Distribution Agreement

In presenting this thesis or dissertation as a partial fulfillment of the requirements for an advanced degree from Emory University, I hereby grant to Emory University and its agents the non-exclusive license to archive, make accessible, and display my thesis or dissertation in whole or in part in all forms of media, now or hereafter known, including display on the world wide web. I understand that I may select some access restrictions as part of the online submission of this thesis or dissertation. I retain all ownership rights to the copyright of the thesis or dissertation. I also retain the right to use in future works (such as articles or books) all or part of this thesis or dissertation.

Signature:

_____ _____

Courtney L. Boudreau Date

Correlates of Disclosure of Sexual Violence among Kenyan Youth

By

Courtney L. Boudreau

Master of Public Health

Global Epidemiology

Roger W. Rochat, MD

Committee Chair

Howard Kress, PhD

Committee Member

Kathryn M. Yount, PhD

Committee Member

Correlates of Disclosure of Sexual Violence among Kenyan Youth

By

Courtney L. Boudreau

B.S., Northeastern University, 2012

Thesis Committee Chair: Roger W. Rochat, MD

An abstract of

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

in Global Epidemiology

2015

Abstract

Correlates of Disclosure of Sexual Violence among Kenyan Youth

By Courtney L. Boudreau

Sexual violence (SV) against children is a public health problem that can have short and long-term consequences on health and well-being. Disclosure of SV increases the likelihood that children will be able to access health services and receive psychosocial support. Previous research in high-income countries has found that child SV victims are more likely to disclose when they are female, experience fewer SV events, and experience SV perpetrated by a stranger. No studies have examined correlates of SV disclosure in Kenya. In 2010, the Kenya Ministry of Gender, Children and Social Development, the U.S. Centers for Disease Control and Prevention's (CDC) Division of Violence Prevention, the United Nations Children's Fund (UNICEF) Kenya Country Office, and the Kenya National Bureau of Statistics (KNBS) conducted a nationally representative survey of violence against children in Kenya. Data from this study were used to assess the correlates of disclosure of reported SV prior to the age of 18 among Kenyan youth aged 13-24. Among those surveyed, 27.8% of girls and 14.5% of boys reported experiencing SV prior to 18. Among SV victims, just 44.6% of girls and 28.2% of boys reported ever having disclosed the experience. Weighted logistic regression analysis of the sample found that the odds of disclosure were significantly decreased when victims were male (OR: 0.45; 90% CI: 0.31-0.68) and when the victim reported a greater number of SV events (OR: 0.98; 90% CI: 0.96-0.99). The odds of disclosure were significantly increased when any perpetrator was a family member (OR: 2.15; 90% CI: 1.32-3.50) and when any perpetrator was a known person that was not a relative or family member (OR: 1.67; 90% CI: 1.06-2.65). While male gender and greater number of SV experiences have been shown to be associated with a decreased odds of disclosure, the findings related to perpetrator identity are inconsistent with the literature. These findings highlight the importance of context-specific research and merit further research on SV disclosure in Kenya. Policymakers and public health practitioners should account for the correlates of disclosure in designing policies and interventions to encourage disclosure and provide adequate services for child SV survivors.

Correlates of Disclosure of Sexual Violence among Kenyan Youth

By

Courtney L. Boudreau

B.S., Northeastern University, 2012

Thesis Committee Chair: Roger W. Rochat, MD

A thesis submitted to the Faculty of the

Rollins School of Public Health of Emory University

in partial fulfillment of the requirements for the degree of

Master of Public Health

in Global Epidemiology

2015

Acknowledgements

I would like to sincerely thank my advisors for their contribution to this work: Dr. Roger Rochat for mentoring me throughout my graduate education, Dr. Howard Kress for allowing me the opportunity to work on this project and sharing his expertise and advice, and Dr. Kathryn Yount for her thoughtful feedback throughout the thesis process. I appreciate the advice I received from Dr. Penelope Howards, Dr. Michael Kramer, Ms. Cheryl Raskind-Hood, Dr. Kate Winskell, Dr. AliceAnn Crandall, Dr. Yuk Fai Cheong, and Dr. Aaron Siegler. I would also like to Kate Grannemann for her encouragement and editing abilities. Finally, I am grateful to my parents for their endless support and love.

Table of Contents

Correlates of Disclosure of Sexual Violence among Kenyan Youth

Courtney L. Boudreau

BACKGROUND

I. Introduction

Sexual violence (SV) against children is a health and human rights issue that affects individuals across cultures and contexts. Research has shown that experiencing SV can have detrimental short and long-term effects on health and wellbeing [1]. Disclosure of SV can moderate the effect of the violence itself [2, 3]. In some cases, disclosure may have a positive effect on health, by linking victims to care, providing psychosocial support, and decreasing psychological symptoms [2-4]. Immediate linkage to services is particularly important when there is a risk of HIV transmission, risk of pregnancy, or severe physical injury. However, disclosure has been shown to increase symptoms of psychopathology, particularly when the response to disclosure is negative [5, 6]. Reactions to disclosure depend on many factors, such as community perceptions of SV and the identity of the perpetrator [2, 7]. Whether or not the child discloses is also dependent on other factors, including the victim's perception of the event, the victim's demographic characteristics, and his or her relationship with the perpetrator [8]. To date, no studies have examined predictors of disclosure of SV in Kenya. This study aims to determine which factors predict retrospective reporting of disclosure of sexual violence among Kenyan youth. Data come from the Kenya Violence Against Children Study (VACS): a cross-sectional, national, cluster survey of young people ages 13-24 years who were interviewed about experiences of violence before the age of 18. Using logistic

regression to model predictors of disclosure of SV allows public health practitioners to understand which children are more likely to disclose SV and to design interventions to ensure that exposed children can access adequate medical and legal services. This literature review summarizes the existing SV literature, focusing on disclosure and research from Sub-Saharan Africa.

II. Systematic Literature Review Methods

The author searched PubMed using the phrase: ("disclosure of child sexual abuse" OR "disclosure of child sex abuse" OR "disclosure of sex abuse" OR "disclosure of sexual abuse" OR "disclosure of sexual violence" OR "disclosure of intimate partner violence") AND ("risk factors" OR "risk factor" OR "protective factors" OR "protective factor" OR "predictors" OR predictor OR correlations OR correlation OR associations OR association OR determinant OR determinants). This search resulted in 354 relevant articles. The author read the title and abstract of each to determine its relevance to the current research. Relevant articles were retrieved and included in the review. Additional searches were done to provide more general information about SV not pertaining to disclosure and to provide background information on Kenya. Additional articles were chosen based on recommendations from experts and retrieved from Google searches of grey literature.

III. Definitions

Throughout the relevant literature, different terms are used to describe experiences of sexual violence. The World Health Organization defines sexual violence as “any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person’s sexuality using

coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" [9]. This term encompasses many acts, including but not limited to: rape, sexual harassment, sexual abuse, child sexual abuse, forced marriage, denial of contraception, forced abortion, female genital mutilation/cutting (FGM/C), and forced prostitution or trafficking [9]. Most research on sexual violence tends to examine either intimate partner violence (IPV) or child sexual abuse (CSA) but does not often examine SV during childhood as a whole. All instances of CSA are considered SV during childhood, but IPV is only considered to be such when it is sexual in nature and occurs prior to the age of 18.

The VACS defines sexual violence as experiencing: "(1) unwanted touching in a sexual way, such as unwanted touching, kissing, grabbing, or fondling; (2) unwanted attempted intercourse in which sexual intercourse was attempted when the respondent did not want to engage in sexual intercourse, but the assailant did not succeed in completing sexual intercourse; (3) pressured intercourse in which the respondent was pressured or threatened in some other way to have sexual intercourse against his or her will or; (4) physically forced intercourse in which the respondent was physically forced to have sexual intercourse against his or her will" [10].

IV. Prevalence of Sexual Violence and Disclosure Rates

Few studies examine SV against children in Africa, while even fewer look specifically at Kenya. Prior to the 2010 Kenya VACS, prevalence estimates of SV against children in Kenya ranged from 7.6-23.8% [11].

Mandatory reporting laws, differential definitions of sexual violence and age of adulthood, different methods of data collection, and other cultural and personal factors

affecting disclosure influence estimates of SV prevalence [1]. Studies have shown that any single report survey may seriously underestimate the prevalence of SV and that the setting of the survey influences participation [12, 13].

V. Characteristics of Sexual Violence

Although the majority of research on SV has come from high-income countries, several patterns have emerged in the perpetration of abuse. These characteristics influence children's decisions to disclose their experiences of SV. It is important to note that these characteristics come from reports of SV, and that the true characteristics of SV may be different since the characteristics may predict disclosure.

Sexual violence is a highly gendered issue [26]. Although this is reflected in the fact that most reported perpetrators are male and most reported victims are female, the influence of gender is also evident in community perceptions and disclosure patterns among males and females [7, 27, 28]. The characteristics of sexual violence may also differ based on the victim's sex [29]. Girls are more likely than boys to experience intrafamilial SV, while boys are more likely than girls to have a female perpetrator [27].

The majority of perpetrators of SV are people that the child knows [27, 30]. This is particularly true when the abuse occurs at younger ages [27, 30]. Studies have shown that reports of extrafamilial violence are more common than intrafamilial violence, with intrafamilial SV making up about one-third of cases [27, 31]. These prevalence estimates may not reflect true rates of each type of violence, but rather the willingness to report each type. A Portuguese study comparing the two forms of CSA found that victims of intrafamilial victims were significantly different from extrafamilial victims in the following ways: lower victim age, greater proximity to the perpetrator, abusers had

higher rates of previous sexual abuse, lower rates of penetrative abuse, decreased physical violence, increased emotional violence, and reduced number of injuries or biological evidence [32]. Perpetrators of SV may choose vulnerable children as victims and to "groom" the child to gain their trust and prevent disclosure [4].

Studies in lower-income countries have found that childhood SV is not associated with socioeconomic status [27]. An analysis of cross-sectional DHS data from Sub-Saharan Africa (Ghana, Liberia, Nigeria, Uganda, Zambia and Zimbabwe) also did not find of evidence of any such association [33].

Certain public health practitioners have hypothesized that an African myth – that men can be cleansed of HIV by having sex with a virgin – may drive sexual violence [34, 35]. However, this practice has not been widely observed and perpetuates the idea that perpetrators are of one phenotype [35]. Believing that this myth is a driver of SV can be dangerous, as it distracts from the reality that most perpetrators are known [27], and is stigmatizing against people living with HIV [35].

VI. Sequelae of Sexual Violence

The long and short-term effects of experiencing SV during childhood have been well documented [36]. All victims of SV should have access to immediate medical treatment, including PEP, EC, STI prophylaxis, and mental health services [19, 30]. If these services are unavailable or the victim is unable to access them, the child may be at risk of unintended pregnancy and potential morbidities, HIV or STI infection, gynecologic trauma, and psychological trauma. Certain consequences are more likely to occur in cases where penetration occurs. Although the majority of CSA is non-penetrative, children of older ages are at higher-risk of experiencing penetration [27]. In

addition to the immediate consequences of sexual violence, long-term mental and physical health consequences can occur, regardless of the nature of the violence.

Individuals who have experienced CSA report worse overall health [36]. This includes higher levels of gastrointestinal symptoms, gynecologic issues, pain disorders, cardiopulmonary complaints, and obesity [36]. CSA victims have significantly higher rates of psychological symptoms such as post-traumatic stress and dissociation throughout the course of their life [1]. Victims are at a higher risk of being sexually victimized again and more likely to experience violence in their early romantic relationships [1]. Additionally, a longitudinal cohort study in Tanzania found that experiencing CSA prior to 13 was significantly associated with incomplete adherence to antiretroviral therapies [37].

Researchers have suggested that intrafamilial sexual abuse has more severe consequences than extrafamilial abuse [32]. Lower victim age, closer relationship with the abuser, and increased emotional violence were thought to be responsible for the differences in mental health consequences between the two groups [32]. In cases of extrafamilial SV, mental health outcomes may be less likely if the victim has someone in their life that they feel comfortable disclosing to. In many cases, these children may disclose to their parents – which may not be possible in cases of intrafamilial SV. Although the perpetrator's identity may influence the severity of SV sequalae, all types of SV have been associated with negative physical and mental health outcomes.

VII. Community perceptions of Sexual Violence

Community perceptions of SV impact the community's response to acts of sexual violence. These perceptions influence the child's disclosure, the recipient of disclosure's

reaction, as well as the health and legal infrastructure available for response. In addition to these concerns, community perceptions may allow abuse to be passed on generationally if it is seen as commonplace. For example, a 2004 study of community norms found that adults who have experienced certain forms of abuse are more likely to view these same forms of abuse as acceptable [38]. It is therefore important to address community perceptions in areas where prevalence of SV is known to be high.

A large qualitative study in Namibia and South Africa examined the attitudes towards SV against children through in-depth interviews with children, parents, community members, police officers, teachers, social workers, health workers, and NGO staff [7]. Participants reported that intergenerational touching of the genitals, or "sex play" was not uncommon, which could create ambiguity for children and adults about whether or not abuse is occurring. Additionally, participants reported that adult sexual desire for a "child" was inappropriate, but felt that female children as young as 9 years old were no longer children. Participants also reported that men's desire for young girls was a testament to their masculinity. Many participants reported that rape was the fault of the female, for choosing to wear certain clothes or act a certain way. Participants also reported that young people and women lacked status in society and were not respected by elders. This may impede young people's ability to refuse sexual advances from those who are older than them or who are men. Another common theme was that men must have sex once they are sexually aroused and that children were "convenient" for sexual gratification because they either cannot speak or can be bribed not to speak. Participants also discussed rape as a form of paternal control and as a punishment for the mother of the child. It was also common in many cases that the perpetrators were under the

influence of alcohol. Participants mentioned that children who are left alone (by divorce, orphanhood, or work) may be particularly vulnerable to SV or may engage in transactional sex in order to provide for themselves. Another common theme was community stigma toward victims of SV, which was cited as a reason for non-disclosure, particularly in cases of incest. Finally, despite claims that child rape is abominable, participants reported many instances in which rapists were protected, particularly in cases of incest [7].

A qualitative study in one district of Tanzania used focus groups to understand community perceptions of child rape, and had similar findings to those in South Africa [26]. Six key themes were found: rape is a common and hidden problem, abandoning tradition and modeling Western behavior contributes to rape, poor child care leads to child rape, survivors of rape are blamed for disclosing the incident, insufficient, costly, and corrupt support services are a barrier to health-seeking, and collaboration of key-stakeholders is needed to improve help-seeking. Again, participants reported that disclosure was not beneficial due to high levels of stigma, potential loss of marriage potential, and a lack of available services [26].

In South Africa and Tanzania, residents felt that childhood rape was correlated with poverty [7, 26]. Poverty was seen as risk factor in that: young girls who had no means to support themselves may resort to transactional sex, children may be left alone if their parents were in poverty and needed to work far away, and unemployed men may be unable to get a girlfriend and may therefore resort to child rape. This is interesting since previous studies, including one of six African countries, found no association between socioeconomic status and SV against children [27, 33]. Despite these findings, several

researchers cite poverty as an important driver of sexual violence against children in Africa [34, 35].

Results from these two studies do not necessarily provide insight into the community perceptions of SV in Kenya. Only one study has examined Kenyan beliefs about SV, specifically looking at professionals' perceptions of CSA [17]. This study employed focus groups with 36 child protection workers from different tribes to understand the individual, family, and cultural risk and protective factors for CSA in Kenya [17]. Protective factors identified were: traditional values (modest dress and tribal law), gender norms (mother in house to protect children, high value of virginity, separate housing for males and females), placing a high value on children (strong extended families, children as the future), and taboos (sex with a child will cause death). Risk factors identified were tribal factors (polygamy, child marriage, herding lifestyle where children may travel alone, female genital mutilation, male dominance), a culture of silence around sexual matters, patriarchy, foreign influence (refugees and Western ideals), and individual factors (being an AIDS orphan, homelessness) [17]. In addition to affecting SV prevalence, these community perceptions are likely to impact disclosure of, and response to SV.

VIII. Pros and Cons of Disclosing Sexual Violence

Disclosure of SV is thought to be an important part of the victim's healing process and may allow the child to access appropriate medical care and psychological services [39]. However, disclosure does not always guarantee that the child will be able to access services or receive appropriate support when services are accessed [4]. Additionally, disclosure does not imply disclosure to someone who has the power to respond:

researchers have suggested that adolescents may be more likely to disclose to peers [40]. Depending on the context and circumstances of abuse, disclosure can have a positive or negative outcome.

Several theoretical models of trauma recovery cite the importance of disclosure as a way to reduce the negative psychological and physical consequences of SV during childhood [39]. Studies have shown that disclosure of SV soon after the event is associated with lower levels of psychological symptoms later in life [2, 3]. A U.S. national telephone sample of women found that those who did not disclose childhood rape within one month had significantly higher levels of post-traumatic stress disorder and major depressive disorder in adulthood, as compared with those who disclosed within a month of the incident [3]. Another study in the United States found that delaying disclosure was associated with higher levels of post-traumatic stress among women, but did not observe this association among men [41]. However, another study of male CSA victims found that delaying disclosure was related to higher levels of mental distress later in life [39]. Several studies found that disclosure had a negative effect on psychological health. A study of Black and Latina women in the U.S. found higher levels of depression among those who disclosed, after controlling for chronic stress and other adverse events during childhood [42]. A South Korean study found that disclosure of SV was associated with reporting more depressive symptoms [43].

The effect of disclosure on mental health symptoms is dependent on the reaction to disclosure, which may explain why disclosure had a negative impact on symptoms in some groups and a positive impact in others. Several studies of CSA and IPV in the United States have found that victims who disclose during childhood and receive a

negative reaction (such as disbelief or being blamed) have significantly higher levels of post-traumatic stress than those who receive a positive reaction [5, 6]. A Dutch study of CSA victims supported these findings; positive reactions were associated with fewer psychological symptoms [44]. Ullman and Filipas also observed this phenomenon among U.S. sexual assault victims [2]. Additionally, they found that negative reactions to disclosure were associated with being from an ethnic minority group, more severe victimization, and intrafamilial abuse. Intrafamilial abuse has been associated with negative reactions to disclosure in other studies [44]. One follow-up study of college-aged CSA victims found that women were equally as likely as men to report receiving negative reactions to disclosure [41]. Reactions to disclosure are influenced by SV characteristics as well as community perceptions of SV.

Freyd's betrayal trauma theory can help to explain why victims of intrafamilial SV may not self-acknowledge or disclose the abuse. In this framework, victims may suppress memories of sexual abuse when their survival needs conflict with abuse by a parent [45]. This response can be conceptualized as an adaptive behavior, as victims of intrafamilial violence depend on their abusers for food, shelter, and other basic needs. Ullman posits that this theory can be extended to explain why victims of intrafamilial violence may be less likely to disclose than those experiencing extrafamilial violence [46].

Community gender norms affect the outcome of disclosure in different ways for males and females. In a qualitative study of Somali refugees, women reported that disclosing sexual violence could reduce women's chances of finding a husband [47]. In a study of sexual gender based violence in the Democratic Republic of the Congo (DRC),

rape victims reported that their families began mistreating them after the rape, that they would be unlikely to find a husband, and that they faced stigma from community members [48]. These women also reported being ostracized and abandoned by their husbands (especially if a woman contracted HIV as a result of the rape). The authors explained that the stigma towards rape survivors is influenced by community perceptions of marriage, the worth of women, and rape [48]. Somalian women reported that if a woman became pregnant as a result of the rape, she may not disclose so as to protect the child from stigma while growing up [47]. This idea was also seen in the DRC, where men reported their reluctance to raise a child that was not their own biologically [48].

Boys may not disclose SV because of cultural ideas of masculinity [39]. They may feel that boys should be strong enough to resist sexual advances or strong enough to deal with the abuse on their own [49]. Boys may believe that it is impossible for a woman to be a perpetrator or that sexual abuse cannot happen to boys [49]. In fact, a common reason for non-disclosure is not thinking that what happened was a crime [28]. Boys may also fear being thought of as homosexual [28]. This is of particular importance in the Sub-Saharan African context, where being homosexual is highly stigmatized and often criminalized [50].

Victims often do not disclose because they are afraid of further violence to themselves or their families [28, 30]. Reporting SV to police and legal authorities, if they have the capacity to respond, may mitigate the risk of violence from the perpetrator. A study from the Philippines found that the child's clear disclosure and medical testimony were the most important predictors of perpetrator conviction [51]. This highlights the importance of the disclosure itself, and of healthcare workers' responsibility to accurately

record the child's disclosure, document the medical examination, and file a police report when necessary.

A study of U.S. rape victims found that among those who did not report the incident to police cited fear of reprisal, not wanting family to know, and not wanting other people to know as the most important reasons for non-disclosure [52]. Other reasons included lacking proof, fear of being treated badly by police, lawyers, or other parts of the justice system, not being clear about whether a crime was committed, not knowing how to report, and not thinking it was serious enough to report [52].

IX. Correlates of Disclosing Sexual Violence

A number of studies have examined the correlates of disclosure of SV (Tables 1 and 2). Significant correlates of disclosure may differ across contexts (population vs. clinical, different countries), outcomes (CSA, childhood rape), data collection methods (telephone survey, chart abstraction, qualitative interviews) and analytic techniques (different modeling strategies). Despite these differences, many of the studies came to similar conclusions about significant correlates of disclosure. Hypothesized correlates of disclosure in Kenya are presented in each section.

Demographic Characteristics

Gender

All studies that examined the effect of gender found that females were more likely than males to disclose sexual violence [41, 53-55]. Boys may be hesitant to disclose if they do not see the abuse as a problem, they are afraid of being thought of as homosexual, or they are trying to uphold masculine norms of strength [4]. We

hypothesize that girls in our study population will be more likely to disclose SV than boys.

Age at survey

Research has suggested that older age at the time of the survey or interview is associated with disclosure [54, 55]. However, both of these studies analyzed data from forensic interviews. These findings may therefore not extend to a population-based study since children may have different understandings of their responsibilities in a forensic interview as opposed to a household survey. Since the VACS was administered to people aged 13-24, we hypothesize that older participants may be more likely to disclose SV as they may no longer be living with their family.

Race

Studies in the United States have found that race is not associated with disclosure of SV in childhood [54, 56], yet one study found that being white is correlated with disclosing SV [53]. It is possible that the groups were not racially diverse enough to provide an accurate picture of the influence of race on disclosure behavior. The association between race and disclosure is also likely confounded by other factors. Race was not included as a potential correlate in the VACS analysis.

Family structure

Priebe and Svedin found that coming from a single-parent home is associated with disclosure among males but not females [40]. Schonbucher found that children still living with both parents were more likely to disclose [57], while Kogan similarly found that never having lived with both parents was negatively associated with disclosure [58]. Having both parents in the home may be associated with higher social support; children

may be more likely to feel that they will obtain a positive or helpful response from their parents. Conversely, orphans may not have a trusted adult in their life to disclose to. Priebe and Svedin did not hypothesize as to why males may be more likely to disclose if they are from a single parent home [40]. Perhaps the abuse was perpetrated by one of the parents and the disclosure led to the single-parent situation. We hypothesize that being a double or single orphan prior to the experience of SV will decrease the likelihood of disclosure.

SV Characteristics

Age at first incident of SV

Some studies have found that children who are older at the time of the incident are more likely than younger children to disclose SV [54, 56, 59]. However, other studies have found the opposite: younger children are more likely to disclose [8]. One study found that 7-10 year olds were the most likely to disclose while 14-17 year olds were the least likely to disclose [58]. Lam found no association between age and disclosure [55]. Priebe and Svedin also found no association but dichotomized age at 15 years [40]. It seems that age may have different effects on disclosure throughout childhood. A path analysis of disclosure found that older victims of CSA felt more responsible for the abuse and that this was a main influence on their decision not to disclose [8]. Older victims may be more aware of the inappropriateness of the incident, while younger children may not understand the abuse [56]. However, younger children may be more likely to tell someone about the abuse if they do not realize the stigma that accompanies SV [56]. In the Kenyan setting, it is important to consider that older children may be more aware of social stigmas towards SV victims and therefore refrain from disclosing. We hypothesize

that children who are older at the onset of SV will be less likely to disclose, as they may be better able to understand the implications of disclosure.

Perpetrator identity

Victims of intrafamilial perpetration are less likely to disclose their experience than children who are abused by people outside of their family [8, 44, 53, 56-58]. Since intrafamilial abuse is associated with negative reactions, children may anticipate this and be less likely to disclose. A qualitative study of U.S. victims of extrafamilial CSA and their parents reported that children's expected reactions to disclosure were highly correlated with their parents' true reactions [60]. The lower rates of disclosure among intrafamilial SV victims may be confounded by the correlation of other factors with intrafamilial abuse such as lower victim age and increased emotional violence [32, 44].

Children who experience sexual violence by a stranger are more likely to disclose SV in high-income countries [40, 56]. This may be due to community perceptions that strangers usually perpetrate SV, implying that these findings may not translate to other settings with different perceptions of SV [61]. Children may also more clearly understand that the act is inappropriate when the perpetrator is unfamiliar to them [56]. Children are also more likely to disclose when the perpetrator is a minor [57] and when the perpetrator is male [55]. We hypothesize that victims of SV perpetrated by either a known perpetrator, a romantic partner, or a family member will be less likely to disclose SV as compared with victims who are unknown.

Perceived "severity" of SV

Research on SV often discusses the "severity" of the violence, but does not always provide clear definitions for what this means. More "serious" or "severe" cases of

SV are more likely to be disclosed [27, 55], particularly among girls [40]. More serious cases may be more obviously inappropriate to the child or they may be physically harmed and unable to hide the abuse. Penetrative SV may be considered more severe, but research has shown it is not associated with disclosure [53, 57, 58]. Being threatened during the abuse is associated with disclosing SV [53, 56], as is the use of a weapon [56]. Being injured during the act is not associated with disclosure [53, 56] but children whose families are threatened are less likely to disclose [53, 58]. We hypothesize that disclosure rates among respondents who were physically forced to have sex will not differ between those who were physically forced to have sex and those who experienced unwanted sexual touching, attempted sex, or pressured sex.

Frequent abuse may also be deemed more "severe," but the literature does not always differentiate between a series of incidents by the same perpetrator or re-victimization by another perpetrator. Some studies have found that experiencing a series of assaults is associated with not disclosing SV [56-58]. However, other research has found that there is no distinction between disclosure behavior of those experiencing a single assault versus a series of assaults [53]. No association has been found between the duration or frequency of abuse and disclosure [40, 54, 55]. We hypothesize that the total number of experiences of SV will be negatively correlated with disclosure. This association may exist because children who do not disclose may be more likely to face re-victimization as compared with a child who did disclose. The correlation between chronic violence and disclosure may also occur because children who experience chronic violence may fear repercussions from the perpetrator.

Prior experience of physical violence

One study showed that experiencing physical abuse is not associated with disclosure behaviors [40]. This is in line with research that being injured during the assault is not associated with disclosure [53, 56]. Perhaps physical violence is not occurring at the same time as SV and therefore does not affect disclosure behaviors. Experiencing physical violence may not impact the factors that drive disclosure. We do not expect to find an association between physical violence and disclosure.

Prior experience of emotional violence

No prior studies have examined emotional violence (EV) prior to SV as a correlate of disclosure. However, researchers have found a correlation between intrafamilial SV and EV and an association between intrafamilial SV and a decreased likelihood of disclosure [32, 60]. Therefore, emotional violence may be associated with a decreased likelihood of disclosure. Therefore, we hypothesize that those who experience EV prior to SV will be less likely to disclose SV than those who did not previously experience EV.

Intoxication during SV

Two studies have found that the victim being intoxicated during the assault is not associated with disclosure [40, 53]. We do not expect intoxication during SV to be correlated with disclosure.

Other correlates of disclosure

A South African study found that late (after 72 hours) presentation of sexual assault (and thereby late or potential non-disclosure) at the hospital was associated with fear of the perpetrator, being under 9 years old, and being afraid of what relatives would

say about the alleged assault [59]. Other barriers to disclosure in South Africa include fear of not being believed, poor access to the police, fear of ruining one's reputation, fear of breached confidentiality, poor treatment by the criminal justice system and health professionals, and believing that reporting the crime will not result in conviction [30].

In a qualitative research study, Somalian women reported not disclosing because they did not know that psychological help was available. Additionally, due to national instability, women did not report because there was no legal infrastructure to respond [47].

South African and Somalian barriers to disclosure may also be applicable in Kenya. It is important not only to examine the correlation between disclosure and demographic or SV characteristics, but also social and community correlates of non-disclosure. Researchers have suggested that rapes consistent with prevailing "rape myths" (i.e. rapes are always violent, perpetrator is a stranger) are more likely to be reported than those that are not [61]. It may therefore be important to also examine community ideas of "typical SV" stereotypes when researching disclosure in the future.

An analysis of 2009-2010 Demographic and Health Survey data from Kenya found that among those who experienced IPV (both physical and sexual), just 2.38% reported to police, 0.88% reported to medical personnel, and 4.67% reported to social services [62]. Formal reporting in Kenya was associated with older ages and being formerly married [62].

More studies have focused on correlates of disclosure of IPV than correlates of disclosure of CSA [63]. Examining SV occurring prior to age 18 includes all cases of CSA, and unwanted sexual experiences before the age of 18. SV prior to age 18 also

includes cases of sexual IPV, but not all studies differentiate between physical and sexual IPV and studies of IPV tend to focus on middle-aged women [63]. A review of correlates of disclosure of IPV found that female gender, white race, younger ages, higher socioeconomic status, fewer feelings of shame, fear, embarrassment, concern for safety of themselves and others, and dependence on their partner, greater severity and frequency of abuse, and the IPV being witnessed are all associated with disclosing IPV [63].

X. Kenya Background

Kenya is an East African nation with a population of approximately 45 million people, of which about half are under the age of 18 [14]. The population is made up of seven major tribal groups [14]. In 2006, the lack of legal framework for SV, combined with society's perception that rates of SV were increasing, led to the passage of the Sexual Offenses Act [15]. This bill criminalized the purposeful transmission of HIV, expanded definitions of sex crimes, and provided free health care and counseling to rape victims [16]. Prior to the passage of this law, there were no minimum sentences for offenders and the sexual abuse of males was not criminalized [17]. In order for the Sexual Offenses Act to be effective, it is important that Kenyan citizens are aware of its existence. However, a 2011 population-based survey found that 67.4% of adults surveyed were unaware of the act [18]. Although the Children's Act of 2001 defines a child as anyone under the age of 18, parliamentarians debated lowering the age to 16 during the passage of the Sexual Offenses Act [15]. The original definition of 18 was maintained, yet minimum sentences reflect Kenyan views on the relative unacceptability of SV across the child lifespan. For example, someone who defiles (penetrates) a child under the age of 11 will be sentenced to life in prison, while defilement of a child aged 16-18 holds a 15-year minimum

sentence [16]. In 2009, the Kenyan Ministry of Health released a second edition of national guidelines on the management of sexual violence that included sections on medical management, psychosocial support, forensic management, humanitarian issues, and quality assurance and improvement for post-rape care [19]. In addition to providing direct services, healthcare workers are also responsible for collecting evidence and filling out a post-rape care report, which is then transferred to police [19]. According to these guidelines, post-exposure prophylaxis (PEP), emergency contraception (EC), and STI prophylaxis should be provided when indicated. In 2013, there were approximately 1.6 million adults living with HIV in Kenya [20]. An HIV prevalence of 6% puts SV victims at significant risk of contracting HIV.

The social, political, and economic context of Kenya may influence the prevalence of sexual violence [21]. In 2007, the Kenyan elections triggered a period of unrest during which ethnic violence killed approximately 1,500 people [22]. Children may have been at increased risk of experiencing SV during this period of instability. A 2011 population-based survey found a significant increase in SV during the election violence period, with higher rates of violence seen among certain ethnic groups [18]. A large number of Kenyans live in informal settlements, placing them at high risk of experiencing violence due to a lack of security [23]. These settlements often lack adequate sanitation; increasing women and children's risk of experiencing of violence while traveling to go to the bathroom [23]. High rates of poverty could lead individuals to join sex work, substantially increasing the likelihood that they will experience violence [24]. A large number of Kenyan children are engaged in commercial sex work; a 2006 report estimated that there were between 12,000 and 18,000 Kenyan girls under the age

of 18 in the sex industry [24]. Finally, it is important to consider that Kenya is a patriarchal society in which gender equity has not yet been achieved [17, 23]. This social organization may influence norms related to violence against both male and female children. These contextual factors may contribute to the high prevalence of SV in Kenya. Much of the research about child sexual abuse (CSA) in Kenya is unpublished [11]. Lalor's 2004 article was a summary of organizational reports and interviews he conducted with relevant actors in Kenya. The majority of research lacked operational definitions or did not ask directly about CSA or incest [11]. Researchers have highlighted the importance of ascertaining public sector perceptions of sexual violence against children, as has been done in South Africa [25]. Although the passage of the Sexual Offenses Act demonstrated political will to address SV against children, only one small study has examined the attitudes of those who would be involved in response, such as police officers, social workers, healthcare workers, community leaders, or laypersons [17]. More research on SV against children in the Kenyan context should be conducted in order to understand the complexities of the issue and to design interventions specific to Kenya.

XI. Conclusion

The majority of research on SV during childhood has occurred in the United States and other high-income countries. To our knowledge, no studies examine the correlates of disclosure of SV in Kenya. We expect that some correlates of disclosure will be cross-cultural, but that others may be specific to the Kenyan setting. Correlates are influenced by community perceptions of sexual violence as well as gender norms and the societal role of children.

Examining the correlates of disclosure will allow us to better estimate the prevalence of SV in Kenya. We may be able to better target policy efforts to encourage disclosure of SV. Encouraging disclosure would allow victims to receive the necessary medical treatment (counseling, PEP, STI prophylaxis, EC, etc.) and would also connect them with the legal system and protect them from the perpetrator. Additionally, understanding disclosure could help the courts to understand that victims of SV may not always disclose, but that this does not imply that their perpetrator is innocent [4]. Finally, convicting the perpetrator may prevent him or her from abusing other children [4].

The benefits of disclosure can only be obtained if the survivor of SV has access to a clinic, the clinic staff and police have the training and resources to respond, and there are laws in place to convict perpetrators. We must also ensure the immediate safety of SV victims. The child's access to the clinic is dependent on the recipient of disclosure, and whether he or she feels that such a response is necessary. In addition to the immediate benefits of disclosure, telling someone about the violence may mitigate the mental and physical health outcomes that may arise in the future. This, again, is dependent on the response of the disclosure recipient. The victim's willingness to disclose, the recipient's response, the criminal justice infrastructure, and the healthcare infrastructure are all influenced by community perceptions of sexual violence. It is therefore essential that programs to promote disclosure take a multi-level approach to improving response to childhood SV.

METHODS

I. Data Collection

Data for this analysis comes from the 2010 Violence Against Children Study in Kenya. The Kenya Ministry of Gender, Children and Social Development, in conjunction with the Kenya National Bureau of Statistics, Centers for Disease Control and Prevention (CDC) Atlanta and UNICEF, undertook this cross-sectional, nationally representative survey. Data were collected from selected households based on a three-stage cluster sample design. This survey followed the World Health Organization's guidelines on ethics and safety in studies on violence against women. The CDC's Institutional Review Board and the Ethical Review Committee of the Kenya Medical Research Institute approved the study.

A technical working group of local and national experts developed the survey and pilot-tested it in villages outside of the sampling frame. The survey was translated from English into 12 languages, back-translated into English, and cross-validated. Trained interviewers administered the survey to boys and girls between the ages of 13 and 24. For children under 18, consent to participate in a survey about on "health, education and life experiences" was obtained from the legal guardian. A two-stage assent process was followed to ensure that all respondents were willing to participate in the survey. The survey was administered in a private location and respondents who requested services were connected with a counselor and all participants were provided with a list of service organizations and agencies.

Data were entered into Epi Info version 3.5.1; 12.7% of surveys were entered twice to ensure data quality. Household response rates were 90.3% for females and

89.6% for males. Individual response rates were 94.0% for females and 89.8% for males. Competed surveys were available for 1,227 females and 1,456 males.

II. Measures

Outcome – Disclosure of sexual violence

The outcome for this analysis was a dichotomous variable capturing whether or not participants who reported experiencing SV prior to the age of 18 told anyone about the incident(s) ("Did you ever tell anybody about any of these incidents- unwanted touching, attempted sex, physically forced sex, or pressured sex?"). Therefore, disclosure in this analysis refers not to disclosure to the interviewer, but disclosure to any person prior to the survey.

SV is defined as having at least one experience of one of the following types of SV: unwanted touching ("How many times in your life has anyone touched you in a sexual way without your consent, but did not try and force you to have sex?"), attempted sex ("How many times in your life has anyone tried to make you have sex against your will, but did not succeed?"), physically forced sex ("How many times in your life have you been physically forced to have sex against your will and sexual intercourse was completed?"), or pressured sex ("How many times in your life has someone pressured you to have sex when you did not want to, and sex happened?"). Each type of SV was clearly defined by the interviewer prior to asking the participant to respond. For each type of SV, the respondent was asked how old they were the first time the event occurred. Only those respondents that reported experiencing SV prior to 18 were included in the analysis. Although FGM/C is also a form of sexual violence it is not included in this analysis because survey respondents were not asked about disclosure of FGM/C.

Additionally, disclosure of FGM/C may not be comparable to disclosure of other forms of SV as the child's family and medical community are often aware of its occurrence.

Potential correlates of disclosure

Demographic Characteristics of the Victim

Gender, age at time of survey, and family status (whether or not the child was a single or double orphan prior to experience of SV) were considered as potential correlates of SV.

Physically forced sex

Whether or not participants reported experiencing "physically forced intercourse in which the respondent was physically forced to have sexual intercourse against his or her will."

Age at first experience of SV

The victim's age at the first occurrence of sexual violence.

Prior experience of emotional violence

Whether or not the participant reported experiencing any type of emotional violence (EV – "Did any adult ever say or do something on purpose to humiliate you in front of others?" "Did any adult ever make you feel unwanted?" "Did any adult ever threaten to abandon you?"), prior to their first experience of SV. The number of respondents who experienced EV prior to SV is likely an underestimate; age at first SV

was provided as a specific age while the responses to age at first EV was given as a range of years.

Prior experience of physical violence

Whether or not the participant reported experiencing any type of physical violence (PV – "Has a parent or adult relative ever: Punched, kicked, whipped, or beat you with an object? Used or threatened to use a knife or other weapon against you?" "Have persons of authority such as teachers, police, or military ever: punched, kicked, whipped, or beat you with an object? Used or threatened to use a knife or other weapon against you?" "Has your current or previous romantic partner ever: slapped you or pushed you? Hit you with a fist, kicked you, or beat you with an object? Used or threatened to use a knife or other weapon against you?"), prior to their first experience of SV. Experiencing PV prior to sexual violence was chosen because SV itself may cause physical violence. The number of respondents who experienced PV prior to SV is likely an underestimate; age at first SV was provided as a specific age while the responses to age at first PV was given as a range of years.

Romantic Partner Perpetrator

Whether or not any perpetrator of SV was a romantic partner ("Were any of the people a boyfriend, romantic partner or husband?"). Respondents could report multiple occurrences of SV, meaning that one respondent could have experienced SV perpetrated by multiple perpetrator types.

Intrafamilial Perpetrator

Whether or not any perpetrator of SV was a person in the victim's family ("Were any of them relatives?")

Other Known Perpetrator

Whether or not any perpetrator of SV was known to the victim but was not a romantic partner or a person in their family ("Did you know any of the people who did this to you?") – excluding if they were romantic partner or relative.

Number of total experiences of sexual violence

The total number of experiences of all types of sexual violence ("How many times in your life has anyone touched you in a sexual way without your consent, but did not try and force you to have sex / has anyone tried to make you have sex against your will, but did not succeed / have you been physically forced to have sex against your will and sexual intercourse was completed / has someone pressured you to have sex when you did not want to, and sex happened?").

Intoxication during SV

Whether or not the participant was ever on drugs or drunk at the time of the incident ("Were you ever drinking or on any illegal drug when a sexual incident happened?")

III. Analysis

Respondents who refused to answer or replied "Don't know" when asked about experiences of the four types of SV (sexual touching, attempted sex, physically forced

sex, and pressured sex), these observations were coded as missing data (refused: 0.7% of females and 0.5% of males; "Don't know": 0.5% of females and 1.3% of males). Only one observation had missing data for age at first experience of SV. Intoxication status was not included in the analysis because so few respondents (<5%) reported being intoxicated when SV occurred. Among those coded as having experienced SV prior to 18, 94.6% (n=489) had complete data for the analysis variables. Of those who had incomplete data, 24 respondents were missing data on disclosure only, two respondents were missing data for physically forced sex only, and an additional two respondents were missing data for both variables. Among respondents who had missing data for disclosure (n=26), 22 were truly missing, three responded, "don't know," and one refused to answer. Only those with complete data were included in analysis (n=489, 66.5% female).

SAS 9.4 (Cary, N.C.) survey procedures were used to analyze data. Therefore, all percentages presented are weighted percentages that account for the sample design. Initial variable selection was based on a review of relevant literature. Bivariate analyses (χ^2) of each variable with the outcome were conducted. Variables were then assessed for collinearity based on variance decomposition proportions and conditions (SAS Macro, Department of Epidemiology, Rollins School of Public Health at Emory University). Mean-centered variables were created from the age at survey and age at first experience of SV variables to address collinearity between each of these terms with the intercept. All variables were entered into the model. Backwards elimination was then conducted manually to eliminate non-significant ($p<0.10$) terms. This level of significance was chosen based on the small sample size and the formative nature of this research. Backwards elimination was conducted on the total sample as well as for males and

females separately. All covariates related to the perpetrator's identity were kept in the model if at least one was found to be significant. This was done to account for the fact that these were pseudo-dummy variables. Model selection decisions were data-driven because no literature exists on the correlates of disclosure within the Kenyan context. All analyses accounted for the sample design by using weight, cluster, and strata statements in SAS survey procedures.

RESULTS

Within this sample, 27.8% of females and 14.5% of males reported experiencing sexual violence prior to age 18 (Table 4). The reported prevalence of SV was significantly higher among females as compared with males for all types of SV (α=0.05). For both males and females, sexual touching was the most common type of SV reported.

Among those who reported experiencing SV prior to 18, the average age at first reported experience of SV was 14.4 years for females and 13.4 years for males; with males reporting being significantly younger at age of first SV (Table 5). Age at time of survey was not significantly different between genders (18.6 years for females; 18.2 years for males). Almost one quarter (23.9%) of female SV victims reported becoming a single or double orphan prior to the reported experience of SV. This percentage was not significantly different from male SV victims who were orphaned prior to SV (18.9%).

Females reported experiencing an average of 10.9 experiences of SV. Males reported an average of 5.9 experiences of SV; the difference between genders was not significant. Females reported a significantly higher prevalence of physically forced sex as compared with males (22.4% of females and 8.0% of males). Among reported SV victims, 12.8% of females and 14.9% of males reported experiencing emotional violence prior to SV; a non-significant difference across gender. The majority of reported SV victims reported having experienced physical violence prior to SV (59.4% of females and 60.2% of males); prevalence of PV was not significantly different across gender.

About half of females (53.3%) and males (48.4%) reported that at least one of the perpetrators of reported SV was a romantic partner. Fewer SV victims reported that any perpetrator was a family member (20.5% of females, 15.4% of males). Females reported

that 44.7% of perpetrators were known (excluding family members and romantic partners), while males reported that they knew 40.0% of their perpetrators. Very few SV victims reported that the perpetrator was unknown to them (5.6% of males and 5.9% of females). The differences between genders for the three perpetrator types were not significant. Disclosure of SV prior to the survey was significantly different between males and females, with 44.6% of females and 28.2% of males reported having ever disclosed any reported experience of SV to anyone. Disclosure in this analysis refers not to disclosure of SV to the interviewer, but disclosure of SV prior to the survey.

Unadjusted odds ratios of disclosure for females, males, and the total sample are presented in Table 6. Due to small cell sizes (<25 observations), odds ratios for males are not presented for four variables (orphan status, physically forced sex, EV prior to SV, and family member perpetrators). Among females who reported experiencing SV, the total number of experiences of sexual violence was negatively associated with disclosure. For every additional reported experience of sexual violence, the odds of disclosure significantly decreased by 2% (α=0.10). Also among females, having a perpetrator who was a family member increased the odds of disclosure by a factor of 2.19 (α=0.10). No unadjusted odds ratios were found to be significant for males (α=0.10).

When observations for males and females were combined, the total number of experiences of SV was no longer significantly associated with disclosure (α=0.10). If any perpetrator was a family member, the odds of disclosure were significantly increased by a factor of 1.76 (α=0.10). Gender was found to be a significant correlate of disclosure; the odds of disclosure among males were .48 the odds of disclosure among females (α=0.10).

Backwards elimination model selection (α=0.10) was conducted for females, males, and the total sample. Among males, no variables were significantly associated with disclosure. Among the total sample, the final selected model found gender, total number of experiences of SV, and family member perpetrator to be significant correlates of disclosure of SV (Table 7). The variable denoting romantic partner perpetrator was kept in the model as it is a pseudo-dummy variable. Males were less likely to disclose; the adjusted odds of disclosure for males were 0.45 (0.31, 0.68) times the odds of disclosure for females. The more events of SV the respondent reported experiencing, the less likely s/he was to have told someone about the experiences. The odds of disclosure decreased by a factor of 0.98 (0.96, 0.99) for every additional reported experience of SV. Victims who reported having at least one experience of SV perpetrated by a family member were more likely to disclose the experience. Having a perpetrator who was a family member was associated with a 2.15 (1.32, 3.50) higher odds of disclosure, as compared to victims of SV who had no perpetrators that were family members. Having a known perpetrator was not a family member or romantic partner increased the odds of disclosure by a factor of 1.67 (1.06, 2.65). The total number of experiences of SV and family member perpetrator became more strongly associated with disclosure when only female observations were analyzed (Table 8). Among the female only sample, having a known perpetrator was no longer significantly associated with disclosure.

DISCUSSION

This study is the first to demonstrate correlates of prior disclosure of reported sexual violence prior to the age of 18 in Kenya. The high prevalence of SV that was reported among children in this nationally representative sample underscores the importance of addressing this issue. Enumerators for the Kenya VACS were trained in survey administration and precautions were taken to ensure that children were surveyed in a private area. However, it is still likely that certain children may not have disclosed to the interviewer, meaning that the prevalence of SV may be even greater than reported. Therefore, the outcome of reported disclosure prior to the interview may be biased, as those who did not disclose to the interviewer are not included in the analysis. Gaining a deeper understanding of the factors associated with children's reported disclosure of SV will allow policy-makers and public health practitioners to take targeted action to aid children who are SV survivors.

Among those who reported exposure to SV prior to age 18, more than half of all girls and over two-thirds of boys reported that they had never told anyone about their experiences. By disclosing their experience to someone in their community, these children may have been able to access health services, receive counseling, or be removed from the abusive situation. Observed rates of disclosure are lower than those observed in previous research, though no studies have examined disclosure in low-income countries [54, 55, 58]. Possible explanations for the lower rates of reported disclosure of SV in Kenya are multiple. Cultural beliefs about SV and gender norms may lead fewer children to tell anyone about their experiences. Stigma towards victims of SV may be higher in Kenya than in the other locations where surveys were conducted. Children may be aware

of the attitudes towards SV and anticipate a negative reaction to disclosure. There may be less awareness of SV and what constitutes SV as compared with high-income countries. Finally, children may not disclose exposure to SV because of the lack of accessible services for SV victims. In places where services are available, children may not be aware of them, may not have the means to access them, or may be unaware that they should seek help after what happened to them. These explanations may not only prevent children from disclosing SV to someone in their life, but may also prevent the child from reporting exposure to SV during the interview. Victims who have disclosed their experience of SV in the past may be more likely to report SV during the survey. Therefore, reported disclosure prevalence (disclosure prior to the survey) may be an overestimate. This could bias results if those who do not disclose to the enumerator and did not disclose to anyone in the past have SV characteristics that are different from those who disclosed to the interviewer but did not in the past.

Consistent with literature from high-income countries, males who reported exposure to SV were significantly less likely than females to report having told anyone about their experience of SV [53-55]. Societal norms about masculinity may influence boys' decisions to disclose SV [39]. Males may feel emasculated by the experience and believe that they should have been able to resist the perpetrator or that they should deal with the experience alone [49]. They may believe that boys cannot be victims of SV, that women cannot perpetrate SV, or that SV is not a crime [28, 49]. Additionally, males may also fear being perceived as homosexual, as it particularly stigmatized in Sub-Saharan Africa [28, 50].

Having more experiences of SV was associated with lower odds of disclosure. This correlation was observed among the all SV victims and female victims, but was not significant among males. This association may be a result of the small number of males who reported disclosing SV. Research in high-income countries has also found a negative association between the frequency of SV and disclosure [56-58]. More frequent SV may normalize the abuse, making children feel that it is an inescapable occurrence in their lives. More events of SV may be associated with prolonged manipulation to convince the child not to disclose. The child may become more ashamed to disclose SV the more often it has happened. This association may also exist because children who do not disclose may be at higher risk of re-victimization by the same perpetrator or a different perpetrator. The high number of experiences of SV reported by all SV victims in this analysis emphasizes the importance of encouraging disclosure to prevent further occurrences from occurring.

Children who experienced intrafamilial SV were paradoxically more likely to have disclosed SV. This contradicts findings from high-income countries, where victims of intrafamilial SV were less likely to disclose [8, 44, 53, 56-58]. This relationship was found to be significant among all SV victims and among female victims. It was non-significant among males, which may be a result of small sample size or the effect may only be present among females. Victims of intrafamilial SV may be more likely to disclose because of cultural family values. Perhaps in the Kenyan context, SV among family members is more clearly a violation than SV by another perpetrator. Different family and housing structures may lead to a higher likelihood that someone may discover the SV, essentially forcing the child to disclose. Children who experience SV by a

member of their family may be more concerned that an event will happen again, as opposed to a perpetrator that they may not see very often. This may prompt the child to disclose in order to prevent another event from occurring. It is also a possibility that children who have previously disclosed intrafamilial SV may be more likely to report this to the enumerator. Children who have never disclosed intrafamilial SV may be less likely to disclose to the enumerator because they are ashamed or may still be living with the perpetrator and fear the ramifications of disclosure to the enumerator. If this were the case, the disclosure rate among victims of intrafamilial SV would be biased in the opposite direction.

Among the total sample, if any perpetrators were known to the victim but were not romantic partners or family members the odds of disclosure were increased by a factor of 1.67. This finding also contradicts with the majority of published literature on the topic of disclosure. This finding may indicate more about the reference group than it does about those with a known partner. This variable excludes those who experienced SV by a perpetrator who was not a family member or a romantic partner, so the reference group consists of those who had a family member perpetrator, romantic partner perpetrator, or a stranger perpetrator. Because such a small number of reported perpetrators were family members and strangers, the reference group consists mainly of those who experienced SV by a romantic partner perpetrator (71.7%). Therefore, it is possible that those who experience SV perpetrated by a romantic partner are unlikely to disclose, partially explaining the increased likelihood of disclosure among partner types. Those coded as having experienced perpetration by a romantic partner may have also experienced perpetration by another perpetrator type, which could explain why the

romantic partner variable was not significantly associated with disclosure. In fact, when a variable was created that included those who only experienced SV that was perpetrated by a romantic partner, the unadjusted odds of disclosure was found to be significantly decreased (0.60 (0.36, 0.99); α=0.10). Victims of SV by a romantic partner may be less likely to disclose because they believe intimate partner sexual violence to be a normal occurrence. Re-victimization creates a situation in which the effect of perpetrator identity on disclosure is complex and difficult to understand without further research.

One limitation to this study is the small number of participants who reported SV and reported disclosing this experience to someone in their life. A larger sample may have allowed us to better understand the factors that influence disclosure of SV. Another limitation of the research is the ambiguity of the outcome variable. Although the respondent reports disclosure, we cannot know to whom they disclosed or when they disclosed. They may have told someone who did not have the ability or the will to help them or they may have disclosed SV years after it occurred. We therefore cannot ascertain whether disclosure was beneficial to the child. Delayed disclosure may still be emotionally beneficial for the child, but this is dependent on the reaction to disclosure [5, 6]. If the child experienced multiple SV events with different perpetrators, it is unclear which of the events they disclosed. Since the sample includes all SV prior to 18, the correlates of disclosure may be different depending whether the incident would be classified as IPV or CSA. Finally, this research is not likely to be generalizable to other contexts. Even within Kenya, disclosure of SV may have different correlates because of the number of distinct ethnic groups that exist within the country.

Despite the limitations of this research, it has several strengths. The overall study is nationally representative; implying that the characteristics of SV observed in this sample should be similar throughout Kenya. The definition of sexual violence includes a broad range of actions and is not limited only to cases of rape. Since it is a population-level survey, it provides a more accurate representation of disclosure rates than would a clinical sample. Participants ranged from 13-24, decreasing the amount of recall bias that may be present if older adults were surveyed. Finally, the private nature of survey administration increased the likelihood that children would report SV to the interviewer.

CONCLUSION

The purpose of examining correlates of disclosure is to understand which victims of SV are less likely to disclose. However, if efforts are made to increase disclosure, it is also necessary for interventions that will help to shift societal attitudes towards SV and to ensure that child-friendly services are available for SV victims. This will increase the likelihood that disclosure will have a positive effect on the child and decrease the likelihood of physical and psychological symptoms [5, 6]. Ensuring that Kenya's child SV survivors receive adequate services is essential and may also reduce the burden on the healthcare system in the future by reducing morbidities associated with SV [5, 6].

Female gender, fewer experiences of SV, intrafamilial perpetrator identity, and known perpetrator identity are positively associated with disclosure among Kenyan children who experienced SV. Therefore, public health practitioners should consider this when developing interventions. Awareness campaigns should publicize the high prevalence of SV and emphasize that it is not something that only happens to females.

Community organizations that work with young boys should be trained to respond properly to disclosure and to recognize signs of SV. Because about half of all SV victims had a perpetrator who was a romantic partner, interventions in teens to encourage healthy relationships may be beneficial. The overall low rate of disclosure highlights the need for increased awareness of SV. Community norms have been shown to play a role in responses to disclosure and children's willingness to disclose SV; research should examine Kenyan attitudes towards SV [61]. The Kenyan Government should ensure that the health and justice infrastructures are prepared to respond to child SV and should inform the public that these services are available. This study will help to bring attention to the issue of sexual violence and will help clinicians and practitioners understand which children may be more likely to disclose experiences of sexual violence.

APPENDIX A: SYSTEMATIC REVIEW TABLES

Table 1: Bivariate associations of disclosure of reported sexual violence

Author, Year Country Age Gender Setting	Outcome	N	N (%) experienced outcome	% disclosed	Associated with Disclosure	Not Associated with Disclosure
Smith, D.W. et al., 2000 [56] United States Adult females reporting incidents prior to 18 National telephone survey	Disclosure of Childhood Rape	3,220	288 (9%)	72%	Weapon used during the rape, threatened during the rape (vs. non-disclosure), older age, series of rapes, stranger perpetrator (long v. short)	Race, receipt of injury, weapon used (long v. short)
Goodman-Brown et al., 2003 [8] United States 2-16 year old males and females SAP questionnaire victims referred to district attorney's office	Time of disclosure of CSA	218	218 (100%)	n/a	n/a	n/a
Hanson et al., 2003 [53] United States 12-17 year old males and females National telephone survey	Disclosure of CSA	4,023	326 (8%)	68%	Female gender, being white (compared to "other" or black), life threatened, Assault by a relative (not father)	Hispanic race, injury, victim substance use, single vs. series assault, or penetration assault
Kogan, 2004 [58] United States 12-17 year old males and females National telephone survey	Disclosure of Unwanted Sexual Experience	4,023	263 (13%)	74%	Onset 14-17 is negatively associated, 7-10 is positively associated with disclosure, serial incidents, family member perpetrator is negatively associated, stranger perpetrator, not feeling fear for a family member, never living with both parents is negatively associated with disclosure	Penetration (approaching a negative association)
Nofziger and Stein, 2006 [64] United States 12-17 year old males and females National telephone survey	Disclosure of Sexual Violence	4,023	325 (8%)	68%	Reported for both physical assault and sexual assault, cannot tease out individual associations	Reported for both physical assault and sexual assault, cannot tease out individual associations

Table 1 (Continued): Bivariate associations of disclosure of reported sexual violence

Lippert et al., 2009 [54] United States 2-18 year old males and females Review of case files from child advocacy centers	Full disclosure of CSA	987	987 (100%)	73%	Female gender, older age at onset, older age at interview, extrafamilial abuse, Vaginal/anal penetration, previous disclosure, caregiver aware of abuse, caregiver responded to abuse, reason for referral is disclosure	Child race, Suspect cohabitation with the child, Duration of abuse, Caregiver support,
Priebe and Svedin, 2009 [40] Sweden Male and female high school seniors Self-report questionnaire	"Could" disclose CSA	4,339	1,493 (34%)	79% (45% non-response for boys)	**Girls**: more severe abuse, non-immigrant family **Boys**: not living with both mom and dad, non-vocational education **Both**: Perp is a stranger, parental bonding	**Girls**: not living with both mom and dad, education program **Boys**: more severe abuse, immigrant status **Both**: Frequency of abuse, Offender on alcohol/drugs, Victim on alcohol/drugs, Age difference between victim and perp, victims age (<15), physical violence, SES, parent employment status, mental health
Schonbucher et al., 2012 [57] Switzerland 15-18 year old males and females Qualitative study	CSA Immediate Disclosure	26	26 (100%)	30%	Extrafamilial Perpetrator, only one instance of CSA, Older age, perpetrator is a minor, victim not guilty or ashamed, parents still living together	Penetrative CSA
Lam, 2014 [55] Hong Kong 13-16 year old males and females Population-based and clinic-based	Disclosure of CSA	830	177 (21%)	59%	Female gender, more severe abuse, male abuser, older age at time of interview	Frequency, age of onset

Table 2: Significant correlates of disclosure of reported sexual violence in multivariate logistic regression models

Author, Year Country Age Gender Setting	Outcome	N	N (%) experienced outcome	% disclosed	Significant Predictors of Disclosure (Logistic Regression)	Non-Significant Predictors of Disclosure (Logistic Regression)
Smith, D.W. et al., 2000 [56] United States Adult females reporting incidents prior to 18 National telephone survey	Disclosure of Childhood Rape	3,220	288 (9%)	72%	Perpetrator is a stranger, probability of disclosure increases with age **Study looks at long-delay (>1 mo) v. short-delay**	Related vs. non related, series rape
Goodman-Brown et al., 2003 [8] United States 2-16 year old males and females SAP questionnaire victims referred to district attorney's office	Time of disclosure of CSA	218	218 (100%)	n/a	**Linear regression path analysis**: older children &intrafamilial victims have greater fear negative consequences of disclosure, older children felt greater responsibility, fear of negative consequences= delayed disclosure, intrafamilial take longer to disclose, feeling more responsibility= delayed disclosure, extrafamiliar abuse more common among males	Gender and type of abuse (intrafamilial/extrafamilial) not associated with responsibility
Hanson et al., 2003 [53] United States 12-17 year old males and females National telephone survey	Disclosure of CSA	4,023	326 (8%)	68%	Being white (among females and males), Female gender (among blacks) Life threat (among whites and females), not being physically injured (among whites and females), penetration (among blacks) **Significant interaction:** Gender × Penetration, Gender × Knowing the Perpetrator, African American × Penetration Assault, African American × Life Threat - so separate models were run for gender and race	victim substance use, single vs. series assault, or penetration assault among whites males and females), gender among whites, life threat among blacks and males, physical injury among blacks and males

Table 2 (Continued): Significant correlates of disclosure of reported sexual violence in multivariate logistic regression models

Kogan, 2004 [58] United States 12-17 year old males and females National telephone survey	Disclosure of Unwanted Sexual Experience	4,023	263 (13%)	74%	11-13 less likely to disclose compared with 14-17, Unknown perpetrator	Family Perpetrator
Nofziger and Stein, 2006 [64] United States 12-17 year old males and females National telephone survey	Disclosure of Sexual Violence	4,023	325 (8%)	68%	Female gender, respondent deviance (females, breaking the law), peer deviance (females), having witnessed violence (females), event occurred outside neighborhood or school (females), fear (females), increases in age is associated with non-disclosure (males and females)	Respondent deviance (males), peer deviance (males), having witnessed violence (males), event occurred outside neighborhood or school (males), fear (males), occurring in school, occurring in neighborhood, being injured
Lippert et al., 2009 [54] United States 2-18 year old males and females Review of case files from child advocacy centers	Full disclosure of CSA	987	987 (100%)	73%	Female gender, older age at onset , previous disclosure, caregiver support	Age at interview, vaginal/anal penetration, suspect relationship to the child (intra v. extra), Child race, Suspect cohabitation with the child, Duration of abuse
Priebe and Svedin, 2009 [40] Sweden Male and female high school seniors Self-report questionnaire	"Could" disclose CSA	4,339	1,493 (34%)	79% (45% non-response for boys)	**Girls**: less severe abuse, more frequent abuse, offender at first abuse was a stranger **Boys**: non-vocational education, not living with both mom and dad **Both**: Perceive parents as caring /overprotective or non-caring /not-overprotective	**Girls**: educational program, living with parents **Boys**: abuse severity, abuse frequency, offender identity **Both**: Perceive parents as caring /overprotective or non-caring /not-overprotective, Offender on alcohol/drugs, Victim on alcohol/drugs, Age difference between victim and perp, victims age (<15), physical violence, SES, parent employment status, mental health
Lam, 2014 [55] Hong Kong 13-16 year old males and females Population-based and clinic-based	Disclosure of CSA	830	177 (21%)	59%	**Clinical** (n=30, almost all female): More severe abuse, low parental attachment **Community:** Male abuser, tendency to disclose in general	Age of onset, frequency, duration, relation with abuser, children's attribution scale, peer attachment , current age

Table 3: Summary of hypothesized effects on the odds of disclosure of reported sexual violence prior to age 18 among respondents aged 13-24, Kenya VACS, 2010.

Measure	Hypothesized effect on odds of disclosure	Strength of literature
Male gender	Decrease	Strong
Older age at time of survey	Increase	Weak
Single or double orphan prior to SV	Decrease	Weak
Older age at first experience of SV	Decrease	Weak
Greater number of experiences of SV	Decrease	Strong
Any physically forced sex	No effect	Strong
Emotional violence prior to SV	Decrease	No literature
Physical violence prior to SV	No effect	Weak
Any perpetrators were romantic partners	Decrease	Strong
Any perpetrators were family members	Decrease	Strong
Any perpetrators were known[#]	Decrease	Strong

# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners

APPENDIX B: RESULTS TABLES

Table 4: Prevalence of reported sexual violence prior to age 18 among respondents aged 13-24, Kenya VACS, 2010. †

	Females n=1,227		Males n=1,456		
	n	**(%)**	**n**	**(%)**	
Sexual touching	209	(18.8%)	122	(8.9%)	*
Attempted sex	141	(12.0%)	87	(6.6%)	*
Physically forced sex	70	(5.9%)	19	(1.1%)	*
Pressured sex	85	(7.6%)	45	(3.2%)	*
Any sexual violence	320	(27.8%)	197	(14.5%)	*

† Percentages presented are weighted percentages
* t-tests for differences between gender are significant at the 0.05 level

Table 5: Characteristics of reported sexual violence prior to age 18 among respondents aged 13-24, Kenya VACS, 2010. †

	Females n=304	**Males** n=185	
Demographic characteristics			
Age at time of survey (Mean (SD))	18.6 (0.2)	18.2 (0.2)	
Single or double orphan prior to SV (%)	23.9%	18.9%	
Characteristics of reported SV exposure			
Age at first experience of SV (Mean (SD))	14.4 (0.2)	13.4 (0.3)	*
Total number of experiences of SV (Mean (SD))	10.9 (2.1)	5.9 (1.0)	
Any physically forced sex (%)	22.4%	8.0%	*
Emotional violence prior to SV (%)	12.8%	14.9%	
Physical violence prior to SV (%)	59.4%	60.2%	
Any perpetrators were romantic partners (%)	53.3%	48.4%	
Any perpetrators were family members (%)	20.5%	15.4%	
Any perpetrators were known# (%)	44.7%	40.0%	
Disclosed SV to anyone (%)	44.6%	28.2%	*

† Percentages presented are weighted percentages, data presented are from the complete analysis sample
* t-tests and Rao-Scott chi-square tests for differences between gender are significant at the 0.05 level
# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners

Table 6: Unadjusted odds ratios of reported disclosure of SV among respondents aged 13-24 who reported SV exposure prior to age 18, Kenya VACS, 2010.

	Unadjusted Odds Ratio of Reported Disclosure (90% CI)		
	Females n=304	**Males n=185**	**Total n=489**
Demographic Characteristics			
Age at time of survey	1.00 (0.93, 1.08)	1.10 (0.98, 1.23)	1.03 (0.97, 1.10)
Single or double orphan prior to SV	2.42 (0.96, 6.08)	~	2.02 (0.96, 4.28)
Male gender	-	-	0.48 (0.33, 0.71) *
Characteristics of reported SV exposure			
Age at first experience of SV	1.02 (0.90, 1.15)	1.09 (0.98, 1.23)	1.07 (0.99, 1.16)
Total number of experiences of SV	0.98 (0.96, 0.99) *	0.99 (0.96, 1.02)	0.98 (0.97, 0.99)
Any physically forced sex	1.24 (0.65, 2.34)	~	1.38 (0.79, 2.42)
Emotional violence prior to SV	1.63 (0.61, 4.33)	~	1.47 (0.72, 3.02)
Physical violence prior to SV	0.70 (0.39, 1.25)	0.81 (0.40, 1.66)	0.73 (0.46, 1.17)
Any perpetrators were romantic partners	0.75 (0.42, 1.33)	0.94 (0.49, 1.83)	0.83 (0.54, 1.28)
Any perpetrators were family members	2.19 (1.19, 4.02) *	~	1.76 (1.08, 2.87) *
Any perpetrators were known[#]	1.30 (0.83, 2.02)	1.36 (0.75, 2.47)	1.35 (0.95, 1.92)

* OR is significant at the 0.10 level
# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners
~ Odds ratios not presented dues to unstable estimates (cell sizes <25 observations)

Table 7: Adjusted odds ratios of reported disclosure of SV based on the final model (gender, total number of reported experiences of SV, perpetrator types) among respondents ages 13-24 who reported experiencing SV prior to age 18, Kenya VACS, 2010.

	Adjusted Odds Ratio of Reported Disclosure of SV (90% CI)	
Demographic Characteristics		
Male gender	0.45 (0.31, 0.68)	*
Characteristics of reported SV exposure		
Total number of experiences of SV	0.98 (0.96, 0.99)	*
Any perpetrators were romantic partners	1.23 (0.69, 2.21)	
Any perpetrators were family members	2.15 (1.32, 3.50)	*
Any perpetrators were known[#]	1.67 (1.06, 2.65)	*

* OR is significant at the 0.10 level
# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners

Table 8: Adjusted odds ratios of reported disclosure of SV exposure based on the final female-only model (total number of reported experiences of SV, perpetrator types) among respondents ages 13-24 who reported experiencing SV prior to age 18, Kenya VACS, 2010.*

	Adjusted Odds Ratio of Reported Disclosure of SV (90% CI)	
Characteristics of reported SV exposure		
Total number of experiences of SV	0.97 (0.96, 0.99)	*
Any perpetrators were romantic partners	1.20 (0.57, 2.53)	
Any perpetrators were family members	2.88 (1.54, 5.41)	*
Any perpetrators were known[#]	1.62 (0.95, 2.76)	

* OR is significant at the 0.10 level
# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners

Table 9: Summary of hypothesized effects on the odds of disclosure of reported sexual violence prior to age 18 among respondents aged 13-24, Kenya VACS, 2010, compared with significant findings.

Measure	Hypothesized effect on odds of disclosure	Significant unadjusted effect on odds of disclosure (Females)	Significant unadjusted effect on odds of disclosure (Total)	Significant adjusted effect on odds of disclosure (Females)	Significant adjusted effect on odds of disclosure (Total)
Male gender	Decrease	n/a	Decrease	n/a	
Older age at time of survey	Increase				
Single or double orphan prior to SV	Decrease				
Older age at first experience of SV	Decrease				
Greater number of experiences of SV	Decrease	Decrease		Decrease	Decrease
Any physically forced sex	No effect				
Emotional violence prior to SV	Decrease				
Physical violence prior to SV	No effect				
Any perpetrators were romantic partners	Decrease				
Any perpetrators were family members	Decrease	*Increase*	*Increase*	*Increase*	*Increase*
Any perpetrators were known[#]	Decrease				*Increase*

# Denotes existence of any perpetrators who were known to the victim but who were not family members or romantic partners

References

1. Collin-Vezina, D., I. Daigneault, and M. Hebert, *Lessons learned from child sexual abuse research: prevalence, outcomes, and preventive strategies.* Child and Adolescent Psychiatry and Mental Health, 2013. **7**(1): p. 22.
2. Ullman, S.E. and H.H. Filipas, *Predictors of PTSD symptom severity and social reactions in sexual assault victims.* J Trauma Stress, 2001. **14**(2): p. 369-89.
3. Ruggiero, K.J., et al., *Is disclosure of childhood rape associated with mental health outcome? Results from the National Women's Study.* Child Maltreat, 2004. **9**(1): p. 62-77.
4. Paine, M.L. and D.J. Hansen, *Factors influencing children to self-disclose sexual abuse.* Clin Psychol Rev, 2002. **22**(2): p. 271-95.
5. Roesler, T.A., *Reactions to disclosure of childhood sexual abuse. The effect on adult symptoms.* J Nerv Ment Dis, 1994. **182**(11): p. 618-24.
6. Edwards, K.M., et al., *Informal Social Reactions to College Women's Disclosure of Intimate Partner Violence: Associations With Psychological and Relational Variables.* J Interpers Violence., 2014.
7. Jewkes, R., L. Penn-Kekana, and H. Rose-Junius, *"If they rape me, I can't blame them": reflections on gender in the social context of child rape in South Africa and Namibia.* Soc Sci Med, 2005. **61**(8): p. 1809-20.
8. Goodman-Brown, T.B., et al., *Why children tell: a model of children's disclosure of sexual abuse.* Child Abuse Negl, 2003. **27**(5): p. 525-40.
9. Krug, E.G., et al., *World report on violence and health*. 2002, World Health Organization: Geneva.
10. *Violence against Children in Kenya: Findings from a 2010 National Survey. Summary Report on the Prevalence of Sexual, Physical and Emotional Violence, Context of Sexual Violence, and Health and Behavioral Consequences of Violence Experienced in Childhood.* 2012, United Nations Children's Fund Kenya Country Office, Division of Violence Prevention, National Center for Injury Prevention and Control, U.S. Centers for Disease Control and Prevention, and the Kenya National Bureau of Statistics: Nairobi, Kenya.
11. Lalor, K., *Child sexual abuse in Tanzania and Kenya.* Child Abuse Negl, 2004. **28**(8): p. 833-44.
12. Fergusson, D.M., L.J. Horwood, and L.J. Woodward, *The stability of child abuse reports: a longitudinal study of the reporting behaviour of young adults.* Psychol Med, 2000. **30**(3): p. 529-44.
13. Waltermaurer, E.M., C.A. Ortega, and L.A. McNutt, *Issues in estimating the prevalence of intimate partner violence: assessing the impact of abuse status on participation bias.* J Interpers Violence, 2003. **18**(9): p. 959-74.
14. *The World Factbook: Kenya*. 2014, Central Intelligence Agency.
15. Onyango-Ouma, W., et al., *The making of the Kenya sexual offenses act, 2006: Behind the scenes.* . 2009, Kwani Trust: Nairobi.
16. *Sexual Offences Act*. 2006.
17. Plummer, C.A. and W. Njuguna, *Cultural protective and risk factors: Professional perspectives about child sexual abuse in Kenya.* Child Abuse & Neglect, 2009. **33**(8): p. 524-532.

18. Johnson, K., et al., *A national population-based assessment of 2007-2008 election-related violence in Kenya.* Confl Health, 2014. **8**(1): p. 2.
19. *National Guidelines on Management of Sexual Violence in Kenya*. 2009, Kenyan Ministry of Health.
20. *AIDSinfo*. 2013, UNAIDS.
21. Lachman, P., *Understanding the current position of research in Africa as the foundation for child protection programs.* Child Abuse Negl, 2004. **28**(8): p. 813-5.
22. *KENYA: Human Rights Watch urges inquiry into post-election violence*. 2008, IRIN: Nairobi.
23. *Kenya: Briefing to the UN Committee on the Elimination of Discrimination against Women*. 2010, Amnesty International.
24. Niles, C., *Report reveals Kenyan child sex industry of 'horrific' magnitude*. 2006.
25. Pierce, L. and V. Bozalek, *Child abuse in South Africa: an examination of how child abuse and neglect are defined.* Child Abuse Negl, 2004. **28**(8): p. 817-32.
26. Abeid, M., et al., *Community perceptions of rape and child sexual abuse: a qualitative study in rural Tanzania.* BMC Int Health Hum Rights., 2014. **14**: p. 23.
27. Finkelhor, D., *Current information on the scope and nature of child sexual abuse.* Future Child, 1994. **4**(2): p. 31-53.
28. Lehrer, J.A., E.L. Lehrer, and M.P. Koss, *Unwanted sexual experiences in young men: evidence from a survey of university students in Chile.* Arch Sex Behav., 2013. **42**(2): p. 213-223.
29. Edinburgh, L., E. Saewyc, and C. Levitt, *Gender differences in extrafamilial sexual abuse experiences among young teens.* J Sch Nurs., 2006. **22**(5): p. 278-284.
30. Adefolalu, A., *Fear of the perpetrator: a major reason why sexual assault victims delayed presenting at hospital.* Tropical Medicine and International Health, 2014. **19**(3): p. 342-347.
31. Saewyc, E.M., S. Pettingell, and L.L. Magee, *The prevalence of sexual abuse among adolescents in school.* J Sch Nurs, 2003. **19**(5): p. 266-72.
32. Taveira, F., et al., *[Intra and extra-familiar sexual abuse].* Acta Med Port., 2009. **22**(6): p. 759-766.
33. Yahaya, I., et al., *A comparative study of the socioeconomic factors associated with childhood sexual abuse in sub-Saharan Africa.* Pan Afr Med J., 2012. **11**: p. 51.
34. Murray, L. and G. Burnham, *Understanding childhood sexual abuse in Africa.* Lancet, 2009. **373**(9679): p. 1924-6.
35. Epstein, H. and R. Jewkes, *The myth of the virgin rape myth.* Lancet, 2009. **374**(9699): p. 1419; author reply 1419-20.
36. Irish, L., I. Kobayashi, and D.L. Delahanty, *Long-term physical health consequences of childhood sexual abuse: a meta-analytic review.* J Pediatr Psychol, 2010. **35**(5): p. 450-61.
37. Whetten, K., et al., *Trauma history and depression predict incomplete adherence to antiretroviral therapies in a low income country.* PLoS One, 2013. **8**(10): p. e74771.

38. Bensley, L., et al., *General population norms about child abuse and neglect and associations with childhood experiences.* Child Abuse Negl, 2004. **28**(12): p. 1321-37.
39. Easton, S.D., *Masculine norms, disclosure, and childhood adversities predict long-term mental distress among men with histories of child sexual abuse.* Child Abuse Negl., 2014. **38**(2): p. 243-251.
40. Priebe, G. and C.G. Svedin, *Child sexual abuse is largely hidden from the adult society. An epidemiological study of adolescents' disclosures.* Child Abuse Negl., 2008. **32**(12): p. 1095-1108.
41. Ullman, S.E. and H.H. Filipas, *Gender differences in social reactions to abuse disclosures, post-abuse coping, and PTSD of child sexual abuse survivors.* Child Abuse Negl, 2005. **29**(7): p. 767-782.
42. Sciolla, A., et al., *Childhood sexual abuse severity and disclosure as predictors of depression among adult African-American and Latina women.* J Nerv Ment Dis., 2011. **199**(7): p. 471-477.
43. Lee, Y. and S. Kim, *Childhood maltreatment in South Korea: retrospective study.* Child Abuse Negl., 2011. **35**(12): p. 1037-1044.
44. Lange, A., et al., *Long-term effects of childhood sexual abuse: objective and subjective characteristics of the abuse and psychopathology in later life.* J Nerv Ment Dis, 1999. **187**(3): p. 150-8.
45. Freyd, J.J., *Betrayal trauma: The logic of forgetting childhood abuse*. 1996, Cambridge, MA: Harvard University Press.
46. Ullman, S.E., *Relationship to perpetrator, disclosure, social reactions, and PTSD symptoms in child sexual abuse survivors.* J Child Sex Abus, 2007. **16**(1): p. 19-36.
47. Byrskog, U., et al., *Violence and reproductive health preceding flight from war: accounts from Somali born women in Sweden.* BMC Public Health., 2014. **14**: p. 892.
48. Kelly, J., et al., *'If your husband doesn't humiliate you, other people won't': gendered attitudes towards sexual violence in eastern Democratic Republic of Congo.* Glob Public Health, 2012. **7**(3): p. 285-98.
49. Donnelly, D.A. and S. Kenyon, *"Honey, We Don't Do Men": Gender Stereotypes and the Provision of Services to Sexually Assaulted Males.* Journal of Interpersonal Violence, 1996. **11**(3): p. 441-448.
50. Taegtmeyer, M., et al., *Challenges in providing counselling to MSM in highly stigmatized contexts: results of a qualitative study from Kenya.* PLoS One, 2013. **8**(6): p. e64527.
51. Sugue-Castillo, M., *Legal outcomes of sexually abused children evaluated at the Philippine General Hospital Child Protection Unit.* Child Abuse Negl., 2009. **33**(3): p. 193-202.
52. Cohn, A.M., et al., *Correlates of reasons for not reporting rape to police: results from a national telephone household probability sample of women with forcible or drug-or-alcohol facilitated/incapacitated rape.* J Interpers Violence., 2013. **28**(3): p. 455-473.
53. Hanson, R.F., et al., *Correlates of adolescent reports of sexual assault: findings from the National Survey of Adolescents.* Child Maltreat, 2003. **8**(4): p. 261-72.

54. Lippert, T., et al., *Telling interviewers about sexual abuse: predictors of child disclosure at forensic interviews.* Child Maltreat., 2009. **14**(1): p. 100-113.
55. Lam, K.Y., *Factors Associated with Adolescents' Disclosure of Sexual Abuse Experiences in Hong Kong.* J Child Sex Abus., 2014.
56. Smith, D.W., et al., *Delay in disclosure of childhood rape: results from a national survey.* Child Abuse Negl, 2000. **24**(2): p. 273-87.
57. Schonbucher, V., et al., *Disclosure of child sexual abuse by adolescents: a qualitative in-depth study.* J Interpers Violence., 2012. **27**(17): p. 3486-3513.
58. Kogan, S.M., *Disclosing unwanted sexual experiences: results from a national sample of adolescent women.* Child Abuse Negl, 2004. **28**(2): p. 147-65.
59. Adefolalu, A.O., *Fear of the perpetrator: a major reason why sexual assault victims delayed presenting at hospital.* Trop Med Int Health, 2014. **19**(3): p. 342-7.
60. Hershkowitz, I., O. Lanes, and M.E. Lamb, *Exploring the disclosure of child sexual abuse with alleged victims and their parents.* Child Abuse Negl., 2007. **31**(2): p. 111-123.
61. Davidsson, J., et al., *Association between experiencing rape, police reporting, and self-reported health among women visiting three gynecology clinics in Sweden.* Acta Obstet Gynecol Scand., 2009. **88**(9): p. 1000-1005.
62. Palermo, T., J. Bleck, and A. Peterman, *Tip of the iceberg: reporting and gender-based violence in developing countries.* Am J Epidemiol, 2014. **179**(5): p. 602-12.
63. Sylaska, K.M. and K.M. Edwards, *Disclosure of intimate partner violence to informal social support network members: a review of the literature.* Trauma Violence Abuse., 2014. **15**(1): p. 3-21.
64. Nofziger, S. and R.E. Stein, *To tell or not to tell: lifestyle impacts on whether adolescents tell about violent victimization.* Violence Vict, 2006. **21**(3): p. 371-82.