Factors that Protect Children from Violence: Findings from a Community-based Sample of South African Children

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FACTORS THAT PROTECT CHILDREN FROM VIOLENCE: FINDINGS FROM A COMMUNITY-BASED SAMPLE OF SOUTH AFRICAN CHILDREN

A Dissertation
Presented to
the Graduate School of
Clemson University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Philosophy
International Family and Community Studies

by
Nancy Suzanne Falconer
May 2018

Accepted by:
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ABSTRACT

The elevated prevalence of violence polyvictimization in Sub-Saharan communities underscores the need for contextually relevant child protection. Yet research on methods that counter violence is scarce in these settings. Since multi-sectoral methods have shown higher potential than single violence interventions alone, the World Health Organization with 9 partners created the INSPIRE model. INSPIRE utilizes an integrated approach to violence, coordinated across formal and informal settings of civil and private society. This secondary analysis employed a cross-sectional correlational design, consisting of a sample of 2,477 South African children aged 10-17 from the Young Carers 2009-2010 study conducted in a low-income, HIV-endemic province of South Africa. Multiple logistic regressions were used to assess the associations between 4 INSPIRE-based violence prevention strategies (VPSs), both individually and in graded doses, to 9 violence outcomes. Findings showed that individual VPSs had significant negative associations to every violence outcome, with interventions of material supplement at home and at school having the broadest range of lessened likelihood to experiences of violence. These findings confirm research of current Sub-Saharan studies validating social protection as an effective means to ease poverty’s stresses, thereby reducing the likelihood of children’s violence exposure. Combined interventions were associated with amplified protection for children. Importantly, combined interventions evidenced potential strength to counter violence resistant to single interventions. These study findings provide insights for stakeholders seeking effective interventions and combinations that effectively prevent and reduce children’s exposure to violence by addressing the root causes that harm them, their families, and their communities.
DEDICATION

To the children

with personal investment and ongoing prayers for gentler days ahead

They are the reason for these Walden years.

If no one had acted to improve my situation [living in institutional care],

I could still be mingling with rats which was the order of the day,

scabies on me and so much more.

Believe me, as someone who has survived violence,

it never leaves you the same.

The repercussions are grave and damaging.

However, I am not what I went through:

I am the courage that escaped,

the spark that lit the fire as so many child survivors are.

- Ruth Wacuka, Careleaver, Keynote Address at the Africa Expert Consultation on Violence against Children in All Care Settings
ACKNOWLEDGEMENTS

This work incarnates the tenets of the INSPIRE model, that is, collaboration is required across sectoral spheres to accomplish a worthy outcome. As such, this effort has taken a host of committed partners from various parts of the world, all to whom I owe a hefty debt of thanks.

The original Young Carers research team was comprised of the two principal co-investigators, Drs. Caroline Kuo and Lucie Cluver, with Drs. Marisa Casale, Franziska Meinck, and Lorraine Sherr. Without Oxford’s generous bestowal of the original data set, none of this would have been birthed. Dr. Susan Hillis, Dr. Beverly Nyberg, and Dr. Lucie Cluver had substantive roles in the conceptualization and approach to this study. In addition, Drs. Caroline Kuo and Marisa Casale have been faithful guides in this present study. To all, I am not only grateful, but honored by your company in this quest. Your lives and noble work inspire me to follow in your tread of skilled and productive service.

If it takes a village to raise a child, then it takes an academic team to mentor an old scholar. Each of my committee members played her unique role with flair, deserving warm recognition of her involvement in the midst of her own work demands. This intrepid squad of scholars included my co-chairs Susan Limber (unceasingly cheerful) and Martie Thompson (trusty trail guide in the Valley of the Shadow of Statistics), Arelis Moore de Peralta (ever-affectionate Caribbean psychosocial support), Jill McLeigh (insightful child protection redactor) and Beverly Nyberg (not only the expert liaison between the YC team and this study, but a cherished friend from our Bau days when we shared a home and life among Congolese school girls).
Un grand merci to Clemson’s Institute on Family and Neighborhood Life faculty, staff, and students for being the lift under my international research wings, for all those lively discussions in class and over lunch, and above all, for being my South Carolina family who equipped me to join them in studied investment for a more thoughtful world.

Special thanks to Erin & Paul, who opened their home until I acquired my Falcon perch; to the Wednesday Women for weekly encouragement; to Theo, Pat, and Debbie, dear friends who reinforced courage with compassion; and to mellifluous Fred who supplied steadying music and weekly piano puzzlers to untangle my own conundrums.

Fond thoughts to Deborah, who unveiled the span of Cape Town from the scaled heights of Lion’s Head, and who works with brilliance and concern for grieving children in South Africa. At AIDSImpact 2017 we heard Dr. Heidi van Rooyen who encouraged our poetic research inquiry, sharing this voice of countless children lost in analyses’ mire.

Now that you have found my unfaced place
in the census count
and pulled me up as a person,
and thus have heard my heartbeat,
and had a glimpse of the interior of my soul,
How will you deal with living a life
that includes rape, murder, bigotry,
bombs, beatings,
and the stoning to death of children,
among other things that cannot be re-presented
as numbers in a survey?
And if you cannot empathize with these things
slicked up wet by floods of blood and tears,
how will you ever deal honestly
with the enthrallments
and ecstasies of life that erase the pain
reported so dutifully by your local poet?
Am I you?
Can you find yourself in me?
What is my number now?

~ Ivan Brady, 2009
Overflowing affection to my family for their constant support as I have pursued my passions in the wide world. Tender thanks to my father, Jim Stanway (1934-2014), who from earliest memories in the water taught me to swim long with courage despite the roll of waves to the worthy goal on the far shore. Ongoing warm appreciation to Mom with sisters Pam and Kari; to my ever-enthusiastic Aunt Mary Jo; and to the Falcon Nation—my exuberant cheerleaders and merry life companions—J&J the Minnetonka Vikings, ETKTQTs the Coastal Kids, Sweet Song Chantalle, DMO, my All-American Clemson Tiger lunch date, and Just Jack Dandy (2007-2017) for all those walks whether through woods or over water that restored my soul in quiet places.

*Bolingo be mpe koyokana* to my husband Phil for living a bifurcated life during these three intense years, another meander in our lifelong journey of traveling wonder—L’Chaîm!

Above all, unceasing praise to my loving Lord who opened wide this door of opportunity that has led to so many other corridors of collaboration (I Timothy 1:12).
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>TITLE PAGE ..................................................................................................................i</td>
</tr>
<tr>
<td>ABSTRACT ...................................................................................................................ii</td>
</tr>
<tr>
<td>DEDICATION ..................................................................................................................iii</td>
</tr>
<tr>
<td>ACKNOWLEDGMENTS ......................................................................................................iv</td>
</tr>
<tr>
<td>LIST OF TABLES .........................................................................................................ix</td>
</tr>
<tr>
<td>LIST OF FIGURES ........................................................................................................x</td>
</tr>
</tbody>
</table>

## CHAPTER

### I. INTRODUCTION TO THE STUDY .................................................................1

- Background of the Study ..........................................................................................2
- Statement of the Problem .........................................................................................4
- Significance of the Study ........................................................................................5
- Definitions of Terms ...............................................................................................8
- Research Questions and Hypotheses ......................................................................11

### II. REVIEW OF THE LITERATURE ...............................................................15

- The Context of Violence in Africa ........................................................................15
  - High Rates of Child Abuse in Africa ..................................................................15
  - Physical and Emotional Violence ......................................................................17
  - Sexual Violence ..................................................................................................18
  - Community Violence ..........................................................................................20
  - Witnessing Violence ............................................................................................21
  - Polyvictimization ................................................................................................22
  - Risk Factors of Violence ......................................................................................24
- Protecting Children from Violence .......................................................................26
  - International Instruments that Guide the Protection of Children in Africa ..........27
  - INSPIRE’S Seven Strategies ..............................................................................30
- Summary ..................................................................................................................39

### III. RESEARCH DESIGN – METHODS AND PROCEDURES .......................42

- Young Carers Study Method and Protocol ...........................................................42
Table of Contents (Continued)

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research Measures</td>
<td>50</td>
</tr>
<tr>
<td>Approach to Analysis</td>
<td>56</td>
</tr>
<tr>
<td>Threats to Validity</td>
<td>57</td>
</tr>
<tr>
<td>IV. RESULTS</td>
<td>60</td>
</tr>
<tr>
<td>Data Preparation</td>
<td>60</td>
</tr>
<tr>
<td>Research Hypothesis Testing</td>
<td>65</td>
</tr>
<tr>
<td>Summary of Results</td>
<td>93</td>
</tr>
<tr>
<td>V. DISCUSSION</td>
<td>95</td>
</tr>
<tr>
<td>Key Findings</td>
<td>95</td>
</tr>
<tr>
<td>Study Implications</td>
<td>113</td>
</tr>
<tr>
<td>Limitations</td>
<td>117</td>
</tr>
<tr>
<td>Recommendations for Future Research</td>
<td>120</td>
</tr>
<tr>
<td>Conclusion</td>
<td>124</td>
</tr>
<tr>
<td>APPENDICES</td>
<td>127</td>
</tr>
<tr>
<td>A: Violence Prevention Strategies</td>
<td>128</td>
</tr>
<tr>
<td>B: Violence Outcomes</td>
<td>130</td>
</tr>
<tr>
<td>C: International Review Board Approval for Secondary Analysis</td>
<td>132</td>
</tr>
<tr>
<td>D: Authorization to Use the Young Carers Data Set</td>
<td>140</td>
</tr>
<tr>
<td>E: Authorization to Use Ivan Brady’s Untitled Poem</td>
<td>131</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>142</td>
</tr>
</tbody>
</table>
## LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1 Young Carers sample characteristics</td>
<td>62</td>
</tr>
<tr>
<td>4.2 Associations between the VPS of parent and caregiver social support “positive parenting” and violence outcomes, controlling for age, gender, and urbanicity</td>
<td>69</td>
</tr>
<tr>
<td>4.3 Associations between VPS of income and economic strengthening’s “basic necessities” and violence outcomes, controlling for age, gender, and urbanicity</td>
<td>73</td>
</tr>
<tr>
<td>4.4 Associations between the VPS of response and support services’ “formal social support” and violence outcomes, controlling for age, gender, and urbanicity</td>
<td>77</td>
</tr>
<tr>
<td>4.5 Associations between the VPS of education and life skills’ “school structural support” and violence outcomes, controlling for age, gender, and urbanicity</td>
<td>81</td>
</tr>
<tr>
<td>4.6 Cell counts and percentages associated between the number of VPSs and individual violence outcomes</td>
<td>83</td>
</tr>
<tr>
<td>4.7 Associations between the number of VPSs and individual violence outcomes</td>
<td>85</td>
</tr>
<tr>
<td>5.1 Overview of individual associations between VPSs and violence outcomes</td>
<td>105</td>
</tr>
<tr>
<td>5.2 Overview of dose associations between VPSs and violence outcomes</td>
<td>112</td>
</tr>
</tbody>
</table>
# LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>KwaZulu-Natal census districts with municipalities</td>
<td>44</td>
</tr>
<tr>
<td>3.2</td>
<td>Location of Lamontville in the greater Durban area of the eThekwini Municipality</td>
<td>46</td>
</tr>
<tr>
<td>3.3</td>
<td>Location of Manguzi in the uMhlabuyalingana Municipality</td>
<td>48</td>
</tr>
<tr>
<td>4.1</td>
<td>VPS protective factors and significant violence outcomes</td>
<td>92</td>
</tr>
</tbody>
</table>
CHAPTER I

INTRODUCTION TO THE STUDY

_There can be no keener revelation of a society's soul than the way it treats its children._

~ Nelson Mandela

Violence is a pervasive societal ill affecting nearly three out of four—that is, 1.7 billion—of the world’s children yearly (Know Violence in Childhood, 2017). Recent multi-faceted international research exposing the extent and weighty consequences of violence against children has created global attention and engagement to halt this oft-hidden abuse. To accelerate progress on the Sustainable Development Goals’ (UN, n.d.) wide-ranging efforts with its specific Target 16.2 of eliminating violence against children, nine global organizations under the leadership of the World Health Organization created INSPIRE (WHO, 2016). As a comprehensive violence prevention and response strategy of policies, programs, and practices, INSPIRE takes an integrated approach to violence that is coordinated through collaboration across formal and informal settings of civil and private society. Its seven strategies include: (1) Implementation and enforcement of laws; (2) Norms and values, (3) Safe environments; (4) Parent and caregiver support; (5) Income and economic strengthening; (6) Response and support services; and (7) Education and life skills (WHO, 2016). Cross-sectoral methods have shown higher potential for greater impact than single societal sector interventions alone (Hillis, Mercy, & Saul, 2017; WHO, 2016). This study examined whether four INSPIRE-based violence prevention and response strategies (VPSs) – Parent and caregiver support, Income and economic strengthening, Response and support services, and Education and
life skills – were associated with the decreased likelihood of experiencing nine violence exposures (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence) in children aged 10-17, who were originally surveyed in a 2009-2010 South African study. This chapter presents the background of the proposed research study, the statement of the problem, the significance of the study, the definitions of terms, and two research questions with their associated hypotheses.

**Background of the Study**

Emerging research gathered from the extensive Know Violence in Childhood Initiative indicates that nearly three-fourths of the world’s children aged 2-17 experience physical, emotional, or sexual violence every year (Know Violence in Childhood, 2017). Violence refers to a wide-range of destructive behaviors. WHO defines violence as the “intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, which either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation” (2016, p. 14). According to this definition, exposure to violence entails more than acts causing physical harm, with broader consequences than injuries or death. Its scope includes “both communicable and noncommunicable disease, psychological harm, risky behaviors, educational and occupational underachievement and involvement in crime” (WHO, 2016, p. 14). Violence is perpetrated against children by caregivers and other adults, as well as by their peers (Know Violence in Childhood, 2017).
Children experience violence both directly as victims, and indirectly as witnesses of violence (Hillis et al., 2017). Regrettably, exposure to any kind of violence, whether as victims or witnesses, is an adverse childhood experience (ACE; Felitti et al., 1998) that can harm children (Bacchini, Affuso, & Aquilar, 2015). Though childhood victimization is often hidden, the pervasive and costly consequences of violence are revealed through extensive literature documenting its public and mental health, social, and economic immediate and long-term toll on individuals and communities (Anda, Butchart, Felitti, & Brown, 2010; Banyard, Hamby & Grych, 2017; Mathews & Benvenuti, 2014). Sub-Saharan African studies demonstrate that victims of child abuse evidence consistently poorer outcomes in physical and mental health than non-victims (Meinck, Cluver, Boyes, & Loening-Voysey, 2016).

Opposing violence as an acceptable societal norm, the United Nations (UN) sounded a call-to-action as a part of its Post-2015 Sustainable Development Goals (SDGs) to eliminate violence against children in all forms (UN, n.d.; UN Children’s Fund [UNICEF], 2014b). In response, WHO with nine partners—the Centers for Disease Control and Prevention, End Violence Against Children, Pan American Health Organization, the U.S. President’s Emergency Plan for AIDS Relief, Together for girls, UNICEF, United Nation’s Office on Drugs and Crime, USAID, and the World Bank—created INSPIRE. This comprehensive plan’s acrostic highlights its seven strategies for violence prevention and response that cross justice, civic planning, social welfare, health, finance, and education sectors: (1) Implementation and enforcement of laws; (2) Norms
and values, (3) **Safe environments**; (4) **Parent and caregiver support**; (5) **Income and economic strengthening**; (6) **Response and support services**; and (7) **Education and life skills** (WHO, 2016).

**Statement of the Problem**

Although the INSPIRE-based VPSs have proven effective in counteracting violence within high-income countries (WHO, 2016), less is known regarding their efficacy as protective factors against violence exposure in low- and middle-income countries (LMICs) where children bear a disproportionate measure of abuse annually (WHO, 2016). Using cross-sectional data from the 2009-2010 Young Carers study of 2,477 urban and rural children aged 10-17 living in low-income, HIV-endemic communities within the middle income country of South Africa, this study utilized multivariable regression analyses to examine whether four INSPIRE-based VPSs available within the original YC data—parent and caregiver support; income and economic strengthening; response and support services; and education and life skills—are associated individually and collectively with a lower likelihood of experiencing the nine violence outcomes.

The nine outcome measures included the direct experiences of physical, emotional, sexual, and community violence, as well as the indirect experiences of witnessing family violence, and witnessing community violence. Three child social demographic factors—age, gender, and urbanicity—were used as controls in the analyses due to their prior associations to the violence outcomes. Standardized child self-report
measures from the 2009-2010 Young Carers study (Young Carers, 2015) conducted in the KwaZulu-Natal province of South Africa were used as the cross-sectional data for this study analysis.

**Significance of Study**

Though study definitions and measures of violence diverge and are difficult to compare, decades of research attest to the public health, mental, social, and economic immediate impact and long-term intergenerational toll of violence on individuals and communities (Anda et al., 2010; Banyard, Hamby & Grych, 2017; Mathews & Benvenuti, 2014). Regional research shows evidence of particularly high rates of child abuse on the African continent (Know Violence in Childhood, 2017), with reported African rates of child abuse reaching as high as 64%, as opposed to 14% in high-income countries such as the United States (Meinck, Cluver, Boyes, & Mhlongo, 2015b). Correspondingly, South African children experience high levels of overall violence across a broad range of adversities (Foster & Brooks-Gunn, 2015).

In a large South African study \((n=3,515)\) in Mpumalanga and Western Cape, 68% of the children (aged 10-17) stated experiencing at least one type of direct or indirect victimization in their lifetime. Fifty-five percent reported at least one type of violence exposure within the past year. Nearly one-third (32%) of the children indicated experiencing at least one type of violence monthly. Over one-quarter (27%) recounted exposure to two or more forms of violence in their lifetime, citing physical and emotional abuse as the most common co-occurring experiences of violence. Nearly one-fifth
(19.6%) noted more frequent intervals of violence polyvictimization (Meinck et al., 2016).

The enduring trauma arising from polyvictimization is greater than that of repeated violence of a single sort, and is therefore of great concern for LMICs where access to and costs of secondary and tertiary treatment are frequently unattainable by those affected (Samms-Vaughan & Lambert, 2017). Though violence prevention is the primary goal in all countries, prevention is crucial in resource-scarce LMICs, both to protect children’s dignity and to reduce ongoing perpetration from children who grow up to continue the damaging cycle of violence with its multifaceted long-term individual and societal impacts (Samms-Vaughan & Lambert, 2017; Shiva Kumar et al., 2017).

The widespread elevated prevalence of polyvictimization in Sub-Saharan communities underscores the enormous need for adaptive and innovative means of child protection that can prevent and mitigate the damaging physical and psychosocial impact of violence (Cook, Cook, Cohen, Oguniyi, & Sewanou, 2016). Policy creation alone has been inadequate to produce effective implementation (Krueger, Nelems, & Quigley, 2016). In light of the SDGs’ call to eliminate violence against all children (UNICEF, 2014b), international policymakers and practitioners in the child protection sector are searching for all-encompassing prevention measures and broad interventions that strengthen both formal and non-formal systems (Cook et al., 2016; Krueger, Vise-Lewis, Thompstone, & Crispin, 2015). As interpersonal violence spills over from one societal setting to another, INSPIRE’s integrated strategy aims to assist countries and local communities to reach key priorities of the SDGs. This study is important to expand the
base of knowledge concerning effective strategies in LMIC communities where multi-sector implementation research is limited (WHO, 2016).

With this objective in view, the Young Carers study location is a fitting setting for research working towards the elimination of violence against children. The nation of South Africa experiences high levels of overall violence with sobering consequences. Not only are the risks of trauma augmented due to violence polyvictimization, but also recent South African research suggests that living in a high violence community amplifies adolescent HIV risks, along with factors of poverty such as food insecurity and informal housing (Cluver, Orkin, Meinck, Boyes, & Sherr, 2016). AIDS-affected children were similarly shown to be at heightened risk for child maltreatment in Sub-Saharan studies (Cluver, Orkin, Boyes, Gardner, & Meinck, 2011; Meinck, Cluver, & Boyes, 2015a).

Sub-Saharan Africa, the region most affected by the HIV/AIDS pandemic, hosts an estimated 85 million HIV/AIDS-affected children (Meinck et al., 2015a; UNAIDS, 2016). The nation of South Africa has the largest HIV epidemic worldwide, reporting 7.1 million of its residents as HIV-positive, accounting for nearly one-fifth (19.2%) of the global total infections (UNAIDS, 2016). In short, nearly one out of every five people living with HIV/AIDS lives in South Africa.

Sadly, adolescents are among the most vulnerable members in this pandemic. This age group is the only population with increasing rates of infection, with HIV/AIDS being the leading cause of adolescent death in Africa (Davies, Pinto, & Bras, 2015; WHO, 2014). As the South African ties between high violence and increased adolescent HIV-risk have been established (Cluver et al., 2016), effective approaches that prevent
and reduce child violence exposure can benefit this highly affected population and vulnerable region by addressing the primary drivers of health and social well-being (Burton, Ward, Artz, & Leoschut, 2015).

**Definition of Terms**

*Caregiver* refers to a person—whether another child, youth, or an adult (person over the age of 25; UNESCO, 2002)—who takes responsibility for the child’s daily care needs. This person may be biologically related or a member of the child’s family, such as a stepfather, or may be wholly unrelated to the child, such as a neighbor or foster parent.

*Child* designates a person under 18 years of age as per the UN Convention on the Rights of the Child (CRC; UNICEF, 1989).

*Child maltreatment* is defined by the CRC as a child’s *neglect* (failure of caregivers to provide necessary food, clothing, shelter, medical attention, and supervision ensuring child well-being and safety [Meinck et al., 2016]); *abuse* (actions carried out or threatened that potentially or actually harm a child physically, emotionally, or sexually), or *exploitation* (using a child for purposes of power, profit, status, or sexual gratification). In the public health domain, WHO (2006) treats sanctioned cultural practices such as female genital mutilation (FGM), or early marriage as child maltreatment since these traditional customs expose children to long-term harm and potentially predispose them to violence (Shiva Kumar et al., 2017). The terms of maltreatment, abuse and victimization are used interchangeably in this study.
Child protection in this study encompasses the total spectrum of policies and practices that shield children from exposure to violence or mitigate maltreatment’s impact on their lives.

HIV/AIDS-affected designates those persons directly or indirectly touched by the epidemic due to the consequences of HIV infection, whether by the illness of a family member or through the outcome of his or her death. An HIV/AIDS-affected household refers to a home where at least one household member has been infected with HIV.

Social protection spans to the spectrum of public and private sector policies and programs targeted to prevent, reduce, and eliminate economic and social susceptibilities to deprivation (UNICEF, 2012). This includes a range of provisions such as emergency food, public housing initiatives, psychosocial support programs, as well as income subsidies and consumption transfers (Cluver et al., 2016; Devereux & Sabates-Wheeler, 2004). Social, economic, and psychosocial interventions of social protection can be administered by a wide variety of actors—governments, NGOs, communities, private citizens, or through mixed sector collaboration (Cluver et al., 2015). The aim of social protection is to shield the marginalized against livelihood risks while enhancing social status and human rights with the overall goal or mitigating economic and social vulnerability (Cluver et al., 2016).

Structural deprivation refers to the indicators of poverty, such as informal or makeshift housing, lack of food, clothing, or other household basic necessities, which manifest household socio-economic vulnerability (Cluver et al., 2015). The prevalence of child exposure to violence is higher in low-income or isolated neighborhoods, with two-
thirds of child murders taking place in low income countries or low-resource communities of middle income countries (UNICEF, 2014a).

*Violence* has no boundaries and permeates all venues of society (WHO, 2016). This study examined *three settings of violence*: family and school, together referred to as *child spaces*, and violence encountered in the community-at-large. In a 2000 South African national victimization survey of youth aged 12-22, participants reported their home as the most common location of violence exposure (21.8%; Leoschut & Kafaar, 2017). As with family violence, South African research documents school as a site for childhood experiences of violence (15.1 to 22.2% nationally), whether from authority figures in the form of punishment, or through bullying from peers (Burton & Leoschut, 2012). Violence in the community is another source of violence exposure for South African children, especially for those coming from low-income areas (Meinck, Cluver, & Boyes, 2017).

*Five kinds of violence* are examined in this analysis. *Physical violence* refers broadly to physical acts that cause or can potentially cause physical injury to a child (U.S. Department of Health and Human Services, 2017). *Emotional* or psychological violence denotes non-physical forms of violence characterized by intimidation, threats, ridicule, denigration, stigma, and discrimination (WHO, 2016). *Sexual violence* comprises both non-consensual attempted or completed sexual contact. Sexual violence also entails voyeurism, harassment, and trafficking, as well as online exploitation (WHO, 2016). *Community violence* refers to settings outside of the child’s home life (whether outdoors or inside community buildings including schools) where children become victims of
assault, fighting, robbery, stabbing, or shooting, whether by an individual or through gang activity (Samms-Vaughan & Lambert, 2017). Witnessing violence can involve incidental or forced viewing of any type of violence (O’Callaghan, McMullen, Shannon, Rafferty, & Black, 2013; WHO, 2016). In this study, witnessing violence refers to seeing, hearing about, or being aware of a range of violence in the family or in the community outside of the home environment.

**Research Questions and Hypotheses**

This analysis investigated whether four INSPIRE-based VPSs are associated with the decreased likelihood of experiencing nine violence outcomes in children aged 10-17 in KwaZulu-Natal province of South Africa. Gaps in the field literature suggested the following research questions:

**Research Question 1:** What are the individual associations between four individual INSPIRE-based VPSs (i.e., parent and caregiver support, income and economic strengthening, response and support services, and education and life skills) and nine violence exposures (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence), after controlling for child socio-demographics?

The first research question explored the main effects between each VPS to each violence outcome, controlling for child socio-demographic factors. This question led to the following hypotheses:
**H1:** After controlling for child age, gender, and urbanicity, having parent and caregiver support will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence).

**H2:** After controlling for child age, gender, and urbanicity, having access to income and economic strengthening will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence).

**H3:** After controlling for child age, gender, and urbanicity, having access to response and support services will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence).

**H4:** After controlling for child age, gender, and urbanicity, having access to structural support in education and life skills will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as in witnessing family violence and witnessing community violence).

**Research Question 2.** After controlling for child socio-demographics, is there a dose association between INSPIRE-based VPSs and violence risk, such that as the
number of INSPIRE-based VPSs increases, the likelihood of experiencing each of nine violence exposures decreases?

The second research question examined if there was a graded dose association between the numbers of VPSs and violence likelihood, such that a greater number of reported VPSs would be associated with a decreased risk for violence exposure. This question led to the following hypotheses:

**H5:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing physical violence in the home and school will decrease.

**H6:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing emotional violence in the home and school will decrease.

**H7:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing sexual violence will decrease.

**H8:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing community violence at-large and at school will decrease.

**H9:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of witnessing family violence will decrease.

**H10:** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of witnessing community violence will decrease.
This analysis filled a gap in the literature as the first known study to investigate cross-sectional associations between INSPIRE-based VPSs and the likelihood of experiencing nine violence exposures in low-income, resource-scarce communities within the middle income country of South Africa, which has been highly impacted by violence and HIV/AIDS. Although this study represents only an initial step into a more thorough inquiry of the VPSs’ effects in mitigating childhood violence, this, and other related inquiries are important for the sake of vulnerable populations of children in LMICs. Comprehensive strategies of interventions that promote coordinated implementation of VPSs may shield susceptible children from the enduring harms of violence, and thus have strong implications in future policy guidelines and effective field practice.

The following chapter examines the relevant literature. It surveys the context of violence against children in Africa, focusing especially on its occurrence in South Africa; it investigates the prevalence and consequences of polyvictimization, and risk factors that predispose children to elevated violence exposure; it documents the historical initiatives and instruments that protect children from violence; lastly, it highlights the INSPIRE seven-sector strategy, providing current examples of evidence-based approaches to the elimination of violence against children in each category.
CHAPTER II
REVIEW OF THE LITERATURE

This chapter presents a detailed review of the literature relevant to the proposed research questions. The first section begins with an examination of the context of violence for children living in Africa, with a specific focus on those children living in South Africa. The second section sets the historical background of international efforts to eliminate violence. It then surveys violence prevention and response strategies that have proven effective in decreasing violence outcomes for children. The chapter concludes with a summary of the key concepts that frame the proposed research questions.

The Context of Violence in Africa

High Rates of Child Abuse in Africa

Comparisons across countries and cultures of interpersonal violence are difficult due to divergent definitions of terms, study measurements, population samples, and data gaps (Know Violence in Childhood, 2017; Meinck et al., 2016). However, Know Violence in Childhood’s recent Global Report 2017 revealed the Sub-Saharan African region to be consistently at the highest levels across seven indicators of childhood violence. These indicators included country levels of child homicide, violent discipline at home, bullying in schools, physical fighting in schools, physical violence against adolescent girls, and sexual violence against adolescent girls measured at different time frames.
Annual child homicide rates (0-19 years) reported in the *Global Report 2017* vary considerably in Africa, from 1 death out of 100,000 population in Malawi, Senegal, and the islands of Cabo Verde and Mauritius—lower rates than those of East Asia and the Pacific, Central and Eastern Europe-Commonwealth, and industrialized Countries (1.5-1.6) with weighted population measures. South Africa reported 8 in 100,000 population in child homicide. However, other African nations had some of the highest prevalence rates; Swaziland measured 16, and Lesotho 18 out of 100,000 population.

Some form of violent punishment was reported globally by three out of every four children (1-14 years) in the past month. However, the rate in Eastern and Southern Africa, as well as Western and Central Africa rose to eight out of 10 children. In the Sub-Saharan countries of Burundi, Ghana, and Mozambique, rates reached as high as nine of ten children experiencing corporal punishment at home (*Know Violence in Childhood*, 2017).

Akin to corporal punishment, the *Global Report 2017* cited being bullied at school as the most common form of violence for those aged 13-15. In Central Eastern Europe-Commonwealth, Latin America and the Caribbean, and East Asia and the Pacific, nearly one of every three children reported this experience at least once in the past two months of school. However, in Africa, this represented a form of violence reported by every other child (47% in Eastern and Southern Africa; 51% in West and Central Africa).

In physical fighting in school within the past year, the Sub-Saharan region reported a prevalence of 45% (13-15 years) as opposed to 24% in the East Asia and Pacific region. In a lifetime measure of physical and sexual violence against adolescent
girls (15-19), prevalence varied regionally. Industrialized countries and Central and Eastern Europe-Commonwealth were the lowest at 6-11%, whereas Western and Central Africa reported over one-third (34%) of teen girls experiencing some form of physical violence. Regrettably, more than half of adolescent girls in the Democratic Republic of Congo (DRC) indicated physical violence abuse. Sexual violence had its highest prevalence in Africa where more than 10% had been victimized. Levels of sexual abuse were highest globally in Cameroon (22%), the DRC (21%), and Uganda (19%; Know Violence in Childhood, 2017).

Explanations for these elevated figures include entrenched poverty; growing numbers of orphans due to war and the HIV/AIDS pandemic; social norms upholding harsh discipline, as well as gender and power disparities; modernization by Western European culture usurping traditional values and long-established community structures of child protection; and multi-level corruption; all of which are challenges faced by the people of South Africa (Meinck et al., 2015b). In addition, South African apartheid policies disrupted kinship ties within families, resulting in numerous disadvantaged single parent households often supported by grandparents (Meinck et al., 2015b). As a result of these combined factors, violence has become a distinctive feature of South African society, creating a general culture of violence (Meinck et al., 2017) with children experiencing a wide range of adversities (Martin, Revington, & Seedat, 2013).

**Physical and Emotional Violence**

The physical and emotional abuse of children is a weighty issue in the country of South Africa (Mathews & Benvenuti, 2014). Children coming from families affected by
HIV/AIDS and those facing chronic illness with high levels of disability are at high risk for physical and emotional abuse and are proportionally more vulnerable to victimization with increasing levels of poverty (Meinck et al., 2016). In a South African violence prevalence study conducted between January 2010 to June 2011, 56.3% of the South African children ($n=3,514$ at baseline) surveyed reported lifetime physical violence, with 37.9% indicating victimization in the past year, and 16.6% stating frequent monthly physical victimization (Meinck et al., 2016). Pertaining to emotional abuse, 35.5% of the children indicated lifetime emotional abuse, with 31.6% reporting emotional violence within the past year; 20.7% asserted that emotional abuse occurred monthly (Meinck et al., 2016).

**Sexual Violence**

Gaining an accurate sense of the extent of sexual violence is problematic for several reasons. Measures for sexual violence vary across studies, making comparisons across sites difficult (Meinck et al., 2016). Moreover, as abuse is accompanied by victim shame and fear, perpetrator threat, and cultural taboo, recording accurate rates is daunting even in neutral locations where young people feel comfortable disclosing their experiences (Burton et al., 2015; Madu & Peltzner, 2000). Rates of sexual violence among children and adolescents from high-income country studies stand as high as 45% for females and 19% for males (Meinck et al., 2015b). Worldwide, girls are more susceptible to sexual violence, especially in its forms of intimate partner violence, rape, early marriage, trafficking, and genital mutilation, with males as the predominant perpetrators (WHO, 2016).
This pattern generally holds in Sub-Saharan Africa studies. Together for Girls (2017) reports a lifetime prevalence of sexual abuse for girls and boys prior to the age of 18 as 32% and 18% respectively in Kenya; 22% and 15% in Malawi; with figures of 25% and 10% in Nigeria. However, in a study of sexual violence among secondary students (n=414, 52.2% female) in a northern province of South Africa measuring any form of forced physical sexual contact from someone at least five years older or a person in a position of power, rates reached 53% for female adolescents and 56% for their male counterparts (Madu & Peltzner, 2000).

South Africa’s first national study on the incidence of child sexual abuse, violence, and neglect (Burton et al., 2015) conducted with mixed urban and rural groups aged 15-17 (n=9,730), found that one in five (19%) young people had experienced some form of sexual abuse. Contrary to other research in this domain, findings revealed that boys were equally or more vulnerable than girls, though the nature of victimization differed. While girls mentioned contact abuse (ranging from unwanted kissing to forced intercourse), boys were more likely to experience exposure abuse (the forced viewing sexual images or acts). Overall, boys reported a slightly higher rate of abuse (20%) than their female counterparts (19%). A South African longitudinal study revealed school dropout, prior sexual contact abuse, and physical assault in the community as strong predictors of girls’ sexual victimization (Meinck et al., 2017).

Akin to African traditions that support severe punishment, male dominance has been found to include sexual gratification in patriarchal families (Meinck et al., 2015b). Studies on South African social attitudes note that some cultures have a high tolerance for
sexual coercion, with some commentators noting the generalized belief in the “virgin cure,” that sex with an infant or young child is believed to remedy HIV infection (Meinck et al., 2015b). Globally, sexual abuse is highly associated with elevated risks for revictimization, bullying victimization, substance abuse, mental health distress that may continue into adulthood, with increased rates of sexual abuse perpetration; a grave consequence of sexual violence in Africa is the increased probability for HIV infection, especially in areas of high virus prevalence like South Africa (Meinck et al., 2017).

**Community Violence**

Community violence compounds physical and social risks, often eroding normal protective supports (Garbarino & Kostelny, 1996). Boys have more likelihood than their female counterparts to be both perpetrators and victims of community violence, particularly homicide, involving weapons of firearms and knives. For every one reported homicide there are hundreds of unknown victims, predominantly male, who sustain injuries (WHO, 2016).

Community violence in South Africa is one of the most prevalent forms of violence exposure, especially for those children coming from low-income areas (Meinck et al., 2017). The most common modes of violence exposure are through witnessing violence in the street, neighborhood, or at school; being robbed or assaulted directly; or witnessing a family member being hurt or killed (Martin et al., 2013). In a sample of children ($n=247$) interviewed in Cape Town, 58% recounted seeing someone attack another person with a weapon in the neighborhood (Shields, Nadasen, & Pierce, 2009). Ninety-two percent stated that they had witnessed a neighborhood assault, with 66%
relating that they themselves had been hit or attacked. South Africa’s homicide rate is five times the global average and is its leading cause of child mortality (Foster & Brooks-Gunn, 2015; Leoschut & Kafaar, 2017).

South Africa’s high levels of violence and crime are complex. Attributed to a history of conflict and war throughout the colonial past and apartheid periods, community violence has been normalized with widespread social acceptance and aggravated by high levels of unemployment and sub-standard housing, combined with weak law enforcement (Mathews & Benvenuti, 2014). Though typically associated with the threat of physical force to physically harm someone (Leoschut & Kafaar, 2017), community violence for children also includes vandalism of their school property by peers. Consistent with studies from high-income countries, rates of being bullied in Africa are higher among younger adolescents than their older teen counterparts (Boyes, Bowes, Cluver, Ward, & Badcock, 2014).

Witnessing Violence

Witnessing violence in the family. In a 2000 South African national victimization survey of youth aged 12-22, 41.4% reported violence and crime as common life events, listing their home as the most common venue of violence exposure (21.8%; Leoschut & Kafaar, 2017). U.S.-based research in a family preservation study found the two most prominent risk factors for family violence were structural deprivation (in the form of lower socio-economic status, unemployment, or housing instability) and parental characteristics (physical and mental health, alcohol use, and domestic violence). The risk of family violence is greatly augmented at the cumulative threshold of three or more
factors (Patwardhan, Hurley, Thompson, Mason, & Ringle, 2017). Although family violence is found within the confines of the most intimate of societal settings, family violence does not operate in isolation; rather, it is heavily influenced by its surrounding socio-ecological factors and underlying norms and values which amplify the family variables contributing to child violence exposure (Leoschut & Kafaar, 2017).

**Witnessing violence in the community.** Common violence exposures cited in African studies is witnessing the death of loved ones or community members, and exposure to human remains in neighborhoods or surrounding areas (Foster & Brooks-Gunn, 2015). In a study of teen boys and girls ($n=2,041$) in the urban centers of Nairobi, Kenya, and Cape Town, South Africa, more than 80% of the participants had experienced at least one (with an average of two) severe lifetime traumas as victims or witnesses. The most frequent traumas were witnessing community violence in the street, neighborhood, or at school (63%); being attacked or robbed (35%); and witnessing a family member being hurt or killed (33%) (Seedat, Nyami, Njennga, Vythilingum, & Stein, 2004).

**Polyvictimization**

Current research suggests considering the impact of the co-occurrence of violence during childhood and addressing its social root causes rather than its diverse symptoms (Leoschut & Kafaar, 2017). In a large South African study ($n=3,515$) in Mpumalanga and Western Cape, 68% of the children aged 10-17 recounted experiencing at least one type of direct or indirect victimization in their lifetime, and 55% reported such an experience within the past year. Over one-quarter (27%) indicated exposure to two or more forms of violence within these same time frames, citing physical and emotional abuse as the most
common co-occurring experiences of violence. Nearly one-fifth (19.6%) reported frequent multiple victimization (Meinck et al., 2016).

These findings regarding the prevalence of polyvictimization are well-documented by additional South African studies. Research in Capetown among 617 adolescents aged 12-15 years revealed that nearly all youth participants (98.9%) had witnessed community violence in their lifetime, with 40.1% experiencing community violence either in the form of a threat or assault (Kaminer, du Plessis, Hardy, & Benjamin, 2013). Nearly 77% had witnessed domestic violence, with 58.6% being victimized in their home. At school, 75.8% described either direct or indirect forms of violence; 8% of the participants reported sexual abuse. In total, 93.1% of the youth surveyed had experienced one or more types of violence, with over half of the participants reporting four or more types of violence victimization. The researchers concluded that safe spaces for these children were minimal, with daily exposure to violence across multiple domains (Kaminer et al., 2013). This reality of experienced multiple violence gives credence to Finkelhor, Ormrod, Turner, and Holt’s (2009) suggestion that victimization types are interconnected.

Sadly, polyvictimization is doubly damaging. First, one sort of victimization engenders susceptibility to other forms (Cole, Maxwell, & Chipaca, 2014). Second, the enduring trauma arising from the multiple concurrent experience of violence is greater than that of repeated violence of a single sort (Samms-Vaughan & Lambert, 2017). Polyvictimization, therefore, is of great concern for LMICs where the access to and costs
of secondary and tertiary treatment are frequently unattainable by the affected population (Samms-Vaughan & Lambert, 2017).

**Risk Factors of Violence**

Violence is not attached to a single societal risk factor, such as age. Rather risk factors are an interplay of cultural, biological, and individual aspects that escalate children’s danger of violence exposure (Know Violence in Childhood, 2017). The social ecological model (Bronfenbrenner, 1979) reveals violence factors embedded throughout societal levels, from the micro-level of individuals, to the near relationships of families, then outward to the broader connections within communities to the macro-level of beliefs, norms, and values. A socio-ecological perspective likewise considers the influence of factor interactions within and between societal levels which make some children more vulnerable to violence than others (Krug, Mercy, Dahlberg, Zwi, 2002; WHO, 2016).

At the individual level, known risks include age, sex, and level of education (WHO, 2016), as well as mental health factors and impulse control (Know Violence in Childhood, 2017). A South African study found girls and older children to be at higher risk for sexual and emotional abuse, whereas younger children were more likely to experience physical abuse (Meinck et al., 2016). At the individual level, girls who completed secondary school tended to experience less childhood violence (Know Violence in Childhood, 2017).

At the close level of the family, low socio-economic status, weak parent-child relationships, poor parenting practices, witnessing domestic violence, or early marriage
contribute to creating home cultures of violence (WHO, 2016). Meinck et al.’s (2015b) systematic review of 23 quantitative African studies found high correlation of factors at the close level of caregivers for sexual victimization risk in four studies. Living with a single parent or having divorced parents was highly associated with abuse victimization, similar findings to research conducted in high-income countries. The sexual victimization pathway was unclear whether children living in these home situations were more vulnerable due to less supervision, poorer quality relationships with caregivers, or the insertion of stepparents into their situations (Meinck et al., 2015a).

At the community level, poverty, areas of elevated crime, and high population density are associated with violence (WHO, 2016). For example, South African urban children were two-and-a-half times more likely to experience high levels of victimization than their rural peers (Leoschut & Kafaar, 2017). Childhood violence was shown to be higher in countries with raised under-five child mortality rates (Know Violence in Childhood, 2017). At the level of the society, policies that maintain gender, social, and economic inequalities; inadequate or absent social support and protections; or social vulnerabilities due to disasters, poor governance, corruption, or deficient law enforcement are all risk factors of violence against children (Know Violence in Childhood, 2017; Meinck et al., 2017; WHO, 2016). However, the principal factors which entrench violence in a culture are its social norms that tolerate abuse and exploitation as beyond community control, or viewed as normal life events (Know Violence in Childhood, 2017; WHO, 2016). This perception, added to victims’ shame and fear, accounts for the low levels of violence reported globally (Know Violence in
Childhood, 2017; WHO, 2016). The low status of women and children, coupled with cultural gender and power inequalities, are viewed as the structural roots of violence in many settings (Meinck et al., 2017).

Frequently, initiatives address violence exposures as separate, single risk issues. However, it is vital to recognize that though violence exposure due to particular risks may vary, they all may arise from common causal factors (Shiva Kumar et al., 2017). For example, a South African study showed that children of families affected by HIV/AIDS or other chronic illness with high levels of disability were at high risk for abuse; these children were also proportionally more vulnerable to victimization with increasing levels of poverty (Meinck et al., 2016). Understanding the relationships among a society’s abuse risks is essential. Unless the underlying primary drivers of violence are addressed, headway on the target of eliminating violence against children will not be reached (WHO, 2016).

**Protecting Children from Violence**

In many countries the true magnitude of violence against children has been vastly underestimated. The Know Violence in Childhood Initiative, an extensive global effort of research and systematic study in the areas of Home and Families, Schools, and Communities and Public Spaces, revealed that three out of four children—1.7 billion—experience or witness some form of interpersonal violence or abuse yearly (Know Violence in Childhood, 2107). Societal violence violates the child’s right to be protected from the maltreatment of neglect, abuse, and exploitation (UNICEF, 2014b) that is anchored in the UN Convention on the Rights of the Child (CRC; UNICEF, 1989).
the children of the African continent, their protection is further emphasized in the African Charter on the Rights and Welfare of the Child (UN, 1990). These international instruments and their implications for policy and practice for the protection of vulnerable children in Africa are discussed in the following section.

**International Instruments that Guide the Protection of Children in Africa**

The CRC and the African Charter on the Rights and Welfare of the Child (UN, 1990)—international instruments ratified by the nation of South Africa—uphold children’s right to be defended from harm (Mathews & Benvenuti, 2014), with the underlying assumption that no violence against children is justifiable and all its forms preventable (UN, 2011). The CRC has numerous articles upholding children’s dignity as citizens with an explicit call to safeguard them from violence. CRC Article 4 states governments’ responsibility to take all obtainable measures to ensure child protection from any form of maltreatment. Articles 11, 34, 35, and 36 speak against trafficking, kidnapping, and all forms of child exploitation, and Article 37 takes up protection from cruel and harmful forms of punishment. The core of the CRC concerning child protection is Article 19 that calls nation states to defend children from all forms of violence, whether physical or mental (UNICEF, n.d.).

Like the CRC, the African Charter on the Rights and Welfare of the Child (UN, 1990) mandates special safeguards and care for the children of its continent. The document noted with concern that the situation of most African children remained critical due to “their unique socio-economic, cultural, traditional and developmental circumstances, natural disasters, armed conflicts, exploitation and hunger” (Preamble,
paragraph 4), added to children’s natural physical and mental vulnerability. Article 5 launched a general call for protection by law of the child’s inherent right to life, survival, and development, stressing state parties’ responsibilities to ensure to the maximum extent possible the protection of children from harm. Article 16 outlined state parties’ prevention of torture, physical or mental injury or abuse, neglect, or maltreatment; Article 21 promoted child protection from harmful social and cultural practices; Article 27 spoke against sexual exploitation; and Article 29 banned the sale, trafficking, and abduction of children (UN, 1990).

However, despite adopted international policies in Africa invoking the rule of law in guarding children from violence, policy alone has been inadequate to restrain violence’s prevalence. Concerned by increasing levels of violence in light of mounting evidence of its enduring negative impact on physical, mental, and public health consequences to individuals and communities, the United Nations, in its ambitious Post-2015 Sustainable Development Goals (SDGs), called for concerted global efforts towards the elimination of violence against children (UN, n.d.). Though the entire scope of SDGs aims for the health and well-being of the world’s children, there are five goals that collectively work towards ending violence against children and terminating its impacts in family and community settings.

In the united effort to end violence against children, Goal 4 strives to insure inclusive and equitable quality education with the promotion of lifelong learning opportunities. Specifically, its Target 4.a seeks to provide non-violent learning environments. Goal 5 aims for gender equality and the empowerment of all women and
girls. Target 5.2 seeks to eliminate trafficking and sexual exploitation of women and girls; Target 5.3 speaks to ending harmful practices such as female genital mutilation, and early or forced marriage.

Goal 8 promotes inclusive and sustainable economic growth, with full employment and decent work for all adults. Its Target 8.7 speaks for the elimination of forced labor, modern slavery, and any form of exploitation. SDG 16 encompasses the promotion of peaceful and equitable societies for sustainable development, providing equal access to justice while building effective, accountable, and inclusive institutions on all levels (UN, n.d.). Target 16.2 is at the core for the movement for the elimination of violence against children, specifically advocating the end of abuse, exploitation, trafficking, and torture of children (UN, n.d.; WHO, 2016).

Recognizing that violence is embedded within community settings, Target 16.1 aims to end of all forms of violence and related deaths everywhere. Goal 11 works toward making cities and settlements safe, inclusive, and sustainable. Its Target 11.7 calls for safe and affordable transport systems; Target 11.7 asks for green and public spaces that are secure for all member of the community.

Together the SDGs’ specific targets against violence in all its forms provide a unique opportunity to catalyze combined action that builds safe, stable, nurturing environments and relationships for children (WHO, 2016). Striving to synergize the span of societal assets in this global effort, WHO and its partners created INSPIRE, a violence prevention and response plan whose acrostic highlights seven sector strategies: (1) Implementation and enforcement of laws; (2) Norms and values, (3) Safe environments;
(4) Parent and caregiver support; (5) Income and economic strengthening; (6) Response and support services; and (7) Education and life skills (WHO, 2016). Each strategy includes a key objective and rationale with specific programs, policies, and practices that advance the strategy. INSPIRE has strong potential both to aid and be supported by the achievement of SDGs 1, 3, 4, 5, 8, 10, 11, and 16 that address poverty, health, education, gender equality, safe environments, and justice, all elements which counter violence risk factors (WHO, 2016).

**INSPIRE’S Seven Strategies**

Ten global organizations collaborated to create INSPIRE as part of the worldwide effort to eliminate violence against children. These were the Centers for Disease Control and Prevention, End Violence Against Children, Pan American Health Organization, the U.S. President’s Emergency Plan for AIDS Relief, Together for girls, UNICEF, United Nation’s Office on Drugs and Crime, USAID, and the World Bank. INSPIRE’s strategies are based on the premise that no society is immune from violence, with growing evidence that violence against children is preventable (UN, 2011; Know Violence in Childhood, 2017). Its aims are supported by mounting consensus among communities intolerant of violence against society’s most vulnerable members. INSPIRE recognizes that just as violence risks exist at four interrelated societal levels—individual, close relationships, community, and society—so too protective factors and opportunities for violence prevention reside within these same levels.

INSPIRE’s public health approach asserts that violence can be faced by addressing root causes and their related risk factors at each level (WHO, 2016). Using
Cure Violence’s (2017) conceptualization of violence as an epidemic disease, INSPIRE seeks to halt the transmission of violence, prevent its spread, and change community norms, conditions, and practices that sustain its diffusion. Thus, INSPIRE’s collaborative approach to violence, coordinated across formal and informal settings of civil and private society, has high potential for greater impact than strategies offering single interventions alone (Hillis et al., 2017; WHO, 2016).

The following section outlines evidence from INSPIRE’s integrated strategies in the prevention of and response to violence against children.

**Implementation and enforcement of laws.** INSPIRE’s first strategy seeks to develop and strengthen legal protections and policies in combination with law enforcement practices. The value of these actions is to publicly demonstrate that violence is wrong and will not be tolerated within a society, moving a culture toward eradication of harmful beliefs. Ancillary to the benefit of legal enforcement is keeping perpetrators of violence accountable while reducing overall exposure to violence (WHO, 2016). Criminalizing sexual abuse and exploitation and addressing youth risks in the sale of alcohol, firearms, and other weapons are important extensions of this category of community action. An example of effective intervention in this area comes from a recent South African study. Stricter licensing and reduced firearm circulation in 2001-2005 resulted in the saving of an estimated 4500 lives in five of its major cities, with the steepest reductions among males ages 15-29. INSPIRE’s judicial approach is an extension of the CRC’s terms that state parties must create and enforce laws that protect children from maltreatment (UN, 1989.; UN 2011).
**Norms and values.** Addressing deep-seated cultural norms and behaviors is an imperative part of preventing child victimization. Often violence is seen as legitimate, as in the cases when parents, teachers, or marriage partners use punitive practices to control or promote expected behavior; girls are pushed into sexual relations or early marriage due to male norms of entitlement; older male peers coerce younger counterparts into gang activity for safety and status; and children don’t disclose abuse due to fear of stigma and shame (WHO, 2016).

The two following examples illustrate how interventions can influence the adoption of changed values that result in decreased violence outcomes.

*Yaari-Dosti* has successfully sought to reduce gender-based violence in Latin America, India, and Ethiopia by working with groups of young men to redefine masculinity. In India after 24 months, its young male participants ($n=1,138$; age 16-29) related 20-30% fewer incidents of domestic violence (Verma et al., 2008). The second example, called “edutainment,” was a South African multi-media drama intervention called *Soul City* produced for television, serial magazine-like booklets, and radio broadcast. *Soul City’s* fourth year’s season was produced to influence audience values around the issue of domestic violence. Follow-up from the series stated reaching 86%, 25%, and 65% of its television, booklet, and radio audiences. An additional focus of this media intervention was to bring awareness of violence support services, including a helpline created by the *Soul City* producers. Audience attitude shifts were noticed as evaluations reported a 10% increase of respondents who disagreed that domestic violence
was a private matter between the couple alone (Usdin, Scheepers, Goldstein, & Japhet, 2005).

**Safe environments.** The strategy of safe environments focuses on the creation and continuation of safe streets and places in the community where children gather and spend time apart from home and school. This INSPIRE strategy has the goal of fostering positive behaviors and deterring harmful ones through improving the physical environment and eliminating violence “hot spots,” benefitting all community members alike (WHO, 2016). A South African study showed that most episodes of youth violence occurred in particular community locations, such as individual streets or specific venues such as bars and clubs (Nicol et al., 2014).

Crime Prevention Through Environmental Design (CPTED) provides an example of an evidence-based safe environment intervention in the country of Colombia (Cerdá et al., 2012). Municipal action in 2004 provided an intervention of free public transportation from selected high risk neighborhoods to parks, libraries, and community centers in the central part of Medellín, with unserved areas functioning as study controls for program evaluation (Cerdá et al., 2012). A sample of 225 respondents from the intervention sites and 241 respondents from the control neighborhoods were surveyed. The drop in the homicide rate from 2003-2008 was 66% greater in intervention neighborhoods, with other incidences of violence reduced by 74%. As the study results were not disaggregated by age, it was surmised that all residents benefited from the crime reductions. These results are substantial since 40% of the intervention population were youth aged 12-20 (Cerdá et al., 2012). As this demographic includes older adolescent boys in the highest
category of homicide risk, safe environment interventions are impactful in the overall
goal of eliminating violence against children and its perpetration (WHO, 2016).

**Parent and caregiver support.** Increasing caregiver support encompasses the
replacement of harsh parenting practices with non-violent discipline, enhancing parent-
child relationships and interactions through improved communication patterns and
deepened bonds of attachment. Positive parenting practices avert separation of children
from their homes and reduce both the risk of domestic violence and child maltreatment
(WHO, 2016). In a South African setting, caregiver warmth, as well as parental
supervision of the child’s activities, were found to be important in the reduction of
sexually risky behaviors, which are often linked to heightened probabilities of
experiences of violence (Cluver et al., 2016; Meinck et al., 2015a).

Parenting for Lifelong Health (PLH) is being developed with preliminary
evidence of intervention effectiveness in high-poverty rural settings of South Africa
(Cluver et al., 2017). A 10-session pilot program featured parent and teens aged 10-17
years (n=30 parent/child dyads). The PLH program conducted by local NGO staff was
founded on social learning and conducted in group settings. Lessons included instruction
with role play for topics such as positive parenting skills, promotion of good behavior,
praising each other, and non-violent limit setting, with home practice of skills between
meetings. The baseline and posttest scores showed reduction in violent discipline as
attested by the caregiver. Positive parenting showed large effects in posttest in both the
parental and teen report, with significant results in the perceived access to social support
measures. In an area with limited resources and few social work personnel, these results
were noteworthy regarding the success of utilizing local staff to implement preventions to reduce violence exposure in the family (Cluver et al., 2017).

**Income and economic strengthening.** Poverty was associated with physical child abuse in two African-based quantitative studies reviewed in an African violence risk and protective factor inquiry (Meinck et al., 2015a); this result corresponds to data originating in high-income countries linking poverty with increased susceptibility to physical violence victimization. Income and economic strengthening seeks to improve families’ economic base and financial stability to diminish adult stress levels that may heighten the likelihood of child maltreatment and domestic abuse. In this way, income and economic strengthening have the potential to indirectly protect children from violence, thereby decreasing their likelihood of their becoming its perpetrators (WHO, 2016).

Social protection in the form of direct cash subsidies to at-risk youth have helped to reduce child sexual abuse and exploitation in studies conducted in Kenya, Zambia, Zimbabwe, Malawi, and Tanzania (The Transfer Project Team, 2017). Cash transfers are able to address the underlying structural factors of poverty with its inherent barriers to education. Economic interventions of this nature have indirectly overcome gender inequalities in the selection of which children attend school in the home (The Transfer Project Team, 2017). Studies specific to South Africa suggest that social protection grants have been effective in reducing household poverty while improving child outcomes (Meinck et al., 2015a).
Response and support services. The sixth INSPIRE category is unique as the only strategy having both aspects of prevention and response to violence. By providing follow-up resources and psychosocial support through counseling and related services, its objective is to reach both victims and perpetrators to break violence cycles (WHO, 2016). Improving response and support services, such as access to quality health care, social welfare programs, and criminal justice services, can help reduce the likelihood of repeated violence (Richter et al., 2009). Support from caring adults and outside organizations have been found essential to a spectrum of healthy lifestyle behaviors for children (Yakubovich et al., 2016). Studies indicate that participation in community-based organizations may help create a more positive home environment characterized by more effective parenting with less physical and emotional abuse, more caregiver praise, and less domestic conflict and violence (Yakubovich et al., 2016).

Due to the shortage of trained specialists and the costs associated with support services, few child victims in LMICs receive needed health and social services (WHO, 2016). Ten percent or fewer of child sexual abuse cases related receiving any sort of response service in studies conducted in Cambodia, Haiti, Kenya, Malawi, Swaziland, Tanzania, and Zimbabwe where lifetime prevalence of sexual abuse ranged from 4% in Cambodia to more than 37% in Swaziland (Sumner et al., 2015). For these reasons, there has been a growing movement to equip lay health workers to carry out interventions relating to maltreatment and youth violence, such as fighting and sexual victimization (WHO, 2016). This approach has been effective in programs for individuals and groups using Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) to support child victims.
of violence, and especially those recovering from sexual assault (Bass et al., 2013; Murray et al., 2015).

**Education and life skills.** The objective of the seventh INSPIRE category is to increase access to effective, equitable schools that promote life and social skills training, ensuring that schools are safe learning environments. Learning how to cope with adversity and manage risks without resorting to violence is an important component of this prevention strategy (WHO, 2016). Though corporal punishment was banned in Uganda in 1977, a district study in Luwero showed more than 90% of children aged 11-14 years reporting lifetime physical violence from staff at their school (Devries et al., 2015). A Ugandan not-for-profit organization, Raising Voices, created The Good School Toolkit, a behavioral intervention focused on reducing physical violence against primary school pupils from school staff (Devries et al., 2015). Forty-two primary schools were selected from a cluster-randomized pool of 151 schools in the Luwero District. All students of the approximate ages of 11-14 in primary grades 5, 6, and 7, and staff members who spoke either English or Luganda were eligible to participate in the cross-sectional surveys at base- and end-line. Twenty-one schools were randomly selected to participate in the intervention implementation conducted over eighteen months, the remaining 21 schools were waitlisted and served as controls for the study; a total of 3,820 students participated in the self-report surveys.

Content of the Good School Toolkit intervention included setting school-wide goals with deliverable action plans, the creation of multiple groups (administration, teachers, students, and parents), encouraging empathy, and providing knowledge and
practice of alternative non-violent forms of discipline. Ongoing support with modeling of behaviors and skills was provided by Raising Voices throughout the intervention. Throughout the implementation period, schools celebrated the successful achievement of their goals. Prevalence of physical violence at the 18-month end-line was lower in the intervention schools (31%) as compared to the control schools (49%), though the absolute value of physical violence remained high in the past week and past term outside of schools (Devries et al., 2015).

Another application of violence prevention in the area of education and life skills involved orphaned Zimbabwean girls. For students who received help in the form of fee payment, school supplies, uniforms, and health and hygiene articles, dropout was reduced by 82%, with early marriage decreasing by 63% (Hallfors et al., 2011). As school attendance is linked to lower victimization and perpetration of certain kinds of violence (childhood sexual violence, early marriage, domestic violence, and youth violence), educational support interventions shield children from the consequences of violence, such as unintended pregnancy, HIV, and other sexually transmitted infections (WHO, 2016).

In conclusion, as children frequently experience violence in combinations (Meinck et al., 2016), the response to prevent and mitigate single traumas and polyvictimization must also run across the societal spectrum with multi-pronged implementation. The most successful interventions to date have combined multiple levels of integrated services focused on specific risks, reaching the people involved and those behaviors associated with violence in locations of high incidence (Shiva Kumar et al., 2017). In keeping with study results such as these, INSPIRE was not created as a single
sector approach, but rather as a collaborative effort across a community, with integrated strategies reinforcing the impact of the entire plan to stop violence against children.

INSPIRE’s seven strategies with their varied approaches aim to prevent and respond to the spectrum of violence embedded within the socio-ecological landscape from the level of the individual, through close relationships, outward to the surrounding community, to the influential realm of cultural beliefs. INSPIRE’s impact relies on involvement and resources from nation-states, professional associations, public and faith-based organizations, foundations, and academic institutions to strengthen the systems underlying each sector so that they are able to deliver effective programs and services in breaking the cycle of violence against children (WHO, 2016). Furthermore, INSPIRE prevention and response efforts promote the aims of other SDGs targeting risk factors that contribute to violence against children, including, poverty, health, gender equality, education, safe environments, and justice (WHO, 2016).

Summary

This chapter commenced by highlighting recent research (Know Violence in Childhood, 2017) revealing that Sub-Saharan children experience the highest levels of violence globally across seven indicators of childhood violence. The chapter then surveyed five forms of violence exposure, noting the high prevalence and negative consequences of polyvictimization for children in Africa, with special focus on its frequent occurrence in South Africa. It then examined diverse individual risk factors associated with child age, gender, and socio-economic status, finding that various combinations of risk factors were associated with different kinds of violence. Moving out
through the layers of the social landscape, it then investigated the risk factors more broadly associated with the general health, infrastructure, policy, and norms of society that predispose children to experience violence, whether as victims or witnesses.

Next, this review considered the historical backdrop of international instruments and initiatives protecting children from violence. Lastly, it highlighted the current seven-fold approach for the elimination of violence against children detailed in the INSPIRE model. Four INSPIRE categories of intervention: (a) parental and caregiver social support, (b) income and economic strengthening, (c) response and support services, and (d) education and life skills, all measured within the South African 2009-2010 Young Carers Study, served as the foundation for this present investigation.

Although many studies have analyzed the negative consequences of ACEs (Felitti, et al., 1998), few have investigated the connections between positive childhood experiences via family and community support as protective factors against violence. Parental and caregiver social support, income and economic strengthening, response and support services, and education and life skills have the potential to reduce violence against children (Cluver, Orkin, Yakubovich, & Sherr, 2016; Hillis et al., 2010). This study was designed to address the paucity of evidence regarding whether these protective factors are associated singly or together with a lower likelihood of violence among children living in the middle income country and highly HIV/AIDS-affected area of South Africa. Altogether, this detailed review of the literature reveals the need to address the following research questions:
Research Question 1. What are the individual associations between four

individual INSPIRE-based VPSs (i.e., parent and caregiver support, income

and economic strengthening, response and support services, and education and

life skills) and nine violence exposures (the direct experiences of physical,

emotional, sexual, and community violence, as well as the indirect

experiences of witnessing family or witnessing community violence), after

controlling for child socio-demographics?

Research Question 2. After controlling for child socio-demographics, is there a
dose association between INSPIRE-based VPSs and violence risk, such that as

the number of INSPIRE-based VPSs increases, the likelihood of experiencing

each of the nine violence exposures decreases?

Chapter III describes the research design used for the study, including the

methodology, study procedures, measures, approach to analysis, and threats to validity.
CHAPTER III
RESEARCH DESIGN – METHODS AND PROCEDURES

This study employed a cross-sectional correlational design to explore the associations between four INSPIRE-based violence prevention strategies (VPSs) and nine violence outcomes from a sample of 2,477 South African child participants aged 10-17 of the Young Carers study located the resource-scant, HIV-endemic KwaZulu-Natal province. This chapter details the Young Carers research design, its study protocol, sample characteristics, research measures, approach to analysis, and threats to validity.

Young Carers Study Method and Protocol

Participants and Procedure

The Young Carers (YC) study. This research study involved secondary analysis of cross-sectional data obtained from the Young Carers survey data collected from both an urban and a rural site in the KwaZulu-Natal (KZN) province. The YC study conducted research assessing the difficulties that South African children in low-income and resource-scarce communities face due to the social and economic impacts of the HIV/AIDS epidemic. Established in collaboration with four South African Government departments—Social Development, Health, Basic Education, and Agriculture—this study is part of the National Action Committee for Children Affected by AIDS program to identify factors that could benefit South African children, the majority of whom have never known life without HIV/AIDS. Now broadened to encompass the holistic health of both child and caregiver, government and non-governmental organizations are utilizing
these YC study findings to develop and implement effective policy and interventions (Young Carers, 2015).

The selection process for choosing study participants was based on logistic and scientific criteria. The primary criterion was to choose sites of high HIV prevalence (≥ 30%) due to the interest in AIDS-affected populations of caregivers and children (Department of Health, 2008). In 2008, South Africa’s eastern province of KZN had the highest HIV prevalence among antenatal clinic attendees in South Africa, with an estimated 37.4% versus the national prevalence estimate of 28% (Department of Health, 2008); all of the 11 census districts in KZN met the YC criterion of HIV prevalence. Of these districts, Greater Durban’s urban eThekwini Metropolitan Municipality census district (antenatal prevalence of 31.6%) and the rural northeastern uMkhanyakude census district (antenatal prevalence of 39.3%; Department of Health, 2008) were selected as representative sites based on established South African criteria of urban and rural settings (Statistics South Africa, 2003b; see Figure 3.1 for a map of the KZN province’s 11 census districts with their 43 municipalities). Though HIV prevalence (28%) has diminished since the time of the original YC’s study, KZN continues to have the most elevated rates among South Africa’s nine provinces (Shisana et al., 2014).
Source: National Government of South Africa, 2018

Note. The red stars denote the two chosen study districts of (1) Greater Durban’s urban eThekwini Metropolitan Municipality and (2) the rural uMhlabuyalingana municipality located within the northeastern uMkhanyakude census district.

Formed in 1994, KZN is bounded by the Indian Ocean and the neighboring countries of Swaziland, Lesotho, and Mozambique. Its area covers over 36,433 miles with a population near 11 million, the second most populous South African province. KZN residents are primarily Black Africans who speak isiZulu as their first language.
(77.8%; Worldbook, 2017b). Its largest city, Durban, is South Africa’s third largest, serving as its chief port and manufacturing hub.

Besides the elevated HIV prevalence rate, unemployment and poverty are higher in KZN than elsewhere in South Africa; two-fifths of the workforce were described as unemployed, with more than one-third of its residents living below the US $2 per day poverty line (Thurlow, Gow, & George, 2009). Regarding child health, KZN had the second highest rate in South Africa of under-five deaths (57.8 per 1,000 live births in 2016; Province of KwaZulu-Natal, 2017). As a province, KZN ranks third nationally with a homicide rate of 36.0 per 100,000 people (Africa Check, 2017; World Atlas, 2017a).

**Urban site (Lamontville).** The chosen urban site, Lamontville Township (Wards 74 & 75), was in eThekwini district, KZN’s only metropolitan municipality, located 20 kilometers south of the greater Durban area (see Figure 3.2 for the location of Lamontville). Lamontville is the oldest of the townships in the eThekwini, built in 1943 for the rising African middle class, while simultaneously housing thousands of workers from the south Durban industrial areas (Makhatini, 2011). Akin to other South African townships, Lamontville has a history of segregation connected to migrant labor, civil unrest, and violence in reaction to apartheid policies and practices. As a center of political activism, it has been the home of several key leaders, with a resulting raised political consciousness among the residents (Makhatini, 2011).

The population density of the area was estimated at 6,826 people per square kilometer, comprised almost entirely of Black Africans (95% of Ward 75, nearly 100% in Ward 74; Statistics South Africa, 2003a), reflecting the divisions of the apartheid era.
(Casale, 2013). The 2001 socio-demographic data available at the time of the original study reflected the KZN province as a whole, with approximately 30% of adults over the age of 20 years not ever having attended secondary school. Under half of the labor force was employed (40% and 45% respectively for Wards 74 and 75), with 34% of household living in informal dwellings (e.g., shacks), though most households had service coverage of electricity (86%) and running water (80%) available to the dwelling or yard. The original study noted possible discrepancies between the available data in the 2001 national census and the current reality in 2009-2010 (Casale, 2013).

Figure 3.2. *Location of Lamontville in the greater Durban area of the eThekwini Municipality*

Source: Mapstudio, 2009
Rural site (Manguzi). The chosen rural site was part of the greater Manguzi area of the uMhlabuyalingana municipality. Located 15 kilometers south of the Mozambique-South Africa border, this community is part of KwaZulu-Natal’s northeastern district of uMkhanyakude (see Figure 3.3 below). Though wards exist in the area, the smallest geopolitical units are called *isigodi*, tribal jurisdictions administered by local leaders. Data were collected in twelve randomly chosen *isigodi* in Manguzi.

As a rural community, Manguzi lacked road infrastructure (90% of roads were only sandy tracks) and regular transport, with limited electrical, water, and communication services (Casale, 2013). Socio-demographics at the time of the survey showed a high poverty level with accompanying social challenges in the area. According to 2001 census data available to the original YC study, unemployment in the labor force stood at 70% (Statistics South Africa, 2003a). According to 2010/2011 Integrated Development Plan (IDP) for the uMhlabuyalingana Municipality at the time of the YC survey, nearly 50% of the population lived in traditional dwellings of reed or thatch huts. The IDP further stated that 47% of the economically active residents either received no income or less than 1600 South African rand (approximately US $200) per month (Casale, 2013).

Though in 1996, education became constitutionally universal and free to all residents (Department of Basic Education, 2018), IDP statistics stated only 8% of the population had obtained a Grade 12 education or had advanced to tertiary studies (Casale, 2013), revealing the need for improved quality in education, especially in the rural districts (Department of Basic Education, 2018). Most households were involved in
subsistence farming, difficult in the sandy terrain without irrigation (Casale, 2013). Most travel was done by foot to reach schools, clinics, or other destinations. Two hospitals and 17 clinics served the entire municipality with a life expectancy of 43 years (Casale, 2013).

Figure 3.3. Location of Manguzi in the uMhlabuyalingana Municipality

Source: Kwasizabantu Mission, 2007

**Data collection.** Data were collected in 2009-2010 from 2,477 children 10-17 years old. A door-to-door sampling strategy with introductory screening questions of every household was adopted in both the rural and urban sites to determine household eligibility. Households having an adult caring for at least one child in the age range of 10-17 years met the requirement to be interviewed. The study sought a minimum of 1,000
caregiver-child dyads at each site based on power analysis requirements (Casale, 2013). Each child participant completed a face-to-face interview and standardized questionnaire to collect qualitative and quantitative information pertaining to their physical and psychological health, social functioning, and education. All interviewers had experience working with vulnerable children and were trained for conducting home visits dealing with sensitive information with the outside support of community guides and research supervisors (Casale, Wild, & Kuo, 2013).

**Ethical procedures.** The Young Carers ethical protocols received approval from the Universities of Oxford (reference number SSD/CUREC2/09-52), Cape Town, and KwaZulu-Natal (reference number HSS/0473/011), and the provincial Health and Education Departments. Child participants and their caregivers provided both verbal and written informed consent. Participants received only certificates of thanks to avoid any impression of coercion and to reduce tensions between households in the community.

Only the interviewer was present with the child participant to minimize response bias during the survey process. Confidentiality was strictly maintained except in circumstances when participants risked harm or requested assistance. In those cases, immediate referrals were made to social and health services through prior agreement. Strict protocols were established to regulate the quality control, hardcopy submission, transport, and delivery of the survey questionnaires in field, as well as data storage (Casale et al., 2013). The author of the secondary study was granted local International Review Board approval from Clemson University (reference number 2017/142; see Appendix C).
Research Measures

Internationally recognized and validated psychometric instruments were used where possible in the original YC study. Additionally, care was taken to use verified instruments from populations closest to those in the 2009-2010 sample to assess study demographics, along with risk and protective factors. However, other measures, such as the Household Map (the child and interviewer would draw an outline of the home divided into rooms, indicating who slept in each room, their age, sex, relationship to the participant, as well as the employment status) were created for the YC study to discern the family structure and socio-economic demographics (Cluver et al., 2013). These qualitative measures were followed up with quantitative assessments to better understand the child’s situation.

Violence Prevention Strategies

Four VPSs were available for secondary analysis from the original 2009-2010 YC study. VPSs were dichotomously scored as 1 (yes, the child experienced this VPS), or 0 (no, the child did not), pertaining to the protection offered in each of the four INSPIRE categories. The four VPSs with their representative composite measures are described below.

The VPS of parent and caregiver social support, represented by the composite measure “positive parenting,” assessed authoritative non-violent parenting. Positive parenting encompassed 10 items, nine of which comprise the Alabama Parenting Questionnaire (APQ), with one additional item measuring caregiver praise for household help ($\alpha = .75$ in a South African orphan study; Cluver & Gardner, 2007; Cluver, Gardner,
& Operario, 2007). In the original YC survey, the 10 items were both negatively and positively phrased. For this analysis, all 10 items were phrased in the positive sense; six were recoded to reflect that direction (see Appendix A). These 10 items assessed consistent discipline (e.g., “You talk your caregiver out of punishing you when you have done something wrong”), caregiver monitoring of child’s activities and friends (e.g., “You go out without a set time to be home,” and “Your caregiver does not know who you are friends with”), as well as caregiver praise for the child’s character or performance in school or at home (e.g., “Your caregiver compliments you when you have done something well,” and “Your caregiver praises you for behaving well”). The response frequencies of often and always were coded yes. Children reporting yes to seven of the 10 items, demonstrating the caregiver’s habit of positive parenting the majority of the time, received the score of 1.

The VPS of income and economic strengthening, represented by the composite measure “basic necessities,” assessed the household’s capacity to provide the child’s everyday life requirements. Basic necessities was a measure of poverty comprised of eight socially-perceived necessities for children as identified by the Centre for South Africa Social Policy in the Indicators of Poverty and Social Exclusion Project (Wright, 2008), and later corroborated by over 80% of the South African population in a nationally representative survey (South African Social Attitudes Survey 2006; Pillay, Roberts, & Rule, 2006). Seven items assessed the household’s current ability to provide three meals, enough clothing to keep the child warm and dry, more than one pair of shoes, toiletries to wash every day, medical attention and medication when ill, school fees and equipment.
An eighth item on the original YC survey, the ability of the household to provide a school uniform, was removed from this current study as “school uniform” was assessed in the VPS of *education and life skills* measure of four items provided by the school to sustain the child’s enrollment. Children reporting *yes* to five of the seven items, demonstrating the household’s capacity to meet the majority of the child’s need, received a score of 1.

The VPS of *response and support services*, represented by the composite measure “formal social support,” assessed formal community connections with two items from the *Social Support Scale* (Adolescent Pathways Project, 1992). The original scale of 24 items was used in prior study of AIDS-orphaned children in Cape Town (Cluver & Gardner, 2007; Cluver et al., 2007). In the current study, formal social support included two items, religious leader social support and teacher or school principal social support, assessing whether the child viewed a leader of a faith community or school teacher or administrator as a source of psychosocial support outside the informal realm of friends and family. Children reporting *yes* to either of these community psychosocial support resources received the score of 1.

The VPS of *education and life skills*, represented by the composite measure “school structural support,” assessed whether the child had structural support to sustain educational progress with four items developed by YC with the South African Department of Education. School structural support assessed whether the child received school meals, free uniform, free transport, or free textbooks in the past school year. Children reporting *yes* to one or more items of educational support items received the score of 1.
Violence Outcomes

Dichotomous outcome measures assessed nine violence exposures found within the original YC study. These entail the direct experiences of physical, emotional, sexual, and community violence, as well as indirect exposure to violence through witnessing family violence and witnessing community violence.

Physical violence assessed physical violence in child spaces of home and school. The category of physical violence at home was assessed with two items from the UNICEF Measures for National-level Monitoring of Orphans and other Vulnerable Children (Snider & Dawes, 2006): whether the caregiver had slapped or punched the child, or hit the child with hard object or belt. Children who experienced either of these forms of physical violence at home in the past year will receive the score of 1.

The category of physical violence at school was assessed with three items from the standardized Social and Health Assessment Peer Victimization Scale adapted from the Multidimensional Peer Victimization Scale (Ruchkin, Schwab-Stone, & Vermeiren, 2004) for Cape Town AIDS-orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007): whether the child had been beat up, kicked, or punched; threatened by physical proximity so as to make the child uncomfortable; or sustained physical harm while at school. Children experiencing any of these forms of physical violence by school peers in the past year received the score of 1.

Emotional violence assessed emotional violence in child spaces of home and school. The category of emotional violence at home was assessed with three items from the UNICEF Measures for National-level Monitoring of Orphans and other Vulnerable Children.
Children (Snider & Dawes, 2006): whether the caregiver had threatened to send the child away, threatened to invoke ghosts, or insulted the child. Children experiencing any of these forms of emotional violence at home in the past year received the score of 1.

The category of emotional violence at school was assessed with four items from the standardized *Social and Health Assessment Peer Victimization Scale* adapted from the *Multidimensional Peer Victimization Scale* (Ruchkin et al., 2004) for Cape Town AIDS-orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007): whether the child had experienced peer name calling or cursing, trouble caused between the child and friends, ridicule, or shunning. Children experiencing any of these forms of emotional violence from school peers in the past year received the score of 1.

*Sexual violence* was assessed with two items constructed by social workers in South Africa and used in Cape Town AIDS orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007): whether the child had experienced inappropriate touch by others, or sexual coercion. Children ever experiencing (lifetime) either of these forms of sexual violence received the score of 1.

*Community violence* measured both exposure to violence in the general community and violence at school. The category of community violence at-large was assessed with two items from the *Child Exposure to Community Violence Checklist* (CECV; Richters & Martinez, 1993), adapted by the YC study to reflect the most frequent types of community violence reported by South African Police Statistics (SAPS Strategic Management, 2005): whether the child ever experienced (lifetime) physical
assault, or robbery in the past year in the community-at-large. Children experiencing either of these direct forms of violence received the score of 1.

The category of community violence at school was assessed with two items from the standardized Social and Health Assessment Peer Victimization Scale adapted from the Multidimensional Peer Victimization Scale (Ruchkin et al., 2004) for Cape Town AIDS-orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007): whether the child had experienced personal loss through theft, or property damage by vandalism. Children experiencing either of these direct forms of community violence by a school peer in the past year received the score of 1.

Witnessing home violence was assessed with two items from the UNICEF Measures for National-level Monitoring of Orphans and other Vulnerable Children (Snider & Dawes, 2006): whether the child had witnessed domestic conflict with shouting, or domestic physical violence. Children experiencing either of these indirect forms of home-based violence in the past week received the score of 1.

Witnessing community violence was assessed with two items from the adapted YC CECV (Richters & Martinez, 1993; SAPS Strategic Management, 2005): whether a child had witnessed either a shooting or a stabbing in an unspecified location outside of the home. Children ever experiencing (lifetime) either of these indirect forms of general community violence received the score of 1.

Socio-demographic Variables

Due to their correlations to violence against children, the three child demographic covariates of age, gender, and urbanicity were examined for their main effects. The
category of child age, spanning 10 to 17 years in the survey sample, was dichotomized according to UNESCO’s (2002) definitions of children (10-14) and youth (15-17). Gender was used in the original binary categories of male or female. Likewise, the location was binary (urban or rural), using survey categories from the 2001 *South African Census* (Statistics South Africa, 2001).

**Approach to Analysis**

The data were analyzed using SPSS software version 24.0 (IBM Corporation, 2016). Descriptive statistics explored the patterns in the YC sample demographics, and the covariates of age, gender, and location of the child in the Durban district. Descriptive statistics also explored each variable of interest within the composite VPS and violence outcome measures.

Each of the hypotheses regarding the four VPSs’ associations with nine violence exposures was analyzed in two phases. The first phase examined the association between each VPS and each violence outcome, while controlling for socio-demographic covariates. The second phase assessed the associations between increasing numbers of reported VPSs (from zero to four) and each violence outcome, while controlling for socio-demographic covariate main effects.

**Research questions and approaches to analyses**

RQ 1. *What are the individual associations between four individual INSPIRE-based VPSs (i.e., parent and caregiver support; income and economic strengthening; response and support services; and education and life skills) and nine violence exposures (the direct experiences of physical, emotional,*
sexual, and community violence, as well as the indirect experiences of witnessing family or witnessing community violence), after controlling for child socio-demographics?

To address this study question and test its four related hypotheses, binary logistic regressions were used to determine the main effects of each VPS’s association with each violence outcome. Each violence outcome was dichotomously scored as 1 (yes, they experienced this violence), or, 0 (no, they did not). Adjusted odds ratios with 95% confidence intervals were examined to determine which VPSs were significantly associated with each violence exposure, adjusting for the covariates.

RQ 2. After controlling for child demographics, is there a dose association between INSPIRE-based VPSs and violence risk, such that as the number of INSPIRE-based VPSs increases, the likelihood of experiencing each of the nine violence exposures decreases?

To address this question and test its six related hypotheses, the VPSs were summed as dichotomous variables to produce a composite VPS measure with a score ranging from zero to four. Multiple logistic regression tested the association with the nine violence outcomes, controlling for each of the three covariates. The group with no VPSs served as the reference category for the dose variable.

**Threats to Validity**

Features of this study threatened its validity, including its use of self-report measures and its cross-sectional design. These threats were directly addressed with strategies to diminish error within the study. Firstly, as the survey measures were based
on participants’ self-report of difficult topics and personal circumstances taken from interviews within private home settings where fear and menace are real (Burton et al., 2015; Madu & Peltzner, 2000), social desirability bias (Nederhof, 1985) could have affected the accuracy of the measures.

To address these concerns, interviewer staff trained to work with vulnerable children and questionnaire formats conducted the 60-minute face-to-face sessions in location as private as possible. Confidential health information regarding the child or family member was immediately placed in a sealed envelope and passed to responsible supervisors to add a layer of protection to the process of inquiry. Additionally, the scales used within the YC studies were contextualized to South African setting and were pretested in earlier studies of close circumstances to the YC study; they were subsequently verified for validity as constructs.

Secondly, as cross-sectional data, the study results can have no implied causality in either direction. No reference can be made to the prediction of lessened violence due to the presence of VPSs, either acting alone or with cumulative effects. This study examined the associations of these phenomenon only. Overall, many threats to validity were avoided by a strict adherence to sound data collection protocol, as well as to data analysis preparation and interpretation to ensure accurate results. However, children’s self-report and cross-sectional nature of the study may have affected the accuracy of the results and generalizability of the findings.

In summary, this study utilized a cross-sectional, correlational design with a sample of 2,477 child participants aged 10-17 living in the KwaZulu-Natal province of
South Africa. The study raised two research questions about the relationships among four VPSs (parent and caregiver support, income and economic strengthening, response and support services, and education and life skills) and nine violence outcomes (physical, emotional, sexual, community, witnessing family violence, and witnessing community violence). A total of 10 hypotheses were tested. The results of these analyses are presented in Chapter IV.
CHAPTER IV
RESULTS

A total of 2,477 children aged 10-17 years participated in the original Young Carers study conducted in low-income, HIV-endemic urban and rural communities in the KwaZulu-Natal province of South Africa. The secondary analysis of these data examined the associations of four types of family- or community-based violence prevention strategies with nine violence outcomes. The following chapter details the analyses and results for the 10 study hypotheses.

Data Preparation

Descriptive statistics were computed to explore all study variables. Frequencies, means, and standard deviations were used to assess the demographic and health characteristics of the 2,477 children and their representative households included in the Young Carers 2009-2010 KwaZulu-Natal survey. Table 4.1 describes the overall sample characteristics. Participants had a mean age of 13.6 years (SD = 2.23), over half were girls (53.9%), and most lived in rural locations (51.7%). Nearly all of the children attended school (98.5%), and very few had any major interruption to their educational trajectory (97.8%). All of the children in the study had resident caregivers, with the majority living with their mother (61.7%) or grandmother (17.9%). A small fraction of the sample (4.6%) lived in youth or child-headed households with the main caregiver being 25 years or younger. Less than half of the youth (42.8%) had at least one employed
person in the household. Under one-fifth (16.9%) of the participants lived in informal housing of shacks or on the streets.

Nearly one-third (30.3%) of the youth indicated the death of at least one parent; a fraction (4.6%) self-identified as double orphans with the loss of both parents. Over one-quarter (25.2%) shared living space with one or more sick persons. Mothers were mentioned most frequently as the ill family member (39.1%), followed by grandparents (34.6%). Of those with currently unwell family members in the home, 11.7% self-diagnosed the illness as HIV/AIDS.
Table 4.1. *Young Carers sample characteristics*

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<th>N (%) or M [SD]</th>
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<tr>
<td><strong>Total sample (n)</strong></td>
<td>2477</td>
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<tr>
<td>Female gender</td>
<td>1334 (53.9%)</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td>13.6 [2.23]</td>
</tr>
<tr>
<td>Rural resident</td>
<td>1279 (51.7%)</td>
</tr>
<tr>
<td><strong>School enrollment</strong></td>
<td>2439 (98.5%)</td>
</tr>
<tr>
<td>Uninterrupted studies</td>
<td>2326 (97.8%)</td>
</tr>
<tr>
<td>Household employment (at least one member employed)</td>
<td>1060 (42.8%)</td>
</tr>
<tr>
<td><strong>Housing</strong></td>
<td></td>
</tr>
<tr>
<td>Informal</td>
<td>404 (16.9%)</td>
</tr>
<tr>
<td>Formal</td>
<td>2072 (83.1%)</td>
</tr>
<tr>
<td><strong>Age of primary caregiver</strong></td>
<td>44.2 [13.2]</td>
</tr>
<tr>
<td>Living in home with caregiver aged 25 years or younger</td>
<td>114 (3.6%)</td>
</tr>
<tr>
<td><strong>Relationship to primary caregiver with whom they reside</strong></td>
<td></td>
</tr>
<tr>
<td>Biological mother</td>
<td>1528 (61.7%)</td>
</tr>
<tr>
<td>Biological father</td>
<td>108 (4.4%)</td>
</tr>
<tr>
<td>Foster/ step mother/father</td>
<td>103 (4.1%)</td>
</tr>
<tr>
<td>Grandmother</td>
<td>447 (17.9%)</td>
</tr>
<tr>
<td>Aunt/ uncle</td>
<td>148 (6.0%)</td>
</tr>
<tr>
<td>Other relative</td>
<td>24 (1.0%)</td>
</tr>
<tr>
<td>Other</td>
<td>17 (0.4%)</td>
</tr>
<tr>
<td>Orphan, at least one deceased parent</td>
<td>731 (30.3%)</td>
</tr>
<tr>
<td>Double orphan</td>
<td>113 (4.6%)</td>
</tr>
<tr>
<td><strong>Age of child at first orphanhood</strong></td>
<td>8.10 [4.21]</td>
</tr>
<tr>
<td>Sick family member in household</td>
<td>624 (25.2%)</td>
</tr>
<tr>
<td><strong>Sick family member relationship</strong></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td>244 (39.1%)</td>
</tr>
<tr>
<td>Father</td>
<td>28 (4.5%)</td>
</tr>
<tr>
<td>Grandparent</td>
<td>216 (34.6%)</td>
</tr>
<tr>
<td>Sibling</td>
<td>33 (5.3%)</td>
</tr>
<tr>
<td>Aunt/uncle</td>
<td>62 (9.9%)</td>
</tr>
<tr>
<td>Child</td>
<td>15 (2.4%)</td>
</tr>
<tr>
<td>Sick family member was reported to have HIV/AIDS</td>
<td>106 (11.7%)</td>
</tr>
</tbody>
</table>
The covariates of age, gender, and urbanicity were prepared as dichotomous variables. The YC variable of age that spanned ages 10-17 years was collapsed into two age categories of 10-14 (62.5%) and 15-17 years of age (37.5%). Though this study’s overall sample of participants was referred to as “children” per the CRC definition (UNICEF, 1989), in regards to the covariate of age, the two groups were differentiated as “children” (10-14) and “youth” (15-17) according to UNESCO’s 2002 definition guidelines. Gender was retained as the original YC binary categories of male (46.1%) and female (53.9%). Likewise, urbanicity was retained as the original YC settings of urban (48.3%) or rural home locations (51.7%).

**Construction of Composite Measures**

**Violence prevention strategies.** As fully described in Chapter III, the four violence prevention strategies (VPSs) represent composite measures constructed from scales used within the original YC study (see Appendix A). Representing the VPS of parent and caregiver social support, the composite measure of *positive parenting* was comprised of 10 items, seven of which were required to receive the score of 1 ($n=2,476, 55.5\%=1$). Representing the VPS of income and economic strengthening, the composite measure of *basic necessities* was comprised of seven items, five of which were required to receive the score of 1 ($n=2,476, 81.5\%=1$). Representing the VPS of response and support services, the composite measure of *formal social support* was comprised of two items, one of which was required to receive the score of 1 ($n=2,476, 36.8\%=1$). Representing the fourth VPS of educational and life skills, the composite measure of
school structural support was comprised of four items, one of which was required to receive the score of 1 \( n=2,411, 86.9\%=1 \).

To analyze the cumulative VPS association to the nine violence outcomes, a dose variable was created. Individual VPSs were summed with scores ranging from 0 to 4 \( n=2,476 \). Twenty-four participants indicated experiencing no VPS (1.0%), with 218 (8.8%) children reporting at least 1 VPS. Eight hundred and ninety-nine children (36.3%) cited the presence of 2 VPSs, and another 971 (39.2%) indicated at least 3 VPSs in their lives. Only 364 (14.7%) of the children attested to having all 4 VPSs. Due to the low frequencies in the 0 to 1 VPS range, these two categories were collapsed into a single group, which served as the referent category in the dose analyses.

**Violence outcomes.** As outlined in Chapter III, the nine violence outcome measures represent composite measures constructed from scales used within the original YC study (see Appendix B). The composite measure of physical violence at home was comprised of two items; yes to at least one item within the past year was required to receive the score of 1 \( n=2,475, 34.9\%=1 \). The composite measure of physical violence at school was comprised of three items; yes to at least one item within the past year was required to receive the score of 1 \( n=2,472, 13.8\%=1 \). The composite measure of emotional violence at home was comprised of three items; yes to at least one item within the past year was required to receive the score of 1 \( n=2,475, 18.6\%=1 \). The composite measure of emotional violence at school was comprised of four items; yes to at least one item within the past year was required to receive the score of 1 \( n=2,472, 32.5\%=1 \). The
composite measure of sexual violence was comprised of two items; yes to at least one item within the child’s lifetime was required to receive the score of 1 \( (n=2,475, 2.9\% = 1) \).

The composite measure of community violence at-large was comprised of two items; yes to at least one item within a mixed time frame (past year and lifetime) was required to receive the score of 1 \( (n=2,475, 27.2\% = 1) \). The composite measure of community violence at school was comprised of two items; yes to at least one item within the past year was required to receive the score of 1 \( (n=2,472, 25.4\% = 1) \).

The composite measure of witness of home violence was comprised of two items: the witness of adult conflict with shouting, and the witness of adult physical fighting. Yes to one item within the past week was required to receive the score of 1 \( (n=139, 100\% = 1) \). Unexpectedly, there was a large amount of missing data for adult physical fighting in the home \( (n=141) \). A case-by-case examination revealed that whenever a child answered no to one item, they simultaneously answered yes to the other. This situation created an overall 100% positive reporting from respondents. Thus, with no variability in the composite measure, this violence exposure was dropped, leaving eight remaining analyses. The composite measure of witness of community violence was comprised of two items; yes to at least one item within the child’s lifetime was required to receive the score of 1 \( (n=2,475, 10.1\% = 1) \).

**Research Hypothesis Testing**

**Hypotheses 1-4**

The first research question investigated whether four INSPIRE-based VPSs were individually associated with decreased likelihood of experiencing eight violence
exposures in children aged 10-17 in KwaZulu-Natal province of South Africa. This question led to four hypotheses. Associations between each VPS and individual violence outcomes controlling for social demographic covariates were tested with logistic regression and significance was tested with adjusted odds ratios (AOR) and 95% confidence intervals (CI). The analyses and results are described below for each hypothesis.

**H1.** After controlling for child age, gender, and urbanicity, having positive parenting will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as witnessing community violence).

Hypothesis 1 was tested using multiple logistic regression with eight individual violence outcomes serving as dependent variables in separate analyses. The composite measure of positive parenting with the covariates of child age, gender, and urbanicity were entered as predictor variables. Results are reported below and in Table 4.2.

**H1A. Positive parenting and physical violence at home.** Multiple logistic regression revealed no significant association between positive parenting and physical violence at home (AOR .95; 95% CI .80, 1.12). All covariates were significant, with youth, males, and urban dwellers being less likely to experience physical violence at home than their child, female, and rural counterparts. Hypothesis 1A was not supported by this analysis.

**H1B. Positive parenting and physical violence at school.** Multiple logistic regression revealed no significant association between positive parenting and physical
violence at school (AOR 1.00; 95% CI .80, 1.26). The covariates of age and urbanicity were significant, with youth and urban dwellers less likely to experience physical violence at school than their child and rural counterparts. Hypothesis 1B was not supported by this analysis.

**HIC. Positive parenting and emotional violence at home.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between positive parenting and emotional violence at home (AOR .67; 95% CI .54, .82), such that children with positive parenting were less likely to experience emotional violence at home. The covariate of urbanicity was significant, with urban dwellers less likely to experience emotional violence at home than their rural counterparts. Hypothesis 1C was supported by this analysis.

**H1D. Positive parenting and emotional violence at school.** Multiple logistic regression revealed no significant association between positive parenting and emotional violence at school (AOR .91; 95% CI .77, 1.07). The covariate of age was significant with youth less likely to experience emotional violence at school than their child counterparts. Hypothesis 1D was not supported by this analysis.

**H1E. Positive parenting and sexual violence.** Multiple logistic regression revealed no significant association between positive parenting and sexual violence (AOR .77; 95% CI .48, 1.23). All covariates were significant, with youth more likely to experience sexual violence than their child counterparts. Males and urban dwellers were less likely to experience sexual violence than their female and rural counterparts. Hypothesis 1E was not supported by this analysis.
H1F. Positive parenting and community violence at-large. Multiple logistic regression revealed a significant positive association ($p < 0.01$) between positive parenting and community violence at-large (AOR = 1.34, 95% CI = 1.12, 1.60), such that children with positive parenting were more likely to experience community violence at-large. No covariates were significant. Hypothesis 1F was not supported by this analysis.

H1G. Positive parenting and community violence at school. Multiple logistic regression revealed no significant association between positive parenting and community violence at school (AOR 1.15; 95% CI 0.95, 1.38). The covariate of age was significant, with youth being less likely to experience community violence at school than their child counterparts. Hypothesis 1G was not supported by this analysis.

H1H. Positive parenting and witness of community violence. Multiple logistic regression revealed no significant association between positive parenting and witnessing community violence (AOR 1.12; 95% CI 0.85, 1.46). All the covariates were significant, with youth, males, and urban dwellers being more likely to witness community violence than their child, female, and rural counterparts. Hypothesis 1H was not supported by this analysis.

Overall, Hypotheses 1 was partially supported with the significant negative association between positive parenting and emotional violence at home.
Table 4.2. Associations between the VPS of parent and caregiver social support’s “positive parenting” and violence outcomes, controlling for age, gender, and urbanicity

<table>
<thead>
<tr>
<th>VPS</th>
<th>Direct &amp; Indirect Violence Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical at home</td>
</tr>
<tr>
<td>Parent &amp; caregiver social support</td>
<td>n=2472</td>
</tr>
<tr>
<td>Positive parenting</td>
<td>.95 (.80, 1.12)</td>
</tr>
<tr>
<td>Age</td>
<td>.51 (.43, .62)</td>
</tr>
<tr>
<td>Gender</td>
<td>.81 (.69, .97)</td>
</tr>
<tr>
<td>Urbanicity</td>
<td>.82 (.69, .97)</td>
</tr>
</tbody>
</table>

AORs are Adjusted Odds Ratios. Bolded cells indicate that the 95% confidence interval does not include 1.

a = p < .05; b = p < .01; c = p < .001
**H2.** After controlling for child age, gender, and urbanicity, having access to income and economic strengthening will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as witnessing community violence).

Hypothesis 2 was tested using multiple logistic regression with eight individual violence outcomes serving as dependent variables in separate analyses. The composite measure of basic necessities with the covariates of child age, gender, and urbanicity were entered as predictor variables. Results are reported below and in Table 4.3.

**H2A. Basic necessities and physical violence at home.** Multiple logistic regression revealed no significant association between having basic necessities and physical violence at home (AOR 1.14; 95% CI 0.91, 1.42). All covariates were significant, with youth, males, and urban dwellers being less likely to experience physical violence at home than their child, female, and rural counterparts. Hypothesis 2A was not supported by this analysis.

**H2B. Basic necessities and physical violence at school.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between having basic necessities and physical violence at school (AOR 0.57; 95% CI 0.43, 0.74), such that children with necessities supplied were less likely to experience physical violence at school. The covariates of age and urbanicity were significant, with youth and urban dwellers less likely to experience physical violence at school than their child and rural counterparts. Hypothesis 2B was supported by this analysis.
**H2C. Basic necessities and emotional violence at home.** Multiple logistic regression revealed significant negative association ($p < 0.001$) between having basic necessities and emotional violence at home (AOR .66; 95% CI .52, .85), such that children with necessities supplied were less likely to experience emotional violence at home. The covariate of urbanicity was significant, with urban dwellers less likely to experience emotional violence at home than their rural counterparts. Hypothesis 2C was supported by this analysis.

**H2D. Basic necessities and emotional violence at school.** Multiple logistic regression revealed no significant association between having basic necessities and emotional violence at school (AOR .92; 95% CI .74, 1.15). The covariate of age was significant with youth less likely to experience emotional violence at school than their child counterparts. Hypothesis 2D was not supported by this analysis.

**H2E. Basic necessities and sexual violence.** Multiple logistic regression revealed a significant negative association ($p < 0.01$) between having basic necessities and sexual violence (AOR .47; 95% CI .28, .77), such that children with necessities supplied were less likely to experience sexual violence. The covariates of gender and urbanicity were significant, with males and urban dwellers less likely to experience sexual violence than their female and rural counterparts. Hypothesis 2E was supported by this analysis.

**H2F. Basic necessities and community violence at-large.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between having basic necessities and community violence at-large (AOR = .59; 95% CI .47, .74), such that
children with necessities supplied were less likely to experience community violence at-large. No covariates were significant. Hypothesis 2F was supported by this analysis.

**H2G. Basic necessities and community violence at school.** Multiple logistic regression revealed no significant association between having basic necessities and community violence at school (AOR .82; 95% CI .65, 1.04). The covariate of age was significant, with youth being less likely to experience community violence at school than their child counterparts. Hypothesis 2G was not supported by this analysis.

**H2H. Basic necessities and witness of community violence.** Multiple logistic regression revealed a significant negative association ($p < 0.01$) between having basic necessities and witnessing community violence (AOR .62; 95% CI .44, .86), such that children having necessities supplied were less likely to witness community violence. All the covariates were significant, with youth, males, and urban dwellers being more likely to witness community violence than their child, female, and rural counterparts. Hypothesis 2H was supported by this analysis.

Overall, Hypothesis 2 was partially supported with the significant negative association of having basic necessities to the five violence outcomes of physical violence at school, emotional violence at home, sexual violence, community violence at-large, and the witness of community violence.
Table 4.3. Associations between VPS of income and economic strengthening’s “basic necessities” and violence outcomes, controlling for age, gender, and urbanicity

<table>
<thead>
<tr>
<th>VPS</th>
<th>Physical at home</th>
<th>Physical at school</th>
<th>Emotional at home</th>
<th>Emotional at school</th>
<th>Sexual Violence</th>
<th>Community violence at-large</th>
<th>Community violence at school</th>
<th>Witness of community violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Income &amp; economic</td>
<td>n=2472</td>
<td>n=2472</td>
<td>n=2475</td>
<td>n=2472</td>
<td>n=2475</td>
<td>n=2475</td>
<td>n=2472</td>
<td>n=2475</td>
</tr>
<tr>
<td>strengthening</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Basic necessities</td>
<td>1.14 (.91, 1.42)</td>
<td>.57 (.43, .74)</td>
<td>.66 (.52, .85)</td>
<td>.92 (.74, 1.15)</td>
<td>.47 (.28, .77)</td>
<td>.59 (.47, .74)</td>
<td>.82 (.65, 1.04)</td>
<td>.62 (.44, .86)</td>
</tr>
<tr>
<td>Age</td>
<td>.51 (.62, .76)</td>
<td>.72 (.56, .92)</td>
<td>.98 (.79, 1.22)</td>
<td>.73 (.61, .88)</td>
<td>1.59 (.99, 2.55)</td>
<td>.88 (.73, 1.06)</td>
<td>.76 (.62, .92)</td>
<td>1.65 (.127, 2.15)</td>
</tr>
<tr>
<td>Gender</td>
<td>.81 (.69, .96)</td>
<td>1.09 (.87, 1.38)</td>
<td>.91 (.74, 1.12)</td>
<td>1.00 (.84, 1.18)</td>
<td>.56 (.34, .93)</td>
<td>1.14 (.95, 1.36)</td>
<td>1.01 (.84, 1.21)</td>
<td>1.37 (.105, 1.79)</td>
</tr>
<tr>
<td>Urbanicity</td>
<td>.82 (.69, .97)</td>
<td>.74 (.58, .95)</td>
<td>.63 (.51, .78)</td>
<td>1.16 (.98, 1.38)</td>
<td>.48 (.28, .81)</td>
<td>1.14 (.95, 1.37)</td>
<td>1.19 (.99, 1.43)</td>
<td>2.09 (.157, 2.77)</td>
</tr>
</tbody>
</table>

AORs are Adjusted Odds Ratios. Bolded cells indicate that the 95% confidence interval does not include 1.

a = p < .05; b = p < .01; c = p < .001
**H3:** After controlling for child age, gender, and urbanicity, having access to response and support services will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well as witnessing community violence).

Hypothesis 3 was tested using multiple logistic regression with eight individual violence outcomes serving as dependent variables in separate analyses. The composite measure of formal social support with the covariates of child age, gender, and urbanicity were entered as predictor variables. Results are reported below and in Table 4.4.

**H3A. Formal social support and physical violence at home.** Multiple logistic regression revealed a significant negative association ($p < 0.05$) between formal social support and physical violence at home ($\text{AOR} .82; 95\% \text{ CI} .69, .97$). All covariates were significant, with youth, males, and urban dwellers being less likely to experience physical violence at home than their child, female, and rural counterparts. Hypothesis 3A was supported by this analysis.

**H3B. Formal social support and physical violence at school.** Multiple logistic regression revealed no significant association between formal social support and physical violence at school ($\text{AOR} .89; 95\% \text{ CI} .70, 1.13$). The covariates of age and urbanicity were significant, with youth and urban dwellers less likely to experience physical violence at school than their child and rural counterparts. Hypothesis 3B was not supported by this analysis.
**H3C. Formal social support and emotional violence at home.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between formal social support and emotional violence at home (AOR .65; 95% CI .52, .81), such that children receiving formal social support were less likely to experience emotional violence at home. The covariate of urbanicity was significant, with urban dwellers less likely to experience emotional violence at home than their rural counterparts. Hypothesis 3C was supported by this analysis.

**H3D. Formal social support and emotional violence at school.** Multiple logistic regression revealed no significant association between formal social support and emotional violence at school (AOR 1.03; 95% CI .87, 1.23). The covariate of age was significant with youth less likely to experience emotional violence at school than their child counterparts. Hypothesis 3D was not supported by this analysis.

**H3E. Formal social support and sexual violence.** Multiple logistic regression revealed no significant association between formal social support and sexual violence (AOR 1.29; 95% CI .81, 2.08). All covariates were significant with youth more likely to experience sexual violence than their child counterparts, while males and urban dwellers were less likely to experience sexual violence than their female and rural counterparts. Hypothesis 3E was not supported by this analysis.

**H3F. Formal social support and community violence at-large.** Multiple logistic regression revealed no significant association between formal social support and community violence at-large (AOR = .91; 95% CI .75, 1.09). No covariates were significant. Hypothesis 3E was not supported by this analysis.
**H3G. Formal social support and community violence at school.** Multiple logistic regression revealed no significant association between formal social support and community violence at school (AOR .97; 95% CI .80, 1.17). The covariate of age was significant, with youth being less likely to experience community violence at school than their child counterparts. Hypothesis 3G was not supported by this analysis.

**H3H. Formal social support and witness of community violence.** Multiple logistic regression revealed a significant negative association ($p < 0.05$) between formal social support and witnessing community violence (AOR .73; 95% CI .55, .98), such that children receiving formal social support were less likely to witness community violence. All the covariates were significant, with youth, males, and urban dwellers being more likely to witness community violence than their child, female, and rural counterparts. Hypothesis 3H was supported by this analysis.

Overall, Hypothesis 3 was partially supported with the significant negative association of formal social support to the three violence outcomes of physical violence at home, emotional violence at home, and the witness of community violence.
Table 4.4. Associations between the VPS of response and support services’ “formal social support” and violence outcomes, controlling for age, gender, and urbanicity

<table>
<thead>
<tr>
<th>VPS</th>
<th>Physical at home</th>
<th>Physical at school</th>
<th>Emotional at home</th>
<th>Emotional at school</th>
<th>Sexual Violence</th>
<th>Community violence at-large</th>
<th>Community violence at school</th>
<th>Witness of community violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Direct &amp; Indirect Violence Outcomes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Response &amp; support services</td>
<td>n=2472</td>
<td>n=2472</td>
<td>n=2475</td>
<td>n=2472</td>
<td>n=2475</td>
<td>n=2475</td>
<td>n=2475</td>
<td>n=2475</td>
</tr>
<tr>
<td>Formal social support</td>
<td>.82 a ( .69, .97)</td>
<td>.89 ( .70, 1.13)</td>
<td>.65 c ( .52, .81)</td>
<td>1.03 ( .87, 1.23)</td>
<td>1.29 ( .81, 2.08)</td>
<td>.91 ( .75, 1.09)</td>
<td>.97 ( .80, 1.17)</td>
<td>.73 a ( .55, .98)</td>
</tr>
<tr>
<td>Age</td>
<td>.51 c ( .43, .61)</td>
<td>.72 b ( .57, .93)</td>
<td>.98 ( .80, 1.22)</td>
<td>.74 c ( .62, .88)</td>
<td>1.61 a (1.01, 2.57)</td>
<td>.89 ( .74, 1.07)</td>
<td>.76 b ( .63, .92)</td>
<td>1.65 c (1.27, 2.16)</td>
</tr>
<tr>
<td>Gender</td>
<td>.80 b ( .68, .95)</td>
<td>1.09 ( .87, 1.38)</td>
<td>.89 ( .73, 1.10)</td>
<td>1.00 ( .85, 1.19)</td>
<td>.59 a ( .36, .97)</td>
<td>1.14 ( .95, 1.36)</td>
<td>1.01 ( .84, 1.21)</td>
<td>1.35 a (1.04, 1.76)</td>
</tr>
<tr>
<td>Urbanicity</td>
<td>.83 a ( .71, .99)</td>
<td>.66 c ( .53, .84)</td>
<td>.58 c ( .47, .71)</td>
<td>1.15 ( .97, 1.36)</td>
<td>.41 c ( .25, .69)</td>
<td>1.03 ( .86, 1.23)</td>
<td>1.15 ( .96, 1.38)</td>
<td>1.89 c (1.44, 2.48)</td>
</tr>
</tbody>
</table>

AORs are Adjusted Odds Ratios. Bolded cells indicate that the 95% confidence interval does not include 1.

a = p < .05; b = p < .01; c = p < .001
**H4:** After controlling for child age, gender, and urbanicity, having access to structural support in education or life skills will be negatively associated with each violence exposure (physical violence in the home and school, emotional violence in the home and school, sexual violence, and community violence at-large and at school, as well witnessing community violence).

Hypothesis 4 was tested using multiple logistic regression with eight individual violence outcomes serving as dependent variables in separate analyses. The composite measure of school structural support with the covariates of child age, gender, and urbanicity were entered as predictor variables. Results are reported below and in Table 4.5.

**H4A. School structural support and physical violence at home.** Multiple logistic regression revealed no significant association between school structural support and physical violence at home (AOR 1.07; 95% CI .81, 1.42). The covariates of age and gender were significant, with youth and males being less likely to experience physical violence at home than their child and female counterparts. Hypothesis 4A was not supported by this analysis.

**H4B. School structural support and physical violence at school.** Multiple logistic regression revealed a significant negative association ($p < 0.05$) between school structural support and physical violence at school (AOR .67; 95% CI .45, .98). The covariates of age and urbanicity were significant, with youth and urban dwellers less likely to experience physical violence at school than their child and rural counterparts. Hypothesis 4B was supported by this analysis.
**H4C. School structural support and emotional violence at home.** Multiple logistic regression revealed a significant negative association ($p < 0.05$) between school structural support and emotional violence at home (AOR .69; 95% CI .49, .98), such that children receiving school structural support were less likely to experience emotional violence at home. The covariate of urbanicity was significant, with urban dwellers less likely to experience emotional violence at home than their rural counterparts. Hypothesis 4C was supported by this analysis.

**H4D. School structural support and emotional violence at school.** Multiple logistic regression revealed a significant association ($p < .05$) between school structural support and emotional violence at school (AOR .74; 95% CI .57, .97), such that children receiving school structural support were less likely to experience emotional violence at school. The covariate of age was significant with youth less likely to experience emotional violence at school than their child counterparts. Hypothesis 4D was supported by this analysis.

**H4E. School structural support and sexual violence.** Multiple logistic regression revealed no significant association between school structural support and sexual violence (AOR .85; 95% CI .32, 2.24). The covariate of urbanicity was significant with urban dwellers less likely to experience sexual violence than their rural counterparts. Hypothesis 4E was not supported by this analysis.

**H4F. School structural support and community violence at-large.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between school
structural support and community violence at-large (AOR = .58; 95% CI .44, .77). No covariates were significant. Hypothesis 4F was supported by this analysis.

**H4G. School structural support and community violence at school.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between school structural support and community violence at school (AOR .54; 95% CI .41, .72). The covariate of age was significant, with youth being less likely to experience community violence at school than their child counterparts. Hypothesis 4G was supported by this analysis.

**H4H. School structural support and witness of community violence.** Multiple logistic regression revealed a significant negative association ($p < 0.001$) between school structural support and witnessing community violence (AOR .48; 95% CI .34, .69), such that children receiving school structural support were less likely to witness community violence. All the covariates were significant, with youth, males, and urban dwellers being more likely to witness community violence than their child, female, and rural counterparts. Hypothesis 4H was supported by this analysis.

Overall, Hypothesis 4 was partially supported with the significant negative association of school structural support to the six violence outcomes of physical violence at school, emotional violence at home, emotional violence at school, community violence at-large, community violence at school, and the witness of community violence.
Table 4.5 Associations between the VPS of education and life skills’ “school structural support” and violence outcomes, controlling for age, gender, and urbanicity

<table>
<thead>
<tr>
<th>VPS</th>
<th>Direct &amp; Indirect Violence Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical at home</td>
</tr>
<tr>
<td></td>
<td>AOR (95% CI)</td>
</tr>
<tr>
<td>Education &amp; life skills</td>
<td>n=2409</td>
</tr>
<tr>
<td>School structural support</td>
<td>1.07 (.81, 1.42)</td>
</tr>
<tr>
<td>Age</td>
<td>.52 c (.44, .63)</td>
</tr>
<tr>
<td>Gender</td>
<td>.83 a (.70, .98)</td>
</tr>
<tr>
<td>Urbanicity</td>
<td>.84 (.70, 1.01)</td>
</tr>
</tbody>
</table>

AORs are Adjusted Odds Ratios. Bolded cells indicate that the 95% confidence interval does not include 1.
a = p < .05; b = p < .01; c = p < .001
**Hypotheses 5-10**

The second research question examined if there was a graded dose association between the numbers of VPSs and violence likelihood, such that a greater number of reported VPSs would be associated with a decreased risk for violence exposure. This question led to six hypotheses. In order to test the study hypotheses regarding the association of the cumulative VPSs to individual violence outcomes, individual VPSs were summed with scores ranging from 0 to 4. Due to consistently low frequencies in the 0 to 1 VPS range, these two categories were collapsed into one single group, which served as the referent group in the individual violence outcome analyses.

The associations between cumulative dichotomous VPSs and individual violence outcomes, controlling for socio-demographic covariates were tested with logistic regression; significance was tested with adjusted odds ratios (AOR) and 95% confidence intervals (CI). Chi-square testing affirmed that all cell sizes were adequate for robust logistic regression results (see Table 4.6). Only sexual violence had smaller overall numbers (total $n=73$) than the other seven violence outcomes, with the lowest cell numbers in the 0-1 VPS ($n=16$) and 4 VPSs ($n=16$) categories. The numbers of children indicating 4 VPS protective factors were consistently lower as compared with 2 VPS and 3 VPS levels in the same category (see Table 4.6).
Table 4.6. Cell counts and percentages associated between the number of VPSs and individual violence outcomes

<table>
<thead>
<tr>
<th>Number of VPSs</th>
<th>Physical at home</th>
<th>Physical at school</th>
<th>Emotional at home</th>
<th>Emotional at school</th>
<th>Sexual</th>
<th>Community at-large</th>
<th>Community at school</th>
<th>Witness in community</th>
</tr>
</thead>
<tbody>
<tr>
<td>n = yes</td>
<td>n=864 (34.9%)</td>
<td>n=341 (13.8%)</td>
<td>n=460 (18.6%)</td>
<td>n=804 (32.5%)</td>
<td>n=73 (2.9%)</td>
<td>n=672 (27.2%)</td>
<td>n=629 (25.4%)</td>
<td>n =249 (10.1%)</td>
</tr>
<tr>
<td>0-1 referent</td>
<td>80 (33.2)</td>
<td>49 (20.3)</td>
<td>74 (30.7)</td>
<td>80 (33.2)</td>
<td>16 (6.6)</td>
<td>82 (34.0)</td>
<td>71 (29.5)</td>
<td>46 (19.1)</td>
</tr>
<tr>
<td>2</td>
<td>305 (33.9)</td>
<td>121 (13.5)</td>
<td>186 (20.7)</td>
<td>297 (33.1)</td>
<td>22 (2.4)</td>
<td>236 (26.3)</td>
<td>217 (24.2)</td>
<td>88 (9.8)</td>
</tr>
<tr>
<td>3</td>
<td>368 (37.9)</td>
<td>131 (13.5)</td>
<td>155 (16.0)</td>
<td>323 (33.3)</td>
<td>19 (2.0)</td>
<td>271 (27.9)</td>
<td>263 (27.1)</td>
<td>87 (9.0)</td>
</tr>
<tr>
<td>4</td>
<td>111 (30.5)</td>
<td>40 (11.0)</td>
<td>45 (12.4)</td>
<td>104 (28.6)</td>
<td>16 (4.4)</td>
<td>83 (22.8)</td>
<td>78 (21.4)</td>
<td>28 (7.7)</td>
</tr>
</tbody>
</table>
For ease of interpretation in the analyses, inverse adjusted odds ratios (IAORs) are provided and interpreted for dose categories that were significant. The analyses and results for each hypothesis are reported below and displayed in Table 4.7 and Figure 4.1.
Table 4.7. Associations between the number of VPSs and individual violence outcomes with controlling variables

<table>
<thead>
<tr>
<th>VPSs</th>
<th>Physical at home</th>
<th>Physical at school</th>
<th>Emotional at home</th>
<th>Emotional at school</th>
<th>Sexual Violence</th>
<th>Community violence at-large</th>
<th>Community violence at school</th>
<th>Witness of community violence</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
<td>AOR (IAOR) [95% CI]</td>
</tr>
<tr>
<td>0-1</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
<td>Referent</td>
</tr>
<tr>
<td>2</td>
<td>.95 (.70, 1.30)</td>
<td>.60 (1.67)</td>
<td>.59 (1.69)</td>
<td>.96 (.71, 1.29)</td>
<td>.36 (2.78)</td>
<td>.69 (1.45)</td>
<td>.74 (.53, 1.01)</td>
<td>.47 (2.13)</td>
</tr>
<tr>
<td>3</td>
<td>1.10 (.81, 1.49)</td>
<td>.59 (1.69)</td>
<td>.42 (2.38)</td>
<td>.95 (.70, 1.28)</td>
<td>.29 (3.45)</td>
<td>.74 (1.35)</td>
<td>.84 (.62, 1.15)</td>
<td>.44 (2.27)</td>
</tr>
<tr>
<td>4</td>
<td>.77 (.54, 1.10)</td>
<td>.46 (2.17)</td>
<td>.30 (3.33)</td>
<td>.77 (.54, 1.10)</td>
<td>.60 (.29, 1.24)</td>
<td>.57 (1.75)</td>
<td>.63 (.59)</td>
<td>.40 (2.50)</td>
</tr>
<tr>
<td>Age</td>
<td>.51 (.43, 1.62)</td>
<td>.70 (.55, 1.90)</td>
<td>.93 (.75, 1.16)</td>
<td>.73 (.61, 1.87)</td>
<td>1.50 (.93, 2.41)</td>
<td>.87 (.72, 1.05)</td>
<td>.75 (.62, 1.91)</td>
<td>1.57 (1.20, 2.06)</td>
</tr>
<tr>
<td>Gender</td>
<td>.81 (.68, 1.96)</td>
<td>1.07 (.54, 1.35)</td>
<td>.87 (.71, 1.07)</td>
<td>.99 (.84, 1.18)</td>
<td>.56 (.34, 0.92)</td>
<td>1.12 (.94, 1.34)</td>
<td>1.00 (.83, 1.20)</td>
<td>1.34 (1.02, 1.75)</td>
</tr>
<tr>
<td>Urbanicity</td>
<td>.83 (.70, 1.98)</td>
<td>.67 (.53, 1.84)</td>
<td>.57 (.47, 1.71)</td>
<td>1.14 (.96, 1.35)</td>
<td>.43 (.26, 0.72)</td>
<td>1.03 (.86, 1.23)</td>
<td>1.15 (.96, 1.38)</td>
<td>1.93 (1.47, 2.53)</td>
</tr>
</tbody>
</table>

AORs are Adjusted Odds Ratios. IAORs are Inverse Adjusted Odds Ratios for significant negative associations of VPSs and violence outcomes. Bolded cells indicate that the 95% confidence interval does not include 1.

a = p < .05; b = p < .01; c = p < .001
**H5.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing physical violence in the home and school will decrease.

Hypothesis 5 was tested using multiple logistic regression with physical violence at home and at school serving as dependent variables in separate analyses with the cumulative VPSs and covariates of child age, gender, and urbanicity entered as predictor variables. Results are reported below and in Table 4.7.

**H5A. Physical violence at home.** Multiple logistic regression revealed no significant association at any level between cumulative VPSs and physical violence at home (2 VPSs v 0-1 VPS, AOR .95; 95% CI .70, 1.30; 3 VPSs v 0-1 VPS, AOR 1.10; 95% CI .81, 1.49; 4 VPSs v 0-1 VPS, AOR .77; 95% CI .54, 1.10). All the covariates were significant, with youth, males, and urban dwellers being less likely to experience physical violence at home than their child, female, and rural counterparts. Hypothesis 5A was not supported by this analysis.

**H5B. Physical violence at school.** Multiple logistic regression revealed significant negative associations at all levels between cumulative VPSs and physical violence at school (2 VPSs v 0-1 VPS, p < 0.01, AOR .60; 95% CI .42, .87; 3 VPSs v 0-1 VPS, p < 0.01, AOR .59; 95% CI .41, .85; 4 VPSs v 0-1 VPS, p < 0.001, AOR .46; 95% CI .29, .72). The covariates of age and urbanicity were significant, with youth and urban dwellers being less likely to experience physical violence at school than their child and rural counterparts. Hypothesis 5B was supported by this analysis.
Inverse adjusted odds ratios revealed that participants with two and three protective factors were more than one and two-thirds (1.67 and 1.69 respectively) times less likely to experience physical violence at school than their counterparts who had zero to one protective factors. Participants with four protective factors were more than two (2.17) times less likely to experience physical violence at school than their peers who had zero to one protective factors (see Figure 4.1).

Overall, Hypothesis 5 was partially supported with the significant negative associations of all levels of cumulative VPSs to physical violence at school.

**H6.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing emotional violence at home and school will decrease.

Hypothesis 6 was tested using multiple logistic regression with emotional violence at home and school serving as dependent variables in separate analyses with the VPSs and covariates of child age, gender, and urbanicity entered as predictor variables. Results are reported below and in Table 4.7.

**H6A. Emotional violence at home.** Multiple logistic regression revealed a significant negative association at all levels between cumulative VPSs and emotional violence at home (2 VPSs v 0-1 VPS, \( p < 0.001 \), AOR .59; 95% CI .43, .82; 3 VPSs v 0-1 VPS, \( p < 0.001 \), AOR .42; 95% CI .31, .59; 4 VPSs v 0-1 VPS, \( p < 0.001 \), AOR .30; 95% CI .20, .46). The covariate of urbanicity was significant, with urban dwellers being less likely to experience emotional violence at home than their rural counterparts. Hypothesis 6A was supported by this analysis.
Inverse adjusted odds ratios revealed that participants with two protective factors were more than one and two-thirds (1.69) times less likely, while those with three protective factors were over two and one-third (2.38) times less likely to experience emotional violence at home than their counterparts who had zero to one protective factors. Participants with four protective factors were three and one-third (3.33) times less likely to experience emotional violence at home than their peers who had zero to one protective factors (see Figure 4.1).

**H6B. Emotional violence at school.** Multiple logistic regression revealed no significant association at any level between cumulative VPSs and emotional violence at school (2 VPSs v 0-1 VPS, AOR .96; 95% CI .71, 1.29; 3 VPSs v 0-1 VPS, AOR .95; 95% CI .70, 1.28; 4 VPSs v 0-1 VPS, .77; 95% CI .54, 1.10). The covariate of age was significant, with youth being less likely to experience emotional violence at school than their child counterparts. Hypothesis 6B was not supported by this analysis.

Overall, Hypothesis 6 was partially supported with the significant negative associations of all levels of cumulative VPSs to emotional violence at home.

**H7.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing sexual violence will decrease.

Hypothesis 7 was tested using multiple logistic regression with sexual violence serving as the dependent variable with the VPSs and covariates of child age, gender, and urbanicity entered as predictor variables. Results are reported below and in Table 4.7.

**Sexual violence.** Multiple logistic regression revealed that participants with 2 VPSs and those with 3 VPSs significantly differed from those with 0-1 VPS on the
likelihood of experiencing sexual violence (2 VPSs v 0-1 VPS, $p < 0.01$, AOR .36; 95% CI .19, .71; 3 VPSs v 0-1 VPS, $p < 0.001$, AOR .29; 95% CI .14, .57). No significant association was found between those with 4 VPSs and the referent group (AOR .60; 95% CI .29, 1.24). The covariates of gender and urbanicity were significant, with males and urban dwellers being less likely to experience sexual violence than their female and rural counterparts.

Inverse adjusted odds ratios revealed that participants with two protective factors were more than two and three-quarters (2.78) times less likely, while those with three protective factors were nearly three and one-half (3.45) times less likely to experience sexual violence than their counterparts who had zero to one protective factors (see Figure 4.1).

Overall, Hypothesis 7 was partially supported by this analysis by the significant negative associations of 2 and 3 VPSs to sexual violence.

**H8.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of experiencing community violence at-large and at school will decrease.

Hypothesis 8 was tested using multiple logistic regression with community violence at-large and at school serving as dependent variables in separate analyses with the VPSs and covariates of child age, gender, and urbanicity entered as predictor variables. Results are reported below and in Table 4.7.

**H8A. Community violence at-large.** Multiple logistic regression revealed significant negative associations at all levels between cumulative VPSs and community
violence at-large (2 VPSs v 0-1 VPS, \( p < 0.05, \text{AOR} .69; 95\% \text{CI} .50, .93; 3 \text{ VPSs v 0-1 VPS, \( p < 0.05, \text{AOR} .74; 95\% \text{CI} .55, 1.00; 4 \text{ VPSs v 0-1 VPS, \( p < 0.01, \text{AOR} .57; 95\% \text{CI} .40, .82)\}. No covariates were significant. Hypothesis 8A was partially supported by this analysis.

Inverse adjusted odds ratios revealed that participants with two protective factors were nearly than one and one-half (1.45) times less likely, while those with three protective factors were over one and one-third (1.35) times less likely to experience community violence at-large than their counterparts who had zero to one protective factors. Participants with four protective factors were one and three-quarters (1.75) times less likely to experience community violence at-large than their peers who had zero to one protective factors (see Figure 4.1).

**H8B. Community violence at school.** Multiple logistic regression revealed no significant associations for 2 VPSs versus 0-1 VPS, and 3 VPSs versus 0-1 VPS and community violence at school (2 VPSs, \( \text{AOR} .74; 95\% \text{CI} .53, 1.01; 3 \text{ VPSs, AOR} .84; 95\% \text{CI} .62, 1.15)\). However, a significant negative association was found when comparing those with 4 VPSs to the referent group on the likelihood of experiencing community violence at school (4 VPSs v 0-1 VPS, \( p < 0.01, \text{AOR} .63; 95\% \text{CI} .43, .91)\). The covariate of age was significant, with youth being less likely to experience community violence at school than their child counterparts. Hypothesis 8B was partially supported by this analysis.

Inverse adjusted odds ratios revealed that participants with four protective factors were more than one and one-half (1.59) times less likely to experience community violence at school.
violence at school than their peers who had zero to one protective factors (see Figure 4.1).

Overall, Hypothesis 8 was partially supported with the significant negative associations of cumulative VPSs to community violence at-large and community violence in school.

**H9.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of witnessing family violence will decrease.

Hypothesis 9 could not be tested due to the lack of variability in the composite measure of witnessing family violence as all of the YC respondents affirmed witnessing family violence in either of its forms of shouting conflict or domestic violence. Thus, no conclusion could be made regarding the original hypothesis.

**H10.** After controlling for child age, gender, and urbanicity, as the number of overall VPSs increases, the likelihood of witnessing community violence will decrease.

Hypothesis 10 was tested using multiple logistic regression with witnessing community violence serving as the dependent variable with the VPSs and covariates of child age, gender, and urbanicity entered as predictor variables. Results are reported below and in Table 4.7.

**Witnessing community violence.** Multiple logistic regression revealed a significant negative association at all levels between cumulative VPSs and witnessing community violence (2 VPSs v 0-1 VPS, $p < 0.001$, AOR .47; 95% CI .32, .70; 3 VPSs v 0-1 VPS, $p < 0.001$, AOR .44; 95% CI .30, .66; 4 VPSs v 0-1 VPS, $p < 0.001$, AOR .40; 95% CI .24, .66). All covariates were significant, with youth, males, and urban dwellers
being more likely to witness community violence than their child, female, and rural counterparts.

Inverse adjusted odds ratios revealed that participants with two protective factors were more than two (2.13) times less likely, while those with three protective factors were over two and one-quarter (2.27) times less likely to witness community violence than their counterparts who had zero to one protective factors. Participants with four protective factors were two and one-half (2.50) times less likely to witness community violence than their peers who had zero to one protective factors (see Figure 4.1).

Overall, Hypothesis 10 was fully supported with the significant negative associations of all levels of cumulative VPSs to the witnessing of community violence.

Figure 4.1. VPS protective factors and significant violence outcomes

KEY: Phys school = physical violence at school; Emo home = emotional violence at home; Comm gen'l = community violence at-large; Comm school = community violence at school; Sexual = sexual violence; Witness comm = witness of community violence
Summary of Results

Two research questions were proposed for this study regarding the associations of four VPSs, whether single or cumulative, to eight individual violence outcomes, taking into consideration the social demographics of child age, gender, and urbanicity. Ten hypotheses were proposed and tested. The study results fully supported one hypothesis and partially supported another 8 of the 10 hypotheses. One hypothesis could not be tested due to the lack of variability in the composite violence measure. A summary of the overall findings is detailed below.

Hypotheses 1-4

Results partially supported Hypotheses 1-4. Logistic regression models that entered each VPS separately with the covariates of age, gender, and urbanicity showed significant results. Findings showed that single VPSs had significant negative associations to every violence exposure tested, after controlling for demographic factors. Positive parenting was significantly negatively associated with one violence outcome: emotional violence at home. Basic necessities was significantly negatively associated with five violence outcomes: physical violence at school, emotional violence at home, sexual violence, community violence at-large, and the witnessing of community violence. Formal social support was significantly negatively associated with three violence outcomes: physical violence at home, emotional violence at home, and the witnessing of community violence. School structural support was significantly negatively associated with six violence outcomes: physical violence at school, emotional violence at home,
emotional violence at school, community violence at-large, community violence at school and the witnessing of community violence.

Hypotheses 5–10

Logistic regression models that entered cumulative VPSs with the covariates of age, gender, and urbanicity showed significant results of graded dose responses to individual violence exposures. Overall one hypothesis was fully supported, with another four hypotheses partially supported; one hypothesis was dropped from the analyses. In total, six violence outcomes showed significant decreasing likelihood of exposure with increasing numbers of protective factors. These were physical violence at school, emotional violence at home, sexual violence, community violence at-large, community violence, and witnessing community violence. Only physical violence at home and emotional violence at school showed no significant associations to the cumulative VPSs at any level. Findings are discussed in detail in Chapter V.
CHAPTER V

DISCUSSION

This study analyzed the associations of both single and cumulative violence prevention strategies (VPSs) to eight direct and indirect violence outcomes within the settings of family, school, and community. Conspicuously, the research results showed no violence exposure untouched by a significant association to interventions of prevention and response, whether single or combined. Key findings from these investigations with their implications for practitioners will be discussed. Lastly, study limitations will be acknowledged, as well as recommendations for further research given in this important domain of child protection.

Key Findings

Associations of Single VPSs to Violence Outcomes

The first research question explored the associations between each of four VPSs with the eight individual violence outcomes. After controlling for the child’s socio-demographic variables of age, gender, and urbanicity, logistic models showed significant negative associations in every VPS category to violence outcomes, though the strength and range of association varied with every VPS tested (see Table 5.1). The results of these analyses are discussed below from those VPSs having the least number of decreased associations with the violence outcomes to those having the largest number of significant association.
**Parent and caregiver support.** Positive parenting was the composite measure that represented the VPS of parent and caregiver support in these analyses. Over half (55.5%) of the YC participants responded that they experienced firm, but supportive parenting in their home.

Contrary to expectation, there was a significant positive association with community violence at-large and positive parenting. It is possible that those children who experience violence in the community have an increased likelihood to receive greater support and affirming parental care at home to counter these adverse experiences.

There was only one significant generalized association of positive parenting to the eight violence outcomes, which was the exposure to emotional violence at home. This result indicated that children raised with positive parenting were less likely to experience emotional violence at home. Though this exposure was the only significant association within this individual VPS category, the association was highly significant ($p < 0.001$).

This result is important since the home is a frequent venue for violence. In a 2000 South African national victimization survey of youth aged 12-22, the highest percentage (21.8%) of participants reported home as the most common location of violence exposure (Leoschut & Kafaar, 2017). Though causality cannot be implied, these findings suggest the positive parenting model has strong protective associations that may reduce children’s experience of emotional violence, decreasing violence’s toll in the home with nurturing relationships of accord and warm parental support. Though preliminary Sub-Saharan studies have marked the short-term influence of positive parenting upon reduced physical and emotional violence in the home (five to nine month post-intervention caregiver report...
only, not confirmed by adolescent report; Cluver et al., 2017), further research needs to examine the associations of positive parenting to a range of children’s violence exposures to gain insight into potential wider associations in this same setting.

Response and support services. Formal social support was the composite measure that represented the VPS of response and support services. This VPS is unique as the only strategy having both aspects of prevention and response to violence. Unexpectedly, formal social support had significant negative associations to only three violence outcomes. These were physical violence at home ($p < .0.05$), emotional violence at home ($p < 0.001$), and the witnessing of community violence ($p < 0.001$).

A possible explanation for this low number of significant associations could be the limited means of formal social support available in these communities. Only 36.8% of the YC participants responded positively to having the support of a religious leader, classroom teacher, or school principal in their lives. Due to the paucity of formal support available, future investigations should consider examining a range of informal social support to investigate the effect of these alternatives on the reduced likelihood of violence in children’s lives.

Previous research has demonstrated that support from caring adults and external organizations are essential to a spectrum of healthy lifestyle behaviors for children, helping to create a more harmonious home environment with less physical and emotional abuse, more caregiver praise, and less domestic conflict and violence (Yakubovich et al., 2016). This study’s findings upheld this earlier research. Notably, formal social support was the only VPS associated with the decreased likelihood of physical violence at home.
This association, coupled with the decreased likelihood of emotional violence at home, suggests the importance of the network of outside relationships to better outcomes within the intimacy of the home environment through the dual action of prevention of and response to violence. This finding is important since, as already noted, the home is a frequent location of violence for many children.

Though two other VPSs, basic necessities and school structural support, were associated with the witness of community violence, it is insightful to see formal social support’s associations to the decreased likelihood of violence exposure extend outside of the home environment. Though no significant associations were found to the forms of violence at school, findings suggest that formal social support had a highly significant ($p < 0.001$) protective association to the witnessing of community violence.

Community violence is one of the most prevalent forms of violence exposure in South Africa, especially for those children coming from low-income areas (Meinck et al., 2017). The most common modes of community violence exposure are through witnessing violence in the street, neighborhood, or at school; being robbed or assaulted; or witnessing a family member being hurt or killed (Martin et al., 2013). Sadly, whether community violence is experienced as a victim or witness, it can be equally traumatizing to children (Bacchini et al., 2015; Felitti et al., 1998). Given the study results of formal social support to the decreased likelihood of witnessing community violence, future research should seek to better understand the latent factors operative in this important protective association.
**Income and economic strengthening.** Basic necessities was the composite measure that represented the VPS of income and economic strengthening in the study analyses. Over three-quarters (81.5%) of the participants responded that they had the basic provisions required for daily life. Basic necessities had a significant negative association to the majority (five of the eight) of violence outcomes. These were physical violence at school ($p < 0.001$), emotional violence at home ($p < 0.001$), sexual violence ($p < 0.01$), community violence at-large ($p < 0.001$), and the witnessing of community violence ($p < 0.01$).

Poverty was associated with physical child abuse in African-based studies examining African risk and protective factors for violence (Meinck et al., 2015a). This result corresponds to data originating in high-income countries linking poverty with increased susceptibility to physical violence victimization. Income and economic strengthening seeks to improve families’ economic base and financial stability to lessen adult stress levels that may heighten the likelihood of child maltreatment and domestic abuse (WHO, 2016). These current findings concur with African field research that income and economic strengthening have the potential to indirectly protect children from violence.

However in the present study, in contrast to the above-mentioned African studies, having basic necessities was not associated with decreased likelihood of experiencing physical violence in the home, which in the original study was tied to the social norm of corporal punishment. Nevertheless, basic necessities was strongly associated with physical violence at school, as well as significantly linked to the decreased likelihood of
experiencing or witnessing community violence at-large. In this way, these study findings corroborate earlier research demonstrating the provision of basic necessities as an important intervention in the protection of children from physical violence exposure in various venues. Additionally, besides physical violence in the home, having basic necessities was strongly associated with decreased emotional violence in the home. An untested explanation of this robust connection with the home setting is the easing of adult stress associated with the strains of poverty that may diminish caregiver susceptibility to punitive parenting.

It was unanticipated that while the association between having basic necessities and physical violence at school was highly significant, the association did not extend to any of violence’s other forms in school—whether emotional or community violence at school. It is possible that emotional violence at school is not shaped by either the lack or supply of basic necessities, but involves other factors. The lack of association with community violence at school, centered on the theft or vandalism of goods, shows the possibility that this violence also has other root causes and related risk factors than those of physical violence at school.

Conspicuously, basic necessities was the only individual VPS associated with the decreased likelihood of sexual violence. Prior studies in Sub-Saharan Africa have shown social protection in the form of direct cash subsidies to at-risk youth have helped reduce child sexual abuse and exploitation (The Transfer Project Team, 2017). This important finding underscores the current Sub-Saharan literature of the efficacy providing basic necessities to reduce the likelihood of children experiencing sexual violence.
Findings from the controlling demographics suggested that older females within rural communities have the higher likelihood of sexual violence than their younger male counterparts from urban locations, corresponding to other African studies (Together for Girls, 2017). Provision to at-risk teen girls may reduce sexual exploitation of their need to procure basic supplies. With the potential of self-report measures to bias study results (due to the increased vulnerability associated with responding honestly to culturally sensitive topics such as sexual violence), it is possible that the actual number of victimized children was much greater than conveyed (2.9%; Burton et al., 2015; Madu & Peltzner, 2000). As sexual violence in Africa is associated with revictimization, bullying, and perpetration, as well as the heightened risk of HIV infection (Meinck et al., 2017), it is crucial that further research examine how best to provide basic life necessities with dignity and sustainability.

**Education and life skills.** School structural support was the composite measure that represented the VPS of education and life skills. This VPS was a relevant measure for the YC participants as virtually all children (98.5%) in the study stated being enrolled in school at the time of the study; likewise nearly all (97.8%) the children indicated no long-term absences interrupting their educational progress. Corresponding to these figures, this VPS was experienced by the vast majority of YC participants; over 8 of 10 students (86.9%) reported receiving one or more means of school structural support in the form of free meals, transport, uniforms, and textbooks.

School structural support had a large number of significant negative associations to violence, the broadest of all the individual VPSs, significantly linked to six of the eight
violence outcomes. These were physical violence at school ($p < 0.05$), emotional violence at home ($p < 0.05$), emotional violence at school ($p < 0.05$), community violence at-large ($p < 0.001$), community violence at school ($p < 0.001$), and the witnessing of community violence ($p < 0.001$). It is likely that in its provision of meals with the educational support of needed supplies, school structural support utilizes a pathway similar to basic necessities, alleviating the duress of poverty, while promoting equity among students that make children less susceptible to violence. Alternatively, there could be a mediator, such as individuals or groups that provide these school supports acting in a protective role against violence. More research of moderators needs to be done to better understand these relationships.

While both basic necessities and school structural support were associated with the decreased likelihood of experiencing physical violence at school, school structural support was the only individual VPS that touched both emotional violence at school and community violence at school. South Africa research documents school as a common site for children’s experience of violence (15.1 to 22.2% nationally), whether from authority figures in the form of punishment or through bullying from peers (Burton & Leoschut, 2012). While Know Violence’s Ending Violence in Childhood: Global Report 2017 found that being bullied at school was the most common form of childhood violence for the world’s children in the middle age range of 13-15 years, African statistics showed exposure to bullying by virtually every other child (47% in Eastern and Southern Africa; 51% in West and Central Africa). This important finding of the association of having school structural support to the lessened likelihood of experiencing various forms of
violence at school contributes to the current field literature (Leoschut & Kafaar, 2017), suggesting that the provision of educational needs may help ensure that schools are safe learning environments for all their students regardless of household income.

Overall, this study showed no form of violence untouched by a significant association to interventions of prevention and response. This key finding suggests the value of formal and informal interventions in reducing children’s experience of violence across a range of common violence exposures. Furthermore, each VPS had its own constellation of associations to violence, suggesting the influence of specific interventions to particular exposures. Moreover, some VPSs were more strongly associated to reduced likelihood of violence outcomes than others, pointing to pathways of abuse that may have common root causes that can targeted by specific interventions.

In this study, the “human side” of individual interventions, as portrayed by positive parenting practices and formal response and support services, was less associated with diminished violence outcomes, while those VPSs tied to economic provision, whether at home or school, were more broadly associated with decreased likelihoods of violence. This finding is important as South African research has shown that children coming from HIV/AIDS-affected households and those facing chronic illness with high levels of disability are at high risk for physical and emotional abuse, being proportionally more vulnerable to victimization with increasing levels of poverty (Meinck et al., 2016). A conceivable explanation for these previous findings may be that poverty’s multiple aspects, with their associated stresses upon both adult and child, increase the likelihood of violence perpetration and polyvictimization. Findings from the current study suggest
that interventions that release poverty’s underlying pressures, while allowing children access to education, are associated with better overall protection of children from a wide range of violence exposures. (See Table 5.1 for a summary of study findings.)
Table 5.1. *Overview of individual associations between VPSs and violence outcomes*

<table>
<thead>
<tr>
<th>VPS</th>
<th>Direct &amp; Indirect Violence Outcomes</th>
<th>p-values (p &lt; )</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Physical at home</td>
<td>Physical at school</td>
</tr>
<tr>
<td>Positive parenting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td>Basic necessities</td>
<td></td>
<td>.001</td>
</tr>
<tr>
<td>Formal social support</td>
<td>.05</td>
<td></td>
</tr>
<tr>
<td>School structural support</td>
<td>.05</td>
<td>.05</td>
</tr>
<tr>
<td>COVARIATE</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>Gender</td>
<td>x</td>
<td></td>
</tr>
<tr>
<td>Urbanicity</td>
<td>(x)</td>
<td>x</td>
</tr>
</tbody>
</table>

x = significant negative association; + = significant positive association; ( ) = not significant for all 4 VPSs
Associations of Cumulative VPSs to Violence Outcomes

Previous research in lower income communities located in high-income countries demonstrated the efficacy of a collaborative approach to the elimination of violence against children. These positive outcomes led INSPIRE to promote broad research in LMICs regarding the effectiveness of a comprehensive strategy that combines and reinforces sectoral assets and strengths (WHO, 2016). As INSPIRE’s effectiveness centers on preventions and responses across multiple societal sectors, this discussion now turns from the consideration of the single interventions of the first research question to the four VPSs’ collective associations to the eight individual violence outcomes.

The second research question examined if there was a graded dose association between the increasing number of VPSs and the likelihood of violence, such that a greater number of reported VPSs would be associated with a decreased risk for individual violence exposures. After controlling for the child socio-demographic factors of age, gender, and urbanicity, logistic models showed significant negative associations for doses of two to four VPSs to six of the eight violence outcomes (see Table 5.2). The next section provides a discussion of the results of these analyses, first with the consideration of two violence outcomes that had no significant associations to two or more VPSs, followed by the six violence outcomes which displayed significant decreasing likelihood of their occurrence with increasing numbers of protective factors.

Physical violence at home. Contrary to expectation, the cumulative VPSs had no association to physical violence at home, though over one-third (34.9%) of the participants responded that they had experienced this violence in the past year. A possible
explanation for this finding is the fact that corporal punishment is an accepted practice of many African cultures (Bornstein, 2010; Know Violence in Childhood, 2017). As such, it is plausible that deep-seated methods of parental discipline would not be changed through economic or scholastic provision of basic necessities. In the analysis of single VPSs, only response and support services were significantly associated with physical violence at home, pointing to the potential of outside psychosocial preventions and responses to lead and sustain in normative change. Further research is needed to better understand this relationship.

**Emotional violence at school.** As with physical violence in the home, cumulative VPSs had no significant associations to emotional violence at school at any level though nearly one-third (32.5%) of the participants responded that they had experienced this form of violence in the past year. A possible explanation for this unexpected result was mentioned in the discussion of school structural support. Emotional violence at school exemplifies one aspect of bullying in this study, along with physical violence at school and community violence at school. Like corporal punishment, bullying represents a widely prevalent socially accepted form of violence for which this study’s cluster of preventions and responses was not linked as a protective factor. Only the single VPS of school structural support was significantly associated with emotional violence at school. This connection may indicate the potential of equitable instrumental provision that sustains student attendance to lead to safer learning environments. Further research is needed to better understand the relationship between school structural support and bullying.
**Physical violence at school.** Cumulative VPSs had increasing significant associations to physical violence at school at all levels, though few children (13.8%) responded that they had experienced this form of violence in the past year. The results demonstrated a dose response to physical violence at school, with children reporting all VPSs over two (2.17) times less likely to experience this form of violence. This finding demonstrates the protective association of combined VPSs to the reduced likelihood of children experiencing physical violence at school.

**Emotional violence at home.** Cumulative VPSs had increasing significant associations to emotional violence at home at all levels with nearly one-third (32.5%) of the participants responding that they had experienced this form of violence in the past year. The results demonstrated a dose response to emotional violence at home, with children reporting all VPSs three (3.33) times less likely to experience this form of violence. It is notable that emotional violence at home was significantly associated with all four individual VPSs in the first research question. When analyzed in the context of the second research question, the combined VPSs at every level had an elevated association ($p < 0.001$) to emotional violence at home. This finding demonstrates the strong protective association of combined VPSs to reduce the likelihood of children experiencing emotional violence at home.

**Sexual violence.** Cumulative VPSs had increasing significant associations to sexual violence at the 2 VPSs and 3 VPSs levels, though few children (2.9%) responded that they had experienced this form of violence during their lifetime. Though this represents a limited dose response, this finding demonstrates the protective association of
the combined VPSs to the reduced likelihood of children experiencing sexual violence. In the first phase of analysis, only income strengthening showed significant association to sexual violence. However, in the second phase, having an increasing number of VPSs showed decreasing association with sexual violence. Moreover, combined VPSs showed an elevated protective association with sexual violence—the highest degree of this study—with children reporting 3 VPSs nearly three-and-one-half (3.45) less likely to experiencing this form of violence. Importantly, this finding supports the INSPIRE approach to violence prevention; that is, violence exposures difficult to counter through single interventions may be effectively prevented through multi-sector approaches.

**Community violence at-large.** Cumulative VPSs had increasing significant associations to community violence at-large at all levels with over one-quarter (27.2%) of the participants reporting the experience of robbery in the past year or assault during their lifetime. Though cumulative VPSs showed significant negative associations at each level, there was not an uninterrupted dose response as the adjusted odds ratio at 3 VPSs increased rather than decreased. However, the overall trend from 2 VPSs to 4 VPSs showed a dose response to community violence at-large, with children reporting all VPSs nearly two (1.75) times less likely to experience this form of violence. Though a limited dose response, this finding demonstrates the potential protective association of combined VPSs to the reduced likelihood of children experiencing community violence at-large.

**Community violence at school.** Cumulative VPSs had a significant association to community violence at school at 4 VPSs, with over one-quarter (25.4%) of the participants responding that they had experienced this form of violence in the past year.
As such, there was not a complete dose response as lower VPS level results showed no significant associations. However, children reporting 4 VPSs were over one-and-one-half (1.59) times less likely to experience this form of violence. Though an incomplete dose response, this finding demonstrates the protective association of the combined VPSs to the reduced the likelihood of children experiencing community violence at school. Similarly to sexual violence, it is noteworthy that in the first research question, only school structural support showed significant association to community violence at school. Importantly, this finding further validates the INSPIRE approach to violence prevention; that is, violence exposures difficult to counter through single interventions may be effectively prevented through multi-sector approaches.

**Witnessing community violence.** Cumulative VPSs had increasing significant associations to witnessing community violence at all levels, though few (10.1%) of the participants responded that they had experienced this form of violence during their lifetime. The results demonstrated a robust dose response to witnessing community violence, with children reporting all VPSs two-and-one-half (2.50) times less likely to experience this form of violence. While emotional violence at home was significantly associated with three of the individual VPSs, the combined VPSs had an elevated association ($p < 0.001$) at every level to witnessing community violence. This finding demonstrates the strong protective association of combined VPSs to the reduced likelihood of witnessing community violence.

Overall, these study findings suggest a robust graded dose association between combined VPSs and the likelihood of violence for children living in a low-income HIV-
endemic setting. Six of the eight analyzed violence exposures showed significant decreased risk with increasing numbers of VPSs. Even violence that was not highly associated with the individual VPSs in the first research question analysis, such as sexual and community violence at school, showed limited dose responses, suggesting the protective efficacy of simultaneous versus solo interventions to reduce the risk of violence that children experience at home, school, and the community. Table 5.2 summarizes the dose response associations to the reduced likelihood of violence exposure. Implications of these findings are discussed in the next section.
### Table 5.2. Overview of dose associations between VPSs and violence outcomes

<table>
<thead>
<tr>
<th>Number of VPSs</th>
<th>Physical at home</th>
<th>Physical at school</th>
<th>Emotional at home</th>
<th>Emotional at school</th>
<th>Sexual Violence</th>
<th>Community at-large</th>
<th>Community at school</th>
<th>Witness of community violence</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>.01</td>
<td>.001</td>
<td>.01</td>
<td>.05</td>
<td></td>
<td></td>
<td></td>
<td>.001</td>
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<tr>
<td>3</td>
<td>.01</td>
<td>.001</td>
<td>.001</td>
<td>.05*</td>
<td></td>
<td></td>
<td></td>
<td>.001</td>
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<tr>
<td>4</td>
<td>.001</td>
<td>.001</td>
<td>.01</td>
<td>.01</td>
<td></td>
<td></td>
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<td>.001</td>
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<tr>
<td>COVARIATE</td>
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<tr>
<td>Age</td>
<td>x</td>
<td>x</td>
<td>x</td>
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<td>x</td>
<td>x</td>
<td>+</td>
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<tr>
<td>Gender</td>
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<td>x</td>
<td></td>
<td>x</td>
<td>+</td>
<td></td>
</tr>
<tr>
<td>Urbanicity</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td></td>
<td></td>
<td>x</td>
<td>+</td>
</tr>
</tbody>
</table>

p-values ($p <$)

* = Adjusted odds ratio increased from 2 VPSs to 3 VPSs levels, but decreased at the 4 VPSs level

x = significant negative association; + = significant positive association
Study Implications

Findings from this study contribute to the growing body of research in the field of child protection. Significant relationships emerged among specific interventions and particular types of violence, with those individual interventions targeting the economic alleviation of poverty’s stresses more highly associated to better outcomes for children. Most importantly, combined interventions showed a wider span of association to reduced violence exposure than single interventions, such that even those individual violence outcomes unaffected by solo interventions registered diminished risk and heightened protection. These results support the view that a comprehensive approach across multiple sectors combines and reinforces both formal and informal societal assets and strengths, thereby preventing and mitigating violence’s impact on children.

Social Protection

Social protection refers to the spectrum of public and private sector policies and programs targeted to prevent, reduce, and eliminate economic and social susceptibilities to structural deprivation. Understanding the benefits of social protection upon a diverse spectrum of violence exposures will allow stakeholders working in areas of high violence risk and limited community resources to choose influential interventions that maximize the effectiveness of available personnel and program funds to diminish violence’s impact upon children. Findings from this study are clear that interventions that mitigate poverty’s underlying economic strain and resulting caregiver stress while allowing children access to education are associated with better overall protection of children from a diverse range of violence exposures. The two VPSs of income and economic
strengthening and school structural support showed the broadest associations to lowered overall violence risk. The common bond between these two interventions likely was the provision of needed supplies for daily life and those that maintained regular school attendance.

The aim of social protection is to shield the marginalized against livelihood risks while enhancing children’s social status and human rights, with the overall goal of mitigating economic and social vulnerability that strains the entire household. To further this objective, services may consider offering a range of supplies within any of their offered community programs, such as the delivery of emergency food, items for daily needs, clothing, as well as income subsidies and consumption vouchers. These interventions can be administered by a wide variety of actors—whether governments, NGOs, communities, religious organizations, private citizens, or through mixed sector collaboration. In areas of community-wide deprivation, seeking cost-effective means of providing necessary resources is essential to reduce violence. Community economic building in sustainable ways seems promising.

Lastly, psychosocial support also falls under the broad heading of social protection. Along these lines, study findings confirm the benefit of outside psychosocial support in protecting children from violence. Relationships that establish ties of prevention and response between a community figure or service provider and household may play a role in violence reduction. Correspondingly, training religious, educational, and social service staff in listening skills and basic counseling may assist in mitigating violence exposure.
Coordinated Multi-Sector Interventions and Polyvictimization

Research on reducing the heightened risk of violence for children in low-income, health-challenged LMICs is scarce. Findings from this study suggest that simultaneous family and community interventions on multiple fronts may lessen diverse violence outcomes for a broad range of children, upholding the INSPIRE model as an effective strategy to reduce violence against children. INSPIRE’s integrated strategy aims to address the causes rather than the symptoms of violence, activating sectoral collaboration to diminish violence exposure (WHO, 2016). Specifically, INSPIRE’s approach protects children from violence through implementing and enforcing laws, influencing cultural norms and values, creating safe environments, supporting caregivers, providing economic strengthening, reinforcing response and support services, and increasing access to education and life skills training (WHO, 2016).

This approach is especially pertinent since research from the African field has shown that children frequently experience violence in combinations (Meinck et al., 2016). Moreover, as the enduring trauma arising from polyvictimization is greater than that of repeated violence of a single sort (Samms-Vaughan & Lambert, 2017), it is therefore of great concern for LMICs where the availability to and costs of secondary and tertiary treatment are frequently unattainable by the affected population.

Recognizing the reality of polyvictimization and understanding the potential of integrated evidence-based interventions to mitigate violence’s impact upon children will help to promote diverse collaboration across the widest sectoral span possible to prevent and reduce trauma, whether single or multiple. Stakeholders can pursue involvement and
resources from nation-states, professional associations, public and faith-based organizations, foundations, academic institutions, and philanthropic sources to strengthen the systems underlying each sector. This study and others like it indicate that coordinated efforts across a community may enhance the delivery of effective programs and services to break the cycle of violence against children (WHO, 2016).

**HIV/AIDS and Violence**

Violence refers to a wide-range of destructive behaviors beyond the use or threat of physical force that leads to injury, death, or deprivation. Its scope also encompasses both communicable and noncommunicable disease, psychological harm, resultant risky behaviors, underachievement at school and job, as well as involvement in crime (WHO, 2016). Recent South African research suggested that violence, along with poverty’s indicators of increased food insecurity and expansion of informal housing, were the structural drivers for the rising HIV-infection rate which devastates entire communities and disrupts nations (Cluver et al., 2016).

Stakeholders must recognize violence’s substantiated interconnection with structural deprivation and community health. As this study was done using a sample of children living in a HIV-endemic communities of South Africa, the findings discussed above have important implications for reducing violence’s toll on the public health of a community. Social protection as a single strategy, or best, aligned interventions across the sectors of the community have the potential to diminish violence against children while improving health outcomes. More research is needed to confirm these findings and to examine causality, but study findings suggest many implications.
Findings from this study on the relationship between individual and combined VPSs and violence outcomes indicate the need for practitioners to promote coordinated implementation of formal and informal interventions to reduce the impact of violence upon children. Specifically, critical supports for children may include those that strengthen household economic capacity, as well as efforts that sustain educational advancement through the provision of fees, equipment, and school transport. Comprehensive multi-sector strategies may shield susceptible children from the enduring damage of violence in all its forms, and thus may have strong implications in future policy guidelines and effective field practice.

Finally, the findings and implications of this study are a meaningful contribution to the field of child protection; however, study limitations compromise the strength of the findings and its implications. Therefore, further research is needed regarding the implementation science for the reduction of violence against children. Limitations and recommendations for future research are taken up in the following two sections.

Limitations

A number of study limitations must be acknowledged, both major and minor. First and foremost, this study used a cross-sectional design, therefore its results represent only one moment in time, with the limitation that causality cannot be determined. Some of the implications of this study were discussed in a manner that might indicate causality because of the supporting longitudinal research currently coming from the Sub-Saharan region; however, this study cannot confirm the directionality of the relationships between the VPS interventions and violence exposures. Next, as a secondary study, it could not
test the entire spectrum of the seven INSPIRE VPSs. For this reason, a complete analysis of the INSPIRE model could not be evaluated either for the individual or combined VPSs’ associations to the individual violence outcomes.

The original YC research team conducted private, face-to-face interviews. Though fastidious in their methods and confidentiality protocol, it is possible that survey participants responded in a socially desirable manner to the questionnaire involving sensitive topics which may have added to the child’s vulnerability and potential stigma (Madu & Peltzner, 2000). This phenomenon likely is seen both in the low attestation of sexual violence (2.9%) and the low rate (11.9%) of HIV/AIDS-ill household members in communities of more than 30% prevalence. While it is possible that the children were unaware of the sick member’s HIV status, a 2015 South African study established children as reliable proxy reporters of their caregivers’ HIV illness (Becker, Kuo, Operario, Moshabela, & Cluver, 2015) using the verbal diagnostic tool utilized in the original YC study (Lopman et al., 2006).

As the study relied on self-reported data, it may be further biased in at least two ways. First, respondents might not have fully understood the questions posed, or not have accurately recalled specific situations and their differing time frames. Therefore, these findings need to be corroborated using multiple sources such as qualitative methods, participant observation, medical records, and other secondary sources.

A final major limitation for this study’s interpretation was the use of differing time frames across the individual violence outcomes. Originally set for their psychometric properties of accurate recall, five violence outcomes inquired for incidents
within the past year, but three regard lifetime occurrence. Specifically, when finding an association in this study between the VPSs of basic necessities which is related to sexual violence (lifetime), but not physical violence (past year), it is unclear if the difference in association is due to the type of violence exposure or due to the different time frames. Further research with consistent time frames is needed to verify the results of this study.

Several other limitations reduce the strength of the study findings. The South African sample diverged from the greater population of vulnerable children in Sub-Saharan Africa in that 98.5% of the YC participants indicating regular school attendance, with another 97.8% reporting no major interruption in their studies, a rare phenomenon in the African region lacking universal education. This difference between South Africa’s constitutionally guaranteed compulsory and free education for children aged 7-15 (Department of Basic Education, 2018) and that of the region as a whole is illustrated in the country of Mozambique, South Africa’s neighbor to the north. Administrative data from the period of 2008-2012 showed a 30.6% survival rate of primary school enrollment to the last primary grade, whereas survey data listed the longevity of uninterrupted primary school studies as 60.2% (UNICEF, 2013). Even Mozambique’s latter figure confirms the educational discrepancy between the two countries of the same Sub-Saharan region.

As school attendance is linked with better outcomes for children, defending against both victimization and perpetration (WHO, 2016), an accurate profile of the VPSs’ association to violence exposure could have been modified due to this potential educational protection afforded the South African sample. Therefore, these findings need
to be confirmed using data originating from studies situated in Sub-Saharan settings with lower rates of school enrollment.

Although several limitations were identified, this study was innovative in its design. It used a robust data set from a Sub-Saharan middle-income country challenged by resource scarcity, endemic disease, and crime. Previous research had not tested single and cumulative associations between INSPIRE-based VPSs and the childhood experience of direct and indirect violence outcomes in this setting. Though the study is an important contribution to the field of child protection, more contextualized research is needed to provide stakeholders with information to effectively support and advocate for children living with heightened risks of violence.

**Recommendations for Future Research**

The following recommendations are made to develop future research: (1) development of strategic longitudinal analyses that examine the full spectrum of the INSPIRE VPSs to better understand causal relationships and directionality between interventions and violence outcomes in contextually appropriate settings, (2) use of marginal effects analysis concerning the most effective combinations of interventions to maximize violence protection, (3) use of moderating and mediating factors moderation analysis to investigate if and how the presence of VPSs changes the relationship between violence stressors and health or behavioral outcomes, (4) continued examination of emotional violence to include the effects of HIV/AIDS stigma, (5) investigation of the effectiveness of VPSs for populations at risk such as orphans, the disabled, and those living in HIV-affected households, (6) expanded discussion of the INSPIRE VPSs in
resource-scant settings by considering family and community informal support systems, and (7) further research into relevant covariates for their main effects in the relationships between VPSs and violence exposures.

First, longitudinal analyses must fully investigate the entire spectrum of INSPIRE VPSs to understand causal relationships and directionality in settings that reduce the vulnerability of participants in disclosing sensitive topics (Burton et al., 2015). It is imperative that studies be set in LMICs where both resources for and research regarding the protection of children at heightened violence risk are now limited. Furthermore, as the cultural contexts differ in LMICs, protective factors may differ; practitioners and policymakers must be mindful of these variances to sculpt research questions within full-spectrum studies.

Two examples from this study illustrate the gap left in this analysis due to the incomplete testing of the seven INSPIRE VPSs. The first case concerns why some violence outcomes were weakly associated with the VPSs, seemingly resistant to intervention. In the current study, physical violence at home (related to corporal punishment), and both emotional and community violence at school (related to bullying) were violence exposures associated with only one VPS. These exposures likely represent either accepted socio-cultural norms or accepted behaviors in the community. “Norms and values” represents the second prong of the INSPIRE sectoral model; thus, designing comprehensive longitudinal studies that empirically test yet untried VPSs’ decreased associations with entrenched violence in contextual settings is vital to reduce risk.
Another example of the need for longitudinal research stems from insufficient data to analyze the witness of home violence. Future research is needed to probe which individual VPSs are associated with witnessing violence at home, expanding analyses to associations of combined VPSs. Since children related that the home was the chief location of violence in their lives (Leoschut & Kafaar, 2017), the analysis of domestic conflict and violence is a necessary element to better understand mechanisms to break cycles of violence. A complete spectrum of INSPIRE-based interventions across a range of child violence exposures is essential to follow up these preliminary findings.

Second, a key issue in future research is to carry out marginal effects analyses, which show cumulative percentage likelihoods for different combinations of interventions. These analyses would assess which combinations of VPSs enhance decreased association with violence exposure. Understanding which combined VPSs most effectively mitigate the broadest span of violence would aid practitioners to maximize child protection effects in situations where choices must be made due to limited field resources.

Third, future research would benefit from testing moderating and mediating factors of violence. Moderation analysis could investigate whether the presence of VPSs changes the relationship between violence stressors and health or behavioral outcomes. Knowledge of these relationships and their influences would benefit practitioners in more fully understanding pathways of interventions to an expanded range of violence consequences.
Fourth, as violence and HIV/AIDS has been shown to be interconnected, research is essential to examine the role of stigma in the experience of emotional violence. Exploratory tests in this study showed a significant negative association between the VPSs and emotional violence for children coming from HIV/AIDS-affected households. Insight is needed in this area to support the large number of children coming from HIV/AIDS-affected households.

Fifth, further research should probe whether the VPSs’ association to violence outcomes is different for vulnerable populations in LMICs such as orphans, the disabled, and children affected by HIV/AIDS. Though it is yet unclear whether orphans are more susceptible overall than other children to violence, there is no dispute that the population of orphans is elevated due to the presence of HIV/AIDS in Sub-Saharan countries (Adato, Kadiyala, Roopnaraine, Biermayr-Jenzano, & Norman, 2015; Meinck et al., 2015b). As such, these children’s susceptibility to violence must be further investigated to better prevent and reduce the violence that they and other children of heightened adversity experience.

Sixth, due to the parameters of the INSPIRE model, this study’s analysis was limited to formal social support with no examination of the protective effects inherent in the informal sector. As stated previously, formal service support is scarce in LMICs. However, in the dearth of formal systems, current research finds that in settings of limited institutional support and formal health services, support from family, friends and the surrounding community may provide a valuable resource for coping and health, as well as lower the likelihood of sexual victimization (Casale, 2013; Meinck et al., 2017).
Future research investigating the role of embedded social supports would be beneficial in the larger study of child protection.

Lastly, there are additional covariates that may play a substantive part in violence exposure. For example, the child’s educational level as a potential protective factor is an important consideration not pursued in this present study. It is a common that Sub-Saharan children’s ages diverge by two or more years more from their western counterparts’ age-to-grade level due to factors of family income, health, and location. This being the case, the level of education was not included in the current study analyses. Future research should control for a broader range of child factors to verify their main effects in violence outcomes.

**Conclusion**

The widespread elevated prevalence of polyvictimization in Sub-Saharan communities underscores the massive need for adaptive culturally appropriate means of child protection that can prevent and mitigate the physical and psychosocial impact of violence. Prevention is crucial in resource-scant settings, both to protect children’s dignity and to reduce ongoing cycles of violence with multifaceted long-term impacts. Yet, studies on best practices for reducing the likelihood of violence are limited for children living in these circumstances.

In light of the Sustainable Development Goals’ call to stop violence against all children, policymakers and child protection practitioners are exploring all-encompassing prevention and response measures that strengthen formal and non-formal systems alike. The SDGs’ specific targets against violence provide a unique opportunity to catalyze
collective action that builds safe environments and nurturing relationships for children by disrupting the web of violence spread throughout society’s sectors. INSPIRE’s integrated approach aims to assist communities to reach key priorities of the SDGs, protecting children from violence through a seven-fold strategy of implementing and enforcing laws, influencing cultural norms and values, creating safe environments, supporting caregivers, providing economic strengthening, reinforcing response and support services, and increasing access to education and life skills training.

This analysis responds to the need for contextualized research in LMICs as the first known study to investigate cross-sectional single and cumulative associations between INSPIRE-based VPSs and the likelihood of experiencing direct and indirect violence in resource-scant and HIV-endemic communities within the middle income country of South Africa. Three critical findings resulted from this study.

Firstly, the strong potential of the individual INSPIRE strategies to prevent and reduce the likelihood of violence exposures within LMICs was clearly confirmed as none of the eight violence outcomes were untouched by one or more significant intervention associations. Secondly, these analyses demonstrated strong associations between single interventions that provide material supplement for children at home and at school with the lessened likelihood of experiencing a broad range of violence. This outcome corroborates the findings of current studies exploring social protection as a means to overcome the stresses of structural deprivation, thereby reducing the likelihood of children’s exposure to violence.
Lastly, combined interventions were associated with heightened protection for children living in an area of high violence. Moreover, these cumulative interventions showed potential strength to counter violence exposures otherwise resistant to single interventions. While it is imperative that longitudinal multi-sector implementation research continue in settings of greatest prevalence, overall knowledge gained from this study provides insights for stakeholders seeking effective social protection interventions and comprehensive combinations that effectively prevent and reduce children’s exposure to violence by addressing the root causes that harm them, their families, and their communities.
### APPENDIX A

**VIOLENCE PREVENTION STRATEGIES (VPSs)**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Measure</th>
<th>Frequencies</th>
<th>YC Scale</th>
<th>Source</th>
</tr>
</thead>
</table>
| **Parent & caregiver social support** | *Positive parenting* Yes to 7 to 10 items was scored as 1 | \(n=2,476\) 55.5\%=1 | 1) Your caregiver says that you have done something well.  
2) Your caregiver threatens to punish you and then does not do it.*  
3) You go out without a set time to be home.*  
4) You talk your caregiver out of punishing you when you have done something wrong.*  
5) You stay out in the evening past the time you are supposed to be at home.*  
6) You caregiver compliments you when you have done something well.  
7) Your caregiver praises you for behaving well.  
8) Your caregiver does not know who you are friends with.*  
9) Your caregiver lets you out of a punishment early.  
10) Your caregiver tells you that they like it when you help around the house. | *Alabama Parenting Questionnaire (APQ), with one additional item measuring caregiver praise for household help (\(\alpha=0.75\) in South African orphan study; Cluver & Gardner, 2007; Cluver, Gardner, & Operario, 2007)* |
| **Income & economic strengthening** | *Basic necessities* Yes to 5 to 7 items was scored as 1 | \(n=2,476\) 81.5\%=1 | 1) At home, we can afford three meals a day.  
2) At home, we can afford school fees.  
3) At home, we can afford a visit to the doctor and the medicines I need when I am ill.  
4) At home, we can afford enough clothes to keep me warm and dry.  
5) At home, we can afford toiletries to be able to wash every day.  
6) At home, we can afford school equipment.  
7) At home, we can afford more than one pair of shoes for me. | *Indicators of Poverty and Social Exclusion Project (Wright, 2008), upheld by over 80% of the South African population in a nationally representative survey (South African Social Attitudes Survey 2006; Pillay, Roberts, & Rule, 2006)* |
<table>
<thead>
<tr>
<th>Strategy</th>
<th>Measure</th>
<th>Frequencies</th>
<th>YC Scale</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Response &amp; support services</strong></td>
<td><em>Formal social support</em> Yes to 1 or items was scored as 1</td>
<td>$n=2,476$</td>
<td>1) A religious leader is a person in my life.</td>
<td><em>Social Support Scale</em> (Adolescent Pathways Project, 1992)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>36.8%=$1$</td>
<td>2) A school principal or teacher is a person in my life.</td>
<td></td>
</tr>
<tr>
<td><strong>Education &amp; life skills</strong></td>
<td><em>School structural support</em> Yes to 1 to 4 items was scored as 1</td>
<td>$n=2,411$</td>
<td>1) I received free school meals (1-5 times per week)</td>
<td><em>Structural support to sustain educational progress developed by YC with the South African Department of Education</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td>86.9%=$1$</td>
<td>2) I received free school uniform.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>3) I received free school transport.</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td>4) I received free school textbooks.</td>
<td></td>
</tr>
</tbody>
</table>

*Recoded in the secondary analyses to reflect practices of positive parenting.*
## APPENDIX B

### VIOLENCE OUTCOMES

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Frequencies</th>
<th>YC Scale</th>
<th>Source</th>
</tr>
</thead>
</table>
| **Physical violence** | *Physical violence at home*  
Yes to any item was scored as 1 | Past year  
\(n=2,475\)  
34.9\%=1 | 1) In the past year my caregivers have used a stick, belt, or hard item to hit me.  
2) In the past year my caregivers have slapped, punched, or hit me so that I was hurt. | UNICEF Measures for National-level Monitoring of Orphans and other Vulnerable Children (Snider & Dawes, 2006) |
|                    | *Physical violence at school*  
Yes to any item was scored as 1 | Past year  
\(n=2,472\)  
13.8\%=1 | 1) In the past year other kids have made me uncomfortable by standing too close or touching me.  
2) In the past year other kids have punched, kicked, or beat me up.  
3) In the past year other kids have hurt me physically in some way. | Social and Health Assessment Peer Victimization Scale adapted from the Multidimensional Peer Victimization Scale (Ruchkin, Schwab-Stone, & Vermeiren, 2004) for Cape Town AIDS-orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007) |
| **Emotional violence** | *Emotional violence at home*  
Yes to any item was scored as 1 | Past year  
\(n=2,475\)  
18.6\%=1 | 1) In this past year did your caregivers threaten to send you away or kick you out of the house?  
2) In this past year did your caregivers threaten to call ghosts or evil spirits or harmful people?  
3) In this past year did your caregivers insult you be calling you dumb, lazy, or other names? | UNICEF Measures for National-level Monitoring of Orphans and other Vulnerable Children (Snider & Dawes, 2006) |
|                    | *Emotional violence at school*  
Yes to any item was scored as 1 | Past year  
\(n=2,472\)  
32.5\%=1 | 1) During this past year other kids have called me names or sworn at me.  
2) During this past year other kids have tried to get me in trouble with my friends.  
3) During this past year other kids have made fun of me for some reason.  
4) During this past year other kids have refused to talk to me or made other people not talk to me. | Social and Health Assessment Peer Victimization Scale adapted from the Multidimensional Peer Victimization Scale (Ruchkin et al., 2004) for Cape Town AIDS-orphanhood studies (Cluver & Gardner, 2007; Cluver et al., 2007) |
<table>
<thead>
<tr>
<th>Outcome</th>
<th>Measure</th>
<th>Frequencies</th>
<th>YC Scale</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sexual violence</strong></td>
<td><em>Sexual violence any location</em></td>
<td>Lifetime n=2,475</td>
<td>1) Have you ever in your life had someone touch you in a way that made you feel uncomfortable? 2) Has anyone ever in your life made you do anything with your private parts or their private parts that made you feel uncomfortable?</td>
<td>Constructed by social workers in South Africa and used in Cape Town AIDS orphanhood studies (Cluver &amp; Gardner, 2007; Cluver et al., 2007)</td>
</tr>
<tr>
<td></td>
<td><em>Yes to any item was scored as 1</em></td>
<td>2.9%=1</td>
<td></td>
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</tr>
<tr>
<td><strong>Community violence</strong></td>
<td><em>Community violence at-large</em></td>
<td>Mixed (past year/ lifetime) n=2,475 27.2%=1</td>
<td>1) In this past year have you had things stolen? 2) Have you ever in your life been hit or attacked outside?</td>
<td>Child Exposure to Community Violence Checklist (CECV; Richters &amp; Martinez, 1993) adapted by the YC study to reflect the most frequent types of community violence reported by South African Police Statistics (SAPS Strategic Management, 2005)</td>
</tr>
<tr>
<td></td>
<td><em>Yes to any item was scored as 1</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Community violence</strong></td>
<td><em>Community violence at school</em></td>
<td>Past year n=2,472</td>
<td>1) This past year other kids took something without permission or stole things from me. 2) This past year other kids tried to break or damage something of mine.</td>
<td>Social and Health Assessment Peer Victimization Scale adapted from the Multidimensional Peer Victimization Scale (Ruchkin et al., 2004) for Cape Town AIDS-orphanhood studies (Cluver &amp; Gardner, 2007; Cluver et al., 2007)</td>
</tr>
<tr>
<td></td>
<td><em>Yes to any item was scored as 1</em></td>
<td>25.4%=1</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Witnessing community violence</strong></td>
<td><em>Witnessing violence outside of home</em></td>
<td>Lifetime n=2,475</td>
<td>1) Have you seen someone being shot? 2) Have you seen someone being stabbed?</td>
<td>Adapted by YC study from CECV (Richters &amp; Martinez, 1993; SAPS Strategic Management, 2005)</td>
</tr>
<tr>
<td></td>
<td><em>Yes to any item was scored as 1</em></td>
<td>10.1%=1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX C

INTERNATIONAL REVIEW BOARD APPROVAL FOR SECONDARY ANALYSIS

Exempt Review Application
Clemson University IRB Website

Office use only
Protocol Number:

[ ] Approved  Exemption Category  Expiration date: 

Signature of IRB Chair / Designee  Date

1. Developmental Approval: If you already have developmental approval for this research study (you should know if you do), please give the IRB protocol number assigned to the study. More information available [here].

2. Research Title: Impact of interventions to reduce violence against HIV/AIDS-affected children in South Africa
If different, title used on consent document(s)
If class project, include course number and title

3. Principal Investigator (PI): The PI must be a member of the Clemson faculty or staff. You cannot be the PI if this is your thesis or dissertation. The PI must have completed IRB-approved human research protections training. Training will be verified by IRB staff before approval is granted. Training instructions available [here]. CITI training site available [here].

Name: Dr. Susan Limber
[ ] Faculty  [ ] Staff
Department: Youth, Family, and Community Studies  E-mail: slimber@clemson.edu
Campus address: 2038 Barre Hall  Phone: 864-656-6320
Fax: 864-655-6281

4. Co-Investigator(s): Co-Investigators must have completed IRB-approved human research protections training. Training will be verified by IRB staff before approval is granted. Training instructions available [here]. CITI training site available [here].

Name: N. Suzanne Falconer  E-mail: nfalcon@clemson.edu
[ ] Faculty  [ ] Graduate student  [ ] Other. Please specify.
[ ] Staff  [ ] Undergraduate student

Name: Dr. Martha Thompson  E-mail: mthomp@clemson.edu
Department: Youth, Family and Community Studies  Phone: 779-772-3055
[ ] Faculty  [ ] Graduate student  [ ] Other. Please specify.
[ ] Staff  [ ] Undergraduate student
5. **Additional Research Team Members**: All research team members must have completed IRB-approved human research protections training. Training will be verified by IRB staff before approval is granted. Training instructions available [here](#). CITI training site available [here](#).

[ ] List of additional research team members included. Form available [here](#).

6. **Research Team Roles**: Describe the role of each member of the research team (everyone included in Items 3, 4 and 5), indicating which research activities will be carried out by each particular member. Team members may be grouped into categories.

**Description**: Dr. Limber will guide the research in its overall design. Dr. Thompson will guide the formation of the analytic plan and serve as research consultant in the statistical interpretation of the study. Suzanne Falconer will be responsible for running the analyses on the Young Carer's data and assimilating the results within the context of the broader study questions.

7. **Email Communications**: If you would like one or two of your team members (in addition to the PI) to be copied on all email communications, please list these individuals in the box below.

<table>
<thead>
<tr>
<th>Name</th>
<th>E-mail</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suzanne Falconer</td>
<td><a href="mailto:nfalcon@clemson.edu">nfalcon@clemson.edu</a></td>
</tr>
<tr>
<td>Name:</td>
<td>E-mail:</td>
</tr>
</tbody>
</table>

8. **Study Purpose**: Provide a brief description of the purpose of the study. Use lay language and avoid technical terms. IRB members not familiar with the area of research must understand the nature of the research. Upon conclusion of the study, how will you share your results (e.g., academic publication, evaluation report to funder, conference presentation)?

**Description**: This research will examine a cross-sectional sample from KwaZulu-Natal (Durban) province in South Africa of children 10-17 years old and their primary caregivers (n=2500), using secondary data from both interviews and standardized questionnaires. These data are part of a database that is referred to as the Young Carers (YC) Study. Our study seeks to determine the impacts of individual and bundled interventions on reducing violence against children. These results are important for child advocates in the field and policymakers working towards the elimination of violence against children, which is a 15-year initiative of the Sustainable Development Goals. Our study results will be shared via academic publication, conference presentation, and in the form of a policy brief to the original researchers.

9. **Anticipated Dates of Research**:

   Anticipated start date (may not be prior to IRB approval; may be "upon IRB approval"): **upon IRB approval**

   Anticipated completion date (Expiration date will be determined by the date entered, maximum three years for initial approval with optional extensions. Please include time needed for analysis of individually identifiable data.): **May 2019**

10. **Funding Source**: Please check all that apply.

    - [ ] Submitted for internal funding
    - [ ] Internally funded
    - [ ] Submitted for external funding

    Funding source, if applicable (Do not use initials): __________

    Proposal number (PPN) for the Office of Sponsored Programs: __________
11. Support provided by Creative Inquiry Initiative: ☐ Yes ☐ No
   If yes, all Creative Inquiry students will be members of the research team, please see item # 5.

12. Other IRB Approvals:
   Has this research study been presented to any other IRB? ☐ Yes ☐ No
   Where? ______ When? ______
   If yes, what was their decision? ☐ Approved ☐ Disapproved ☐ Funding
   Please attach a copy of any submissions, approvals, or disapprovals from other IRBs.

13. Exempt Review Checklist: To determine whether this study meets the federal requirements for exemption [45 CFR 46.101], please complete the following checklist. This will indicate if your study can be exempted from IRB continuing review.

   The Federal Code [45 CFR 46.101] permits research activities in the following six categories to be exempted. Please check the relevant exemption category/categories.
   The Federal Office of Human Research Protection has made Decision Charts available here to help in determining whether a particular study falls within a particular Exemption Category.

<table>
<thead>
<tr>
<th>Categories of Research Activities Exempt from Continuing Review</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ B1. Research conducted in established or commonly accepted educational settings, involving normal educational practices, such as:</td>
</tr>
<tr>
<td>a. research on regular and special education instructional strategies, OR</td>
</tr>
<tr>
<td>b. research on the effectiveness of or the comparison among instructional techniques, curricula, or classroom management methods.</td>
</tr>
<tr>
<td>NOTE: Survey and interview procedures with minors are exemptible if the activities fall within this category.</td>
</tr>
<tr>
<td>☐ B2. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures or observation of public behavior, UNLESS:</td>
</tr>
<tr>
<td>a. the information obtained is recorded in such a manner that human participants can be identified, directly or through identifiers linked to the participants; AND</td>
</tr>
<tr>
<td>b. any disclosure of the human participants’ responses outside the research could reasonably place the participants at risk of criminal or civil liability or be damaging to the participants’ financial standing, employability, or reputation.</td>
</tr>
<tr>
<td>NOTE: Survey and interview techniques which include minors are not exempt. Observation of the public behavior of minors, if the researcher is not a participant, is exempt.</td>
</tr>
</tbody>
</table>
B3. Research involving the use of educational tests (cognitive, diagnostic, aptitude, achievement), survey procedures, interview procedures, or observation of public behavior that is not exempt under Category B1, if:
   a. the human participants are elected or appointed public officials or candidates for public office, or
   b. federal statute(s) require(s) without exception that the confidentiality of the personally identifiable information will be maintained throughout the research and thereafter.

B4. Research, involving the collection or study of existing data, documents, records, pathological specimens, or diagnostic specimens, if these sources are publicly available or if the information is recorded by the investigator in such a manner that participants cannot be identified directly or through identifiers linked to the participants.

B5. NOTE: Please contact the IRB office before selecting this category since use of this exemption must be initiated by the agency head of the federal funder.

Research and demonstration projects which are conducted by or subject to the approval of appropriate Federal Department or Agency heads, and which are designed to study, evaluate, or otherwise examine:
   a. public benefit or service programs; or
   b. procedures for obtaining benefits or services under those programs; or
   c. possible changes in or alternatives to those programs or procedures; or
   d. possible changes in methods or levels of payment for benefits or services under those programs.

B6. Taste and food quality evaluation and consumer acceptance studies,
   a. if wholesome foods without additives are consumed, OR.
   b. if a food is consumed that contains a food ingredient at or below the level and for a use found to be safe, or agricultural chemical or environmental contaminant at or below the level found to be safe, by the Food and Drug Administration or approved by the Environmental Protection Agency or the Food Safety and Inspection Service of the U.S. Department of Agriculture.

14. If you selected Exemption Category B4, please complete questions a through g below:
   a. Provide a detailed description of the data or specimens and what information will be used. This research will examine a cross-sectional sample from KwaZulu-Natal (Durban) province in South Africa of children 10-17 years old and their primary caregivers (n=2500), using data from both interviews and standardized questionnaires.
   b. What is the source of the data or specimens? Young Carers’ Data from Oxford University and the University of South Africa at Capetown
   c. Are the data or specimens publicly available without restriction or password? (That is, can the general public obtain the data or specimens? Data are not considered publicly available if access is limited to researchers.) Yes ☐ No ☑
      If yes, please contact the IRB staff for consultation. You may not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46.102).
   d. If the data or specimens are not publicly available, how are you obtaining permission to access these or to use them for research purposes? Dr. Lucia Claver, Principal Investigator for the YC study has granted Suzanne Falconer and the Clemson team access to this data set.
      Please attach a copy of the correspondence or agreement granting you permission.
136

f. How are the data or specimens identified when they are made available to you?

1) Direct Identifier (e.g., subject name, address, social security number).
   a) Will you record any direct identifiers that are available to you? Yes [ ] No [x] 
   b) Will you have access to the data from home or office? Yes [x] No [ ]

2) Indirect Identifier (e.g., an assigned code that could be used by the investigator or the source providing the data or specimens to identify a subject, such as a pathology tracking number or a tracking code used by the source).
   a) Will you or a team member have access to the data set code key? Yes [ ] No [x]

   If you will receive data with indirect identifiers only, please contact the IRB staff for consultation. You may not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46.102).

3) No Identifier (i.e., neither the researcher nor the source providing the data or specimens can identify a subject based upon information provided with the data or specimens).
   If it will be impossible for anyone to identify subjects based upon information provided with the data or specimens, you will not be conducting research involving human subjects as defined in the federal regulations governing research involving human subjects (45 CFR 46). Please contact the IRB staff for confirmation.

4. Will any data or specimens be collected from participants after the submission of this application? (Data or specimens are considered to “exist” if ALL the data or specimens to be used for the research have been collected prior to the submission of this application.)
   Yes [x] No [ ]

   *Your research does not qualify for exemption from IRB review under Exemption Category B4.

PLEASE NOTE: If you are applying for exemption only under Exemption Category B4, please skip to question 22.

15. Study Sample: (Groups specifically targeted for study)

Describe the participants you plan to recruit and the criteria used in the selection process. Indicate if there are any special inclusion or exclusion criteria.

NOTE: If individuals who are incarcerated will be participants, your research is not exemptible. Please complete the Expedited / Full Review Application.

Description: ______

Age range of participants: ______ Projected number of participants: ______

[ ] Employees [ ] Students [ ] Minors (under 18) [ ]

[ ] Pregnant women [ ] Fetuses / neonates [ ] Educationally / economically disadvantaged [ ]

[ ] Minors who are wards of the state, or any other agency, institution, or entity [ ]

[ ] Individuals who are incarcerated [ ]

[ ] Persons incompetent to give valid consent [ ]

[ ] Other—specify: ______

[ ] Military personnel

[ ] State necessity for using this type of participant: ______
16. Study Locations:

- Clemson University
- Other University / College
- School System / Individual Schools
- Other – specify

You may need to obtain permission if participants will be recruited or data will be obtained through schools, employers, or community organizations. Are you required to obtain permission to gain access to people or to access data that are not publicly available? If yes, provide a research site letter from a person authorized to give you access to the participants or to the data. Guidance regarding Research Site Letters is available here.

- Research Site Letter(s) not required.
- Research Site Letter(s) attached.
- Research Site Letter(s) pending and will be provided when obtained.

17. Recruitment Method:

Describe how research participants will be recruited in the study. How will you identify potential participants? How will you contact them? Attach a copy of any material you will use to recruit participants (e.g., advertisements, flyers, telephone scripts, verbal recruitment, cover letters, or follow-up reminders).

Description: ______

18. Participant Incentives:

a. Will you pay participants? □ Yes □ No
   Amount: $_____ When will money be paid?: ______

b. Will you give participants incentives / gifts / reimbursements? □ Yes □ No
   Describe incentives / gifts / reimbursements: ______
   Value of incentives / gifts / reimbursements: $_____ When will incentives / gifts / reimbursements be given?: ______

c. Will participants receive extra credit? □ Yes □ No
   If yes, an equivalent alternative to research participation must be provided and described in your informed consent document(s).

19. Informed Consent:

a. Attach a copy of the informational letter or consent script you plan to provide to your participants (and their parents or guardians, if applicable). Consent Document Templates

b. Will you use concealment (incomplete disclosure) or deception in this study? □ Yes □ No
   If yes, please see guidance regarding Research Involving Deception or Concealment here. Submit a copy of the Additional Pertinent Information / Permission for Use of Data Collected in a Research Study form you will use, and provide a justification in the following space for this use of concealment or deception. ______
20. Procedures:
   a. What data will you collect? ____
   b. Please describe in detail the process each participant will experience and how you will obtain the data. ____
   c. How many participation sessions and how much time will be required for each participant, including follow up sessions? ____
   d. How will you collect data?
      __ in-person contact
      __ email
      __ website
      __ other, describe ____

   Please include copies of surveys, interview questions, data collection tools and debriefing statements. If survey or interview questions have not been fully developed, provide information on the types of questions to be asked, or a description of the parameters of the survey / interview. Please note: finalized survey or interview instruments will need to be reviewed and approved by amendment, before implementation.

   a. Will you audio record participants? [ ] Yes [ ] No
   f. Will you video record participants? [ ] Yes [ ] No
   g. Will you photograph participants? [ ] Yes [ ] No

   If you will audio or video record or take identifiable photographs of participants, please consult the IRB's Guidance on the Use of Audio / Video Recording and Photography here. Please include all the information addressed by this guidance document in the application and, where appropriate, in the consent document(s).

21. Protection of Confidentiality: Describe the security measures you will take to protect the confidentiality of the information obtained. Will participants be identifiable either by name or through demographic data? If yes, how will you protect the identity of the participants and their responses? Where will the data be stored and how will it be secured? Who will have access to the data? How will identifiers be maintained or destroyed after the study is completed?

   Description: ____

22. PI Signature:

   I have reviewed this research protocol and the informed consent document(s), if applicable. I request approval of this research study by the IRB of Clemson University.

   Conflict of Interest Statement:

   Could the results of the study provide an actual or potential financial gain to you, a member of your family, or any of the co-investigators, or give the appearance of a potential conflict of interest?

   [ ] No.

[ ] Yes. I agree to disclose any actual or potential conflict of interest prior to IRB action on this study.

Financial Conflict of Interest Policy for PHS / NIH Supported Research
Financial Disclosure Policy for All Other Sponsored Programs
Signature of Principal Investigator

Date

(hard-copy signature only needed if application will not be submitted via PI’s email account)

Submission Instructions: Exempt applications are processed as received. There is no deadline for submitting exempt applications for review. Approval is usually granted within 14 days of receipt of the application. It is recommended that you submit your IRB application at least a month before your desired start date.

International research - please note that the approval of international research may require additional time due to requirements in other countries, negotiation of Individual Investigator Agreements, arranging appropriate local context reviews, and geographical and communication constraints. It is recommended you plan to submit your IRB application at least three months prior to your desired study start date. More information on local context reviews is available on our FAQ webpage, [http://www.clemson.edu/research/compliance/irb/faq.html](http://www.clemson.edu/research/compliance/irb/faq.html).

Please submit this application and all associated documents from the Principal Investigator’s (PI’s) email address to the IRB staff. Receipt of the application electronically from the PI will qualify the application as a signed electronic submission. Alternatively, the signed, hard-copy application may be mailed or delivered to the Office of Research Compliance, 223 Bracket Hall, Clemson, SC 29634-5704.
Re: Falconer IRB and data use permission

Lucie Cluver <lucie.cluver@spi.ox.ac.uk> 1 mars 2017 à 11:59
À : “N. Suzanne Falconer” <nfalcon@g.clemson.edu>
Cc : Nalinee Patin <npatin@clemson.edu>

Dear Suzanne,

I am happy to confirm that Suzanne Falconer can use the Young Carers dataset for her planned research.

Best wishes, Lucie

Lucie Cluver
Professor of Child and Family Social Work
Dept of Social Policy and Intervention, University of Oxford
Dept of Psychiatry and Mental Health, University of Cape Town

On 1 Mar 2017, at 02:42, N. Suzanne Falconer <nfalcon@g.clemson.edu> wrote:

Hello, Lucie ~

After inquiry, I will need an email letter of permission from you to use the YC data set. Below is the full response from Ms. Patin who administrates Clemson’s IRB protocol. Thank you for sending the brief documentation at your convenience.

"We require an exempt application, under category B4, because the data is not publically available. Since you are affiliated with Clemson, you are covered under Clemson regulatory oversight.

In addition to the exempt research application, we will need documentation from Dr. Cluver that you have permission to use the data for research purposes. This could be either an e-mail or letter."

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Nalinee D. Patin, CIP | IRB Administrator
Clemson University
Office of Research Compliance
Institutional Review Board (IRB)
Clemson Centre, 391 College Avenue, Suite 406
Clemson, SC 29631
E-mail: npatin@clemson.edu
APPENDIX E

AUTHORIZATION TO USE IVAN BRADY’S UNTITLED POEM

From: Ivan Brady <manzanita@koyoteman.com>
Date: March 7, 2018 at 9:59:42 AM EST
To: WordPress <info@ivanbrady.com>
Subject: Re: contact form from website

Dear Suzanne,

Absolutely! Thanks for asking. All best wishes for success with your dissertation and important research.

Sincerely,

Ivan

Ivan Brady

On Mar 7, 2018, at 9:44 AM, WordPress <info@ivanbrady.com> wrote:

From: Suzanne Falconer <nfalcon@clemson.edu>
Subject: permission for poem use

Greetings, Dr. Brady ~

I am a doctoral student on the cusp of completing my dissertation on the topic of factors that protect children from violence. In the acknowledgement section, I would like to use your poem that was read by Dr. Heidi van Rooyen at the recent AIDSImpact 2017 conference held in Cape Town. It begins, "Now that you have found my unfaced place in the census count and pulled me up as a person, and thus have heard my heartbeat, and had a glimpse of the interior of my soul, how will you deal with living a life that includes rape, murder, bigotry, bombs, beatings, and the stoning to death of children, among other things that cannot be re-presented as numbers in a survey?"

As a researcher who is also a practitioner in Sub-Saharan Africa, this poem greatly moved me. As academics too often we analyze children’s statistics, publishing significant results in scholarly journals to add to the literature, but overlook children’s souls in the application. It would be an honor to carry this important message forward as a reminder to myself and my companions of the larger work behind any research endeavor.

Thank you for considering this request and responding at your convenience.

Best wishes,

Suzanne Falconer

N. Suzanne Falconer
Doctoral Student & Research Assistant
Department of Youth, Family, & Community Studies
Clemson University
nfalcon@clemson.edu
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