Short Abstract:
Emerging Partner Violence: Perpetration, Victimization and Help-Seeking During Early Adolescence in Malawi

Intimate partner violence (IPV) is prevalent and results in a substantial public health burden. However, we know relatively little about IPV during early adolescence, when lifelong patterns are forming. This current study is one of the first studies to characterize IPV victimization and perpetration among a cohort of very young, ever-partnered adolescents (N=2,089) in a low-income setting. More than a quarter (27%) of the sample report being victimized. A substantial proportion of both genders (15%) report committing violence against their partner. Girls were more likely to report being a victim of sexual IPV (24% versus 8%), and boys more likely to perpetrate such (9% versus 1%). Childhood adversity was a consistent and strong correlate of both IPV victimization and perpetration. These findings underscore the need to intervene early, when we can still break destructive pathways and foster healthier relationships.

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Extended Abstract:
Emerging Partner Violence: Perpetration, Victimization and Help-Seeking During Early Adolescence in Malawi

Introduction

Globally, over 30% of women have experienced intimate partner violence (IPV) [1]. IPV results in a substantial public health burden, including homicide, injury, depression, and HIV infection [2-5]. Importantly, violence starts early [6]. In a study across 81 countries, 29% of ever-partnered adolescent girls (aged 15-19) reported they had already experienced IPV [7]. There is global movement to combat IPV, including among adolescents. This commitment is most recently reflected in the Sustainable Development Goals to reduce IPV (SDG 5.2.1) and to end violence against children (SDG 16.2). However, a better understanding of the emergence and etiology of IPV – particularly among very young adolescence – is needed to guide effective strategies for meeting these goals.

Currently, most IPV studies focus on adults or older adolescents [e.g., 6, 7], a significant proportion of who are married. We still know relatively little about what happens in dating relationships and among early adolescence (i.e., 10–14 years). While a recent systematic review could find few estimates of IPV among girls under age 15 [8], an exception are those from the Global School-based Student Health Surveys (GSHS). In select countries, the GSHS asked adolescents as young as 13-15 about their experiences of violence; past year physical IPV ranged from 6%-19% for girls and 8-23% of boys [9]. The GSHS are also unique in that they capture IPV prevalence among boys. Until relatively recently, girls were primarily seen as victims, and boys almost exclusively seen as perpetrators of IPV; studies gather gathered data accordingly. However, there is growing recognition that this picture is incomplete.

As with victimization, we know little about IPV perpetration during early adolescence. Data from later adolescence, however, suggests that IPV perpetration may be particularly high during these developmental periods. For example, in South Africa, 40% of adolescent boys aged 15-19 years old report perpetrating IPV [10]. Moreover, girls often perpetrate violence at rates similar to – or even greater than – boys [11, 12]. Finally, many adolescents may both commit and be a victim of violence [13]. From studies in high income contexts, we know that when violence is reciprocal, women are more likely to be severely injured [14].

This paper is one of the first to describe both IPV victimization and perpetration in early adolescence in a low-income context. We concentrate on an age when lifelong expectations and patterns form. In doing so, we can also more accurately measure past childhood experiences and concurrent adolescence risk factors, and thus better uncover the root causes of IPV. This paper analyzes data from a large cohort of young adolescents (aged 10-16 years) in Malawi in order to answer the following questions: 1) what is the prevalence of IPV victimization and perpetration among ever-partnered adolescents?; 2) do adolescents seek help after being victimized?; and 3) which childhood and adolescent experiences are correlated with IPV victimization and perpetration?

Methods

Sample & Setting: This study took place in rural Malawi. Approximately 80% of Malawians live below the international poverty line (US$1.90 per day), and the rates are even higher in rural areas [15]. HIV/AIDS remains a persistent challenge: prevalence among Malawian adults is 7.5% [16]. The sample frame was derived from the Malawi Longitudinal Study of Families and Health (MLSFH) [17]. The MLSFH was established in 1998 to better understand the lives of rural individuals in a low income context, and to specifically focus on health, HIV, and demographic change. The original MLSFH cohort was selected to represent the rural population (~80% of Malawi's population) and is located in three districts (Balaka, Mchinji, and Rumphi). The MLSFH has subsequently undertaken multiple rounds of data collection, yield 20 years of rich data on individual adults and their households. For this study, we created a new, early adolescent cohort by building on prior rounds of MLSFH data collection with adults. For each adult MLSFH respondent who completed a household roster in either 2008 or 2010, we selected children projected to be age 11-15 in 2017. To create sibling matches in households with only one child aged 11-15 at baseline, we extended the age range by one year in

both directions and enrolled the child closest in age to the index child. This produced a cohort of adolescents aged 10-16, a critical age-range in which to assess emerging IPV.

Data collection: Data collection occurred between August, 2017 and June, 2018. A total of 2,089 adolescents were located and interviewed in their local language (Chewa, Yao or Tumbuka). 1,787 were located at or near the homes of the original adult MLSFH respondents; an additional 114 were traced to new homes within the same cluster of villages. Of those who had migrated further, we attempted to locate those still residing within their home district or who had moved to a major city. We captured an additional 262 respondents through migrant tracing. All surveys were conducted privately at the adolescent's home. Adolescents provided assent after guardian consent. There were 13 refusals. In addition to IPV, surveys asked about childhood adversity; social, emotional and cognitive impairment; and indicators of early sexual risk taking; data collection also included HIV testing. The adolescent's caregiver completed a separate survey on household characteristics and wellbeing.

Measures: *Intimate partner violence* was measured among those respondents who reported 1) sexual debut and/or 2) a current or past romantic partner. Questions were adapted from WHO's Violence Against Women instrument (VAWI) [18]. Six questions assessed lifetime physical IPV (e.g., having been slapped, kicked); two assessed lifetime sexual IPV (e.g., forced or coerced intercourse); and three assessed emotional violence (e.g., threatened with harm, humiliated). Respondents were considered to have experienced IPV if they answered any question affirmatively, with separate indicators created for each type of IPV and for total IPV exposure. The VAWI questions were adapted to capture lifetime IPV perpetration, with the same coding scheme applied. We also created a variable labeled "reciprocal IPV" which reflects whether an individual reported both IPV victimization and perpetration. Finally, help-seeking was assessed with the question "When you've been hurt - physically or sexually - have you ever sought help?" For affirmative responses, they were asked who they sought help from.

We focus our investigation of correlates on common risk factors for IPV in older adolescents and adults, though with the additional caveat that much of this evidence comes from high-income contexts. Potential risk factors include adverse childhood experiences, trauma symptoms, depression, and gender attitudes [19-22]. In LMIC, economic hardship may also play an important role [23]. Thus, we used the Adverse Childhood Experiences International Questionnaire (ACE-IQ) [24] to capture lifetime adversity. The ACE-IQ includes 13 domains of individual (e.g., physical abuse), family (e.g., witnessing domestic violence), peer (bullying) and community (e.g., gang violence) influences. We use the frequency coding scheme to create a cumulative measure (0-13); scores are then divided into quintiles. We measured emotional states by using the Posttraumatic Stress Disorder Scale (PTSD-8) [25] and the Beck Depression Inventory (analyzed using the pre-established cut-point for moderate/severe depression) [26]. We used five questions on attitudes towards wife beating (from the DHS) and five questions on female autonomy (from early rounds of the MLSFH) to capture gender ideology; these formed a scale ranging from 0-10 [27]. Caregivers were asked to complete a checklist of potential household assets. We then created a poverty index by summing assets, each weight by the inverse of the proportion of the population owning that particular asset. For these analyses, we divided the index into poverty quintiles. Additional covariates included age (measured continuously) and gender.

Analyses: We estimate the prevalence of IPV victimization and perpetration ever-partnered adolescents, both for the total sample and by gender. Help-seeking was rare, and thus frequency data are presented aggregated across genders. Finally, we use multivariate logistic regression to test associations between potential risk factors and IPV. Two sets of models were created: the first examine the association between individual risk factors and IPV, controlling only for age and gender. A second set examines all examines all potential risk factors simultaneously. The same approach is then applied to the data stratified by gender. Analyses are run using Stata v13.

Preliminary Results

In our sample of rural adolescents aged 10-16, over a quarter (586 of 2089) reported a romantic or sexual partnership. Not surprisingly, partnerships were far more common among older adolescents (63% of 16 year olds) compared to the youngest adolescents (8% of 10 year olds). Thus the mean age of the ever-partnered cohort was 14 (SD 1.5). Partnerships were also more common among boys (32%, n= 342) than among girls (24%; n=244). Marriage and cohabitation, however, was only reported among girls (n=19).

Prevalence of IPV victimization and perpetration

Table 1. Prevalence of lifetime IPV victimization and perpetration among ever-partnered, young adolescents (age 10-16)

	All	Boys	Girls	p-value
Victimization				
Physical IPV	11%	13%	8%	0.070
Sexual IPV	15%	8%	24%	0.000
Emotional IPV	11%	12%	9%	0.321
Any IPV	27%	24%	31%	0.057
Perpetration				
Physical IPV	6%	8%	3%	0.024
Sexual IPV	6%	9%	1%	0.001
Emotional IPV	7%	7%	7%	1.000
Any IPV	15%	18%	10%	0.007
Reciprocal IPV	9%	10%	7%	0.175

Over a quarter of ever-partnered adolescents reported experiencing either physical, sexual or emotional IPV in their lifetime (Table 1), with only modest differences by gender. A lower but still substantial proportion (15%) of adolescents reported perpetrating violence, with 9% of the sample indicating they had both committed and been a victim of IPV. Sexual IPV was more commonly committed by males (9% versus 1% of girls).

Help-seeking among victims

Of the adolescents who reported being a victim of IPV, a quarter (n=40) reported seeking help. Help-seeking was slightly more prevalent among female compared to male victims (29% versus 22% respectively). Adolescents most commonly reported turning to friends (n=21) and family (n=10), with very few seeking care from a health facility (n=3) or other formal support.

Childhood and adolescent correlates of IPV

The most consistent correlate of IPV victimization was childhood adversity (Table 2). For girls, adversity exhibited a similar magnitude of association with both victimization and perpetration. For boys, the cumulative burden of adversity was a more powerful predictor of perpetration: moving up a quintile was associated with an almost 70% increase in the odds of committing violence. Both PTSD and depression also exhibited a strong correlation with IPV victimization (aOR 1.73 and 1.74 respectively). Neither gender ideology nor poverty were associated with IPV.

Table 2. Correlates of lifetime IPV victimization and perpetration among ever-partnered, young adolescents (age 10-16)†

	IPV Victimization		IPV Perpetration	
	Bivariate OR	Adjusted OR	Bivariate OR	Adjusted OR
All				
ACE quintile	1.45***	1.43***	1.65***	1.64***
PTSD	1.99**	1.73*	1.47	1.36
Depression	2.04***	1.74*	2.05**	1.52
Gender ideology	0.98	1.01	0.91	0.94
Poverty quintile	0.97	0.99	1.02	1.02
Boys				
ACE quintile	1.34**	1.34**	1.68***	1.68***
PTSD	1.65	1.65	1.04	0.99
Depression	1.73	1.33	1.45	1.08
Gender ideology	0.93	0.98	0.92	0.91
Poverty quintile	1.02	1.01	1.00	0.98
Girls				
ACE quintile	1.62***	1.58***	1.59**	1.58*
PTSD	2.41*	1.63	2.43	1.95
Depression	2.46**	2.56	3.78**	2.68*
Gender ideology	1.03	1.06	0.90	1.00
Poverty quintile	0.90	0.94	1.06	1.09

†controlling for age & gender
*≤p=.05, **≤p=.01, ***≤p=.001

Discussion

A substantial proportion (27%) of very young adolescents report being victimized in their sexual and romantic relationships, though few sought out any type of help. A lesser but still notable proportion (15%) report committing violence against their partner. This underscores the need to intervene early, when can still break destructive pathways and foster healthier relationships.

The findings from this study also provide important insights into the mechanisms driving IPV, and thus what strategies may be effective in reducing IPV. First, and most surprisingly: this study did not find evidence that adolescents who espoused more unequal gender ideologies were more likely to perpetrate violence. This is contrary to much of the existing literature. Moreover, while boys were more commonly perpetrators of violence, this was not exclusively their domain: 10% of girls reported committing violence against a partner. If women are often perpetrators – and men victims – this challenges us to rethink how we combat IPV. Feminist theory [28] guides many intervention models, and thus the prevailing focus is on changing unequal power dynamics. Our finding suggests, however, that violence may be normalized in relationships for reasons other than

traditional masculinities, and that adolescents may benefit from learning more productive ways to handle conflict [29, 30].

Second, our findings indicate that childhood adversity may be an important driver of IPV. The association was remarkably similar for both for victimization and perpetration, and for both boys and girl. This adds to a robust literature in high-income countries linking childhood adversity, including witnessing domestic violence, to later IPV experiences. A similar literature is emerging in LMIC countries, including Malawi and South Africa [22, 31]. We extend this work to a new developmental period (early adolescence), showing that childhood adversity has a strong influence on the quality of formative relationships. The next step will be to better understand the mechanisms by which ACEs affect IPV. For instance, chronic stress may rewire the brain in ways that make it more difficult to control anger and impulses [32]. Alternatively, the mechanism may involve social learning [33]: when violence is modelled at home, adolescents may learn that it is socially-acceptable and enact violence in their own relationships.

Setting the stage for lifelong healthy relationships likely begins in early adolescence. To date, most IPV prevention initiatives have been developed and tested among older populations in high-income contexts. Though a few target young adolescents [19], there is a need to greatly expand the resources available to younger children and adolescents. IPV prevention could start in childhood. Parenting programs, for example, show potential to prevent childhood violence in high income contexts, and are currently being testing in LMIC [34, 35]. Our findings suggest that trauma-focused care and support could also help mitigate the impact of adversity on later IPV behaviors [36]. As noted above, interventions that teach conflict resolution may also be an effective tool. Interventions that are showing promise in higher resource settings, which often operate on multiple levels (e.g., in both schools and in communities) need to be adapted and tested in low-income settings. More work should be done to examine whether gender-specific approaches need to be developed. Given that we did not large gender divides in perpetration, nor gender-specific risk factors, it is possible that similar approaches would work for both boys and girls. More certainly, our findings are a reminder that boys need equal access to support for victims. Likewise, that prevention efforts need to address perpetration by girls.

This is one of the first studies to characterize IPV victimization and perpetration among a cohort of very young adolescents in a low-income context. Study strengths include the use of standardized measures to capture physical, sexual and emotional IPV; adaption of the same measure to capture perpetration among both girls and boys; and a sample size large enough to investigate correlates of relatively rare events. Its cross-sectional nature, however, precludes causal interpretations. For example, we cannot make any inferences about whether depression in a predictor or consequence of IPV, which has implications for prevention efforts. A follow-up of this cohort is planned for 2020, and may better capture IPV trajectories and risk factors. Finally, while the study assessed both victimization and perpetration, it did not collect information on whether these occurred together (escalading reciprocal violence), or were unique episodes.

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