Article

Sexual Violence Against Female and Male Children in the United Republic of Tanzania

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Abstract

During a household survey in Tanzania, a nationally representative sample of females and males aged 13-24 years reported any experiences of sexual violence that occurred before the age of 18 years. The authors explore the prevalence, circumstances, and health outcomes associated with childhood sexual violence. The results suggest that violence against children in Tanzania is pervasive, with roughly three in 10 females and one in eight males experiencing some form of childhood sexual violence, and its health consequences are severe. Results are being used by the Tanzanian government to implement a National Plan of Action.

Keywords

sexual violence, Tanzania, international, violence against children, health consequences

Introduction

Sexual violence against children is a global human rights and public health issue that impacts emotional, behavioral, psychological, and physical health across the life span

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(Basile & Smith, 2011; Breiding et al., 2011; Jewkes, Sen, & Garcia-Moreno, 2002; Maman, Yamanis, Kouyoumdjian, Watt, & Mbwambo, 2010; Stoltenborgh, van Ijzendoorn, Euser, & Bakermans-Kranenburg, 2011; World Health Organization [WHO], 2006). As of 2006, an estimated 150 million girls and 73 million boys globally under the age of 18 have experienced sexual violence involving physical contact (WHO, 2006).

Violence against children can have a profound impact on core aspects of emotional, behavioral, and physical health and social development throughout life. Short-term impacts of sexual violence include physical injury and emotional trauma (Caspi et al., 2002; Chalk, Gibbons, & Scarupa, 2002; Jewkes et al., 2002) and a range of sexual and reproductive health problems such as unwanted pregnancy, and the transmission of HIV/AIDS, and other sexually transmitted infections (Jewkes et al., 2002). Among adolescents and women, the frequency of pregnancy as a result of rape varies from 5-18%, and younger women who experience rape often have an increased rate of unintended pregnancies (Jewkes et al., 2002).

Situation in Tanzania

The United Republic of Tanzania, a developing East African nation, has a population of approximately 48 million, and approximately 64% of the population is under the age of 24 years (Central Intelligence Agency [CIA], 2013). Tanzania consists of Mainland Tanzania and the archipelago of Zanzibar (CIA, 2013). The nation ranks low on the Human Development Index (HDI), ranking 152nd out of 186 (United Nations Development Programme [UNDP], 2013). The average life expectancy in Tanzania is approximately 60 years (CIA, 2013), which, although low, is 10 years longer than it was in 2008 (United Nations Children's Fund [UNICEF], 2008).

Violence against young women, men, and children is increasingly recognized as an important human rights, health, and social challenge in Tanzania. The unprecedented numbers of orphans and vulnerable children resulting from the AIDS pandemic, combined with the weakening of family and community care structures, increase the risks of violence and exploitation faced by children. Localized data on violence against children in specific areas throughout Tanzania indicate that sexual violence is a serious concern (Lalor & McElvaney, 2010; McCrann, Lalor, & Katabaro, 2006; Stoltenborgh et al., 2011; M. S. Williams, McCloskey, & Larsen, 2008; WHO, 2005; Wubs et al., 2009). According to the WHO Multi-Country Study on Women's Health and Domestic Violence Against Women, up to 11% of women surveyed in Moshi and Dar es Salaam, Tanzania, reported sexual abuse before the age of 15 (WHO, 2005). Another study in northern Tanzania found that 10.9% and 15.3% of females described their first intercourse as being forced or unwanted, respectively (M. S. Williams et al., 2008).

Although these studies have raised awareness about sexual violence in Tanzania, most have been conducted with adults or special populations, and have not focused on children or adolescents, and specifically have not focused on males (Butovskaya, 2012; Jewkes et al., 2002; McAlpine, Henley, Mueller, & Vetter, 2010). As well, extant research often utilizes different definitions and measurements of sexual violence

experienced during childhood (Lalor & McElvaney, 2010; Stoltenborgh et al., 2011), making it difficult to generalize these findings or to get an overall picture of violence against children in Tanzania.

This lack of national information reduces the ability of stakeholders to make informed policy and programmatic decisions. One way to address this gap is to collect national estimates of violence against children through population-based surveys to provide the magnitude and nature of the violence children are experiencing. This information can support efforts to develop effective child-friendly prevention strategies and improve service provision for children who experience violence in Tanzania.

Current Study—National Survey Approach

In 2008, the Multi-Sectoral Task Force (MSTF), which included representation from United Republic of Tanzania government ministries and other nongovernmental partners, was convened in mainland Tanzania and Zanzibar to address the problem of violence against children, with special emphasis on sexual violence. The MSTF initiated efforts to collect the first nationally representative data on violence against both female and male children in Tanzania, as national data were seen as imperative in guiding programmatic action to prevent and respond to violence against children. This study provides, for the first time, national estimates which describe the magnitude and nature of sexual violence experienced by girls and boys in Tanzania.

Method

Participants

A national study was conducted with 13-24-year-old females and males in 2009 using a three-stage cluster household survey design that randomly selected census enumeration areas (EAs), households, and a single eligible respondent within the household. The sampling frame was EAs from the most recent (2002) Tanzania national population census. The sample was stratified by region (mainland Tanzania and Zanzibar) as well as by sex.

The sampling procedure began by selecting 100 EAs from all EAs on mainland Tanzania using a systematic random sample with probability proportional to size. A split sample approach was then implemented whereby 50 EAs were randomly assigned to females and 50 were randomly assigned to males. The survey for females was conducted in different EAs than the survey for males to reduce the chance that perpetrators and victims of sexual violence would be interviewed in the same community. One hundred EAs were also selected from Zanzibar using the same process.[1] Interviews were conducted in 199 of the 200 selected EAs. Weather or security issues prevented data collection in one female EA and interrupted data collection in two male EAs and one female EA. Households in EAs were selected randomly using systematic sampling, and only one respondent was interviewed in each household. If a household had multiple eligible respondents, the Kish (1949) method or a random drawing was used

to select the respondent. If the participant was not available after three attempts, the household was counted as not responding and was not replaced. A detailed description of the survey methodology is provided in the national report (Violence Against Children in Tanzania [TVACS], 2011). Overall, 3,739 interviews were conducted across the four groups: 908 females on mainland Tanzania, 891 males on mainland Tanzania, 1,060 females on Zanzibar, and 880 males on Zanzibar.[2] The overall response rate (household response rate multiplied by individual response rate) was 93.8% for females and males from mainland Tanzania, 92.9% for females from Zanzibar, and 91.9% for males from Zanzibar. The data were weighted to produce nationally representative estimates. Estimates were considered unstable when the relative standard error was greater than 30%.

Measures and Procedure

The survey was retrospective and asked 13-24-year-olds to report on their current and past experiences of violence. Women and men aged 18-24 years were included because they were old enough to assess the prevalence of sexual violence across their full childhood (under 18 years), and young enough for recall bias to have a negligible effect (L. M. Williams, 1994). In addition to questions on sexual violence, the questionnaire included questions on demographics, social support, school, sexual behavior, HIV/AIDS testing, physical and emotional violence, health consequences related to violence victimization, and utilization of social services (Butovskaya, 2012).

The survey was administered in Swahili by Tanzanian enumerators who were trained on the survey content and procedures. The questionnaire was translated from English into Swahili and then back into English. The questionnaire had two components: a short demographic section for the head of household and a comprehensive section administered to the 13-24-year-olds. The questionnaire was developed with standardized and previously tested survey methods (Centers for Disease Control and Prevention [CDC], 2008; Department of Health, 1998; Derogatis, Lipman, Rickels, Uhlenhuth, & Covi, 1974; Eaton et al., 2006; Family Health International, 2000; Jewkes et al., 2006; Knight, Smith, Martin, Lewis, & the LONGSCAN Investigators, 2009; National Bureau of Statistics Tanzania [NBS] & ORC Macro, 2005; Udry, 2003). A version of this survey was used previously in Swaziland (Reza et al., 2009), but adapted with the MSTF and key stakeholders for the unique culture of Tanzania and pilot tested in two EAs not included in the study.

Results for experiences of violence were measured for three time periods: lifetime occurrence, prior to age 18, and in the 12 months prior to the survey. The participants were asked if they experienced any of the four types of sexual violence: forced intercourse, coerced intercourse, attempted unwanted intercourse, and unwanted sexual touching (Box 1). Contextual information, such as the time of the incident, the perpetrator, and type of force was collected on the first and last incident of each of the four types of sexual violence. When reporting contextual information, this article reports the percentage of participants who ever experienced sexual violence in a given context prior to age 18, not the percentage of sexual violence incidents involving a given context.

Box 1. Questions Used to Measure Sexual Violence.

Forced Intercourse: How many times in your life has anyone physically forced you to have sexual intercourse against your will?
Coerced Intercourse: How many times in your life has anyone pressured you to have sexual intercourse against your will and you had sex?
Attempted Unwanted Intercourse: How many times in your life has anyone tried to make you have sex against your will, but sex did not happen? In other words, they did not succeed in making you have sex.
Unwanted Sexual Touching: How many times in your life has anyone touched you in a sexual way against your will, but did not try to force you to have sex? This includes being fondled, pinched, grabbed, or touched inappropriately.
Note. The terms *sex* or *sexual intercourse* were defined as any time someone penetrated a female's vagina or anus, or a male's anus, with their penis, hands, fingers, mouth, or other objects, or penetrating a female's or male's mouth with their penis. Sex also included someone forcing the male's penis into their mouth, vagina, or anus. A female and male version of the questionnaire was adapted to assure appropriateness of questions, definitions, and response options.

Following WHO guidelines on ethics and safety in studies on violence against women (M. S. Williams et al., 2008; WHO, 2001), the survey team presented the survey to the head of the household as a study on health and education of young people, without direct reference to sexual violence, to protect the participants in the event that the head of household was a perpetrator of violence.

Informed consent was obtained for all eligible participants. All interviews were done in private. All participants were offered a list of organizations that specialized in services for victims of violence, and trained psychosocial counselors were on-call for participants who became distressed during the interview. Institutional review boards from the CDC, Muhimbili University, and the Zanzibar Ministry of Health and Social Welfare reviewed and approved the study protocol (TVACS, 2011).

Results

Analytical Approach

The study used SAS (version 9.2) and SAS-callable SUDAAN (version 10) to calculate the prevalence and key information on the context of childhood sexual violence, as well as look at the relationship between health and experiences of childhood sexual violence. Multivariable regression analyses, adjusted for potential confounders (age, community setting, socioeconomic status, religion, and orphan status—the death of at least one parent before the age of 18), were used to assess whether health and childhood sexual violence were associated. Interaction models were not run due to insufficient cell sizes to produce stable estimates.

Findings

The demographic characteristics of the study population, including age breakdown; education, marital, and orphan status; difficulty accessing food in the past 12 months; and religion are presented in Table 1.

Almost three in 10 females and more than one in eight males experienced some form of sexual violence before 18 (Table 2). The most common type of childhood sexual violence reported was unwanted touching followed by attempted unwanted intercourse and coerced sex. About 5% of females reported that they had been physically forced to have intercourse before turning 18 (Table 2).

For females, neighbors, strangers, and dating partners were the most frequently reported perpetrators of at least one incident of childhood sexual violence, whereas dating partners and strangers were the most frequently reported perpetrators of childhood sexual violence against males. The most common places that females and males experienced childhood sexual violence were in their house, the perpetrator's house, or the house of an acquaintance, followed by outdoors or while traveling to/from school or at school (Table 3). A significant percentage of both males (16.6%) and females (37.7%) who experienced childhood sexual violence reported that the perpetrator of at least one incident was 10 or more years older than they were (Table 3).

Of those who reported childhood sexual violence, almost two thirds of females (64.6%) and 50.8% of males reported two or more incidents of sexual violence. For 80.7% of females and 84.4% of males who experienced childhood sexual violence, the first incident of sexual violence occurred when they were 14-17 years of age. Of those who reported childhood sexual violence, 22.0% of females and 11.5% of males sought services (e.g., counseling, health services) and only 13.0% of females and 3.7% (estimate unstable) of males actually received services.

For females, sexual violence was associated with significantly increased probability of having a sexually transmitted disease (STD) diagnosis or symptoms in the previous 12 months, reporting feelings of anxiety and depression in the past 30 days, and recent alcohol use (Table 4). Males who experienced sexual violence were significantly more likely to report having an STD diagnosis or symptoms in the 12 months preceding the survey (Table 5).

Discussion

Tanzania is the first country in sub-Saharan Africa to undertake this type of national study on violence against children that includes both females and males. This survey confirmed that sexual violence is a serious problem, affecting almost three out of 10 females and more than one out of eight males. Also, the finding that more than eight in 10 males and females who experienced childhood sexual violence experienced their first incident between 14-17 years highlights this age period as a critical time to protect children. Swaziland is the only other country in sub-Saharan Africa to conduct a similar national study, but it was limited to females. Notably, females in Tanzania reported being the victim of childhood sexual violence at about the same proportions as females

Table 1. Demographic Data for Females and Males Age 13-24 Years.

Participants (Female *n* = 1,968; male *n* = 1,771)

	Females				Males			
	n	WTD[a] %	95% CI	*N*[b]	*n*	WTD[a] %	95% CI	*N*[b]
Age group								
13-17 years	919	44.7	[40.6, 48.9]	1,968	895	48.8	[43.5, 54.1]	1,771
18-24 years	1,049	55.3	[51.1, 59.4]	1,968	876	51.2	[45.9, 56.5]	1,771
Education								
Ever attended school	1,778	90.4	[85.1, 93.9]	1,967	1,676	95.2	[90.5, 97.6]	1,771
Marriage								
Ever married	462	22.1	[18.2, 26.5]	1,964	83	5.5	[3.6, 8.4]	1,769
Orphan status								
Death of both parents	42	4.7	[3.1, 7.1]	1,946	30	2.3	[1.3, 4.1]	1,761
Death of one parent	316	21.0	[17.8, 24.6]	1,946	277	19.0	[15.3, 23.4]	1,761
Death of at least one parent	358	25.7	[21.9, 29.8]	1,946	307	21.3	[17.2, 26.2]	1,761
Difficulty accessing food in past 12 months								
Never	1,078	53.8	[47.0, 60.4]	1,942	707	37.2	[28.6, 46.7]	1,733
Once in a while	555	29.2	[25.0, 33.9]	1,942	654	40.0	[33.7, 46.6]	1,733
Often	309	17.0	[13.3, 21.4]	1,942	372	22.8	[17.6, 29.0]	1,733
Religion of head of household								
Catholic	303	34.7	[26.4, 44.2]	1,948	260	29.0	[22.0, 37.2]	1,739
Protestant	160	16.2	[11.8, 21.8]	1,948	280	27.7	[20.2, 36.6]	1,739
Muslim	1,380	38.7	[28.1, 50.4]	1,948	1,078	32.6	[21.6, 45.8]	1,739
Other/multiple religions	105	10.4	[6.7, 15.8]	1,948	121	10.7	[6.2, 17.9]	1,739

Note. CI = confidence interval.

[a]WTD% is the percentage after being weighted to reflect national estimates.

[b]Some cases excluded from analysis due to missing data.

Table 2. Prevalence of Sexual Violence (Lifetime or Younger Than 18 Years), Reported by Females and Males Aged 13-24 Years.

	Participants aged 13-24 years, lifetime prevalence								Participants aged 13-24, prevalence under 18 years							
	Females				Males				Females				Males			
	n	WTD[a]%	95% CI	*N*[b]	*n*	WTD[a]%	95% CI	*N*[b]	*n*	WTD[a]%	95% CI	*N*[b]	*n*	WTD[a]%	95% CI	*N*[b]
Any sexual violence	410	34.9	[30.6, 39.6]	1,932	289	21.3	[17.6, 25.4]	1,744	314	27.9	[24.0, 32.2]	1,915	204	13.4	[11.1, 16.1]	1,738
Physically forced intercourse	103	9.6	[7.2, 12.7]	1,958	54	5.1	[3.3, 8.0]	1,758	61	5.5	[3.7, 7.9]	1,956	36	2.2*	[1.2, 4.0]	1,757
Coerced intercourse	65	6.4	[4.9, 8.5]	1,949	40	2.8	[1.6, 4.6]	1,756	35	3.1	[2.0, 4.8]	1,948	28	1.6	[1.0, 2.7]	1,755
Attempted unwanted intercourse	227	18.8	[16.2, 21.8]	1,949	142	11.5	[8.8, 14.9]	1,757	171	14.6	[12.4, 17.0]	1,940	91	6.3	[4.8, 8.2]	1,755
Unwanted touching of participant	229	19.3	[15.9, 23.1]	1,943	184	15.0	[11.7, 19.1]	1,755	180	16.0	[12.9, 19.6]	1,935	129	8.7	[6.7, 11.3]	1,752

Note. CI = confidence interval.

[a]WTD% is the percentage after being weighted to reflect national estimates.

[b]Some cases excluded from analysis due to missing data.

*Estimate is unstable, meaning that the relative standard error was greater than 30%.

Table 3. Description of the First and Last Incident of Childhood Sexual Violence, Reported by Females and Males Aged 13-24 Years Who Experienced Childhood Sexual Violence.

	Females				Males			
	n	WTD[a] %	95% CI	*N*	*n*	WTD[a] %	95% CI	*N*
Perpetrators of sexual violence[b]								
Any relative	28	7.1	[4.1, 11.8]	294	26	14.1	[8.8, 21.9]	194
Dating partner[c]	75	24.7	[18.4, 32.3]	294	107	47.9	[37.9, 58.1]	194
Neighbor	104	32.2	[26.4, 38.6]	294	27	16.6	[10.4, 25.5]	194
Stranger	80	32.0	[24.1, 40.9]	294	34	25.7	[17.0, 36.9]	194
Friend/classmate	28	10.3	[6.2, 16.5]	294	20	8.6[d]	[4.3, 16.4]	194
Authority figure	32	14.7[d]	[7.6, 26.4]	294	7	2.8[d]	[1.2, 6.5]	194
Location of sexual violence[b]								
Someone's house	140	49.0	[41.6, 56.6]	294	97	45.7	[36.5, 55.2]	194
School	41	15.1	[9.4, 23.4]	294	35	13.3	[8.4, 20.4]	194
Traveling to/from school	66	23.0	[16.3, 31.3]	294	23	15.3	[9.2, 24.4]	194
Public building	22	10.0	[6.6, 15.1]	294	9	4.5[d]	[1.3, 14.8]	194
Field/brush/river/roadway	78	24.2	[18.0, 31.9]	294	42	26.7	[18.0, 37.7]	194
Other	12	5.8[d]	[2.7, 11.8]	294	19	6.8[d]	[3.6, 12.7]	194
When the sexual violence occurred[b]								
24:00-07:00	[e]	[e]	[e]	294	[e]	[e]	[e]	194
07:00-12:00	42	11.9	[8.1, 17.2]	294	38	15.4	[9.4, 24.3]	194
12:00-17:00	117	43.4	[35.1, 52.1]	294	66	35.4	[27.9, 43.8]	194
17:00-20:00	110	40.0	[31.3, 49.5]	294	65	36.8	[25.3, 49.9]	194

(continued)

Table 3. (continued)

	Females				Males			
	n	WTD[a] %	95% CI	*N*	*n*	WTD[a] %	95% CI	*N*
20:00-24:00	50	12.3	[8.6, 17.3]	294	36	15.1	[8.7, 25.1]	194
Age differences between perpetrators and victims of sexual violence[b]								
About the same as victim	93	34.1	[27.5, 41.5]	294	95	58.0	[47.4, 67.9]	194
Older than the victim years	215	69.7	[63.0, 75.7]	294	98	45.3	[34.0, 57.2]	194
More than 10 years older than victim	122	37.7	[29.3, 46.8]	294	29	16.6	[9.8, 26.6]	194

Note. Percentages sum to greater than 100% because a person is reporting on up to eight incidents of sexual violence each of which could have a different primary perpetrator. CI = confidence interval.

[a]WTD% is the percentage after being weighted to reflect national estimates.

[b]Analysis of perpetrators of sexual violence was limited to participants who experienced any of the four types of sexual violence before turning 18 years of age. Also, 18-24-year-olds who did not report the age at which the violence occurred on all of their incidents of sexual violence were excluded because it could not be determined for every incident if the sexual violence occurred before the participant turned 18 years of age. This resulted in the analysis including 294 of the 314 female respondents who reported childhood sexual violence and 194 of the 204 males who reported childhood sexual violence. Even when the analysis was limited to this group, some participants did not provide full context information on every incident of childhood sexual violence resulting in the context being unknown for 2-12% of the participants across the contexts. Because the percentage of respondents who did not provide information was more than minimal and not expected to be missing at random, missing cases were included in analyses presented in this subsection.

[c]Reports about sexual violence perpetrated by a spouse are not displayed because (a) only 9% of female respondents and less than 1% of male respondents were married before turning 18 years of age, (b) too few respondents reported spouses as perpetrators (eight females and no males) to generate stable estimates, and (c) it would be unwise to combine spouses with dating partners because they constitute a very distinct group from those who perpetrated in dating relationships.

[d]Estimate is unstable, meaning that the relative standard error was greater than 30%.

[e]Results in cell are not reported because there were five or fewer participants in this cell.

Table 4. Self-Reports of Health-Related Conditions and Behaviors by History of Sexual Violence Victimization Prior to Age 18 Reported by Females Aged 13-24 Years.

Females	No history of sexual violence victimization (n = 1,601)[a]	History of sexual violence victimization (n = 314)[a]	Odds ratio	p value	Adjusted odds ratio[b]	p value
Physical/reproductive health						
Fair/bad general health (n = 1,905)[c]	21.3% [17.3, 26.0] (n = 353)	26.0% [19.1, 34.3] (n = 89)	1.30 (0.91-1.85)	.1456	1.46 (0.98-2.17)	.0615
STD diagnosis/symptoms in last 12 months (n = 1,881)[c]	3.7% [2.5, 5.5] (n = 38)	8.1% [4.9, 13.1] (n = 26)	2.29 (1.12-4.70)	.0221	2.39 (1.13-5.07)	.0213
Mental health						
Anxiety in last 30 days (n = 1,890)[c]	29.5% [25.1, 34.3] (n = 459)	45.4% [36.8, 54.4] (n = 128)	1.99 (1.32-3.00)	.0008	2.26 (1.47-3.47)	.0002
Feelings of depression in last 30 days (n = 1,891)[c]	41.1% [35.2, 47.2] (n = 544)	58.6% [48.4, 68.2] (n = 168)	2.03 (1.34-3.09)	.0008	2.11 (1.30-3.43)	.0021
Ever had suicidal thoughts? (n = 1,905)[c]	6.9% [4.5, 10.4] (n = 76)	11.8% [6.8, 19.6] (n = 29)	1.81 (0.89-3.70)	.0996	1.82 (0.91-3.62)	.0846
Substance use						
Alcohol consumption (n = 1,910)[c]	2.9% [1.8, 4.7] (n = 21)	9.9%[d] [5.1, 18.3] (n = 26)	3.72 (1.78-7.76)	.0004	4.30 (2.06-9.00)	.0000

Note. Data are weighted % [95% CI] (absolute number). STD = sexually transmitted disease; CI = confidence interval.

[a]Absolute numbers do not perfectly correspond to percentages because percentages are weighted and respondents missing information on sexual violence are excluded.

[b]Number of respondents who provided information on the health outcome and childhood sexual violence and consequently were included in the analysis.

[c]Adjusted for age, socioeconomic status, orphan status, and religion. Because of cultural differences between Muslims on mainland Tanzania and Muslims on Zanzibar, these two groups were entered separately into the multivariate analyses.

[d]Estimate is unstable, meaning that the relative standard error was greater than 30%.

Table 5. Self-Reports of Health-Related Conditions and Behaviors by History of Sexual Violence Victimization Prior to Age 18 Reported by Males Aged 13-24 Years.

Males	Never had experiences of sexual violence (n = 1,534)	Had experiences of sexual violence (n = 204)	Odds ratio	p value	Adjusted odds ratio[a]	p value
Physical/reproductive health						
Fair/bad general health (n = 1,721)[b]	25.7% [21.8, 30.0] (n = 330)	30.4% [19.1, 44.7] (n = 71)	1.27 (0.68-2.38)	.4545	1.25 (0.64-2.46)	.5124
STD diagnosis/symptoms in last 12 months (n = 1,695)[b]	4.8% [2.8, 8.4] (n = 38)	8.3% [4.6, 14.4] (n = 23)	1.78 (0.88-3.59)	.1052	2.34 (1.06-5.14)	.0329
Mental health						
Anxiety in last 30 days (n = 1,724)[b]	41.7% [36.4, 47.3] (n = 576)	52.0% [38.4, 65.2] (n = 103)	1.51 (0.90-2.52)	.1107	1.72 (0.98-3.02)	.0543
Feelings of depression in last 30 days (n = 1,726)[b]	47.5% [41.4, 53.7] (n = 645)	57.0% [46.5, 66.8] (n = 113)	1.46 (0.93-2.28)	.0933	1.50 (0.96-2.36)	.0732
Ever had suicidal thoughts? (n = 1,731)[b]	4.5% [3.1, 6.7] (n = 58)	12.7%[c] [5.3, 27.2] (n = 19)**	3.06 (0.92-10.16)	.0643	3.47 (0.93-12.96)	.0615
Substance use						
Drank alcohol in last 30 days (n = 1,728)[b]	7.3% [4.8, 10.8] (n = 72)	11.3%[c] [5.2, 22.8] (n = 17)**	1.62 (0.61-4.27)	.3255	1.53 (0.55-4.23)	.4084

Note. Data are weighted % [95% CI] (absolute number). STD = sexually transmitted disease; CI = confidence interval.

[a]Adjusted for age, socioeconomic status, orphan status, and religion. Because of cultural differences between Muslims on mainland Tanzania and Muslims on Zanzibar, these two groups were entered separately into the multivariate analyses.

[b]Number of respondents who provided information on the health outcome and childhood sexual violence and consequently were included in the analysis.

[c]Absolute numbers do not perfectly correspond to percentages because percentages are weighted and respondents missing information on sexual violence are excluded.

**Estimate is unstable, meaning that the relative standard error was greater than 30%.

in Swaziland on measures of any sexual violence (27.9% in Tanzania and 33.2% in Swaziland) and physically forced intercourse (5.5% in Tanzania and 4.9% in Swaziland; Reza et al., 2009). Similar to Swaziland, dating partners and neighbors accounted for the majority of perpetrators of childhood sexual violence against females in Tanzania (56.9% in Tanzania and 58.5% in Swaziland). In contrast, however, strangers accounted for 32.0% of the perpetrators of childhood sexual violence among females in Tanzania compared with only 13.2% in Swaziland. Among males in Tanzania, the primary perpetrators were dating partners and strangers, together accounting for almost three quarters of the cases.

When girls and boys are looked at together in Tanzania, the proportion of perpetrators who are dating partners is striking, accounting for a quarter of perpetrators against girls and almost half of perpetrators against boys. This pattern is not unique in Sub-Saharan Africa; similar high levels of sexual violence perpetrated by dating partners among both girls and boys has been found in Swaziland, Kenya, and Zimbabwe (Reza et al., 2009; United Nations Children's Fund Kenya Country Office, U.S. CDC and the Kenya National Bureau of Statistics [KNBS]. 2012; Zimbabwe National Statistics Agency [ZIMSTAT], United Nations Children's Fund [UNICEF] and Collaborating Centre for Operational Research and Evaluation [CCORE], 2013). Comparable data on the perpetrators of sexual violence are not readily available for most high-income countries. However, a study in Switzerland confirmed that sexual assaults among teenagers in that culture were also quite common (Schmid, 2012). Romantic relationships and sexual experiences may be hallmarks of adolescence across many cultures. Given that adolescence is an important period of transition and also that many children are raised in family and cultural contexts where partner violence is common, early attention of the risks of sexual violence in the context of dating relationships appears to be very important in Tanzania and elsewhere.

In Tanzania, as has been shown worldwide, exposure to sexual violence as a child was associated with short-term health consequences in females (e.g., STD diagnosis or symptoms, feelings of anxiety and depression, and recent alcohol use) and males (e.g., STD diagnosis or symptoms; Jewkes et al., 2002; Putnam, 2003; Ramiro, Madrid, & Brown, 2010). Reducing the prevalence of violence against children in Tanzania, therefore, has the potential to reduce the incidence and costs of future mental and physical health consequences.

In response to these national study results, the MSTF (2011) agreed on priorities listed in the National Plan of Action to Prevent and Respond to Violence Against Children (2011-2015) to guide prevention and response to violence against children. This national plan includes responses from multiple government sectors, including justice and the police, health, education, HIV/AIDS, social welfare and community development, as well as partnership with nongovernmental, civil society, and international organizations. Given the scarcity of resources, it is critical to build on existing prevention and response initiatives within and across more established structures such as public health, education, and those aimed at addressing well-recognized health problems, such as HIV/AIDS.

The relationship between sexual violence and HIV/AIDS also has important programmatic and policy implications because past research has confirmed that girls

exposed to sexual violence are more likely to engage in HIV-risk behaviors and are at greater risk of HIV infection through direct transmission (Campbell, Baty, Ghandour, Stockman, & Wagman, 2008; Lalor & McElvaney, 2010; M. S. Williams et al., 2008). Sexual violence prevention could be more strongly integrated into existing HIV prevention programming and infrastructure by incorporating violence prevention messaging into routine HIV counseling formats (e.g., antenatal care).

Very few survivors of childhood sexual violence reported receiving services. Children who experience sexual violence are often reluctant to let others know about these experiences for a variety of reasons, including guilt, shame, fear of not being believed, or even being reprimanded for what has occurred. Furthermore, service providers are not always available or equipped to handle cases of sexual violence. Two challenges for strengthening the legal, health, and social response services in Tanzania are overcoming the social pressures that inhibit child survivors of sexual violence from reporting what has happened to them and ensuring that when children do seek services, those services are available and provided with sensitivity and quality of care. UNICEF Tanzania is currently partnered with the Government of Tanzania to build and strengthen the national child protection system with plans for evaluation and national scale-up.

There are a variety of evidence-based preventive interventions that could potentially be adapted to address various dimensions of sexual violence against children in Tanzania (Mercy & Saul, 2009; WHO and the International Society for Prevention of Child Abuse and Neglect, 2006). This evidence base, however, has been primarily established on the basis of research conducted in high-income countries. Consequently, these interventions would need to be adapted to the Tanzanian cultural and socioeconomic context (where poverty and inequalities in access to basic services are widespread) and then evaluated to see whether they work in this new setting. For example, sexual violence perpetrated by dating partners, strangers, and neighbors in Tanzania may be effectively addressed by supporting parents through interventions that educate them about the risks of sexual violence and strengthen the bond and quality of communication between parents and their children. Evidence-based programs promoting positive parenting skills can be effectively applied in low- and middle-income countries to reduce harsh and abusive parenting (Knerr, Gardner, & Cluver, 2013). Reducing harsh and abusive parenting may help to open up channels of communication between parents and their children that may be critical in addressing violence in dating and other relationships. Dating violence programs provide another source of evidence-based programs that could potentially be adapted to Tanzania and other low-resource settings. Two school-based interventions that stand out in this area, Safe Dates and Fourth R, have both been found through experimental design to reduce different forms of dating violence (Foshee et al., 2005; Wolfe et al., 2009). Resources for addressing transactional sex in humanitarian settings provide another source of information that could be applied in Tanzania (United Nations Population Fund, 2009).

The findings of this study are subject to a few limitations. First, these results are based on self-report data, which most likely underestimate the true prevalence of violence against children in Tanzania. Previous research indicates that lack of disclosure is common among sexual violence victims, and can occur for numerous reasons, including

embarrassment or shame and fear of negative reactions from others, especially when the perpetrator was known to them (Ullman, 2002). Second, estimations of the prevalence of childhood sexual violence were based, in part, on participants who were 13-17 years old and had not yet reached their 18th birthday. Thus, some of these participants may still experience sexual violence before turning 18 years old. Third, analyses of the context of sexual violence were limited to the first and last incident of each type of sexual violence experienced by each participant. If a participant experienced more than two incidents of a particular type of sexual violence, the circumstance data of these additional incidents were not collected. The majority of participants experienced fewer than three incidents. Thus, the incident data are complete for 62.1% of females and 75.6% of males who reported childhood sexual violence. Finally, given the cross-sectional nature of this study, temporal order cannot be established between some of the variables (e.g., mental health problems and sexual violence).

Despite these limitations, this study has a number of strengths. The survey was nationally representative with a high response rate among eligible participants, reflecting a strong survey design and rigorous execution. An additional strength of this study is the depth of information collected, notably on the particular circumstances surrounding experiences of sexual violence. Moreover, the involvement of the MSTF in the planning, implementation, interpretation, and response to the survey enhanced the quality, cultural sensitivity, and utility.

The Government of Tanzania, in conjunction with the MSTF, is at the forefront of addressing the problem of sexual violence against children with their efforts to measure the problem and develop and implement a National Plan of Action to Prevent and Respond to Violence Against Children. In addition to laying the groundwork for prevention efforts, this plan will help to ensure that all relevant sectors are willing and able to work together to provide child-friendly protocols and services to survivors of sexual violence, with the ultimate goal of eliminating violence against children in Tanzania.

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Authors' Note

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an earlier version of this article at the Society for Prevention Research Annual Meeting, May 28-31, 2012, San Francisco, California. The findings and conclusions in this manuscript are those of the author(s) and do not necessarily represent the official position of the U.S. Centers for Disease Control and Prevention.

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Notes

1. In Tanzania, it was discovered that three of the selected enumeration areas (EAs) were ineligible for the survey because they were institutions such as prisons or an army base. Because these EAs were ineligible and should not have been included in the sampling frame, they were replaced by randomly selecting an EA in the surrounding district.
2. The number of interviews completed did not meet the initial goal and will result in slightly lower precision than originally estimated. Specifically, 908 females on mainland Tanzania were interviewed versus the goal of 967; 891 males on mainland Tanzania were interviewed versus the goal of 969; 1,060 females on Zanzibar were interviewed versus the goal of 1,011; and 880 males on Zanzibar were interviewed versus the goal of 969.

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