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THEMATIC PAPER

CHILD SEXUAL ABUSE

Risk-taking, revictimisation and perpetration of sexual violence in ten southern African countries

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This paper reports the results of a cross-sectional survey of 11- to 16-year-old school-going youths in ten southern African countries. The survey instrument recorded both the experience of coerced sex and the perpetration of forced sex. There were prominent school and community risk factors for increased risk-taking behaviours, revictimisation and the perpetration of sexual violence. This supports the idea that the local culture can reinforce the antisocial consequences of sexual abuse of boys and girls. There was a suggestion that the school environment can compound the effects of child sexual abuse in terms of conscious knowledge, high-risk behaviour, the risk of revictimisation and disdain for the safety of others.

The mental health consequences of child sexual abuse include increased risk-taking behaviours, revictimisation (Lindegren *et al*, 1998; Cohen *et al*, 2000) and the perpetration of sexual violence (Kendall-Tackett *et al*, 1993). Even for those not directly involved, having a friend or neighbour who is a victim of sexual abuse contributes to an environment where sexual violence is expected and almost normal (Maman *et al*, 2000; Todd *et al*, 2004).

Our recent cross-sectional surveys in ten southern African countries (Andersson *et al*, 2012) looked at the prevalence of child sexual abuse at two time points (2003 and 2007). The facilitated self-administered questionnaire documented both the experience of coerced sex and the perpetration of forced sex, as well as associated risk factors, among 11- to 16-year-old school-going youths.

The study population was a stratified (urban/rural) random sample of census enumeration areas in Botswana, Lesotho, Malawi, Mozambique, Namibia, South Africa, Swaziland, Tanzania, Zambia and Zimbabwe, covering 25–30 enumeration areas in each country. The 445 schools were those serving these areas that included grades 6–9 (students aged 11–17 years). Detailed field methods are described by Andersson *et al* (2012).

Frequency and risk factors of abuse in boys and girls

There is increasing recognition that boys are frequently the victims of child sexual abuse. In our study, 20% of female students (weighted value based on 4432/25 840) and 21% of male students (4080/21 613) aged 11–16 years across the region reported suffering coerced sex. We found very few differences in risk factors for child sexual abuse between male and female respondents. Older children (over 13 years old) and those living in very poor households (insufficient food in the last week) were more likely to report having been victims of forced sex.

Children were at higher risk of abuse if they attended schools where fewer students knew about children's rights. Other risk factors included living in a community where a higher proportion of adults were in favour of transactional sex. Communities reporting higher than average rates of violence against an intimate partner also had a higher risk of child sexual abuse.

Differences between victims and non-victims

Across all ten countries, victims of child sexual abuse reported lower levels of knowledge about children's rights and appropriate child care than did non-victims. They had less helpful attitudes about masculinity and sexuality, and lower levels of self-efficacy. Although the mental health consequences of their experiences varied from child

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to child, across the region victims were found to possess quite different group characteristics from non-victims. Here, results are reported as the adjusted odds ratio (aOR), adjusted for cluster, age, gender, poverty and country.

Revictimisation was prominent among victims of sexual abuse. They were more likely to have been bullied at school than were non-victims (aOR 1.57, 95% CI 1.47–1.68). Across the ten countries, no less than 48% (4086/8512) of victims of sexual abuse reported they had also been bullied or picked on in the past year.

Perhaps surprisingly, 34% of victims (2894/8512) reported they had bullied another child in the past year; a victim of abuse was much more likely than a non-victim to report bullying another (aOR 1.67, 95% CI 1.54–1.80).

Both male and female victims of abuse were more likely than non-victims to say they themselves had forced another child to have sex against their will (aOR 4.8, 95% CI 3.92–4.81). Across all ten countries, this association was much stronger for girls than for boys.

Victims of child sexual abuse also had higher-risk behaviours related to HIV. They were more than twice as likely to have had multiple concurrent sexual partners compared with non-victims (aOR 2.22, 95% CI 1.96–2.52).

Although disdain for the safety of others was common among young people of the region, victims of child sexual abuse were significantly more likely to say they would deliberately spread HIV if they found themselves to be HIV-positive (aOR 1.36, 95% CI 1.26–1.45).

High levels of bullying in schools compound the risks

We found these differences between victims and non-victims were compounded by the nature of the school the children attended. We divided the schools into those with higher levels of bullying and other abuse and lower-level categories, based on whether the rate in each school was above or below the national average (each country calculated separately).

Even non-victims who attended schools with higher levels of bullying had less knowledge about children's rights and child care than did those at schools with lower levels of bullying. They also had less helpful attitudes about masculinity and sexuality, and lower levels of self-efficacy. They were much more likely to have multiple concurrent sexual partners than non-victims in lower-level schools – 28.2% compared with 18.8%. Non-victims at high-bullying schools were much more likely to have forced sex on another child (7.5% compared with 2.8%) and to say they would deliberately spread HIV if infected (29% compared with 22%).

But victims of child sexual abuse who attended schools with higher levels of bullying were especially badly off. They had less knowledge of children's rights and child care than did non-victims at the same schools or victims at low-bullying schools, less helpful attitudes about masculinity and sexuality, and lower levels of self-efficacy. Victims at high-bullying schools were much more likely to have multiple concurrent sexual partners than those at low-bullying schools (41.4% compared with 32.1%).

Where the effect of the school was greatest was in whether or not children reported themselves to be perpetrators of sexual abuse. Victims of sexual abuse who attended schools with high levels of bullying were twice as likely to say they had perpetrated sexual abuse (27.7% compared with 13.3%) than were sexual abuse victims in low-bullying schools. They were 13 times more likely to report that they had perpetrated sexual abuse than were non-victims who attended low-bullying schools (odds ratio 13.5, 95% CI 12.5–14.7). Victims of child sexual abuse attending high-bullying schools were also much more likely than victims at other schools to say they would deliberately infect others if they turned out to be HIV-positive.

Discussion

Our finding that there are both prominent school and community risk factors supports the idea that the local culture can reinforce the antisocial consequences of child sexual abuse of boys and girls. Little is known about how cultural factors interact with victim status, or the way in which they influence the likelihood of high-risk behaviours. However, our results suggest that if a child is experiencing an environment where child sexual abuse is more common, the mental health effects of abuse may be worsened. In respect of some specific behaviours, like forcing sex on other children, there seems to be a multiplicative effect of school environments that tolerate bullying upon the risk of perpetration of sexual abuse. The results of our ten-country survey provide glimpses of some of the implications of high rates of sexual abuse of children for the mental health of the young people concerned, and potentially for society at large. There is an increased rate of inappropriate beliefs and attitudes, risk-taking, bullying and perpetration of coerced sex.

Because this was a cross-sectional study, one cannot jump to conclusions about causality. For instance, one relies on reported age of abuse and age when a perpetrator both being accurate; there is no way to be sure whether knowledge, attitudes, feeling support or self-efficacy preceded or followed the reported abuse. Nonetheless, one can say that these associations are consistent with previously published evidence on the negative mental health outcomes of child sexual abuse. It also fits with our earlier national study in South Africa (Andersson *et al*, 2004) and other studies (Cohen *et al*, 2000; Koenig *et al*, 2004; Sikkema *et al*, 2007).

The way that school culture contributes to these associations adds a layer of complexity. With all the caveats that befit a cross-sectional study, the implication is that the school environment can compound the effects of child sexual abuse in terms of conscious knowledge, high-risk behaviour, the risk of revictimisation and disdain for the safety of others.

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MENTAL HEALTH LAW PROFILES

Mental health law profiles

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The series on mental health law returns to the Middle East with the two papers on Qatar and Jordan. In both these countries, compulsory psychiatric care and treatment have not been supported to date adequately by specific legislation. In both countries, families appear to be the fulcrum of and the primary support for the treatment of patients with mental illness. A main concern arising out of this, in the light of this issue's editorial on gender differences and mental health in the Middle East, may therefore be the implications for the burden placed on women who have to look after relatives at home with a mental illness. Another concern is the appropriateness, nature and quality of compulsory treatment of those women in Qatar and Jordan alleged to be suffering from mental disorders. Have they been getting a fair and equitable deal compared with men?

MENTAL HEALTH LAW PROFILE

Mental health law in Qatar

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This article provides a brief outline of mental health services in Qatar, historical notes on the use of informal traditional conventions under common law for the care under compulsory conditions of people who are mentally ill and information on the ongoing development of the Mental Health Law and its key provisions in the context of the new National Mental Health Strategy.

In Qatar, a national mental health programme was introduced in 1990 with the aim of setting up a community-based mental healthcare model. A planning committee for mental health was established in 2008 within the Supreme Council of Health (SCH) and is responsible for providing policy direction as well as developing mental health services across the spectrum of promotion, prevention, treatment and rehabilitation. The vision is to protect, promote and enhance the mental health

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