partners provide interpretive context to the results and identify prioritized actions to prevent and respond to childhood sexual violence in a data to action process. Since 2016, *INSPIRE: Seven Strategies to End Violence Against Children* (<https://www.who.int/publications/i/item/9789241565356>) has guided interpretation of VACS results and their use in guiding data-driven efforts to address all forms of violence against children, including sexual violence. INSPIRE has served as a framework to link prioritized indicators from VACS to evidence-based prevention and response programs and policies for countries to consider introducing, scaling up or evaluating, depending on their current national strategy.

While VACS cannot tell us why childhood sexual violence declined in all three sub-Saharan African countries that repeated the survey, we do know governments and stakeholders used survey results to guide violence prevention programming and policy. For example, after the 2010 Kenya VACS, the government instituted a new constitution which included articles explicitly protecting children from violence and shortly after passed the Children's Act (2012) and Marriage Act (2014), both of which further expanded legal protections [5]. In addition, PEPFAR (The President's Emergency Plan for AIDS Relief) and the Global Fund have made sizable contributions through HIV prevention programming in each of these three countries and integrates violence prevention interventions and post-violence care clinical services. A notable example is the DREAMS initiative that delivers a package of evidence-based programs on key risk factors of HIV among adolescent girls and young women, including sexual violence, and reaches approximately 2.9 million girls and young women each year [6]. VACS data have also informed PEPFAR's investments in strengthening child protection systems through its Orphans and Vulnerable Children programming. VACS results informed the establishment of a national child protection management system in Kenya, the introduction of a child-friendly courtroom in Eswatini, and the scale up of an evidence-based parenting intervention focused on reducing harsh discipline throughout East and Southern Africa [7].

It is important to consider the impact of UNICEF and WHO as key global health and child protection leaders as they have expanded their attention to violence, as well as the targeted work of partners such as Together for Girls who take a data driven focus specifically on childhood sexual violence elimination. As VACS continue to be implemented globally, and particularly as it is repeated in countries, a clearer

picture may emerge on global trends in childhood sexual violence. Current results show: a pattern of high prevalence; people who perpetrate are typically known and often trusted by their child victims; and sexual violence frequently occurs in homes and schools where children should be safest. Further, few victims of childhood sexual violence receive professional services. Patterns of VACS results continue to demonstrate the gendered nature of sexual violence against girls and boys and highlight the need for gender-informed interventions to reduce the risk and mitigate the consequences of childhood sexual violence for all youth. Continued and regular population-level data collection, such as through VACS, is critically important for countries to understand the burden, contexts, and consequences of violence against children and youth and to galvanize action.

This summary is subject to several limitations. First, VACS provide cross-sectional data or in countries that have repeated VACS, serial cross-sectional data. The surveys cannot provide information on why childhood sexual violence declined in those three countries where it has been repeated. Second, the VACS are adapted by key partners in each country and there is some variation in wording of questions between countries. Third, VACS are household surveys and do not collect data on children who are institutionalized or otherwise living outside family care. Complimentary research is needed globally and VACS countries to better understand and interpret patterns of childhood sexual violence, what is contributing to the observed reduction in prevalence and conduct research with youth not captured in a household survey who may be even more vulnerable to violence.

CONCLUSION

Sexual violence in childhood is a public health and human rights issue with long-term consequences across the lifetime of the affected individuals as well as consequential societal and economic impacts. VACS have documented the prevalence and epidemiologic patterns across more than 24 countries, providing governments and key child protection partners with critical data that can catalyze multi-sectoral action. The countries that have repeated VACS have seen marked improvement in prevalence of violence, demonstrating that violence is preventable, not inevitable. VACS have provided countries with baseline data and in so doing, the survey has led to concerted action to improve this public health challenge, as demonstrated by the repeat VACS in Zimbabwe, Kenya and Eswatini. However, much more work remains, given the high prevalence rates still seen in many countries and to understand the reasons for the declining prevalence of childhood sexual violence that has been observed. Population level surveys repeated regularly and with close attention to ethical and methodological rigor, such as VACS, are a critical tool to elucidate the problem and ignite action.

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Figure S1. Weighted prevalence of sexual violence before age 18 among male and female youth 18-24-years-old, Violence Against Children and Youth Surveys, 2007 - 2022

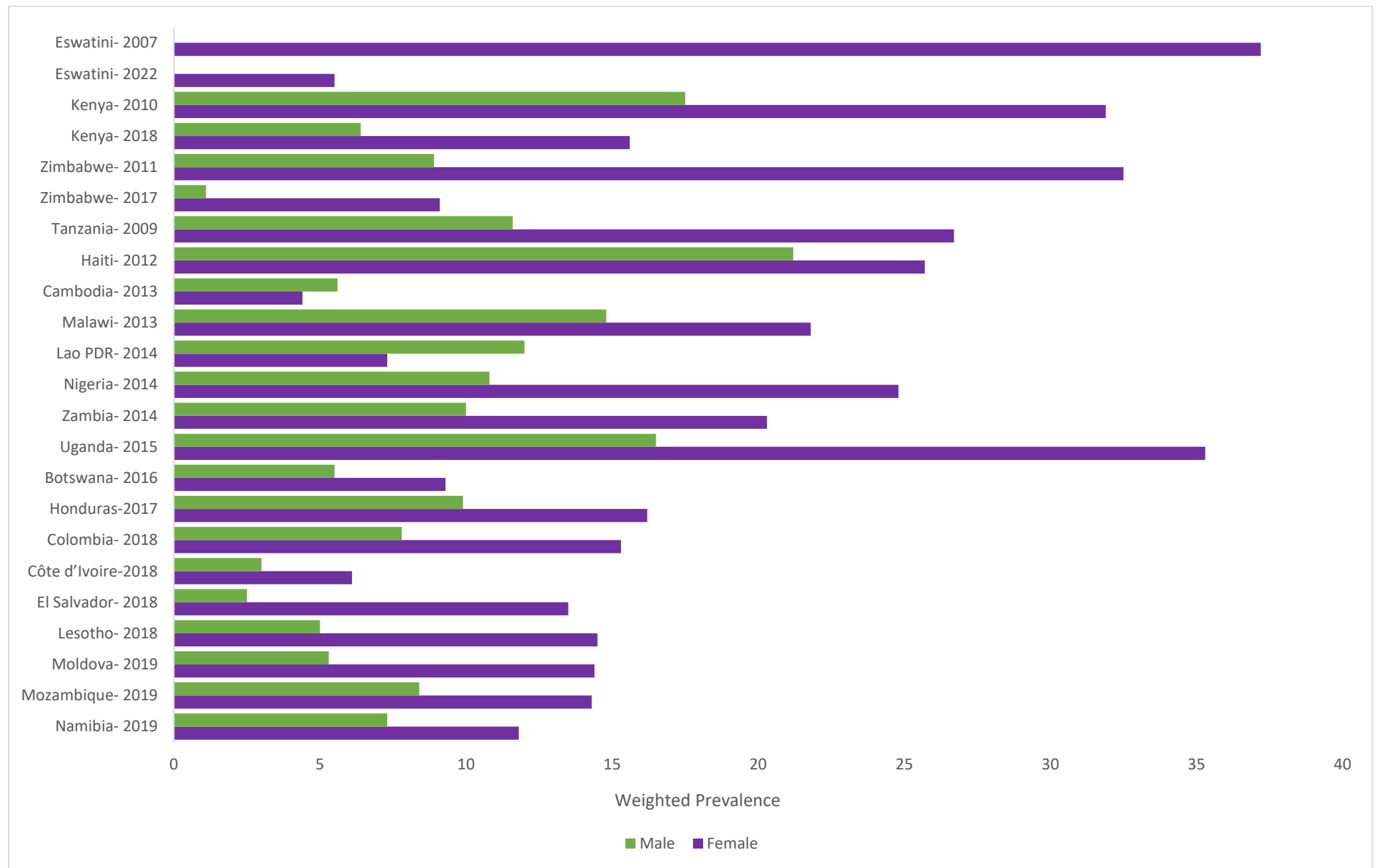


Table S1. Prevalence, disclosure, and receipt of services of sexual violence before age 18, among 18-24-year-olds, Violence Against Children and Youth Surveys, 2007 - 2022

	Female				Male			
	Childhood sexual violence	Disclosure of childhood sexual violence [^]	Help-seeking for childhood sexual violence	Receipt of help for childhood sexual violence	Childhood sexual violence	Disclosure of childhood sexual violence	Help-seeking for childhood sexual violence	Receipt of help for childhood sexual violence
	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)	Weighted % (95% CI)
8 Eswatini- 2007	33.3 (32.7 - 41.6)	48.0 (40.8 - 55.2)	NA	13.6 (10.6 - 17.4)	-	-	-	-
9 Eswatini- 2022	5.5 (4.5-6.5)	66.3 (60.9 - 71.7) ^o	25.7 (20.8 - 30.6) ^o	23.1 (18.4 - 27.8) ^o	2.1 (0.7 - 3.4)*	48.4 (32.9 - 63.8) ^o	**	**
10 Kenya- 2010	31.9 (27.0-36.7)	45.9 (38.8 - 53.1)	6.8 (1.3 - 12.3)	3.4 (0.0 - 7.0)	17.5 (12.9-22.0)	35.8 (23.6 - 48.0)	2.1 (0.0 - 4.6)	0.4 (0.0 - 1.3)
11 Kenya- 2018	15.6 (12.5-18.7)	41.3 (31.0 - 51.6)	12.5 (7.4 - 17.7)	10.7 (5.8 - 15.7)	6.4 (2.8-10.0)	26.7 (9.8 - 43.6)*	3.2 (1.6 - 4.7)	3.2 (1.6 - 4.7)
12 Zimbabwe- 2011	32.5 (27.7 - 37.3)	51.8 [†]	4.3 [†]	2.7 [†]	8.9 (6.1 - 11.6)	45.1 [†]	2.4 [†]	2.4 [†]
13 Zimbabwe- 2017	9.1 (8.1-10.0)	60.8 (55.7 - 65.9)	17.1 (13.1-21.2)	14.3 (10.4 - 18.1)	1.1 (0.3-2.0)	17.3 (0.0 - 48.1)	**	**
14 Tanzania- 2009	26.7 (22.1 - 31.3)	52.3 (41.7 - 62.7) ^o	22.0 (16.0 - 29.5) ^o	13.0 (7.7 - 21.2) ^o	11.6 (8.0 - 15.2)	31.4 (21.8 - 42.8) ^o	11.5 (6.7 - 19.2) ^o	3.7 (1.1-11.2)* ^o
15 Haiti- 2012	25.7 (21.8 - 29.6)	57.0 (48.3 - 65.7)	NP	NP	21.2 (17.1 - 25.3)	37.4 (28.1 - 46.7)	NP	NP
16 Malawi- 2013	21.8 (17.7 - 25.9)	61.2 (51.3-71.2)	9.6 (0.0 - 23.5)	9.0 (0.0 - 22.8)	14.8 (10.2 - 19.5)	64.7 (50.7 - 78.7)	5.9 (0.0 - 11.7)	5.9 (0.0 - 11.7)
17 Cambodia- 2013	4.4 (2.5 - 6.3)	50.6 (32.4 - 68.9)	38.9 (19.4 - 58.4)	NA	5.6 (3.5 - 7.7)	20.6 (5.4 - 35.8)	5.7 (0.0 - 13.8)	NA
18 Nigeria- 2014	24.8 (21.0 - 28.7)	38.3 (30.5 - 46.1)	5.0 (1.9 - 8.0)	3.5 (1.4 - 5.5)	10.8 (8.7 - 13.0)	26.9 (18.1 - 35.7)	2.6 (0.0 - 5.3)	1.5 (0.0 - 3.4)
19 Zambia- 2014	20.3 (16.4-24.3)	51.6 (41.3 - 62.0)	1.4 (0.0 - 3.2)	7.2 (0.0 - 16.8)	10.0 (6.9-13.0)	51.4 (38.2 - 64.6)	7.2 (0.0 - 16.8)	7.2 (0.0 - 16.8)
20 Lao PDR- 2014	7.3 (4.9-9.8)	13.8 (3.8 - 23.8)	<0.1***	<0.1***	12.0 (8.9-15.1)	46.8 (33.6 - 60.1)	32.6 (19.4 - 45.8)	26.2 (14.7 - 37.7)
21 Uganda- 2015	35.3 (30.4-40.2)	56.5 (49.7 - 63.3)	10.1 (5.5 - 14.6)	7.7 (3.7 - 11.6)	16.5 (14.2-18.7)	52.5 (44.4 - 60.6)	6.4 (3.3 - 9.6)	4.6 (1.9 - 7.4)
22 Botswana- 2016	9.3 (7.5-11.2)	67.8 (57.0 - 78.7)	21.0 (12.7- 29.2)	18.0 (10.2 - 25.9)	5.5 (3.8-7.2)	47.8 (30.6 - 65.0)	2.6 (0.0 - 7.4)	2.6 (0.0 - 7.3)
23 Honduras-2017	16.2 (14.0 - 18.5)	64.2 (57.3 - 71.1)	7.9 (4.1 - 11.6)	5.9 (2.7 - 9.0)	9.9 (8.2 - 11.6)	34.2 (25.8 - 42.6)	4.1 (0.0 - 9.0)	0.9 (0.0 - 2.8)*
24 El Salvador- 2018	13.5 (9.5 - 17.5)	72.9 (61.4 - 84.4)	16.3 (7.8 - 24.7)	15.3 (7.6 - 22.9)	2.5 (1.1 - 4.0)	50.7 (29.2 - 72.1)	<0.1***	<0.1***
25 Colombia- 2018	17.8 (10.0 - 25.6)*	41.5 (23.6 - 59.4)*	7.6 (0.0 - 20.2)*	NA	6.6 (3.1 - 10.1)*	45.2 (25.5 - 64.9)*	1.1 (0.0 - 2.9)*	NA
26 Côte d'Ivoire-2018	6.1 (3.2-9.1)	46.3 (37.2-55.5)	1.0 (0.0 - 3.1)	<0.1***	3.0 (1.2-4.7)	45.7 (35.5-55.8)	2.6 (0.0 - 7.2)	2.6 (0.0 - 7.2)
27 Lesotho- 2018	14.5 (12.4-16.6)	39.3 (33.2 - 45.3)	11.4 (7.8 - 14.9)	8.0 (4.7 - 11.3)	5.0 (2.6-7.3)	23.2 (0.0 - 46.6)	<0.1***	<0.1***
28 Namibia- 2019	11.8 (9.6 - 14.0)	50.0 (41.9 - 58.2)	10.5 (7.2 - 13.9)	9.7 (6.5 - 12.9)	7.3 (4.7 - 9.9)	31.2 (22.6 - 39.8)	**	**
29 Moldova- 2019	14.4 (9.5 - 19.3)	37.1 (17.0 - 57.1)	4.9 (0.1 - 9.7)*	3.6 (0.0 - 7.9)*	5.3 (2.8 - 7.9)	18.0 (3.1 - 33.0)*	3.3 (0.0 - 8.7)*	0.7 (0.0 - 2.0)*
30 Mozambique- 2019	14.3 (10.8 - 17.8)	32.2 (25.3 - 39.1)	NP	NP	8.4 (5.8 - 11.0)	28.7 (17.1 - 40.3)	NP	NP

NP = Results not published or publicly released

NA = Results not available

*RSE is >30% but less than or equal to 50%, results should be interpreted with caution

**RSE is >50% and estimate is suppressed.

*** When the prevalence of an indicator is zero percent (0.0%), those results are denoted as <0.1% and should be interpreted with caution. It cannot be assumed that the prevalence of the item in the entire population is an absolute zero.

[^] Disclosure of SV includes childhood and adult exposure to SV if the survivor experienced multiple forms of SV spanning the life course. This is a limitation of this measure.

^o Estimates are among 13-24-year-olds

[†] Confidence intervals are not reported in 2011 Zimbabwe public report

Data and reports can be accessed at www.togetherforgirls.org

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