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Faculty of Social Sciences

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Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income
Countries

by

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Thesis for the degree of PhD in Social Statistics and Demography

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Abstract

Faculty of Social Sciences

School of Economic, Social and Political Sciences

Doctor of Philosophy

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by

Rebecca Jane Harris

Childhood exposure to domestic violence and abuse (DVA) perpetrated between caregivers or other adults in the household is associated with a range of poorer outcomes in later life, including an increased risk of psychiatric disorders, substance misuse, and a higher likelihood of committing violent crimes in adulthood. However, the majority of research on this topic is based on studies conducted in high-income countries (HICs), and evidence on the scale, impact, and early appropriate interventions for children is extremely limited in low- and middle-income countries (LMICs), with many gaps in knowledge. Without this information, a potentially large number of children will grow up without their experiences being acknowledged or recorded, thereby limiting the potential interventions to reduce their risk of poor outcomes.

The overarching aim of this thesis is to enhance and develop the knowledge and understanding of childhood exposure to DVA in LMICs to address these critical gaps in knowledge. It does this by presenting a body of empirical research that explores key stages of the research process through four distinct, but closely linked research papers. These papers are ordered to form a comprehensive understanding of childhood exposure to DVA on a global level.

The papers start with exploring the current measurement scales of childhood exposure to DVA, and uses the COSMIN PROMs approach to question whether existing scales are appropriate for gaining global prevalence estimates of childhood exposure to DVA. The second investigation studies the prevalence of, and risk factors associated with, childhood exposure to DVA in LMICs. It does this through secondary data analysis of ten Violence Against Children Surveys (VACS). Paper Three builds explicitly on Paper Two by investigating the mental health outcomes of children exposed to DVA within ten LMICs, utilising the VACS, focusing on adverse internalising and externalising symptoms in adolescence and early adulthood. Finally, the last paper moves beyond a multi-country comparative approach and instead looks at one LMIC in detail: Nepal. It explores the current understanding and support available for childhood exposure to DVA.

Taken together, the findings in this thesis presents a comprehensive overview of the current state of understanding of childhood exposure to DVA in LMICs, highlighting where further research is required to ensure that children's voices are heard, and appropriate policies and interventions are developed to ensure their protection. Implications for policy, practice, and research are addressed.

Table of Contents

Abstract	ii
Table of Contents	iii
Table of Tables	xiv
Table of Figures	xvii
Research Thesis: Declaration of Authorship	xix
Author's Contribution	xx
Acronyms and Abbreviations	xxi
Chapter 1 Introduction: Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries	22
1.1 Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries: A Brief Overview	22
1.2 Conducting Research on an Emerging Research Area	25
1.3 Research Objectives	27
1.4 Thesis Outline	28
Chapter 2 Current Understanding of Childhood Exposure to Domestic Violence and Abuse in LMICs	32
2.1 Domestic Violence and Abuse (DVA)	32
2.2 Childhood Exposure to Domestic Violence and Abuse	34
2.3 Measuring Childhood Exposure to Domestic Violence and Abuse	37
2.3.1 General Limitations of Measuring Childhood Exposure to DVA	37
2.4 Global Estimates of Childhood Exposure to DVA	39
2.5 Factors Associated with Childhood Exposure to DVA	41
2.5.1 Risk Factors for Childhood Exposure to DVA	41
2.5.2 Co-occurrence of Childhood Exposure to DVA and Maltreatment	43
2.5.3 Intergenerational Transmission of Violence	45

Table of Contents

2.5.4 Outcomes Associated with Childhood Exposure to DVA	45
2.6 Childhood Exposure to DVA on the International Public Health and Policy Agenda	47
2.7 Summary of Knowledge Gaps in Literature.....	48
Chapter 3 Data and Methods	50
3.1 Introduction	50
3.2 Mixed Methods Design of the Thesis	50
3.3 Quantitative Analysis	55
3.3.1 Survey Information: The Violence Against Children Surveys (VACS)	55
3.3.2 Data Availability of the VACS.....	59
3.3.3 Selection of VACS Datasets for Analysis.....	59
3.3.4 Childhood Exposure to DVA within the VACS	60
3.3.5 Existing Research on Childhood Exposure to DVA Using the VACS	64
3.4 Qualitative Analysis	66
3.5 Research Paradigm and Researcher Positionality	67
3.6 Ethical Considerations	69
3.6.1 Ethical Approval.....	69
3.6.2 Reflections on the Ethical Eco-System	69
3.7 Summary.....	71
Chapter 4 Paper One: Childhood exposure to domestic violence and abuse: can global estimates on the scale of exposure be obtained using existing measures?.....	72
4.1 Introduction	73
4.1.1 Childhood Exposure to Domestic Violence and Abuse	74
4.1.2 Measuring Childhood Exposure to DVA	75
4.1.3 Current Review	76

Table of Contents

4.2	Methods.....	76
4.2.1	Search Strategy.....	77
4.2.2	Inclusion Criteria.....	77
4.3	Results.....	77
4.3.1	Child Exposure to Domestic Violence Scale	83
4.3.2	Children’s Perception of Interparental Conflict Scale	84
4.3.3	Juvenile Victimization Questionnaire.....	85
4.3.4	Violence Exposure Scale for Children.....	86
4.4	Discussion	87
4.5	Conclusion.....	91
 Chapter 5 Paper Two: Prevalence and Risk Factors Associated with Childhood Exposure to Domestic Violence and Abuse in LMICs92		
5.1	Introduction	93
5.1.1	Prevalence of Childhood Exposure to DVA in LMICs.....	93
5.1.2	What is a Risk Factor?	94
5.1.2.1	Conceptual Framework for Paper Two	95
5.1.3	Individual Level Factors	96
5.1.4	Family Level Factors.....	98
5.1.5	Community and Society Level Factors	100
5.1.6	Aim and Purpose of Study.....	103
5.2	Methods.....	103
5.2.1	Selection of VACS Datasets for Analysis.....	103
5.2.2	Assessing Risk Factors Associated with Childhood Exposure to DVA within the VACS	104
5.2.3	Selection and Creation of Variables for Analysis.....	104

Table of Contents

5.2.4	Joint Variables and Collinearity	106
5.2.5	Weightings and Differences Between Estimates	106
5.2.6	Methods of Analysis	106
5.3	Results.....	108
5.3.1	Overall Exposure to Violence Statistics	108
5.3.2	Analysis of Risk Factors Associated with Childhood Exposure to DVA in LMICs.....	114
5.3.3	Regression Analysis for Risk Factors Associated with Exposure to DVA in LMICs.....	120
5.3.3.1	Individual Level Factors Regression Model.....	121
5.3.3.2	Family Level Factors Regression Model	121
5.3.3.3	Community and Societal Level Factors Regression Model.....	123
5.3.3.4	Overall Regression Model.....	124
5.3.4	A Probability Scale for Risk Factors Associated with Exposure to DVA in LMICs.....	132
5.4	Discussion	136
5.5	Conclusion.....	142
 Chapter 6 Paper Three: Mental Health Outcomes Associated with		
Childhood Exposure to Domestic Violence and Abuse in LMICs		
		144
6.1	Introduction	145
6.1.1	Conceptualising Mental Health.....	145
6.1.2	Internalising Symptoms Associated with Childhood Exposure to DVA	146
6.1.3	Externalising Symptoms Associated with Childhood Exposure to DVA.....	148
6.1.4	Theoretical Considerations.....	149
6.1.5	Conceptual Framework for Paper Three	151
6.1.6	Aim and Purpose of Study.....	152
6.2	Methods.....	153

Table of Contents

6.2.1	Selection of VACS Datasets for Analysis.....	153
6.2.2	Assessing the Relationship between Childhood Exposure to DVA and Adolescent and Adult Mental Health within the VACS	153
6.2.2.1	Childhood Exposure to DVA in the VACS.....	154
6.2.3	Selection and Creation of Adolescent and Adult Mental Health Variables for Analysis	154
6.2.3.1	Internalising Symptoms	155
6.2.3.2	Externalising Symptoms.....	157
6.2.4	Methods of Analysis	158
6.3	Results.....	160
6.3.1	Bivariate Analysis of Internalising Symptoms Associated with Exposure to DVA in LMICs	161
6.3.1.1	Psychological Distress.....	161
6.3.1.2	Intentional Self-harm	164
6.3.1.3	Suicidal Thoughts	167
6.3.1.4	Suicide Attempt.....	168
6.3.2	Bivariate Analysis of Externalising Symptoms Associated with Exposure to DVA in LMICs	169
6.3.2.1	Engaging in Behaviours Harmful to Health ('Risky Behaviours')	169
6.3.2.2	Perpetration of [Physical] DVA.....	173
6.3.2.3	Perpetration of [Physical] Non-Partnered Violence.....	176
6.3.3	Regression Analysis for Mental Health Outcomes Associated with Exposure to DVA in LMICs.....	177
6.3.3.1	The Association of Childhood Exposure to DVA with Mental Health Outcomes	178
6.3.3.2	The Association of Biological Sex with Mental Health Outcomes	180

Table of Contents

6.3.3.3	The Association of Exposure to Community Violence with Mental Health Outcomes	183
6.3.3.4	Key Associations across Ecological Domains.....	185
6.4	Discussion	189
6.4.1	Discussion of the Key Findings.....	189
6.4.2	Limitations and Recommendations for Future Research.....	193
6.5	Conclusion.....	195
Chapter 7	Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal: Policymaker and Professional Perspectives	197
7.1	Introduction and Rationale	198
7.1.1	Policy and Public Health Interventions for Childhood Exposure to DVA.....	198
7.1.2	Nepal: Country Context and Background	203
7.1.2.1	Geography and Climate	205
7.1.2.2	Political Structure, Economy and Development	206
7.1.2.3	Recent History.....	208
7.1.2.4	The Context of DVA within Nepal	208
7.1.2.5	Childhood Exposure to DVA in Nepal	211
7.1.2.6	Existing Policies and Public Health Interventions for Childhood Exposure to DVA in Nepal	213
7.1.2.7	Rationale for Exploring Childhood Exposure to DVA in Nepal	213
7.1.3	Aim and Purpose of Study.....	215
7.2	Methodology	216
7.2.1	Research Design	216
7.2.2	Identifying a Local Partner and Seeking Ethical Approval and Funding for the Research	216

Table of Contents

7.2.3	Identification of Respondents, Sampling and Recruitment.....	217
7.2.4	Data Collection	219
7.2.5	Data Analysis	220
7.2.6	Reflexivity and Researcher Positionality	221
7.3	Thematic Findings.....	223
	Theme 1: Understanding and Awareness of Childhood Exposure to DVA	225
	Subtheme 1.1: (Mis)understanding and Confusion	225
	Subtheme 1.2: Lack of Awareness Among Policymakers	228
	Subtheme 1.3: Cultural and Societal Influence	231
	Theme 2: Barriers to Providing and Accessing Support.....	233
	Subtheme 2.1: Awareness and Knowledge Gaps Amongst Children	234
	Subtheme 2.2: Systemic and Organisational Barriers.....	235
	Subtheme 2.3: Accessibility Issues for Support Services.....	239
	Theme 3: Existing Support and Resources	242
	Subtheme 3.1: Current Resources and Interventions	243
	Subtheme 3.2: Institutional Collaboration and Challenges.....	246
	Subtheme 3.3: Perceived Responsibility for Policy, Provision, and Support.....	248
	Theme 4: Future Strategies and Interventions to Improve Support for Children	250
	Subtheme 4.1: Empowerment and Education	251
	Subtheme 4.2: Multilevel Interventions	253
	Subtheme 4.3: Policy and Structural Changes	256
7.4	Discussion	259
7.4.1	Summary of Key Findings.....	261
7.4.2	Implications for Policy and Practice	266
7.4.3	Suggestions for Future Research	268

Table of Contents

7.4.4	Limitations.....	269
7.5	Conclusion.....	270
Chapter 8	Discussion and Conclusion	272
8.1	Revisiting the Research Design	273
8.2	Discussion of the Key Findings of this Research	279
	Paper One: Measuring Exposure to DVA	279
	Key Finding 1: Multiple measures for children’s exposure to DVA exist, but there is no standardised approach, and they are sparsely used in LMICs	279
	Key Finding 2: The language used within some of the accepted measures is outdated and does not reflect the current understanding of exposure to DVA	280
	Key Finding 3: Global consensus on a measure is an urgent research priority to obtain country-level or global prevalence rates of childhood exposure to DVA.....	282
	Paper Two: Prevalence and Risk Factors for Exposure to DVA	284
	Key Finding 4: Over 19 million children have been exposed to DVA across the ten LMICs explored – meaning current estimates are much lower than reality.....	284
	Key Finding 5: Females are more likely to be exposed to DVA than males in the ten LMICs explored.....	286
	Key Finding 6: Exposure to DVA often co-occurs with exposure to other violence types	288
	Key Finding 7: Exposure to DVA was most associated with the ecological domain of community and society.....	289
	Paper Three: Mental Health Outcomes for Exposure to DVA.....	293
	Key Finding 8: Childhood exposure to DVA is strongly associated with poorer mental health in adolescence and early adulthood.....	293
	Key Finding 9: There are differences in mental health outcomes by biological sex, with females more likely to experience internalising symptoms	295
	Key Finding 10: Variables in the ecological domains of community and society also impact mental health outcomes.....	297

Table of Contents

Paper Four: Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal	299
Key Finding 11: There is misunderstanding and confusion around childhood exposure to DVA in Nepal, impacting children’s recognition within policy and programmes.....	299
Key Finding 12: The current support structures for children facing violence is fragmented, insufficient, and poorly coordinated	301
Key Finding 13: Further research is required to understand the country-specific context of childhood exposure to DVA within Nepal to initiate a national conversation and work towards the inclusion of childhood exposure to DVA in national policies, provision, and support.....	303
Overarching Contributions of the Thesis	306
8.3 Strengths and Limitations of the Current Research.....	307
8.4 Recommendations for Future Research	313
8.5 Concluding Remarks.....	316
Appendix A Summary of Measures Exploring Childhood Exposure to Domestic Violence and Abuse	318
Appendix B Recoding of Variables for Paper Two Analysis.....	323
B.1 Response Options to Question Types	323
B.2 Recoding of Existing Questions/Variables within the VACS	324
B.3 Creation of New Variables for Analysis for Risk Factors Associated with Exposure to DVA.....	328
B.3.1 Family Economic Conditions (‘Wealth’).....	328
B.3.2 Death of a Biological Parent.....	330
B.3.3 Living with Both Biological Parents	331
B.3.4 Societal Acceptance of DVA	331
Appendix C Childhood Exposure to Types of Violence in the VACS	334
C.1 Exposure to Domestic Violence and Abuse	335

C.2 Exposure to Child Abuse.....	336
C.3 Exposure to Community Violence	339
Appendix D Risk Factors Associated with Exposure to Domestic Violence and Abuse: Results	342
D.1 Individual Level Risk Factors.....	342
D.2 Family Level Risk Factors	344
D.3 Community and Societal Level Risk Factors.....	350
Appendix E Recoding of Variables for Paper Three Analysis	352
E.1 Response Options to Question Types	352
E.2 Recoding of Existing Questions/Variables within the VACS	353
E.3 Creation of New Variables for Analysis for Risk Factors Associated with Exposure to DVA.....	355
E.3.1 Psychological distress.....	355
E.3.2 Engaging in Behaviours Harmful to Health ('Risky Behaviours')	358
E.3.3 Perpetration of [Physical] DVA	359
E.3.4 Perpetration of [Physical] Non-Partnered Violence	362
Appendix F Associated Mental Health Outcomes for Children Exposed to Domestic Violence and Abuse: Bivariate Correlates with Confidence Intervals	365
F.1 Internalising Symptoms	365
F.1.1 Psychological distress (last 30 days).....	365
F.1.2 Intentional Self-Harm (ever).....	367
F.1.3 Suicidal Thoughts (ever)	370
F.1.4 Suicide Attempt (ever)	372
F.2 Externalising Symptoms.....	374

Table of Contents

F.2.1	Engaging in Behaviours Harmful to Health ('Risky Behaviours') (last 30 days).	374
F.2.2	Smoking Tobacco (last 30 days)	375
F.2.3	Binge Drinking (last 30 days)	377
F.2.4	Using Drugs (last 30 days).....	378
F.2.5	Perpetration of Domestic Violence and Abuse (ever)	380
F.2.6	Perpetration of [Physical] Non-Partnered Violence (ever)	381
Appendix G Associated Mental Health Outcomes for Children Exposed to Domestic Violence and Abuse: Regression Models 383		
G.1	Psychological Distress (last 30 days)	383
G.2	Intentional Self Harm (lifetime)	386
G.3	Suicidal Thoughts (lifetime)	388
G.4	Risky Behaviours (last 30 days)	390
G.5	Perpetration of Physical DVA (lifetime)	392
G.6	Perpetration of [Physical] Non-Partnered Violence (lifetime)	394
Appendix H A Map of Nepal..... 396		
Appendix I Policies and Legislation related to Childhood Exposure to DVA397		
I.1	International Rights, Treaties and Conventions on Childhood Exposure to DVA	397
I.2	Examples of Policies on Childhood Exposure to DVA in Other Countries	400
I.3	National Acts, Laws and Policies on Childhood Exposure to DVA in Nepal.....	406
Appendix J Interview Guide for Paper Four: Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal: Policymaker and Professional Perspectives 411		
List of References 421		

Table of Tables

Table 2.1 A taxonomy of children's exposure to domestic violence and abuse (Holden, 2003)	36
Table 3.1 A brief overview of the objectives, data sources, and methods used within this thesis	52
Table 3.2 Overview of the mixing of methods within Paper Four	55
Table 3.3 Countries in which the VACS have been administered, by region and year of survey	57
Table 3.4 Participation rates for the Violence Against Children Surveys (VACS)	60
Table 3.5 Creation of the Exposure to DVA Variable in the Ten VACS Countries Used in Analysis	62
Table 3.6 Response rates for childhood exposure to DVA across the Ten LMICs participating in the VACS used within this thesis	64
Table 4.1 A summary of identified measures	78
Table 4.2 Summary of DVA Measures Applied Cross-Culturally by COSMIN PROMs Indicators	80
Table 5.1 Estimates of childhood exposure to violence types by VACS country (unweighted total number of participants, and weighted percentages)	109
Table 5.2 Estimates of Children Exposed to DVA in Ten LMICs.....	113
Table 5.3 Estimates of childhood exposure to domestic violence and abuse by individual-level associated risk factor and VACS country (weighted percentages).....	115
Table 5.4 Estimates of childhood exposure to domestic violence and abuse by family-level associated risk factor and VACS country (weighted percentages).....	116
Table 5.5 Estimates of childhood exposure to domestic violence and abuse by community and societal level associated risk factor and VACS country (weighted percentages)	118
Table 5.6 Regression Model 1: Individual Model for Childhood Exposure to DVA, presented as Predicted Probabilities	127

Table of Tables

Table 5.7 Regression Model 2: Family Model for Childhood Exposure to DVA, presented as Predicted Probabilities	128
Table 5.8 Regression Model 3: Community and Societal Model for Childhood Exposure to DVA, presented as Predicted Probabilities	129
Table 5.9 Regression Model 4: Overall Additive Model for Childhood Exposure to DVA, presented as Predicted Probabilities	130
Table 5.10 Probability of Exposure to DVA Amongst the VACS Surveys, Explored by Education Level.....	134
Table 5.11 Probability of Exposure to DVA Amongst the VACS Surveys, Explored by Level of Wealth	135
Table 6.1 A summary of adolescent and adult variables relating to mental health within the VACS	155
Table 6.2 Levels of psychological distress reported amongst adults exposed and not exposed to DVA as children within the VACS (last 30 days)	162
Table 6.3 Internalising symptoms reported amongst adults exposed and not exposed to DVA as children within the VACS (lifetime)	166
Table 6.4 Demonstration of risky behaviours harmful to health reported amongst adults exposed and not exposed to DVA as children within the VACS (last 30 days)	171
Table 6.5 Perpetration of Physical Violence (both intimate partner, and non-partnered violence) amongst adults exposed and not exposed to DVA as children within the VACS (lifetime)	175
Table 6.6 Predicted Probabilities for Mental Health Outcomes Associated with Childhood Exposure to DVA.....	178
Table 6.7 Predicted Probabilities for Mental Health Outcomes Associated with Being Female	181
Table 6.8 Predicted Probabilities for Mental Health Outcomes Associated with Exposure to Community Violence	183
Table 7.1 A Summary of Interviews Conducted	219
Table 7.2 Themes and subthemes identified during thematic analysis	223

Table of Tables

Table 8.1 A table summarising the key findings of this research, in relation to the questions posed and the stage of the research process it addresses	275

Table of Figures

Figure 1.1 The Research Process.....	25
Figure 2.1 Regional estimates of the number of children exposed to domestic violence and abuse by Millennium Development Goal Region (UNICEF, 2006)	40
Figure 3.1 The mixed methods sequential explanatory design of this thesis	54
Figure 5.1 Conceptual framework for risk factors associated with childhood exposure to DVA	95
Figure 5.2 A clustered bar graph displaying the percentage of children exposed to violence types by VACS country (using weighted percentages)	111
Figure 5.3 A clustered bar graph displaying estimates of children's exposure to domestic violence and abuse by VACS country (using weighted percentages)	112
Figure 5.4 Probability of individuals with baseline characteristics being exposed to DVA as a child within the VACS	133
Figure 6.1 Conceptual framework for mental health outcomes associated with childhood exposure to DVA.....	152
Figure 6.2 A clustered bar graph displaying the percentage of respondents reporting any psychological distress by VACS country (using weighted percentages)	164
Figure 6.3 A clustered bar graph displaying the percentage of respondents reporting intentional self-harm by VACS country (using weighted percentages)	165
Figure 6.4 A clustered bar graph displaying the percentage of respondents reporting having ever experienced suicidal thoughts by VACS country (using weighted percentages)	167
Figure 6.5 A clustered bar graph displaying the percentage of respondents reporting that they have attempted suicide by VACS country (using weighted percentages).....	168
Figure 6.6 A clustered bar graph displaying the percentage of respondents reporting engaging in risky behaviours by VACS country (using weighted percentages)	172
Figure 6.7 A clustered bar graph displaying the percentage of respondents reporting [Physical] DVA Perpetration by VACS country (using weighted percentages)	174

Table of Figures

Figure 6.8 A clustered bar graph displaying the percentage of respondents reporting perpetration of [physical] non-partnered violence by VACS country (using weighted percentages)	176
Figure 7.1 Standard placement of where childhood exposure to DVA sits within existing policy, provision and services, based on evidence from other countries	200
Figure 7.2 A map of Nepal showing the subdivision of the country into Mountain, Hill and Terai districts. Kathmandu is also noted. Inset is a thumbnail map showing the location of Nepal within South Asia	205
Figure 7.3 The Six Stages of Reflexive Thematic Analysis (Braun & Clarke, 2021)	221
Figure 7.4 Reflection on the position of childhood exposure to DVA within existing policy, provision and services in Nepal. This diagram highlights that exposure is not acknowledged anywhere, and there is also disconnect between DVA and child protection	264

Research Thesis: Declaration of Authorship

Print name: Rebecca Jane Harris

Title of thesis: Children's Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries

I declare that this thesis and the work presented in it are my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;
2. Where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
3. Where I have consulted the published work of others, this is always clearly attributed;
4. Where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
5. I have acknowledged all main sources of help;
6. Where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
7. Parts of this work have been published as:

Harris, R. J., Channon, A. A., & Morgan, S. A. (2024). Childhood exposure to domestic violence: Can global estimates on the scale of exposure be obtained using existing measures? *Frontiers in Public Health*, 12, 1181837. <https://doi.org/10.3389/fpubh.2024.1181837>

Author's Contribution

The second, third and fourth empirical papers (Chapters 5, 6, and 7) presented in this thesis were authored solely by Rebecca Jane Harris. The first empirical paper (Chapter 4) was authored jointly by Rebecca Jane Harris, and two of her supervisors, Professor Andrew Amos Channon and Dr Sara Afshar Morgan. Harris is the principal author of this paper. She conceptualised the initial idea for this investigation, conducted the literature search and critical appraisal and wrote the content of the paper. Channon and Morgan reviewed and commented on the manuscript in preparation for submission to *Frontiers in Public Health*, suggesting edits where appropriate. Harris, herself, was ultimately responsible for producing the body of research presented in Paper One (Chapter 4).

Author contribution statement certified by:

Andrew Amos Channon

Date: 06/06/25

Sara Afshar Morgan

Date: 06/06/25

Acronyms and Abbreviations

CDC	Centers for Disease Control and Prevention
COSMIN PROMs.....	CONsensus-based Standards for the selection of health Measurement INSTRuments for Patient-Reported Outcome Measures (Prinsen et al., 2018)
CREHPA.....	Center for Research on Environment, Health, and Population Activities (Nepal)
DHS.....	Demographic and Health Survey
DVA	Domestic Violence and Abuse
EA.....	Enumeration Areas
ERGO.....	University of Southampton Ethics and Research Governance Committee
GBV	Gender based violence
HICs	High income country
IDI.....	In depth interview
IMAGES.....	International Men and Gender Equality Survey
INGO	International non-governmental organisation
LMIC	Low- and middle-income country
NGO	Non-governmental organisation
PI.....	Principal Investigator
SDGs	Sustainable Development Goals
UN.....	United Nations
UNCRC	The UN Convention on the Rights of the Child (1989)
UNICEF.....	The United Nations International Children's Emergency Fund
VACS	Violence Against Children Surveys
WHO.....	World Health Organization

Chapter 1 Introduction: Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries

1.1 Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries: A Brief Overview

Research has found that children exposed to domestic violence and abuse (DVA) perpetrated by caregivers or other adults in the household are at an increased risk of poorer outcomes, including an increased risk of psychiatric disorders, substance misuse, and a higher likelihood of committing violent crimes in adulthood (English et al., 2003; Evans et al., 2008; Herrera & McCloskey, 2001). However, the majority of research on this topic is based on studies conducted in high-income countries (HICs), and evidence on the scale, impact, and early appropriate interventions for children is extremely limited in low- and middle-income countries (LMICs), with many gaps in knowledge. Without this information, a potentially large number of children will grow up without their experiences being acknowledged or recorded, thereby limiting the potential interventions to reduce their risk of poor outcomes. In addition to this, the knowledge that we do have may not be transferable from HICs to LMICs, and so even existing interventions that are designed may not be applicable.

Whilst there is a lack of standardisation in research studies concerning what constitutes exposure, the most widely accepted definition is that exposure to DVA occurs when an individual visually observes, overhears, is directly involved in (i.e., attempting to intervene) or witnesses the effects (i.e., seeing injuries or emergency services involved) of violent acts perpetrated by one adult or caregiver against another (Evans et al., 2008). This is reflected in Holden's (2003) taxonomy of exposure. Alongside general methodological issues with measuring exposure to DVA (such as underreporting), there is also a lack of standardisation in how exposure should be measured, with many existing tools not being validated within LMICs, meaning that accurate estimates of childhood exposure to DVA globally cannot be obtained.

The last global figures estimate that close to 300 million children have been exposed to DVA (UNICEF, 2006), with LMICs estimated to have a much higher number of children exposed when compared to HICs. However, these estimates are over 15 years old, and include gaps in crucial regions (Northern Africa and South-Eastern Asia), and so a true picture of the state of exposure to DVA in LMICs (and globally), cannot be captured. In addition to this, there is likely to have

been an increase in the number of children who have been exposed to DVA perpetrated within the home in recent years, notably due to the ‘shadow pandemic’ of COVID-19 (UN Women, 2020; World Health Organization, 2020), which saw a global increase in the number of cases of DVA reported. The closure of schools and restriction of movement outside of homes means that should any DVA be perpetrated in a household where children are present, they are much more likely to have been exposed to DVA. Childhood exposure to DVA, and obtaining updated global estimates, is therefore an urgent research priority.

This thesis contributes to the understanding of childhood exposure to DVA within LMICs – an emerging but essential area of research. It does this by taking the topic of exposure to DVA in LMICs from the start of the research process (defining the issue, how to measure it, and its scale), to the end, looking at approaches to policy responses to the issue, via the prevalence, risk factors, and implications. To the researcher’s knowledge, no other studies have been found that put all these elements together and presented as a coherent whole. When read in its entirety, this thesis presents a comprehensive overview of the current state of understanding of childhood exposure to DVA in LMICs, highlighting where further research is required to ensure that children’s voices are heard, and appropriate policies and interventions are developed to ensure their protection. The thesis takes this overview due to the paucity of research into the topic of exposure to DVA in LMICs, and hence, having an overarching picture of the situation, from definition through to approaches to policy responses, will indicate further avenues of research.

This thesis starts by looking at existing measures for exposure to DVA, questioning whether any are appropriate for use within LMICs so that global estimates of childhood exposure to DVA can be obtained, and the current state of exposure within LMICs understood. This is followed by secondary data analysis of existing survey data, aiming to estimate figures on the prevalence of childhood exposure to DVA in ten LMICs, along with trying to understand *who* is more likely to be affected, by looking at risk factors for exposure to DVA within these countries. Following this, outcomes of childhood exposure to DVA within the same ten LMICs are analysed, with a focus on mental health outcomes. Finally, this thesis looks at what is the current situation within one LMIC, Nepal, firstly assessing the understanding of the issue of exposure to DVA within the country, and then looking at the provision of services for children who have been exposed to violence perpetrated within the home, and the barriers and facilitators for providing these services to children who have been affected. This thesis, therefore, looks at the entire research agenda for the topic of childhood exposure to DVA in LMICs, addressing key areas where there is currently a lack of research. Addressing these gaps in knowledge is both timely and

imperative and is essential for meeting the Sustainable Development Goals (SDGs; United Nations, 2015)¹ and ensuring the protection and wellbeing of all children globally.

It is also important to clarify how the term domestic violence and abuse (DVA) is used throughout this thesis, and the limitations that arise from available data in capturing the full range of experiences children may be exposed to. In this thesis, DVA is used in line with UK policy and research frameworks, encompassing a broad range of harmful behaviours including physical, emotional, psychological, sexual, and economic abuse, as well as coercive control. Ideally, this thesis would have examined the full spectrum of DVA and the varied ways in which children may be exposed. However, due to limitations in data availability (particularly in the secondary data analysis chapters – Papers Two and Three), the primary empirical focus is on physical forms of violence perpetrated by one caregiver or adult in the household against another, that are directly witnessed or overheard by children. The survey data used (VACS) do not adequately capture other forms of abuse such as coercive control, nor do they reflect the full range of exposure outlined in frameworks such as Holden’s taxonomy (2003), which includes exposure through observing the initial effects, experiencing the aftermath, and hearing about it through conversations after the event. As such, the empirical papers within this thesis that utilise the VACS is limited in its ability to examine the full breadth of exposure and impact as defined in contemporary scholarship (Callaghan et al., 2018; Katz, 2016; Øverlien, 2013).

This limitation is acknowledged throughout the thesis, and findings are interpreted with care to reflect the scope of the available measures. Nonetheless, this thesis deliberately retains the framing of DVA, rather than intimate partner violence (IPV), as the broader term more accurately reflects the primary aim of the research: to highlight the current state of knowledge on childhood exposure to DVA in LMICs. Indeed, one of the key findings of the thesis is that current measurement tools remain limited and contribute to a narrow conceptualisation of both violence and exposure. This framing is therefore not only a reflection of the research aims but also a call for the development of more comprehensive, contextually relevant data collection methods in future work. This thesis uses the term “childhood exposure to DVA” to reflect the experiences of children who see, hear, or otherwise experience violence between adults in the home, most often perpetrated by one caregiver against another. While available data often describe this exposure in passive terms, such as children “witnessing” or “overhearing” violence, it is important to recognise that violence and abuse are acts committed by individuals. Where possible, language in this thesis has been revised to reflect this, acknowledging that children are exposed to violence that is perpetrated, not abstractly occurring.

¹ In particular, the topic of this thesis addresses SDG 5.2 (Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation), and SDG 16.2 (End abuse, exploitation, trafficking and all forms of violence against children) (United Nations, 2015).

1.2 Conducting Research on an Emerging Research Area

As noted in the previous section, within this thesis, an overview of the different aspects of exposure to DVA has been taken. This, in part, was prompted by the paucity of literature about childhood exposure to DVA in LMICs and the lack of an overall narrative about how to measure, understand and respond to the issue. Reflecting on this dearth of research, a comprehensive research strategy was developed to guide the research conducted in this thesis.

When researching such a complex issue, engaging with a structured and comprehensive research process is essential to ensure that all aspects of the problem are explored. As this topic transcends a variety of disciplines², many different research methodologies and frameworks were consulted (including Clark, Foster, Sloan & Bryman, 2021; Flick, 2020; Howitt & Cramer, 2020; Walker, 2014), and synthesised to form the research strategy for this thesis. The research framework incorporates five distinct stages, each contributing to the investigation and understanding of the phenomenon of childhood exposure to DVA in LMICs. This process is shown in Figure 1.1, which demonstrates how the different components of the thesis were developed within the overall research narrative into exposure to DVA.

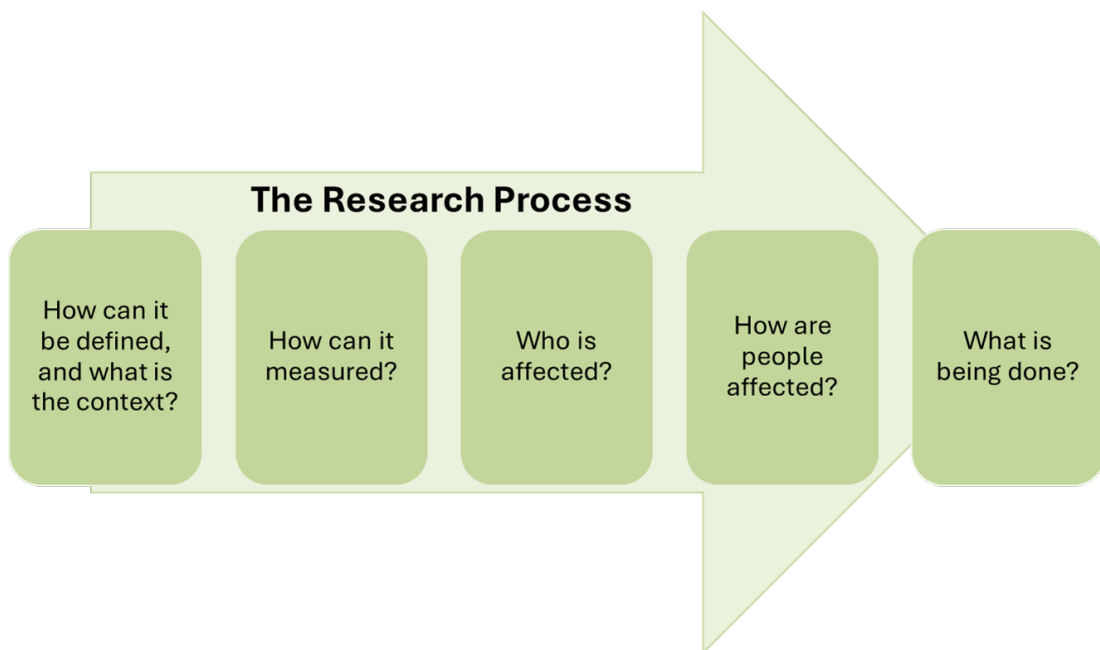


Figure 1.1 The Research Process

² This PhD was funded through an ESRC +3 Interdisciplinary Studentship, which has influenced this thesis. The topic of childhood exposure to DVA can be explored from a number of angles and disciplines, and this thesis brings together a range of subjects at all stages of the research process to ensure a comprehensive exploration of the topic.

Firstly, it is important to define the issue and understand its context. This stage includes clearly defining the phenomenon of investigation and ensuring that it is a definition upon which everybody agrees, understanding the historical and cultural context surrounding the phenomenon, and reviewing existing literature on it.

The second step involves exploring the best way of measuring the issue, an instrumental stage when trying to obtain a comprehensive understanding. A consistent method of measuring the issue will allow for the scale and scope of the phenomenon to be understood, along with a discussion of any potential issues or considerations that need to be taken into account when gathering data.

The third stage of the research framework is concerned with identifying who is affected by the phenomenon, and exploring the extent to which it affects different areas or populations. This step involves examining prevalence rates and investigating the root causes and contributing factors (for example, risk factors) that lead to the phenomenon. Additionally, it encompasses discussing systemic or structural issues that may play a role.

The fourth stage of the research process examines how people are affected by the phenomenon and its associated outcomes. This involves determining how different groups or individuals are affected, assessing the short-term and long-term outcomes, examining how different contexts may influence outcomes, and examining the impacts on individuals, communities, and societies. This is important for deriving recommendations for policy and practice to better support those affected by the phenomenon.

Lastly, the fifth stage involves examining what is being done to combat or deal with the phenomenon. This stage includes exploring existing efforts to mitigate or address the issue, considering potential solutions and their feasibility, and looking for case studies or real-world examples of the phenomenon. This stage also involves examining any interventions or policy responses for the issue and assessing how external factors in the applied context (such as cultural and societal norms) may shape the trajectory of the issue.

Section 1.4 provides an overview of this thesis, which explains where each stage of this research process is addressed. Whilst there are many other aspects that could be explored when conducting research, these noted here will, if fully answered, provide a comprehensive overview of an emerging topic. These five stages offer suggestions on the most critical areas to address to ensure that the research within this thesis provides the best contribution to enhance and develop our understanding of childhood exposure to DVA in LMICs. Whilst more work will be

required to fully understand this complex issue on a global scale, this thesis serves as a comprehensive baseline from which future research can develop.

1.3 Research Objectives

The overarching aim of this thesis is to enhance and develop the knowledge and understanding of childhood exposure to DVA in LMICs. It does this by presenting a body of empirical research that explores key stages of the research process (see Figure 1.1) through a number of distinct, but closely linked research objectives:

Objective 1 (Overview of Literature; Chapter 2): This thesis first aims to assess the current knowledge and understanding of the issue of childhood exposure to DVA in LMICs. It does this by clearly defining the issue explored within the thesis, looking at how the concept has developed both in policy and research, and current available evidence on this topic. This represents Stage 1 of the research process (How can it be defined, and what is the context?; Figure 1.1).

Objective 2 (Paper One; Chapter 4): The second aim of this thesis is to understand the current methods of measuring childhood exposure to DVA, providing an overview and critique of existing measures for childhood exposure to DVA, to discuss the usage of these measures over time, and their validations cross-culturally. This represents Stage 2 of the research process (How can it be measured?; Figure 1.1), explored through the research question:

- What current tools are available to measure childhood exposure to domestic violence and abuse?
- Can existing measures of childhood exposure to domestic violence and abuse be used to obtain global estimates on the scale of exposure?

Objective 3 (Paper Two; Chapter 5): The third aim directly follows the second, seeking to explore the prevalence of childhood exposure to DVA across ten LMICs, and highlighting groups within the population that are more likely to be exposed to DVA. It does this by examining prevalence rates and looking at risk factors associated with exposure to DVA at the ecological domains of individual level factors, family level factors, and community and society level factors. This represents Stage 3 of the research process (Who is Affected?; Figure 1.1), explored through the research question:

- What is the prevalence of, and risk factors associated with, childhood exposure to domestic violence and abuse across selected low- and middle-income countries?

Objective 4 (Paper Three; Chapter 6): This thesis's penultimate aim builds upon the previous chapter's work, to explore the mental health outcomes of those exposed to DVA in LMICs across ten LMICs. Whilst mental health outcomes have been explored previously in HICs, it is essential to also examine them in the LMIC context, and this paper focuses on internalising and externalising symptoms. This stage is particularly important so that the outcomes of childhood exposure to DVA can be understood, so that policy and practice can be better informed to support those affected. This represents Stage 4 of the research process (How are People Affected?; Figure 1.1), explored through the research question:

- How does childhood exposure to domestic violence and abuse influence mental health during adolescence and adulthood within LMICs?

Objective 5 (Paper Four; Chapter 7): The final aim of this thesis is to assess current awareness of, and what is being done to help children exposed to DVA in one LMIC, Nepal. In addition, it aims to explore the changes that need to be made to better support children exposed to DVA. This represents Stage 5 of the research process (What is Being Done?; Figure 1.1), explored through the research question:

- What are the barriers and facilitators to implementing public health interventions for children exposed to domestic violence in Nepal?³

Addressing each of these research objectives will contribute towards the central aim of the thesis: to enhance and develop our knowledge and understanding of childhood exposure to domestic violence and abuse in low- and middle-income countries. The following section details the overview of this thesis and how each of these objectives will be addressed.

1.4 Thesis Outline

This thesis is entitled Childhood Exposure to Domestic Violence and Abuse in Low- and Middle-Income Countries and consists of eight chapters. It includes four standalone papers (Chapters 4, 5, 6, and 7), and follows the University of Southampton's Research Paper PhD Thesis guidelines⁴.

The first three chapters of this thesis comprise of introductory material. Chapter 1 briefly sets this research in context, details the main research objectives pursued, and provides an

³ It is important to note that whilst this was the aim of the thesis, this focus developed throughout the research process. This is reflected on within Paper Four (Chapter 7).

⁴ <https://www.southampton.ac.uk/~assets/doc/quality-handbook/Submission%20of%20a%20Research%20Paper%20PhD%20Thesis%20-%20Guidance.pdf>

overview of the structure of the thesis. It also details the process followed for conducting research in an under-researched area. Chapter 2 and Chapter 3 then lay out the theoretical and empirical underpinnings of the four research papers presented subsequently. Chapter 2 provides a review of existing literature which considers the current state of understanding for childhood exposure to DVA within LMICs, and identifies where further research is required. This chapter also explains the motivation for selecting LMICs as the case for exploration, along with mental health as the focused outcome of exposure to DVA. Chapter 3 then outlines how existing data can be used as a first step to address some of the gaps in our understanding which were highlighted in Chapter 2, and makes an argument that is prevalent throughout this thesis – that further, better data is required to adequately understand, monitor, and improve the issue of childhood exposure to DVA in LMICs.

Chapter 4, Chapter 5, Chapter 6, and Chapter 7 present four distinct but linked empirical research papers which comprise the core of this thesis. Chapter 4 (Paper One⁵) uses the COSMIN PROMs approach (Prinsen et al., 2018) to critically appraise and compare current measures of childhood exposure to DVA, exploring whether global estimates on the scale of exposure can be obtained using these existing measures. The findings of Paper One – which indicates that the current measures to explore the extent of the issue are not validated cross-culturally, leading to concerns about comparisons across different population groups – demonstrate that an accepted standardised measure for childhood exposure to DVA is required, so that accurate figures on the scale of the issue can be obtained. This informs the central research objective of the second paper of this thesis.

Chapter 5 (Paper Two) is a quantitative paper which seeks to understand the prevalence of, and risk factors associated with, childhood exposure to DVA within LMICs. It does this through secondary data analysis of the Violence Against Children Surveys (VACS, Chiang et al., 2016). After identifying respondents who have been exposed to DVA, bivariate analyses was conducted to gain prevalence rates of exposure to DVA across ten LMICs, followed by exploration of risk factors associated with exposure, grouped by the ecological domains of individual, family, and community and society. Logistic regression analysis was then conducted, followed by a probability scale, to provide further insight into what makes a child more likely to be exposed to DVA in LMICs. Its findings indicate that a much higher number of children have been exposed to DVA in LMICs than previously thought, with females having a higher probability of childhood exposure to DVA in eight of the ten countries, and the ecological domain of community and

⁵ Paper One, 'Childhood exposure to domestic violence and abuse: can global estimates on the scale of exposure be obtained using existing measures?', is published in *Frontiers in Public Health – Children and Health, Special Issue Domestic Violence and Abuse: Increasing Global and Intersectional Understanding*. See Harris, Morgan, and Channon (2024).

society was most significantly associated with exposure to DVA perpetrated in the home, suggesting that this is where future research, policies, and interventions should focus.

Chapter 6 (Paper Three) builds explicitly on Chapter 5, by investigating the mental health outcomes of children exposed to DVA within ten LMICs, utilising the VACS. Bivariate analyses and logistic regression modelling were applied to explore internalising symptoms (psychological distress, intentional physical self-harm, and suicidal thoughts), and externalising behaviours (risky behaviours, perpetration of DVA, and perpetration of non-partnered violence). Bivariate analysis revealed that respondents who had been exposed to DVA perpetrated by caregivers or adults in the household in childhood experienced adverse mental health in all of the outcomes explored. In addition to this, those exposed to DVA had a much higher probability of experiencing psychological distress across all ten LMICs compared to those not exposed to DVA perpetrated in their home, and associations were also found for some countries between those who had been exposed to DVA as a child and those who experienced suicidal thoughts, engaged in risky behaviours, perpetrated DVA, and perpetrated non-partnered violence. This indicates that those who have been exposed to DVA as a child within LMICs are at a higher risk of poorer mental health outcomes, in line with literature conducted in HICs. This strengthens the argument for childhood exposure to DVA within LMICs to be placed higher on the research and policy agenda, and further evidences the need for better data to be developed to capture the prevalence of this issue (and the prevalence of its adverse effects) on a global scale, so that appropriate interventions can be developed.

Chapter 7 (Paper Four) explores the understanding of the previous chapters among policymakers and professionals working within the sphere of DVA and child protection services within an LMIC, Nepal. Through in-depth interviews conducted with 21 experts, it investigates the current awareness and understanding of childhood exposure to DVA and explores what is currently being done and what improvements can be made to better protect and support children in Nepal. Through thematic analysis, it reveals a lack of clarity and comprehensive understanding of childhood exposure to DVA amongst professionals and policymakers, where childhood exposure to DVA is often conflated with other forms of violence, such as child abuse. This misunderstanding means that childhood exposure to DVA is not considered a priority area within Nepal, and most likely in other LMICs where other issues are considered more important. The existing support structures for children are not exposure specific and whilst valuable, they are insufficient and poorly coordinated, and significant barriers at all ecological domains exist which prevent children from accessing the support they need. The findings of this paper underscore the need for more comprehensive and sustainable strategies to address childhood exposure to DVA in Nepal, which are child-centric, collaborative, and centred around education – both for policymakers and professionals and for children. Stakeholders cannot effectively

prioritise policy areas if they do not have knowledge about an issue. Therefore, education and sharing knowledge on exposure to DVA within LMICs is essential, which this thesis aims to do.

The final chapter of this thesis (Chapter 8) serves as a discussion and conclusion. It summarises the novel insights provided by the papers presented in Chapters 4-7, considers how these findings relate to existing literature, and details how advancing our understanding of childhood exposure to DVA in LMICs makes contributions both within academia and beyond. Chapter 8 also considers the limitations of the research presented in this thesis and suggests future research that must be pursued if we are to gain a fuller understanding of childhood exposure to domestic violence in low- and middle-income countries. Finally, it offers a succinct conclusion derived from the overall PhD thesis.

Chapter 2 Current Understanding of Childhood

Exposure to Domestic Violence and Abuse in LMICs

This chapter provides an overview of the existing literature on childhood exposure to domestic violence and abuse (DVA) in low- and middle-income countries (LMICs). This is an important stage in the research process (Figure 1.1), as it aids in defining the concept and understanding the current available evidence on the topic.

This chapter will start with defining DVA and exposure to DVA, and then follow the stages highlighted in Section 1.2 that should be addressed when conducting research on an emerging research area. Therefore, it will focus on four main areas: measuring exposure to DVA in a global context, risk factors for exposure to DVA, outcomes of exposure to DVA, and public health and policy responses to exposure.

2.1 Domestic Violence and Abuse (DVA)

To understand the concept of exposure, it is important to first consider that of Domestic Violence and Abuse (DVA). Domestic violence and abuse is defined as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour (Women's Aid, 2018). In the majority of cases, this is inflicted by a partner or ex-partner, but it can also be by a family member or carer (World Health Organization, 2021). This violence can be physical, sexual, emotional, or psychological, as well as involving violence such as economic coercion⁶ (Ellsberg & Heise, 2005; United Nations, 2023). Whilst domestic violence commonly refers to violence within the home between caregivers, in some countries and studies, child or elder abuse, or abuse by any member of a household is also considered domestic violence (World Health Organization & Pan American Health Organization, 2012).

The term 'domestic violence and abuse' is one which is often used interchangeably with terms such as 'intimate partner violence', 'marital violence', 'spousal abuse', 'interparental violence', 'domestic abuse', 'domestic violence', and is encompassed in other terms such as 'family violence' and 'interpersonal violence'. Much of the early research was focused exclusively on male-perpetrated violence within the home towards females, and so terms such as 'wife

⁶ Examples of physical aggression include slapping, hitting, shaking, kicking, burning, or threatening someone with a dangerous object, such as a knife; sexual abuse includes coerced sex through threats or intimidation or through physical force, forcing unwanted sexual acts, forcing sex in front of others, and forcing sex with others (UNICEF, 2006). Finally, emotional and psychological violence involves acts such as humiliation, intimidation, excessive jealousy, control of a victim's activities, verbal aggression, constant belittling and humiliation, and behaviours such as stalking or isolating a victim from friends or family (Evans, Davies, & DiLillo, 2008; United Nations, 2023).

battering' and 'wife abuse' are also common within early literature (Wolak & Finkelhor, 1998). For this thesis, the term domestic violence and abuse (DVA) will be used, as this is more inclusive than other terminology which is often used interchangeably (e.g., 'intimate partner violence' or 'marital violence'), and encompasses all forms of violence perpetrated between adult members of a home which a child could be exposed to. This includes the forms of violence noted above but also includes violence perpetrated by women, bidirectional acts of violence between caregivers, violence between unmarried partners, and violence in same-sex relationships, amongst other forms. It is important to note that DVA is always violence between adults – if a child is the direct victim of violence or abuse, then the term which instead should be used is child abuse (World Health Organization, 2020; Crown Prosecution Service, 2023).

Globally, it is estimated that 30% of women aged 15 and older have experienced physical and/or sexual violence, intimate partner violence, non-partner sexual violence, or both at least once in their life (UN Women, 2023). The 2018 violence against women prevalence estimates revealed that more than 640 million, or 26% of women aged 15 and older, have been subjected to intimate partner violence (World Health Organization, 2021). This statistic is based on analysis of existing data from over 80 countries, and prevalence estimates ranged across regions, from 23.2% in high-income countries and 24.6% in the World Health Organization (WHO) Western Pacific Region, to 37% in the WHO Eastern Mediterranean region, and 37.7% in the WHO South-East Asia region. These figures equate to 243 million women aged 15-49 worldwide⁷ (UN Women, 2020); although this statistic is based upon a relatively narrow age range, and when including older adults, these numbers are likely to be much higher when a broader age range is considered⁸ (Stöckl & Penhale, 2015). It is important to acknowledge that should the analysis be conducted on population-level surveys today, these figures could be higher due to the 'shadow pandemic' – a term coined by UN Women to describe the increase in domestic violence cases

⁷ 15-49 is the age range commonly used in statistics for IPV and DVA, as this is used to indicate women of reproductive age (World Health Organization, 2024a). Many international surveys, such as the Demographic and Health Surveys (DHS) and Multiple Indicator Cluster Surveys (MICS), only interview women within this age range on topics such as DVA, as it captures the period that women are at greatest risk of DVA victimisation (Yakubovich et al., 2018). This is also the age range stated in the SDGs, as to monitor progress on achieving the SDG Target 5.2, the indicator 5.2.1 asks governments to report on the "proportion of ever-partnered women and girls aged 15-49 years subjected to physical and/or sexual violence by a current or former intimate partner in the previous 12 months" (World Health Organization, 2024b). Whilst the focus on women aged 15-49 is justified given the heightened risk of DVA during this period, expanding the demographic scope to include older women and those outside of reproductive age could provide a more comprehensive understanding of DVA and its prevalence and impact globally.

⁸ This idea of age ranges is an important consideration throughout the literature on this topic, as different studies have based their research on varied age ranges, as well as some studies only considering DVA which is male perpetrated, as previously mentioned. Measures of the prevalence of DVA can differ significantly depending on age ranges, the definitions of DVA, and the measures used (Evans et al., 2008). This makes it difficult to compare the incidence of DVA across studies, and across different countries. Issues such as gender bias and underreporting are also important considerations that could affect the reporting of DVA (Aziz, Idris, Ishak, Wahid, & Abu Yazid, 2019).

reported globally in response to countries entering lockdown as part of their coronavirus response in 2020.

2.2 Childhood Exposure to Domestic Violence and Abuse

The concept of exposure to DVA is a relatively new phenomenon when considered within the broader research area of DVA (Holden, 2003). Earlier researchers often describe the child or adolescent as an ‘observer’ or ‘witness’, but more recent research has adopted the term ‘exposed’, as this is more inclusive and does not assume that the individual directly observed the violence whilst it was happening (Holt, Buckley, & Whelan, 2008). In Article 1 of the Convention on the Rights of the Child, a child is defined as “every human being below the age of eighteen years unless under the law applicable to the child, majority is attained earlier” (United Nations Human Rights Office of the High Commissioner, 1990). In some countries, such as the United Kingdom, Australia and some US States, child exposure to DVA is considered a form of child maltreatment (Higgins, Bromfield, Richardson, Holzer, & Berlyn, 2009; National Society for the Prevention of Cruelty to Children, 2020), as the child is living in a psychologically abusive, physiologically arousing, emotionally distressing, and often trauma inducing environment (Graham-Bermann & Brescoll, 2000; Henry, 2018). In 2021, the United Kingdom passed the Domestic Abuse Act, which amongst other measures, recognises children who see, hear, or experience the effects of DVA perpetrated between adults in the home as victims in their own right “if they are related or have a parental relationship to the adult victim or perpetrator of abuse” (Home Office & Ministry of Justice, 2021). This demonstrates a shift in the narrative and understanding of DVA, with children being seen as primary victims of DVA perpetrated within the home, when previously they were secondary, often with the focus on women (usually their mother or primary caregiver). The use of the word ‘experienced’ within the UK’s Domestic Abuse Act (2021) demonstrates the start of a change in terminology within the UK and could perhaps be considered more child-centric when exploring the topic of exposure to DVA – a form of violence which is always between adults. However, within this thesis, the term exposure/exposed will be used to reflect the majority of policies and literature surrounding this topic, and to avoid confusion when talking about exposure to DVA versus experience of child abuse.

Despite exposure to DVA being an extraordinarily prevalent and vital issue, several methodological limitations hinder the research into this area. Exposure to DVA is not a dichotomous concept of whether or not a child has witnessed or overheard violence, and within the literature, there are varying thresholds researchers use to consider a victim ‘exposed’ (Holden, 2003), with many studies failing to provide descriptions of the nature of the victim’s

‘exposure’ within their methodologies (Mohr, Noone Lutz, Fantuzzo, & Perry, 2000). Factors such as the frequency, duration, severity of violence, and type of exposure (i.e., saw a violent act perpetrated by one adult against another, heard about it from another room, or learned about it later), all have the potential to influence classification, along with the timeframe in which they were exposed (Evans et al., 2008). Whilst there is a lack of standardisation in research concerning what constitutes exposure to DVA, the most widely used definition is that a person is considered to be exposed to DVA if they visually observe, overhear, is directly involved in (i.e., attempting to intervene), or witnesses the effects (i.e., seeing injuries or emergency services involved) of violent acts perpetrated by one adult or caregiver against another within their home (Evans et al., 2008).

Holden (2003) examined qualitative reports from children and mothers and proposed a taxonomy of 10 types of exposure to DVA, ranging from being actively involved in the violent incident, to observing the initial effects, to being ostensibly unaware of it. The first six categories reflect some type of direct involvement with the violent incident, whereas the last four categories concern some type of indirect exposure to the incident. Further information on his categories of exposure can be seen in Table 2.1. Whilst having these categories is helpful when considering how exposure to DVA can manifest in different ways, it is likely that children can and will experience multiple categories of exposure (e.g., seeing an assault, and then the injuries caused), and so at least some of these categories may co-occur – a potential issue when classifying types of exposure to DVA using Holden’s (2003) taxonomy. Holden’s taxonomy also specifies a child’s mother as the victim, which could be considered a limitation. However, the types and examples of exposure can be applied to any adult victim when using it to explore the topic of exposure to DVA.

Table 2.1 A taxonomy of children's exposure to domestic violence and abuse (Holden, 2003)

Type of Exposure	Definition	Examples
Exposed prenatally	Real or imagined effects of DVA on the developing foetus	Foetus assaulted in utero; pregnant mother lived in terror; mothers perceived that the DVA during pregnancy had affected their foetus
Intervenes	The child verbally or physically attempts to stop the assault	Asks parents to stop; attempts to defend mother
Victimised	The child is verbally or physically assaulted during an incident	Child intentionally injured, accidentally hit by a thrown object, etc
Participates	The child is forced or “voluntarily” joins in the assaults	Coerced to participate; used as spy; joins in taunting mother
Eyewitness	The child directly observes the assault	Watches assault or is present to hear verbal abuse
Overhears	The child hears, though does not see, the assault	Hears yelling, threats, or breaking of objects
Observes the initial effects	The child sees some of the immediate consequences of the assault	Sees bruises or injuries; police; ambulance; damaged property; intense emotions
Experiences the aftermath	The child faces changes in his/her life as a consequence of the assault	Experiences maternal depression; change in parenting; separation from father; relocation
Hears about it	The child is told or overhears conversations about the assault	Learns of the assault from mother, sibling, relative, or someone else
Ostensibly unaware	The child does not know of the assault, according to the source	Assault occurred away from home or while children were away; or occurred when mother believed child was asleep

Within this thesis, all ten forms of Holden’s (2003) Taxonomy of Exposure are being considered under the phrase ‘exposure to domestic violence and abuse’, except “victimised”, where this would instead be considered child abuse, as it involves direct violence and abuse from an adult to a child (World Health Organization, 2022)⁹.

The most recent global estimates indicate that nearly 300 million children are exposed to domestic violence and abuse (DVA) perpetrated by adults in the home worldwide. However, only between 4.6 and 11.3 million of these children reside in high-income countries (HICs), suggesting a significantly higher number in low- and middle-income countries (LMICs¹⁰)

⁹ This demonstrates how violence against women and violence against children are often interlinked.

¹⁰ The World Bank classifies countries based on their gross national income (GNI) per capita, and LMICs are those with a GNI per capita between \$1,046 and \$12,535 (Hamadeh, Van Romaey, Metreau & Eapen, 2022). These countries face unique challenges in terms of economic development, healthcare, education, and infrastructure. The classification of LMICs is vital for international development efforts, as it helps to target resources and aid to countries that need them the most. Additionally, understanding the specific characteristics and needs of LMICs is crucial for designing effective policies and interventions to support their development. The number of LMICs varies, but it is generally understood that around 130 to 150 countries are classified as LMICs by the World Bank.

(UNICEF, 2006). Whilst the available literature indicates that children in LMICs may be more likely to be exposed to DVA compared to those in HICs (an issue discussed further in Chapter 5, Paper Two), there is a distinct lack of evidence on this topic in LMICs, with the majority of the research being conducted in HICs. This includes information on measuring exposure, identifying risk factors for exposure, and understanding the outcomes of exposure to DVA. Due to the multitude of research gaps, this thesis will focus on childhood exposure to DVA within LMICs, discussing each aspect in detail throughout this thesis.

2.3 Measuring Childhood Exposure to Domestic Violence and Abuse

Perhaps a primary reason why there is no set way of defining and assessing exposure to domestic violence is that the standardised options for measuring exposure are limited in both number and application. Chapter 4 (Paper One) explores this in more detail, along with whether the current scales are fit for purpose when obtaining global estimates of childhood exposure to DVA. This links to the first step of addressing an emerging research topic (Figure 1.1), where the definition and context of the issue needs to be set, along with exploring the scale and the scope. To understand the issue, not only is an accepted definition of both exposure and DVA needed, but the issue also needs to be measured consistently and accurately. However, to date, no globally accepted validated scale exists for childhood exposure to DVA, as many have not been conducted in LMICs. Alongside this, several limitations also exist when measuring exposure to DVA.

2.3.1 General Limitations of Measuring Childhood Exposure to DVA

Along with the difficulty and inconsistencies amongst studies to define exposure to DVA, there are also a number of methodological issues when measuring it. Due to the sensitive nature of the research topic, and fear of the perpetrator, DVA is an area which is often underreported (Ellsberg, Heise, Pena, Agurto, & Winkvist, 2001). This can be due to personal reasons (such as embarrassment, fear of retaliation, or economic dependency) and societal reasons, including imbalanced power relations for men and women in society, the privacy of the family, and victim-blaming attitudes (Gracia, 2004). When considering childhood exposure to DVA, underreporting is even more of an issue, particularly in countries where exposure to DVA is regarded as a form of child maltreatment, as caregivers are fearful of legal consequences (Kantor & Little, 2003).

Underreporting can also occur when reliance is placed on parental reports, as the adult victim of the assaults (the caregiver) may believe that their child is unaware of the DVA perpetrated. This could be due to the mother trying to shield their child from the violence perpetrated against her, or because the child has deceived the mother and either pretended to be asleep or hidden

to protect themselves from harm (DeVoe & Smith, 2002). A child can also underreport when questioned about violence in their home, whether it be due to a lack of understanding of either the questions or what constitutes a ‘normal’ family dynamic, or because of fear of getting either themselves or their caregivers in trouble (Ericksen & Henderson, 1992). In comparison, asking adults to report their own exposure to DVA as a child retrospectively could also incur issues with recall, a finding in some studies looking at childhood maltreatment and abuse (Femina, Yeager & Lewis, 1990; Newbury et al., 2018). These issues are commonly raised in discussions regarding existing scales.

A common critique of research on exposure to DVA is that it is often based on a narrow range of samples but a diverse range of assessments (Clements, Oxtoby & Ogle, 2008). In particular, studies are usually conducted using a sample taken from shelters for women and children seeking refuge from DVA (Wolfe, Crooks, Lee, McIntyre-Smith, & Jaffe, 2003), where it is sometimes assumed that children residing there have been exposed to DVA, rather than the researchers directly assessing levels of exposure (Kashani & Allan, 1998). It has also been argued that the findings of studies conducted using a sample of children residing in DVA shelters may not be generalisable to the population of children, as they may have been exposed to a more severe or extreme level of violence (McIntosh, 2003). In addition, most scales have been trialled on children over the age of five, despite exposure to DVA having reported outcomes on children much younger, even prenatally (Holden, 2003).

Finally, much of the research investigating childhood exposure to DVA on a larger scale does not use a set questionnaire or method of measurement; instead, choosing to involve specific questions about exposure to DVA within a larger, more extensive questionnaire. Examples of these surveys include the UN Multi-Country Study on Men and Violence in Asia and the South Pacific (UNMCS; Fulu, Jewkes, Roselli & Garcia-Moreno, 2013) and the Violence Against Children Surveys (VACS; Chiang et al., 2016). In recent years, a question relating to exposure within the Demographic Health Surveys has also occasionally been asked, which asks respondents, “DV26 As far as you know, did your father ever beat your mother?” (The DHS Program, 2021a). However, the module in which this question is contained is optional and, therefore, not asked each time the surveys are completed. Consequently, it is difficult to monitor the numbers of children exposed to DVA and use these to guide where appropriate interventions should be developed. In addition to this, if this optional module is selected to be asked within a country, one woman is randomly selected per household among all eligible women (those who are currently, or have, been married, or lived with a man as if they were married) to complete it (The DHS Program, 2021b). The question on exposure to DVA also has a very narrow definition of DVA, specifying if their father beat their mother (a particular perpetrator/victim relationship, and only asking about physical violence). However, the

exposure stated is not specific, as opposed to specifying a type of exposure (such as witnessing), meaning that it could apply to multiple types according to Holden's Taxonomy of Exposure (Holden, 2003). This again highlights a need for definitions of both DVA and exposure to be identified and incorporated into a scale so that global statistics can be obtained.

Whilst these are general methodological issues, an accepted standardised scale for measuring types and levels of exposure to DVA would undoubtedly allow for a more effective and empirically sound comparison of results across a wider range of samples, providing a more accurate estimate of both the number of children exposed to DVA globally, along with who is more likely to be exposed – something which is currently lacking in existing literature. Chapter 4 (Paper One) discusses these points in further detail.

2.4 Global Estimates of Childhood Exposure to DVA

As previously mentioned, a significant limitation in this area of research is that there is a lack of studies measuring exposure to DVA in LMICs, with the majority of the data and evidence collected in HICs. The most recent global data on exposure to DVA was conducted in 2006¹¹, when it was estimated that between 133 and 275 million children were exposed worldwide (UNICEF, 2006), with a significantly higher number of children estimated to be exposed in LMICs compared to HICs. Figure 2.1 highlights this, showing exposure estimates by Millenium Development Goal (MDG) region¹², along with the fact that there is currently no estimate for the regions of Northern Africa or South-Eastern Asia (which is a factor in why there is such a wide-ranging overall estimate (UNICEF, 2006). Higher estimates for the number of children exposed to DVA within these regions could be due to several factors, such as cross-cultural variations in living conditions, a lower socioeconomic level (where physical violence is often found to be higher), and there being a higher level of violence in society, which is often seen reflected at a household level (Wright, Fagan, & Crittenden, 2011).

¹¹ These estimates were obtained through reviewing existing studies that measure violence in the home in various countries and did not use a standardised tool. This therefore may have led to under or over-reporting, and the estimates may not be accurate (UNICEF, 2006).

¹² As these figures were produced prior to the introduction of the 2015 Sustainable Development Goals (SDGs), Millenium Development Goal regions are instead used (UNICEF, 2006). Within the SDG regions, Northern Africa is now grouped with Western Asia and South-Eastern Asia with Eastern Asia (UN Stats, 2015). Despite SDG regions now being used to monitor progress against the goals, this thesis will continue to refer to MDG regions to allow for better comparability, as these are the only global estimates of exposure to DVA available.

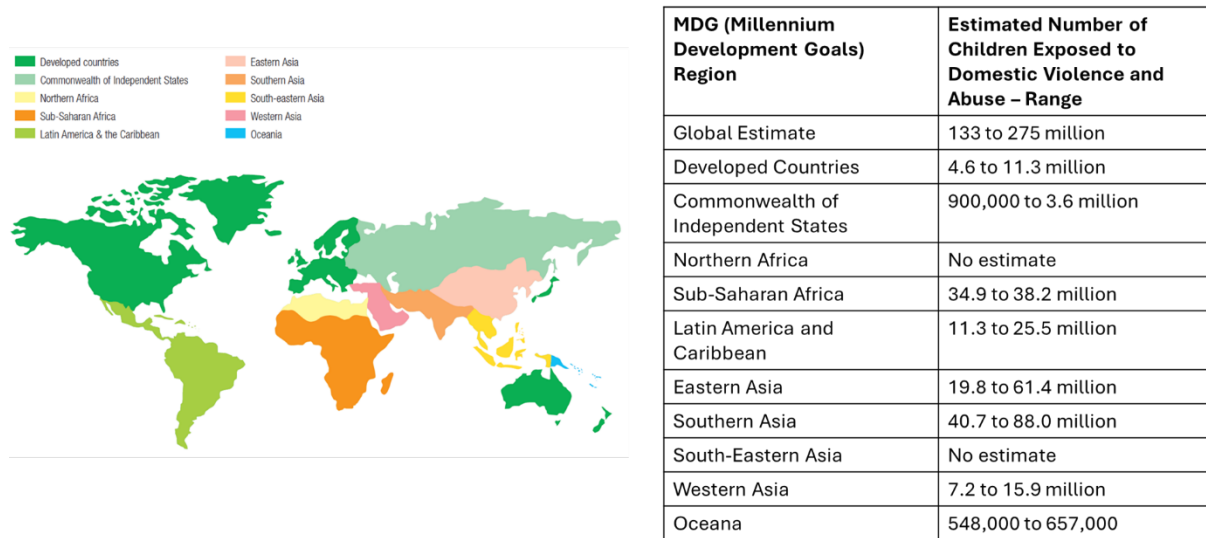


Figure 2.1 Regional estimates of the number of children exposed to domestic violence and abuse by Millennium Development Goal Region (UNICEF, 2006)

While there are no recent global estimates available, any updated figures on childhood exposure to DVA using recent country-level data are likely to be higher. This increase can be attributed to the rise in DVA reported worldwide during the 'shadow pandemic' (of DVA) caused by COVID-19 lockdowns (UN Women, 2020; World Health Organization, 2020). A 2020 report from the United Nations Population Fund (UNFPA) stated that the pandemic could lead to an additional 31 million cases of gender-based violence globally if lockdowns persisted for six months, and for every three months that the lockdown continues, an additional 15 million additional cases were expected (UNFPA, 2020). Factors such as increased stress, disruption of social and protective networks, school closures, movement restrictions, economic insecurity, and reduced access to services can all exacerbate the risk of violence against women and subsequently increase a child's likelihood of being exposed to DVA (World Health Organization, 2020). This correlation has been supported by studies conducted since the pandemic began (Bradbury-Jones & Isham, 2020; Ertan et al., 2020; Kourti et al., 2021; Piquero et al., 2021).

In a report released in April 2020, UN Women stated that in France, cases of DVA increased by 30% since the country went into lockdown, helplines in Cyprus and Singapore registered an increase in calls by 30% and 33%, respectively, and in Argentina, emergency calls for DVA cases increased by 25%. They also reported that Canada, Germany, Spain, the United Kingdom, and the United States all had increased reports of DVA during the crisis, and/or increased demand for emergency shelter (UN Women, 2020). These statistics demonstrate that DVA is a prevalent issue worldwide, and that the pandemic and effects of mandatory lockdown (i.e., loss of jobs, financial strain, uncertainty, and more time spent in the home) appear to have exacerbated the

issue, with many victims unable to seek refuge elsewhere (Godin, 2020). Some studies found that lockdowns intensified the risks faced by individuals already experiencing violence, leading to more severe violence, new challenges in coping with violent situations, and additional forms of harm, including threats that exploited the lockdown to undermine victims' safety and ability to protect themselves from the virus (Fawole, Okedare & Reed, 2021). Closures of schools around the globe to deter the spread of the virus also meant that children were less able to remove themselves from situations where violence may occur, and so their chances of exposure to DVA were likely to have increased. This demonstrates the extent of this issue and the importance of developing interventions for those children exposed, as the number of children who have been exposed to DVA perpetrated by adults in the home is likely to have risen in recent years. However, there are no updated statistics available to evidence this. Childhood exposure to DVA and obtaining global estimates are, therefore, urgent research priorities.

2.5 Factors Associated with Childhood Exposure to DVA

2.5.1 Risk Factors for Childhood Exposure to DVA

Alongside the lack of data on prevalence rates, there is also a knowledge gap in what factors place a child at an increased risk of being exposed to DVA, particularly within LMICs. It is difficult to know who is affected by exposure to DVA if we do not have accurate statistics on the extent of the issue. Understanding who is affected by a phenomenon or issue is an essential part of the research process (Figure 1.1) and vital to understand when developing interventions and improving outcomes for affected children. In general, the literature on risk factors for childhood exposure to DVA is lacking. Much of the literature instead looks at what makes a parent more likely to be a victim of DVA and what makes a child more likely to be at home.

While limited research focuses on risk factors for childhood exposure to DVA, many studies provide insights into the broader community, societal, and country-level factors that can contribute to DVA, thus increasing the potential for a child to be exposed. Despite the majority of research being conducted in HICs, several factors could mean that children are more likely to be exposed to DVA in LMICs, as seen in the most recent global statistics (Figure 2.1; UNICEF, 2006). The socioeconomic status of a country, along with poverty and economic inequality, has been linked to higher rates of DVA. Research suggests that the prevalence of DVA in LMICs is generally higher than in HICs (Keynejad et al., 2020). Additionally, there is evidence to suggest that children in LMICs may spend more time at home compared to children in high-income countries (Grantham-McGregor et al., 2007), meaning that if violence were to be perpetrated in

their home, they are at an increased risk of exposure. This is explored in more detail in Paper Two (Chapter 5).

One such study suggests that characteristics such as concentrated disadvantages, low social cohesion, residential instability, and high levels of poverty and unemployment can increase the risk of DVA. These factors may create an environment that is conducive to violence and can potentially impact children's exposure to DVA (Gracia et al., 2018). This supports social disorganization theory (Shaw & McKay, 1942), which argues that concentrated neighbourhood violence and violence in the community are linked to higher levels of violence in the home. According to this theory, when a community lacks social control mechanisms and has weakened social bonds, it becomes more susceptible to criminal activities, including DVA. The theory suggests that there is a breakdown of informal social control in socially disorganized neighbourhoods, resulting in a higher likelihood of DVA. Factors such as poverty, unemployment, residential mobility, and a lack of community resources can contribute to the disorganization of social structures and weaken the ability of community members to intervene and prevent DVA. Research, such as the study by McDowell and Reinhard (2022), has explored the link between social disorganization theory and DVA. This study examines the geographic distribution of intimate partner violence and its association with community characteristics. The findings suggest that neighbourhoods with higher levels of social disorganization are more likely to have higher rates of DVA. This is supported by numerous studies, such as Kim et al. (2012), who found that poverty, crime rates, and social interactions among residents, along with a lack of green spaces, can influence the occurrence of DVA. Similarly, the prevalence of violence in the community, society or country is another factor which can increase a child's likelihood of being exposed to DVA. If DVA is more common and accepted within a society, it increases the likelihood that children will be exposed to such violence (Malik, 2008; Lourenço et al., 2013). This can be attributed to the fact that exposure to violence becomes normalised in such communities, increasing the likelihood of DVA occurring within households (Malik, 2008). This idea is one that is common in Papers Two, Three, and Four in this thesis.

Cultural norms and attitudes towards gender roles and violence can influence the prevalence of DVA within a society (Lourenço et al., 2013). For example, in societies where patriarchal norms are prevalent, there may be a higher acceptance of DVA and a belief that it is acceptable for men to exert control over women, which can perpetuate and normalise abusive behaviours perpetrated within relationships (Koenig et al., 2003), therefore increasing the likelihood of children being exposed to DVA perpetrated within the household. In addition to this, societal beliefs and values can contribute to the stigma and shame associated with being a victim of DVA (regardless of gender, but perhaps with an increased stigma for male victims). Victims may fear judgment, blame, or social isolation if they disclose their experiences, preventing them

from seeking help or reporting the abuse, which can lead to a higher prevalence of DVA (Mshweshwe, 2020), but also increased underreporting. Gender inequality, national values, and societal beliefs can influence the level of awareness and understanding of DVA (Caprioli, 2005). In societies where there is limited awareness or education about the dynamics of abuse, victims may not recognise their experiences as DVA (Mshweshwe, 2020), and this lack of awareness can contribute to the perpetuation of abusive behaviours whilst hindering efforts to address the issue effectively. These cultural factors can shape attitudes and behaviours related to DVA, increasing the likelihood that children are exposed to such violence (Kim et al., 2012).

Many of these community and societal level risk factors will be explored in Chapter 5 (Paper Two), which looks at the prevalence and risk factors associated with childhood exposure to DVA in ten LMICs. Alongside these community and societal level risk factors, it also looks at individual level risk factors, and family level risk factors. This introduces the idea of ‘ecological domains’¹³ – a concept common across three of the four papers of this research paper thesis and can be found in the conceptual frameworks for Paper Two and Paper Three (Chapter 5 and Chapter 6). These frameworks illustrate how factors within wider society feed down into a community, which then feeds into a family, and to an individual, in a similar way to how other ecological models explore health and behaviours, such as Bronfenbrenner (1979), and is akin to the Dahlgren-Whitehead rainbow, which demonstrates how wider factors filter through to individual characteristics (Dahlgren & Whitehead, 1991).

2.5.2 Co-occurrence of Childhood Exposure to DVA and Maltreatment

A vital consideration in this area of research is the likelihood that someone who has been exposed to DVA may have also been the victim of violence themselves (‘co-occurring maltreatment’). Hamby, Finkelhor, Turner and Ormrod (2010) found a close association between a child witnessing violence perpetrated between caregivers or other adults in the home and child maltreatment (a term encompassing physical abuse, psychological abuse, sexual abuse, neglect, and custodial interference). In their study, which had a sample of 4,549 American children aged between 0 and 17, they found that 33.9% of the children and adolescents who had witnessed DVA had also experienced maltreatment in the past year (compared to 8.6% of non-witnesses), a statistic which rose to 56.8% when considered over their lifetime. The use of the term witness rather than expose again highlights the difficulties with measuring exposure to DVA and gaining accurate and comparable statistics, and actual

¹³ The ecological domains within this thesis represent differences in scale, i.e., geographical/proximal categories. It considers geographical communities as opposed to interest communities (Poplin, 1979), and society is also considered in a geographical context, meaning wider (i.e., country-level) factors.

figures may be higher when considering all ten categories of Holden's (2003) Taxonomy of Exposure.

This increased risk between exposure to DVA and being a direct victim of child abuse is supported by numerous studies, with one in North America finding that children who were exposed to DVA were 15 times more likely to be physically and/or sexually assaulted than the national average (McKay, 1994). Similar statistics have been found in studies from a range of countries, including China, South Africa, Colombia, India, Egypt, the Philippines, and Mexico (Krug et al., 2002). This co-occurrence of exposure to DVA with child maltreatment could mean that, in some reports, it may be challenging to separate exposure to DVA from those who have experienced violence themselves. Therefore, it may be difficult to state that any effects are purely due to exposure (Osofsky, 2003).

The frequent co-occurrence of DVA and child abuse has prompted researchers to consider why this may be. They firstly argue that perpetrators may not discriminate between different family members and so may be violent towards both other adults and children in the household; secondly, adult victims of DVA may not be able to meet the physical, emotional or supervisory needs of their children as a result of physical injury and/or poor mental health (as a result of being a victim of DVA), and finally, children who are exposed to DVA may try to intervene, and be injured by the perpetrator in the process (Devaney, 2015; Holden, 2003). The household environment in which a child grows up could also mean that the violence is more widespread due to factors such as family dysfunction and community violence, and perpetrators of violence could become victims themselves, contributing to this co-occurrence (Devaney, 2015; Finkelhor et al., 2005).

Similarly, exposure to multiple adverse childhood experiences (ACEs; Felitti et al., 1998) has been cited as being a factor associated with childhood exposure to DVA. Witnessing DVA is considered an ACE, as it is considered a stressful or traumatic event which affects a child through the environment in which they live (National Center for Injury Prevention and Control, 2022). Palermo et al. (2019) used the Violence Against Children Surveys (Chiang et al., 2016) to examine risk factors for childhood violence and polyvictimization in Cambodia, Kenya, Haiti, Malawi, Tanzania, and Nigeria. They found that those who had been victims of emotional, physical, or sexual violence were more likely to have also witnessed both DVA and violence in the community prior to the age of 18. This is a finding consistent across other studies. For example, Hamby, Finkelhor and Turner (2012) found that children in the United States who witnessed violence in their family home were more likely to be physically abused by a dating partner, along with being more likely to have suffered abuse as a child, or been a victim of sexual

assault. This demonstrates that this is a factor associated with exposure to DVA, which is common in both HICs and LMICs.

2.5.3 Intergenerational Transmission of Violence

Research also suggests a strong likelihood that children exposed to DVA will be caught in a continuing cycle of violence for the next generation, referred to as the ‘intergenerational transmission of violence’ (Widom, 1989). The single best predictor for children becoming either perpetrators or victims of DVA later in life is whether they grew up in a home where they were exposed to DVA (UNICEF, 2006). Several studies both in HICs and LMICs have found a strong association between exposure to DVA as a child and perpetrating or experiencing violence in intimate relationships as an adult (Roberts et al., 2010; Gupta et al., 2008; Widom, 2017; Crombach & Bambonye, 2015; Ludermir et al., 2017). This should be considered when exploring both risk factors and outcomes of exposure to DVA, as research demonstrates both higher rates of abuse among women whose husbands were abused as children or who saw their mothers being abused (Indermaur, 2001), therefore increasing the likelihood of a child being exposed to DVA, and that children exposed to DVA are more likely to be involved in a violent relationship as an adolescent, either as a perpetrator or as a victim (Ireland & Smith, 2009). This therefore has significant links to each ecological domain explored within this thesis and should be considered when exploring the issue of DVA in relation to prevention, intervention, and policies.

2.5.4 Outcomes Associated with Childhood Exposure to DVA

Despite the methodological issues associated with the measurement of exposure to DVA, lack of a standardised scale, information on prevalence, or risk factors for exposure to DVA, a wealth of evidence suggests that exposure has adverse effects for both children and adolescents. While there may be some positive outcomes of exposure to DVA depending on the context, these instances appear to be the exception rather than the rule (Martinez-Torteya, Bogat, Von Eye & Levendosky, 2009). Therefore, this thesis will instead concentrate on the adverse outcomes.

Irrespective of the increased risk of physical harm, exposure to DVA is also associated with other adverse outcomes. Many studies have found that children who have been exposed to DVA perpetrated between adults may display similar outcomes as children who have experienced abuse themselves (UNICEF, 2006), something which has been demonstrated to be consistent in research undertaken within many different countries and cultural contexts across both high-income countries and LMICs (see Cao et al., 2016). Adolescents and adults who have been exposed to DVA as a child have also been found to have poorer education outcomes, including

reading abilities being up to 40% lower when compared to peers from non-violent homes (James, 1994; UNICEF, 2006), lower IQ and verbal skills (Graham-Bermann, Howell, Miller, Kwek, & Lilly, 2010; Ratner et al., 2006; Towe-Goodman, Stifter, Mills-Koonce, & Granger, 2012), lower academic outcomes (Kitzmann et al., 2003; Supol, Satyen, Ghayour-Minaie, & Toumbourou, 2020), and poorer academic progression when compared to their peers who have not been exposed to DVA (Kiesel, Piescher, & Edleson, 2016). This can impact later-life outcomes, including socioeconomic areas such as future career opportunities and wealth – which, in turn, can affect health outcomes. There is also some evidence that exposure to DVA is associated with neurobiological changes, such as differences in brain structure (Choi, Jeong, Polcari, Rohan & Teicher, 2012; De Bellis et al., 2001), stress response systems (Gunnar & Donzella, 2002; Saltzman, Holden, & Holahan, 2005; Tsavoussis, Stawicki, Stoicea, & Papadimos, 2014), and cortisol reactivity being higher in those who have been exposed to DVA (Davies, Sturge-Apple, & Cicchetti, 2011). These findings suggest that outcomes for exposure to DVA are an urgent research priority.

However, the greatest wealth of research on outcomes associated with exposure to DVA in HICs focuses on mental health outcomes, and therefore, this will be the focus of this thesis. Whilst the term ‘mental health’ can encapsulate many aspects of an individual’s life, including socialisation and interpersonal relationships, within this thesis, internalising and externalising symptoms will be the focus. Internalising and externalising symptoms offer a multidimensional perspective on mental health, encompassing emotional, behavioural, and contextual aspects (Nikstat & Riemann, 2020). Their ability to predict long-term mental health outcomes and capture a wide range of psychological distress and behavioural challenges makes them valuable measures in assessing mental health across an individual’s life (Kim et al., 2023; Thompson et al., 2015).

Internalising symptoms encompass inward-directed issues such as anxiety, depression, and withdrawal, while externalising symptoms involve outward-directed problems like aggression, conduct disorders, and impulsivity. These dimensions provide a comprehensive understanding of an individual's mental health status, covering both emotional and behavioural aspects (Masten et al., 2005). Research has demonstrated the utility of internalising and externalising symptoms in predicting various mental health outcomes across developmental stages. For instance, longitudinal studies have shown that these symptoms in childhood can have implications for mental health trajectories in adolescence and young adulthood, influencing educational and employment outcomes (Veldman et al., 2015). Additionally, the presence of internalising and externalising symptoms has been linked to increased risk for comorbid mental health disorders, highlighting the interconnected nature of these dimensions (Essau & Torre-Luque, 2021). Internalising and externalising symptoms have also been found to be associated

with environmental factors and experiences, such as homelessness, bullying, perpetration of violence, and family functioning (Kim et al., 2023; Kilpatrick et al., 2019; Schaub et al., 2014), demonstrating that they can impact all four ecological domains explored within this thesis and that mental health does not just affect an individual – these mental health outcomes can, in turn, affect family, community, and society. This underscores the relevance of these measures in understanding the impact of social and contextual factors on mental health.

A wealth of studies suggest a link between exposure to DVA and internalising and externalising symptoms (Evans, Davies, & DiLillo, 2008; McTavish, MacGregor, Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Orr, Fisher, Preen, Glauert and O'Donnell, 2020; Wathen, & MacMillan, 2016; Moylan et al., 2010; Vu, Jouriles, McDonald, & Rosenfield, 2016); however, the majority of these are again, based on research from HICs. This thesis will, therefore, look at the mental health outcomes associated with exposure to DVA in LMICs, which will be explored in Paper Three (Chapter 6).

2.6 Childhood Exposure to DVA on the International Public Health and Policy Agenda

As mentioned in Section 2.5.4, internalising and externalising symptoms have been found to be associated with factors much wider than the individual level (Kim et al., 2023; Kilpatrick et al., 2019; Schaub et al., 2014), demonstrating that they can impact all four ecological domains explored within this thesis. This, combined with the potential for intergenerational transmission of violence (Section 2.5.3), means that the potential impact of childhood exposure to DVA should be recognised as a public health issue, warranting specific policy responses and protective frameworks. DVA is already considered a public health issue in some countries, such as in Scotland, the United States, and the United Kingdom (The Improvement Service Scotland, 2019; Connections for Abused Women and their Children, 2022; SafeLives, 2024), and therefore the impact of childhood exposure to DVA should also be considered.

Childhood exposure to DVA is either implicitly, or explicitly mentioned in a few international rights, treaties and conventions, which many countries have agreed or ratified. These are summarised in Appendix I.1. A notable example of the explicit recognition of childhood exposure in international law is found in the Istanbul Convention (2011), particularly in "Article 26: Protection and Support for Child Witnesses." Additionally, Article 56 outlines protective measures for "child witnesses of violence against women and domestic violence," while the preamble acknowledges that children are victims of DVA, including those who witness violence perpetrated within the family context. The United Nations Convention on the Rights of the Child (UNCRC; 1989) similarly implies the need for protection for children exposed to DVA in "Article

19: Protection from Violence, Abuse, and Neglect." This article asserts that children must be safeguarded "from all forms of physical or mental violence, injury, or abuse [...] while in the care of parent(s), legal guardian(s), or any individual responsible for the child's care." The UNCRC is further enhanced by various General Comments, with "General Comment No. 13 (2011): The Right of the Child to Freedom from All Forms of Violence" explicitly addressing childhood exposure to DVA. This document identifies "children who experience and witness violence in the home and in communities" as being in particularly vulnerable situations, highlighting the need for such considerations to be integrated into national coordinating frameworks, as articulated in Clause 72. While numerous countries have ratified these treaties, many struggle with effective enforcement and the allocation of resources necessary for the protection of children. This challenge is not unique to issues of DVA; similar difficulties are observed across various concerns addressed by these international agreements.

The importance of this issue on the international agenda is perhaps reflected in the inclusion in recent years of specific questions relating to childhood exposure to DVA in national questionnaires, such as in the VACS (Chiang et al., 2016), the UNMCS (Fulu et al., 2013), and the DHS (The DHS Program, 2021a), albeit the latter question is contained within an optional module on Domestic Violence. In addition, in 2024, the World Health Organization released "Intersections between violence against children and violence against women: Global Research Priorities" (World Health Organization, 2024). Whilst not explicitly stating childhood exposure to DVA as a research priority, the theme and long-term impact of exposure is present throughout the document.

These examples indicate that childhood exposure to DVA is an emerging area not only in research, but also in international conversation around public health and policy. However, whilst this can be observed to be starting to influence national policies and frameworks in some HICs (Australia and the United Kingdom are two examples) with the incorporation of childhood exposure to DVA in existing policies (discussed further in Section 7.1.1) there is little adoption within policies within LMICs, despite estimations that a high number of children are exposed to DVA within these regions (Figure 2.1). Without a comprehensive policy or monitoring of the issue, little is known about the provision, services, and support available for children who have been exposed to DVA in LMICs, or if these children are even acknowledged at all. Paper Four (Chapter 7) will explore this, with a focus on one LMIC, Nepal.

2.7 Summary of Knowledge Gaps in Literature

In the context of low- and middle-income countries (LMICs), childhood exposure to DVA is not given much consideration at any stage of the research process (Figure 1.1). Firstly, there is a

lack of consensus on the definition and measurement of exposure, leading to a lack of accurate statistics, a problem particularly prevalent in LMICs. As a result, the global scale of the problem is not fully understood. Secondly, recent prevalence rates for individual regions and countries (again, a particularly prominent issue within LMICs) do not exist, along with information on what makes a child more likely to be exposed to DVA. This means that individuals or groups within LMICs at risk of exposure to DVA (and those who have already been exposed) are at risk of being overlooked, potentially meaning that they are left without appropriate support. This leads directly to the third aim of the thesis – to explore the outcomes (in this case, mental health outcomes) associated with childhood exposure to DVA. This is an area in which a wealth of research exists for HICs but is very limited in LMICs, and it is vital for this work to be developed in LMICs to ensure that we understand the effect of DVA in different contexts, and so that affected children can better be supported. Finally, there is a lack of information as to how international agendas are filtering down to policy and action on the ground in LMICs, including whether stakeholders understand childhood exposure to DVA to be able to develop appropriate public health and policy responses.

Examining these research gaps holistically will provide a coherent overview of the current state of exposure in LMICs. Doing so will also highlight where further work is required to prevent childhood exposure to DVA and assist those who have already been affected. This thesis serves as a first step to achieving this, looking at each stage of the research process in turn, with the overall aim of enhancing and developing the knowledge and understanding of childhood exposure to DVA in LMICs.

Chapter 3 Data and Methods

3.1 Introduction

As explained in Section 1.1, this thesis uses a mixed-methods approach to advance our understanding of childhood exposure to domestic violence and abuse (DVA) in low- and middle-income countries (LMICs). There are two qualitative papers, and two quantitative papers.

Chapter 4 (Paper One) uses the COSMIN PROMs approach (Prinsen et al., 2018) to critically appraise and compare current measures of DVA¹⁴ perpetrated between adults in the home, and Chapter 7 (Paper Four) utilises in-depth qualitative interviews with key stakeholders in Nepal to collect primary data to address its research questions. In comparison, Chapter 5 (Paper Two) and Chapter 6 (Paper Three) share their data source and apply quantitative methods to high-quality, nationally representative country datasets from the Violence Against Children Surveys (VACS, Chiang et al., 2016).

This chapter will introduce the mixed-methods approach of this thesis, alongside a brief overview of the quantitative and qualitative methods used in each paper. More in-depth information about the methodologies will be discussed in the methods section of each respective chapter. It will also provide more detailed information about the VACS, its use within this thesis, alongside information including the VACS sampling methods and differences, which will be reflected on within the discussion within each paper, and in Chapter 8 (the overall discussion for this thesis). This chapter will also briefly examine existing research using the VACS, highlighting studies with similar foci to that in this thesis, and explain how this thesis adds to the evidence to advance our knowledge on childhood exposure to DVA between caregivers or other adults in the home in LMICs. Finally, the ethical considerations from this thesis will be discussed alongside the process for obtaining ethical approval.

3.2 Mixed Methods Design of the Thesis

To fully explore childhood exposure to DVA in LMICs, this thesis employs a mixed-methods approach. The overarching aim of this thesis is to enhance and develop the knowledge and understanding of childhood exposure to DVA in LMICs – an emerging area of research in which many gaps currently exist. A mixed-methods approach uses different research methods within the same overarching research aim, and has benefits such as allowing for a fuller exploration of

¹⁴ COSMIN is a qualitative method on quantitative scales. This paper provides a review of existing measures which it critically appraises.

the area ('completeness'), and an ability to answer different research questions through quantitative and qualitative research strategies (Clark et al., 2021).

The mixing of research methods was carefully planned at the early stages of the research project, as outlined by Creswell and Plano Clark (2011). This strategic approach is crucial for gaining a comprehensive understanding when conducting research on an emerging research area (Section 1.2), and allows for identification of specific areas where gaps exist in knowledge and understanding. This was also informed by the literature review (Chapter 2), and links to Figure 1.1. To adequately address these gaps, both qualitative and quantitative methods were employed. Table 3.1 briefly summarises the methods used within this thesis and how it links to the research objectives outlined in Section 1.3.

Table 3.1 A brief overview of the objectives, data sources, and methods used within this thesis

Research Paper/Section (Chapter Number)	Research Objective and Stage of Research Process (Figure 1.1)	Data Source	Type of Data	Broad Methodology	Methods of Analysis
Literature Review (Chapter 2)	To assess the current knowledge and understanding of the issue of childhood exposure to DVA in LMICs <i>How can it be defined, and what is the context?</i>	Existing published literature published including journal articles and reports	Secondary	Review	Review and synthesis of existing literature
Paper One (Chapter 4)	To understand the current methods of measuring childhood exposure to DVA <i>How can it be measured?</i>	Existing published literature published including journal articles and reports	Secondary	Review	COSMIN PROMs approach (Prinsen et al., 2018)
Paper Two (Chapter 5)	To explore the prevalence of childhood exposure to DVA across ten LMICs, and highlighting groups within the population that are more likely to be exposed to DVA <i>Who is affected?</i>	Ten VACS datasets	Secondary	Quantitative	Bivariate analysis, binary logistic regression and interpretation via a probability scale
Paper Three (Chapter 6)	To explore the mental health outcomes of those exposed to DVA in LMICs across ten LMICs <i>How are people affected?</i>	Ten VACS datasets	Secondary	Quantitative	Bivariate analysis and binary logistic regression

Chapter 3

Paper Four (Chapter 7)	To assess current awareness of, and what is being done to help children exposed to DVA in one LMIC, Nepal <i>What is being done?</i>	21 in-depth interviews with experts in child protection or DVA in Nepal	Primary	Qualitative	Thematic analysis (Braun and Clarke, 2006; 2021)

This thesis utilises a mixed-methods sequential explanatory design (Cresswell et al., 2003)¹⁵.

Whilst not typically part of a sequential explanatory design, the literature review serves as a preliminary phase, providing the rationale for the mixed-methods approach and guiding both the quantitative and qualitative phases that follow. The literature review was continuously updated throughout the research process to acknowledge new developments in the research and policy area of childhood exposure to DVA in LMICs.

Papers Two and Three (Chapter 5 and Chapter 6) consist of the quantitative strand of the mixed-methods sequential explanatory design (Strand 1), whereas Paper Four (Chapter 6), the qualitative strand (Strand 2). Both strands were collected and analysed independently, and an independent discussion provided within each paper. However, the studies do inform one another¹⁶, as illustrated in Figure 3.1.

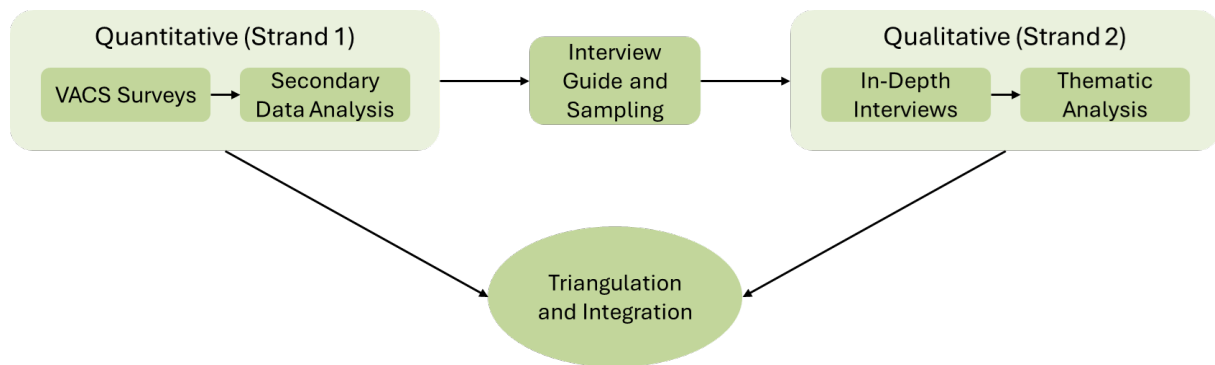


Figure 3.1 The mixed methods sequential explanatory design of this thesis

The findings from Strand 1 inform the interview guide and sampling for Strand 2. Strand 2 allows for exploration and interpretation which gives context and potential explanations behind the quantitative findings in Strand 1. Table 3.2 further illustrates *where* and *how* mixing occurs within Strand 2 within Paper Four (Chapter 7).

¹⁵ An explanatory sequential approach is used when a “researcher is interested in following up quantitative results with qualitative data [...] The qualitative data is used in the subsequent interpretation and clarification of the results from the quantitative data analysis. [...] Either the qualitative or quantitative data (or both equally) may be the primary focus of the study” (Edmonds & Kennedy, 2017, pp. 196-197).

¹⁶ Whilst not a mixing of methods as they are both part of the same quantitative strand, Paper Three (Chapter 6) is directly informed by Paper Two (Chapter 5), as the risk factors identified within Paper Three are used as potential explanatory factors in the binary logistic regression models. This is explained in further detail in Section 6.2.4 Methods of Analysis within Paper Three.

Table 3.2 Overview of the mixing of methods within Paper Four

Where the methods are mixed	How mixing occurs
Creation of interview plan and guide	The interview schedule/topic guide is informed by the quantitative analysis in Chapter 5 and Chapter 6.
Data collection (in Nepal)	Recruitment and sampling of respondents is informed by the quantitative analysis in Chapter 5 and Chapter 6.
Analysis of data collected in Nepal	Findings from Strand 2 will be used to provide context and provide possible explanations for those from Strand 1, and vice versa. This will be reflected on both within Paper Four (Chapter 7), and the overall discussion and conclusion for this thesis (Chapter 8).

Methods are then integrated again through triangulation of the findings in the ‘interpretation phase’ of the research (Creswell & Plano Clark, 2011) in the discussion and conclusion of this thesis (Chapter 7). At this stage, the findings from both strands are triangulated to allow for a comprehensive exploration of the topic of childhood exposure to DVA perpetrated between adults in the home in LMICs.

The remainder of this chapter will provide further information about each of the elements of this thesis.

3.3 Quantitative Analysis

Papers Two and Three (Chapter 5 and Chapter 6) within this thesis utilise quantitative methods to perform secondary data analysis on shared data, the Violence Against Children Surveys (VACS; Chiang et al., 2016). These methods include bivariate analysis and binary logistic regression alongside appropriate interpretation to investigate the relevant research questions. Whilst the specific methods are described in more detail within the relevant methods section of each paper, this section serves as an introduction to the VACS and shared methods and factors across both Papers Two and Three.

3.3.1 Survey Information: The Violence Against Children Surveys (VACS)

The VACS are nationally representative cross-sectional household surveys of males and females aged 13-24, which has been completed in countries across Africa, Asia, the Caribbean, Central and South America, and Eastern Europe. They are designed to measure childhood prevalence and past-year incidence of physical, emotional, and sexual violence, as well as contextual information about violent experiences, risk and protective factors, and health and

social consequences of violence. Additionally, they explore knowledge and use of health services available for those who have experienced violence and barriers to accessing such services (Nguyen, Kress, Villaveces & Massetti, 2019).

The VACS is coordinated by the Centers for Disease Control and Prevention (CDC), who partnered with The United Nations International Children’s Emergency Fund (UNICEF) for the initial VACS for Eswatini (referred to as Swaziland at the time)¹⁷ in 2007. The surveys encouraged the development of Together for Girls in 2010, who partner with organisations including CDC, UNICEF, Joint United Nations Programme on HIV and AIDS (UNAIDS), UN Women, World Health Organization (WHO), The US Agency for International Development (USAID), and the Global Partnership to End Violence Against Children. This allows for a “robust public-private partnership that partners with host country governments to implement the survey and respond to the findings” (Nguyen et al., 2019).

To date, 26 surveys in 23 countries around the world have been implemented, providing data on 12% of the world’s children, adolescents, and youth under the age of 24 (Together for Girls, 2023). A summary of the surveys completed by region and the date that the data was collected can be found in Table 3.3. At the time of analysis, there were 16 VACS country surveys available to researchers (Together for Girls, 2020): Cambodia, Colombia, Côte d'Ivoire, El Salvador, Eswatini, Haiti, Honduras, Kenya, Lesotho, Malawi, Moldova, Namibia, Nigeria, Tanzania, Zambia, and Zimbabwe.

The VACS use consistent protocols, methodology and questionnaires across all surveys so that the prevalence of violence can be compared in a multi-country context. However, each country may make locally appropriate adaptations, some of which will be discussed later in this thesis.

¹⁷ The VACS was undertaken in 2007 prior to Swaziland’s official name changing to Eswatini in 2018. Throughout this thesis, this country will be referred to as Eswatini in line with its current name.

Table 3.3 Countries in which the VACS have been administered, by region and year of survey¹⁸

MDG Region	Country	Year
Africa	* Eswatini	2007
	* Tanzania	2009
	* Kenya	2010
	Zimbabwe	2011
	* Malawi	2013
	* Nigeria	2014
	* Zambia	2014
	Uganda	2015
	Botswana	2015
	Rwanda	2015
	* Zimbabwe	2017
	* Côte d'Ivoire	2018
	* Lesotho	2018
	* Kenya	2019
	Mozambique	2019
	* Namibia	2019
	Ethiopia	In progress
Asia-Pacific	* Cambodia	2013
	Lao PDR	2014
Eastern Europe	* Moldova	2019
Latin America and the Caribbean	* Haiti	2012
	* El Salvador	2017
	* Honduras	2017
	* Colombia	2018
	Jamaica	In progress

* Datasets publicly available for research purposes, and therefore those considered for secondary data analysis within this thesis.

The VACS uses a multi-stage cluster sampling design to select males and females aged 13-24 and uses a three-stage sample design, consisting of the following steps (Nguyen et al., 2019):

1. Random selection of at least 100 geographic enumeration areas (EAs) are taken from the most recent population census data for both males and females. Using at least 100 EAs ensures that there is adequate geographic coverage of a country, and a split sample approach is used which allocates EAs to include either all male, or all female respondents. This ensures that confidentiality is maintained and minimises the chance that a perpetrator and victim of violence would both be interviewed from within the same community.
2. A complete list of all households within each selected area is constructed and a sample of 25-30 households are randomly selected from each EA.

¹⁸ In addition to those listed in Table 3.3, The Baltimore City Health Department Office of Youth and Trauma Services is leading the implementation of the Baltimore Youth Wellness Survey with support from the Centers for Disease Control and Prevention (CDC) and other partners. This is the first of the VACS to be undertaken in the “Developed Countries” MDG Region, and the first time that the VACS has been implemented to explore a city, rather than country.

3. From each selected household, the interviewers identified the head of household, or an individual in the household who was over the age of 18 to introduce the study and determine the eligibility of household members to participate in the study. A list is then compiled of all members of the household by sex and age to determine eligibility for the individual questionnaire. An eligible resident (male or female depending on the selected EA) is randomly selected from the list of eligible respondents 13-24 to complete the individual questionnaire. If they are away from the household at the time of selection, they are not replaced by another eligible member of the household, and instead a new time is agreed and up to three return visits are made.

Individuals are deemed ineligible and excluded if they are non-citizens who are visiting the country, residents of refugee camps, citizens in the military who state that their usual place of residence is at a military base, citizens who are institutionalised, such as in hospitals, prisons and nursing homes, and people who have mental or physical disabilities that impair their communication and ability to understand the questions asked in the survey. Although children living in institutions may have a high risk of violence and abuse perpetrated against them (or having previously been exposed to violence or abuse), they are excluded from the VACS because the researchers argue that they may have mental or physical disabilities that may limit their ability to give consent or understand questions. This group are a small percentage of the population and would not significantly affect the national estimates, and because institutions were not on the sampling frames to draw households (Nguyen et al., 2019).

The survey has two components – a short demographic interview with the head of household, and a longer interview with the randomly selected individual from those who are eligible. The longer interview is based off a structured questionnaire and is focused on their experiences of violence. These are conducted face-to-face by a trained same-sex interviewer in a private location. Caregiver consent is obtained for respondents under the age of 18, and informed consent is obtained for respondents over 18¹⁹. All respondents are provided with a list of free local services and resources to ensure that the safety of individuals is protected, and that they can access services if they need. Respondents who experienced violence perpetrated against them in the last 12 months, requested help, became upset in the interview, and/or reported feeling unsafe in their current living situation were offered direct referrals to a counsellor or social worker (Nguyen et al., 2019). The study received ethical approval from the CDC as well as

¹⁹ For participants under the age of 18, their caregivers are informed that their child will be asked sensitive questions, although specific details of the survey are not disclosed to prevent any potential retaliation related to participation in a violence survey. If the caregiver consents, the minor is then asked to provide assent to participate in a study on health and life experiences and is informed that the interview will be conducted in a private place where no one else can overhear. Once in a private location, the interviewer reads a full consent form to the minor respondent and informs them that some of the questions will address the topic of violence (Nguyen et al., 2019).

national ethics review committees in each country. Sample survey weights are provided in order that the survey estimates are nationally representative (Nguyen et al., 2019). Sample weights were used throughout this thesis when using the VACS.

3.3.2 Data Availability of the VACS

A request for access to the data was then made to the respective managing body, Together for Girls. Full datasets were received for the VACS for the countries Cambodia, Colombia, Côte d'Ivoire, El Salvador, Eswatini, Haiti, Honduras, Kenya, Lesotho, Malawi, Moldova, Namibia, Nigeria, Tanzania, Zambia, and Zimbabwe.

3.3.3 Selection of VACS Datasets for Analysis

The 16 country questionnaires and datasets were examined prior to analysis, and data from Eswatini, Haiti, Kenya²⁰, Tanzania, Zimbabwe, and El Salvador were removed. Eswatini only interviewed females and the exposure only focused on situations where the sexual violence is towards someone under the age of 18 (as opposed to domestic violence). Haiti, Kenya, and Tanzania did not ask about exposure to violence, instead focussing on experiences as a direct victim of different forms of violence. Upon analysis of response rates, it was also revealed that whilst the Zimbabwe questionnaire had questions about childhood exposure to domestic violence and abuse, erroneous skip patterns included in the questionnaire meant that not everybody was given the opportunity to answer these questions. This issue was raised with Together for Girls who were not aware of this issue and agreed that there was an issue with the data. Similarly, El Salvador was excluded due to bad skip patterns and inconsistent weightings. The decision was also made to exclude Colombia Priority Municipalities, as the National dataset is more representative of the country population, therefore allows for better comparability across countries.

Therefore, ten VACS country datasets were used for analysis within this thesis: Cambodia, Colombia National (referred to only as 'Colombia' from now on), Côte d'Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, and Zambia. Participation rates for the selected datasets can be found in Table 3.4. Further details on the sampling methods and calculation of participation rates can be found within the VACS Country Reports (CDC, 2022).

²⁰ The dataset for VACS Kenya (2010) was received, which did not contain any questions about exposure to DVA. Since the analysis for this thesis was conducted, the VACS Kenya (2019) has been made publicly available, which whilst containing questions on exposure to DVA, was not included in the analysis due to the time that it was released in relation to the completion of this thesis.

Table 3.4 Participation rates for the Violence Against Children Surveys (VACS)

MDG Region	Country	Participation Rate (%) ²¹					
		Household		Individual		Overall	
		Within Male EAs	Within Female EAs	Within Male EAs	Within Female EAs	Within Male EAs	Within Female EAs
Sub-Saharan Africa	Côte d'Ivoire (2018)	96.1	97.3	91.2	95.0	87.7	92.4
	Lesotho (2018)	98.8	97.8	98.0	98.3	96.2	96.2
	Malawi (2013)	95.5	94.4	87.4	89.5	83.4	84.4
	Namibia (2019)	93.1	95.4	90.4	92.8	84.2	88.5
	Nigeria (2014)	97.0	97.5	96.7	96.2	93.7	93.7
	Zambia (2014)	94.4	93.3	85.6	86.8	80.0	80.9
Latin America and the Caribbean	Colombia (2018)	52.2	58.5	86.1	92.1	47.5	53.9
	Honduras (2017)	89.5	93.7	83.4	89.4	74.6	83.8
South-Eastern Asia	Cambodia (2013)	97.7	97.2	92.1	93.7	89.9	91.0
Eastern Europe	Moldova (2019)	55.6	56.8	81.7	83.4	45.5	47.3

In general, there are high response rates across the ten VACS countries, however, within the countries of Colombia and Moldova, there was a much lower rate of completion of the household questionnaire compared to the other countries²². Due to the use of variables taken or derived from this household questionnaire in the analysis, the increased non-response in these countries led to a high proportion of the individuals being excluded from the analysis. To ensure that as many respondents as possible in Colombia and Moldova were included in the analysis, individuals that responded but did not have a corresponding household questionnaire were included in an additional category for a number of variables, called “no household questionnaire”.

3.3.4 Childhood Exposure to DVA within the VACS

The VACS was selected as the datasets upon which to perform secondary data analysis, as whilst the primary focus of the survey was not to explore childhood exposure to DVA, the majority of the country questionnaires contain one consistent question relating to exposure to

²¹ The participation rates are for males and females separately based on their enumeration area (EA).

²² The researcher contacted Together for Girls to query why this was, to which they said: “In VACS, the head of household questionnaire does not need to be completed in order for the respondent questionnaire to be completed. For example, there are instances where the Head of Household gave consent for the eligible to participate in the survey but did not agree to complete the head of household questionnaire. So, you will see a completed respondent questionnaire but no matching head of household questionnaire. Another thing is that eligible respondents who are minors need the consent of the head of household (or acting head of household) to participate in the survey. However, if they are emancipated minors (e.g., in some countries 16 years, married, and head of their own household), they also do not need consent from the Head of Household to complete the survey because they are considered head of their own household.”

DVA. This, along with the fact that it has been implemented (and continues to be implemented) in many LMICs, means that it provides one of the only opportunities (to date) to improve our understanding of childhood exposure to DVA perpetrated between adults in the home within LMICs, whilst allowing for comparability across countries.

The prevalence of childhood exposure to physical DVA is assessed by asking VACS participants aged 13-24 how many times they saw or heard their parent punched, kicked, or beaten up by their other parent, or their boyfriend or girlfriend prior to the age of 18²³. Whilst this definition is relatively constricted when considered with the emerging body of literature about exposure, this was the only question the VACS asked about childhood exposure to DVA, and so this is what was used for the purpose of this thesis. Within the VACS questionnaires, slight variations existed across countries, such as the way in which the perpetrator and victim of the domestic violence was described (Table 3.5). The dataset for Cambodia also included an additional question about exposure to domestic violence: “thinking about inside your home, have you ever seen an adult hurt or scare another adult by using or threatening to use a gun, stick, rock, or other similar weapon?”. However, this question was excluded from the creation of the exposure to domestic violence variable to allow for better consistency and comparability across countries²⁴.

For the purpose of analysis within this thesis, the results to this answer were dichotomised, and an exposure “yes/no” variable was created to allow for analysis of childhood exposure to domestic violence. Respondent’s answers to the VACS question regarding childhood exposure to domestic violence were recoded depending on whether the answer had indicated there had been any exposure, regardless of the frequency, to allow for an overall exposure statistic to be obtained. For “don’t know/declined”, this was recoded as missing data, as it was considered a non-response which could obscure accurate exposure if treated as equivalent to “no”. A table illustrating the differences in questions and how they were recoded can be found in Table 3.5.

²³ The country questionnaires of Cambodia and Zambia did not specify before the age of 18.

²⁴ Although the additional Cambodia-specific question on exposure to threats or use of weapons (“have you ever seen an adult hurt or scare another adult by using or threatening to use a gun, stick, rock, or other similar weapon?”) was not used in the primary exposure variable to preserve comparability across countries, exploratory analysis was conducted to assess its overlap with the standard VACS exposure question. Among those who answered “yes” to the standard exposure item, 25.76% also responded “yes” to this additional item. Conversely, 67.57% of those who reported exposure to threats or use of a weapon also answered “yes” to the standard exposure question, suggesting that the additional item may capture a partially distinct subset of respondents.

Prevalence estimates for exposure to this additional item alone showed 7.78% of respondents reported witnessing such incidents. When combining both indicators (i.e., considering a respondent “exposed” if they answered “yes” to either question), the overall prevalence of childhood exposure to DVA in Cambodia rose from 20.41 (95% CI: 18.32-22.68) to 22.94% (95% CI: 20.70–25.39), aligning closely with prevalence figures reported by Kieselbach et al. (2022). Due to the percentage increase being small and insignificant, this supports the validity of the primary exposure measure used in this thesis, while also highlighting the potential for broader definitions to capture a small number of additional cases.

Table 3.5 Creation of the Exposure to DVA Variable in the Ten VACS Countries Used in Analysis

MDG Region	Country (Survey Year)	Question ²⁵	Survey Response Options	Recoded to
Sub-Saharan Africa	Côte d'Ivoire (2018)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than once (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)
	Lesotho (2018)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than one time (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)
	Malawi (2013)	How many times did you see or hear your parent punched, kicked or beaten up by your other parent, or their boyfriend or girlfriend?	Never (1) Once (2) Few (3) Many (4) Don't know/declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)
	Namibia (2019)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than one time (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)
	Nigeria (2014)	How many times did you see or hear your parent punched, kicked or beaten up by your other parent, or their boyfriend or girlfriend?	Never (1) Once (2) Few (3) Many (4) Don't know/declined (99)	No (2) Yes (1) Yes (1) Yes (1) Missing (99)
	Zambia (2014)	How many times did you see or hear your parent punched, kicked or beaten up by your other parent, or their boyfriend or girlfriend?	Never (1) Once (2) Few (3) Many (4) Don't know/declined (99)	No (2) Yes (1) Yes (1) Yes (1) Missing (99)
Latin America and the Caribbean	Colombia (2018)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten up by your father or step-father?	Never (1) Once (2) More than once (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)
	Honduras (2017)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten up by your father or step-father?	Never (1) Once (2) More than one time (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)

²⁵ In all country datasets (with the exceptions of Cambodia and Zambia), this question was preceded by an instruction to the interviewer, specifying, “for respondents 13-17: At any time in your life; for respondents 18-24: Before the age of 18”.

MDG Region	Country (Survey Year)	Question²⁵	Survey Response Options	Recoded to
South-Eastern Asia	Cambodia (2013)	Thinking about inside your home, have you ever seen an adult hurt or scare another adult by slapping, punching or kicking them?	Yes (1) No (2) Don't know/declined (99)	Yes (1) No (2) Missing (99)
Eastern Europe	Moldova (2019)	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than one time (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)

Following the recoding in Table 3.5, response rates for exposure to DVA were examined prior to analysis, a summary of which can be found in Table 3.6. It is important to remember that this is the response rate for a 'valid' response – i.e., when a respondent said a frequency of exposure to DVA, indicating that they had been exposed. Those who answered “don't know/declined” are considered missing.

Table 3.6 Response rates for childhood exposure to DVA across the Ten LMICs participating in the VACS used within this thesis

MDG Region	Country (Survey Year)	<i>n</i>	Response Rate (%)
Sub-Saharan Africa	Côte d'Ivoire (2018)	2408	99.42
	Male	1208	99.34
	Female	1200	99.50
	Lesotho (2018)	8568	99.66
	Male	1467	99.39
	Female	7101	99.72
	Malawi (2013)	2162	99.31
	Male	1133	99.56
	Female	1029	99.03
	Namibia (2019)	5191	96.88
	Male	980	96.02
	Female	4211	97.08
Latin America and the Caribbean	Nigeria (2014)	4203	97.50
	Male	2437	97.91
	Female	1766	96.94
	Zambia (2014)	1819	98.13
	Male	928	98.38
South-Eastern Asia	Female	891	97.87
	Colombia (2018)	2705	98.74
	Male	1299	98.61
	Female	1406	98.86
	Honduras (2017)	5196	99.62
Eastern Europe	Male	2659	99.74
	Female	2537	99.49
	Cambodia (2013)	2376	99.83
	Male	1255	99.68
	Female	1121	100.00
	Moldova (2019)	2002	95.50
	Male	978	96.01
	Female	1024	95.02

Chapter 5 (Paper Two) and Chapter 6 (Paper Three) contain in-depth methodology about how this exposure to DVA variable is used to address the research questions within each respective paper. As previously mentioned, whilst this analysis develops our understanding of the topic of childhood exposure to DVA in LMICs, a narrow definition is used due to the question respondents are asked. Therefore, as mentioned in Section 2.2, further global data is required to adequately understand, monitor, and improve the issue of childhood exposure to DVA in LMICs.

3.3.5 Existing Research on Childhood Exposure to DVA Using the VACS

Part of the research process for this thesis involved ensuring that an up-to-date record was kept of all existing studies (published and grey) that have used the VACS surveys for secondary data analysis. This was conducted via a literature matrix using Microsoft Excel, and it allowed for key

observations to be noted, alongside ensuring that this thesis remained a valuable contribution to the research area.

An interesting shift observed through tracking studies via the matrix is the shift in the type of violence investigated by researchers – in earlier studies, the focus tended to be on physical or sexual abuse by a partner, but later studies such as Fan et al. (2021) used the VACS to explore different types of intimate partner violence (IPV), including emotional, perhaps demonstrating the change in understanding of DVA/IPV. Earlier VACS surveys solely ask about physical violence perpetrated, which could be a potential limitation in later analysis²⁶.

Another observation is that the majority of studies do not focus solely on exposure to DVA, and often either mention in the introduction that exposure can lead to negative health outcomes but do not explore it further in the study, or they combine exposure to DVA as a form of victimisation, along with experiencing DVA and child abuse (Jewkes et al., 2017; Stark et al., 2019). A notable exception to this is a study by Kieselbach, Kress, MacMillan and Perneger (2021), who explored the association between witnessing physical domestic violence between caregivers with other types of violence, and the relationship between witnessing physical domestic violence in the past and current mental distress. To do this, they applied logistic regression to data from the VACS for the countries of Cambodia, Malawi and Nigeria. To assess mental distress, Kieselbach et al. (2021) applied the Kessler K6 mental health scale (Kessler et al., 2003), a scale designed to detect nonspecific distress that includes anxiety and depression, which has been tested extensively for reliability and validity and successfully integrated into several national household surveys and surveillance systems (Tesfaye, Hanlon, Wondimagegn & Alem, 2010; Wijeratne, Williams, Rodrigo, Peris, Kawamura & Wickremasinghe, 2011). They found that between 22.4% and 34.3% of respondents across the three countries had witnessed one caregiver perpetrate physical domestic violence against the other during childhood²⁷. For Cambodia and Malawi, respondents who witnessed domestic violence were more likely to experience mental distress compared to those who hadn't, but in Nigeria, only male respondents who witnessed domestic violence had a higher chance of mental distress, but females had no significant association. These findings are consistent with the findings from the bivariate analysis within Chapter 6 (Paper Three), but in the analysis presented, the Nigerian overall and male populations were more likely to experience psychological distress if they had

²⁶ This thesis also only explores exposure to physical DVA to allow for comparability across the ten countries explored as highlighted in Table 3.5. This is reflected upon in the discussion of this thesis (Chapter 8).

²⁷ The prevalence rates found for these three countries in Paper Two are 19.68%-30.68%, although as explained in Section 3.3.4, not all questions related to exposure to DVA were included in the creation of the main variable used in analysis to allow for comparison across all ten countries. Full exposure to DVA statistics for these three countries, along with the other seven focused on within this thesis can be found in Appendix C.1.

been exposed to DVA, when compared to those who had not been exposed. Only the Nigerian female population were less likely to experience psychological distress if exposed to DVA perpetrated by an adult in the home, compared to those who had not been exposed, although these differences were small (29.05% for the exposed group, 30.93% for the non-exposed group).

Whilst this study is helpful to consider for the current thesis and demonstrates a shift in literature to look at exposure to domestic violence in selected LMICs, this analysis was only conducted on three of the 16 datasets which were available for public use at the time of the analysis (Together for Girls, 2021), and the analysis was conducted seven years after the release of the selected datasets. Whilst sociodemographic characteristics of the respondents were considered, such as their age, sex, highest completed level of schooling and whether the respondent lived with their biological mother at the time of the interview, these were not explored in relation to a child's likelihood to witness DVA. Therefore, this study does not do much to identify risk factors or other factors associated with exposure, and *who* is most at risk of exposure to DVA – an area of research relatively unexplored by existing studies and which this thesis aims to address in Chapter 5 (Paper Two).

Secondary data analysis of the VACS provides a unique opportunity to gain prevalence rates for childhood exposure to DVA (Figure 2.1), along with any factors which would increase the likelihood of a child being exposed (both are explored in Chapter 5, Paper Two). In addition to this, health and wellbeing is explored in detail within the surveys, including multiple questions on mental health, addressing the gap in knowledge on outcomes of exposure to DVA (explored in Chapter 6, Paper Three). When this secondary data analysis is combined with other methods used within this thesis, it addresses critical gaps in our knowledge, and provides a significant contribution to developing our understanding of childhood exposure to DVA within LMICs.

3.4 Qualitative Analysis

As mentioned in Section 3.2, qualitative methods are also utilised within this thesis in Paper Four (Chapter 7) to allow for a richer, more in-depth explanation of parts of the research process (Figure 1.1) when exploring childhood exposure to DVA perpetrated between adults in LMICs.

Unlike the quantitative papers (Chapter 5 and Chapter 6), the qualitative paper draws its data from separate data sources, collected for the purposes of this research. The methodology is detailed within the methods chapters of Paper Four (Chapter 7). Therefore, rather than repeating here within this overall methodological chapter, this short section will instead provide an overview of the qualitative approach, rather than the specific methods.

Although not a qualitative paper in itself, Paper One (Chapter 4) utilises the COSMIN (COnsensus-based Standards for the selection of health Measurement INstruments) approach and criterion for Patient-Reported Outcome Measures (PROMs; Prinsen et al., 2018) to critically appraise and compare the appropriateness of measures of childhood exposure to DVA in LMICs. There are currently no tools for critically appraising and comparing the appropriateness of measures in different contexts, particularly in respect to measuring childhood exposure to domestic violence, but previous studies have utilised the COSMIN PROMs methodology for qualitatively evaluating studies on measurement properties (e.g., Kalle et al., 2022). In particular, the COSMIN PROMs was chosen over other potential tools due to its inclusion of cross-cultural validity as a criterion.

Paper Four (Chapter 7) seeks to explore understanding of childhood exposure to DVA perpetrated between adults in Nepal, along with the current policy, provision and support available for children exposed, and what changes can be made so that children can be better protected. As the focus of this paper is so nuanced, and there is no dataset available to understand the current status of exposure within Nepal, it was decided that conducting in-depth interviews with those directly working in the field of child protection or DVA support would be the most appropriate method to explore the aims of the paper. This would allow for a comprehensive exploration of the topic that would acknowledge context-specific factors which are applicable to the country right now, through speaking to multiple people with a variety of views. This approach, when paired with thematic analysis (Braun & Clarke, 2006; 2021), allows for a nuanced and comprehensive understanding of the key themes occurring across interviews (Gibson & Brown, 2009) so that the main messages can be understood.

This paper, when taken in the wider mixed-methods approach of this thesis (detailed in Section 3.2), helps to build up a comprehensive picture of childhood exposure to DVA in LMICs – an emerging area in which many gaps currently exist.

3.5 Research Paradigm and Research Positionality

This research is situated within a pragmatic paradigm, reflecting the overarching mixed-methods design of the thesis. Pragmatism supports the use of both quantitative and qualitative methods, guided by the principle that the choice of the method should be driven by the research questions and the need to generate useful, actionable knowledge (Creswell & Plano Clark, 2018; Tashakkori & Teddlie, 2010). This flexibility is particularly valuable for addressing complex and under-researched issues such as childhood exposure to DVA perpetrated between adults in LMICs, where both measurable patterns and context-specific understandings are essential.

Within this pragmatic framework, different components of the thesis draw on distinct philosophical approaches depending on their aims. The quantitative papers (Chapters 5 and 6) adopt a post-positivist epistemology, assuming that whilst knowledge is fallible and influenced by bias, it is still possible to systematically measure and estimate phenomena such as prevalence, risk factors, and mental health outcomes associated with childhood exposure to DVA perpetrated between caregivers or other adults in the home. The qualitative paper (Chapter 7), in contrast, aligns more closely with an interpretivist epistemology, seeking to understand how professionals and policymakers in Nepal conceptualise and respond to childhood exposure to adult-perpetrated DVA within their local context. This approach acknowledges that meaning is co-constructed through interaction and is shaped by social and cultural norms.

Ontologically, the thesis recognises that reality is both measurable and constructed: some aspects of childhood exposure to DVA can be observed and quantified, while others are understood and experienced differently across settings. Epistemologically, the thesis integrates both objective and subjective ways of knowing, reflecting the complexity of the topic. Axiologically, the research is underpinned by a commitment to ethical responsibility, cultural sensitivity, and the production of knowledge that can inform positive social change for populations at heightened risk of harm due to systemic, social, or relational factors (Crotty, 1988).

The researcher's own background has influenced the development and focus of the thesis. With a BSc in Psychology and an MSc in Clinical Psychology, alongside professional experience as an Assistant Psychologist, the researcher brings a psychological lens to the study of violence, trauma, and child development. This background informed the formulation of the research questions and shaped how concepts such as mental health were understood and interpreted. In addition, the thesis has been developed within a highly interdisciplinary supervisory environment, involving expertise from the fields of social statistics and demography; public health and population sciences; and psychology and education. This collaborative structure enriched the research process by introducing multiple theoretical and methodological perspectives, and helped to challenge assumptions, refine interpretations, and maintain critical awareness throughout the thesis.

In addition to this professional and academic background, the researcher (and the supervisory team) is based in a high-income country (the United Kingdom) and occupies a position of relative privilege in analysing and interpreting data from LMICs. This positioning necessitated a reflective approach throughout the research process, particularly when engaging with culturally situated understandings of violence, abuse, mental health, and childhood. Efforts were made to critically consider the potential imposition of Western norms, and to work collaboratively with

local partners to ensure the research was culturally appropriate and ethically sensitive. This included reviewing materials for cultural relevance, reflecting on power dynamics, and remaining attuned to the ethical and interpretive complexities of cross-cultural research to ensure reflexive research practice. Further reflexive engagement, particularly with respect to qualitative data collection and interpretation, is provided in Paper Four (Chapter 7).

3.6 Ethical Considerations

3.6.1 Ethical Approval

The research within this thesis was approved by the University of Southampton's Research Integrity and Governance committee through the Ethics and Research Governance Online (ERGO) platform. There were two ERGO applications, one for the secondary data analysis of the VACS (Chapter 5 and Chapter 6; ERGO 62094.A2), and another for the in-depth interviews with experts in Nepal (Chapter 7; ERGO 80830.A1). In Nepal, ethical approval was also given by the Nepal Health Research Council (NHRC 324/2023).

The research presented in this thesis adheres to ethical principles, including voluntary participation, informed consent, respect, integrity, transparency, the right to withdraw, and protection from harm. The research was carried out in full compliance with research ethics standards, including following the guidelines established by the Economic and Social Research Council (ESRC) Framework for research ethics (UK Research and Innovation, 2022).

Furthermore, methods were designed in compliance with guidelines that inform best research practices, and for the research in Nepal, a local partner was consulted and involved throughout the research process as a gatekeeper organisation. This helped to ensure that the work undertaken was culturally sensitive (further information is available in Paper Four, Chapter 7).

A data management plan was created in line with the University of Southampton's research data management policy (University of Southampton, 2024), and was followed throughout the research process. Further information on how ethical procedures were followed are available within the respective methods section of each paper.

3.6.2 Reflections on the Ethical Eco-System

In addition to the mandatory training provided by the University of Southampton on ethics when conducting research, the principal investigator of this research also undertook a voluntary course run by the Global Health Training Centre (The Global Health Network, 2022), which focused on conducting ethical research on sensitive topics in LMICs as a researcher based in a high-income country. This brings into consideration an important point: the need to reflect on

the broader eco-system of ethical considerations that extend beyond formal approval processes towards more reflexive, relational, and contextually grounded principles (Guillemin & Gillam, 2004).

This research engages with sensitive topics (including childhood exposure to DVA and mental health) across countries with diverse cultural, political, and historical contexts. Therefore, it is important to critically consider the ethical implications of conducting research as a Western-based researcher working in LMIC contexts. This includes recognising and addressing potential imbalances in power, voice, and representation. The involvement of a local partner organisation in Nepal as a gatekeeper and collaborator was essential not only for ensuring cultural sensitivity and appropriateness, but also for helping to mitigate the risk of extractive research practices, instead fostering a more reciprocal approach. However, it remains important to acknowledge that the dynamics of collaboration are not free from power imbalances, and ongoing reflexivity is required to ensure that local perspectives are not marginalised in favour of Global North assumptions or priorities (Sultana, 2015).

In addition, the use of secondary data collected via the Violence Against Children Surveys (VACS; Chiang et al., 2016) raises important ethical considerations. Although these surveys are widely used and provide valuable insights, many were conducted several years ago using questionnaires that may not fully align with evolving underpinnings of child protection, consent, or trauma-informed practice (World Health Organization, 2016). The design of these surveys (while often following international protocols) may also have been influenced by political constraints or limitations in ethical oversight at the time of data collection. As a researcher re-analysing these data, it was important to remain conscious of their limitations, including the framing of questions and the possible exclusion of certain forms of harm or vulnerability. The researcher maintained contact with Together for Girls (who manage the VACS) throughout, ensuring transparency and raising queries where necessary.

Engaging with these ethical complexities has underscored the importance of moving beyond procedural compliance to consider how ethics are enacted throughout the research process (Guillemin & Gillam, 2004). Ethical considerations were approached reflexively throughout this project, with attention given to how researcher positionality, the research context, and the nature of the data influenced both the conduct and interpretation of the work (Holmes, 2020). Efforts were made to centre ethical thinking at all stages of the research: collaborating with local partners in Nepal to ensure cultural sensitivity, adapting interview materials to reflect local norms and expectations, critically engaging with the limitations of secondary data sources, and regularly contacting Together for Girls (who manage the VACS) with any questions when necessary. These reflections informed the design, implementation, and presentation of the

research, with a consistent awareness of the responsibilities associated with producing knowledge about sensitive issues in LMIC settings. This approach aligns with calls for greater attention to issues of equity, representation, and power within global research collaborations (Abimbola, 2019; Tindana et al., 2007), and represents an ongoing ethical commitment that will continue to guide future research practice.

3.7 Summary

This chapter has outlined the overarching methodological approach and data sources used across the thesis, which employs a mixed-methods design to explore childhood exposure to DVA perpetrated between caregivers or other adults in the home in LMICs. Due to the paucity of research in this area, and the numerous research gaps, each paper of this research-paper thesis addresses a distinct step of the research process (Figure 1.1), using methods selected to answer specific questions about the topic of childhood exposure to DVA within LMICs.

This chapter has also presented the philosophical foundations of the research, situating the thesis within a pragmatic paradigm and outlining the ontological, epistemological, and axiological assumptions guiding the work. Reflections on researcher positionality and interdisciplinary influence have been discussed to highlight how professional background and power dynamics shaped the research process. Finally, the chapter has detailed both procedural and reflexive ethical considerations, including the importance of culturally sensitive and responsible research practices when working in LMIC contexts.

More detailed methodologies are included within each empirical paper (Chapters 4-7), and collectively, the approaches presented within this thesis establish a rigorous and reflexive foundation to allow for a comprehensive understanding of this emerging, but important research area.

Chapter 4 Paper One: Childhood exposure to domestic violence and abuse: can global estimates on the scale of exposure be obtained using existing measures?

This paper has been published in *Frontiers in Public Health* (Section: Children and Health) as part of the Research Topic *Domestic Violence and Abuse: Increasing Global and Intersectional Understanding* (see Harris, Channon & Morgan, 2024).

The paper presented in this chapter is exactly as it is published, and therefore, there is some repetition (e.g., in defining childhood exposure to DVA and the chosen definitions within this thesis). However, for consistency across the rest of the thesis, the referencing style has been changed, and language from US English to UK English.

Purpose: Childhood exposure to domestic violence and abuse (DVA) can lead to major short- and long-term effects on the victim. Despite this, there is no accepted measure for children's experiences, with most existing measures being validated only in high income countries and not in low- and middle- income countries. As a result, international statistics are not comparable. This paper seeks to critically appraise existing measures and discuss whether any are fit-for-purpose on a global scale.

Method: The COSMIN PROMs approach was followed to critically appraise and compare the appropriateness of measures. A comprehensive literature search was undertaken in seven journal databases for measures mentioned in formally peer-reviewed articles exploring childhood exposure to DVA.

Results: A literature search resulted in the identification of 10 measures and, following criteria to only keep original measures and remove modifications, four measures which have been validated cross-culturally are discussed in detail in line with the COSMIN PROMs criterion: The Child Exposure to Domestic Violence Scale, Children's Perception of Interparental Conflict Scale, Juvenile Victimization Questionnaire and The Violence Exposure Scale for Children. Strengths and limitations of each are discussed, along with any validations undertaken not in the country of origin.

Conclusion: Despite childhood exposure to DVA being an urgent research priority worldwide, the current measures to explore the extent of the issue are not validated cross-culturally, leading to concerns about comparisons across different population groups. The development and implementation of interventions to reduce the levels and effects of exposure relies heavily on cross-cultural comparisons, which may indicate different strategies are needed in different contexts. The lack of these validated comparisons is constraining advances, and the paper advocates for further efforts to be made in this regard.

4.1 Introduction

Childhood exposure to domestic violence and abuse (DVA) is a concept that is increasingly understood to have major short- and long-term effects on the victim (Evans et al., 2008).

Globally, there has been an observed increase in DVA around the world following the responses to Covid-19 (UN Women, 2020), with studies indicating an associated increase in the numbers of children exposed to DVA within a home environment (Bradbury-Jones & Isham, 2020).

However, identifying those children who are exposed to DVA is complicated by a lack of agreement on appropriate ways to measure exposure to DVA, with a range of different tools and measures available. Despite being a global epidemic (UNICEF, 2006), many of the available measures for childhood exposure (also referred to as 'experience' in some literature) have only been tested or used in higher-income settings, leading to concerns around their applicability to different contexts and countries (Latzman et al., 2017).

Existing global estimates on the scale of childhood exposure to DVA are potentially problematic, leading to inconsistent measurements over time. As a result, this form of violence against children does not receive the necessary attention among policymakers. Without a credible baseline indicator, it is difficult to argue for change; it means that international organisations, including multilateral organisations and regional donors, are unable to properly assess the need for intervention (Buse et al., 2012; Shiffman & Smith, 2007). An absence of an appropriate measure raises challenges in estimating the global scale of the issue, and in observing and tracking the social impact of policies and interventions related to child protection and exposure to DVA. This means that international statistics are not comparable, thereby limiting its visibility within international bodies, and the ability to identify countries underperforming in the reduction of childhood exposure to DVA.

Based on a comprehensive literature search, the most recent review of measures exploring childhood exposure to DVA is by Latzman et al. (2017), although this review did not explicitly focus on the validation of available measures, nor explore their applicability globally.

Additionally, the study of childhood exposure to DVA has advanced significantly in the past seven years, with a number of countries now recognising children within DVA legislation (e.g., Australian Institute of Family Studies, 2020; UK Domestic Abuse Bill, 2021).

Despite the majority of research on childhood exposure to DVA being conducted in high income countries (HICs), several factors mean that children could be more likely to be exposed to DVA in low- and middle-income countries (LMICs) (UNICEF, 2006). The socioeconomic status of a country has been linked to higher rates of DVA, while it is also known to be related to poverty and economic inequality. Current research suggests that the prevalence of both DVA and

violence against children in LMICs is higher than in HICs (Keynejad et al., 2020; World Health Organization, 2022), although the evidence base is sparse. However, there is evidence to suggest that children in LMICs may spend more time at home compared to children in high-income countries (Grantham-McGregor et al., 2007), meaning that if violence were to be perpetrated in their home, children in LMICs are at an increased risk of exposure. Therefore, it is essential to ensure that measures for childhood exposure to DVA are applicable on a global context, particularly within LMICs.

The aim of this review was to examine the current measures that have been developed to measure childhood exposure to DVA, to critically appraise these in order to understand if they can be used to obtain global estimates of the numbers and scale of those affected, with a particular focus on LMICs.

4.1.1 Childhood Exposure to Domestic Violence and Abuse

Domestic violence and abuse (DVA) is defined as an incident or pattern of incidents of controlling, coercive, threatening, degrading and violent behaviour (Women's Aid, 2018). In the majority of cases, this is inflicted by a partner or ex-partner, but it can also be by a family member or carer (World Health Organization, 2021). This violence can be physical, sexual, emotional, or psychological, as well as involving violence such as economic coercion (Ellsberg & Heise, 2005; United Nations, 2023). Whilst DVA commonly refers to violence within the home between caregivers, in some countries and studies, child or elder abuse, or abuse by any member of a household is also considered domestic violence (World Health Organization & Pan American Health Organization, 2012). For the purpose of this paper, the term domestic violence and abuse will be used, as this is more inclusive than other terminology which is often used interchangeably (e.g., 'intimate partner violence', or 'marital violence'), and encompasses all forms of violence and abuse that perpetrated between members of a home which a child could be exposed to.

The concept of childhood exposure to DVA, and the psychological impact that this has on an individual, is a relatively new phenomenon when considered within the wider research area of DVA (UNICEF, 2006). Earlier researchers often describe the child or adolescent as an 'observer' or 'witness', but later research instead takes a more child-centric approach, saying that they are 'exposed to', 'affected by' or 'experience' the violence, as this is more inclusive, and does not assume that the individual actually observed the violence whilst it was happening (Holden, 2003; Holt et al., 2008). For clarity, in this study the terms 'exposed/exposure' will be used, covering all the approaches noted above.

Whilst there is limited information on exposure in LMICs, evidence from HICs indicates that children who are exposed to DVA are at an increased risk of psychiatric disorders, substance misuse, and are more likely to commit violent crimes in adulthood (English et al., 2003; Herrera & McCloskey, 2001). There is also a wealth of evidence to support the ‘intergenerational transmission of violence’ (Widom, 2017), which suggests that children exposed to DVA are more likely to become either perpetrators or victims of DVA later in life when compared to those who were not exposed to DVA in childhood (UNICEF, 2006; Godbout et al., 2019; Renner & Slack, 2006). In some countries, childhood exposure to DVA is considered a form of child maltreatment or neglect (Australian Institute of Family Studies, 2020; National Society for the Prevention of Cruelty to Children, 2020), as the child is living in a psychologically abusive, physiologically arousing, emotionally distressing, and often trauma inducing environment (Graham-Bermann & Brescoll, 2000; Henry, 2018).

4.1.2 Measuring Childhood Exposure to DVA

The most recent global estimates available found that close to 300 million children (defined as those aged under 18 or the relevant age of majority in each country) are exposed to DVA worldwide (UNICEF, 2006). However, these figures were obtained through reviewing existing studies that measure violence in the home in various countries and did not use a standardised tool. This, therefore, may have led to under or over-reporting depending on the definitions used, and the estimates may not be accurate. These UNICEF (2006) estimates also did not provide estimates for the regions of Northern Africa, or South-Eastern Asia, accounting for the wide-ranging figure. Higher estimates for the number of children who are exposed to DVA within these regions could be due to a number of factors, such as cross-cultural variations in living conditions, a lower socioeconomic level (where physical violence is often found to be higher), and due to there being a higher level of violence in society, which is often seen reflected at a household level (Wright et al., 2011).

Additionally, although no recent global estimates have been found, any more recent estimates of childhood exposure to DVA would likely be higher due to the increase of DVA reported around the globe due to the ‘shadow pandemic’ (of DVA) caused by the imposed lockdowns due to Covid-19 (UN Women, 2020; World Health Organization, 2020). A 2020 report by the United Nations Population Fund (UNFPA) stated that the Covid-19 pandemic may result in an additional 31 million cases of gender-based violence worldwide if lockdowns were to continue for six months, and for every three months that the lockdown continued, an additional 15 million additional cases were expected (UNFPA, 2020). Increased stress, disruption of social and protective networks, closure of schools, restrictions on movement, economic insecurity, and decreased access to services can all exacerbate the risk of violence for women and increase a

child's likelihood of being exposed to DVA (World Health Organization, 2020), a fact reflected in studies since the start of the pandemic (Bradbury-Jones & Isham, 2020). Childhood exposure to DVA and obtaining global estimates is, therefore, an urgent research priority.

Despite childhood exposure to DVA being an important issue, there are a number of methodological limitations which hinder research into this area. Childhood exposure to DVA is not a dichotomous concept of whether or not a child has witnessed or overheard violence, and within the literature, there are varying thresholds researchers use to consider a victim 'exposed' to DVA (Holden, 2003), with a number of studies failing to provide descriptions of the nature of the victim's exposure within their methodologies (Mohr et al., 2000). Factors such as the frequency, duration, severity, and level of exposure (i.e., saw the violent act, heard about it from another room, or learned about it later), all have the potential to influence classification, along with the timeframe in which they are exposed to the DVA (Evans et al., 2008).

4.1.3 Current Review

Whilst some theoretical and critical reviews of both childhood exposure to DVA and its measurement strategies exist (e.g., Hamby & Finkelhor, 2001; Latzman et al., 2017), no review to date has focused on the suitability or applicability of these measures in a global context, particularly within LMICs.

The first aim of this paper was to provide an overview and critique of existing measures for childhood exposure to DVA, to discuss the usage of these existing measures over time and their validations cross-culturally. The second aim was to discuss key limitations in the field of measuring childhood exposure to DVA and make suggestions for future improvement of research in the area within LMICs, focusing on how these measures can support the development of appropriate interventions within the health system, if validated.

4.2 Methods

There are currently no tools for critically appraising and comparing the appropriateness of measures in different contexts, particularly in respect to measuring childhood exposure to domestic violence. Therefore, we used the COSMIN (COnsensus-based Standards for the selection of health Measurement INstruments) approach and criterion for Patient-Reported Outcome Measures (PROMs; Prinsen et al., 2018).

COSMIN PROMs provides a framework for evaluating the methodological quality of outcome measures, through evaluating their measurement properties. It is a systematic approach to assessing the quality of the measurement properties of these instruments, such as reliability,

validity, and responsiveness. When compared to other potential tools, the COSMIN PROMs criteria includes cross-cultural validity as a criterion, making it an appropriate tool for this paper.

4.2.1 Search Strategy

The following electronic databases were searched: Directory of Open Access Journals, JSTOR, PsycINFO, PubMed, Science Direct, Scopus, and Web of Science. Abstracts were searched for terms related to age (e.g., child*, youth, teen*, juvenile, adoles*), exposure (e.g., expos*, witness*, observ*), DVA (e.g., IPV, domestic violence, domestic abuse), and those related to measurement (e.g., tool, survey, scale, index, questionnaire, assess*, measur*).

4.2.2 Inclusion Criteria

Measures mentioned in formally peer-reviewed articles that have been published in indexed journals were included. Gray literature such as blogs, unpublished dissertations, and unofficial reports were excluded, as despite some measures being mentioned in these, there is limited information about them. Measures exploring childhood exposure to DVA in any capacity were considered, such as self-reported and caregiver reported measures, and included if they measured exposure to any additional forms of violence, e.g., exposure to community violence. Modifications of established measures were examined individually by the research team, and included in the results only if the modifications that had been made were related to the aims of this study. Revisions of original measures by the same authors were included, where appropriate. This was to ensure consistency across the approach to this study, and to ensure a fair comparison of published measures to be considered.

From these resulting papers, the researchers examined abstracts and removed any that did not adhere to the inclusion criteria, and noted the measures used within the remaining papers. Measures that have been applied cross-culturally were examined closely to answer the aim of this research.

4.3 Results

The literature search led to the identification of 10 measures that focus on child exposure to DVA, summarised in Table 4.1 (further detail on each of these is available in Appendix A). The majority of these measures have not been used or applied in countries other than that of their original high-income setting; only four measures that have been applied cross-culturally were identified. These were the Child Exposure to Domestic Violence Scale (CEDV), Children's

Perception of Interparental Conflict Scale (CPIC), Juvenile Victimization Questionnaire (JVQ), and the Violence Exposure Scale for Children (VESC).

Table 4.1 A summary of identified measures

Measure Name	Year of Publication	Country of Publication/Origin	Applied Outside of Country of Origin?	Applied in LMIC?
Caregiver-report Modified version of the Severity of Violence Against Women Scales (DeJonghe et al., 2011)	2011 Adaptation of Marshall (1992).	United States	No	No
Child Exposure to Domestic Violence Scale (CEDV; Edleson et al., 2007)	2008	United States	Yes	Yes
Childhood Experiences of Violence Questionnaire (Walsh et al., 2008)	2008	Canada	No	No
Children's Perception of Interparental Conflict Scale (CPIC; Grych et al., 1992)	1992	United States	Yes	Yes
Computer Assisted Child Maltreatment Inventory (DiLillo et al., 2010)	2010	United States	No	No
Family Aggression Screening Tool (Cecil et al., 2016)	2016	United Kingdom	No	No
Juvenile Victimization Questionnaire (JVQ; Finkelhor et al., 2005)	2005	United States	Yes	Yes
Things I Have Seen and Heard (TISH; Richters & Martinez, 1990)	1990	United States	No	No
Timeline Followback Interview – Children's Exposure to Partner Violence (Lam et al., 2009)	2009	United States	No	No
Violence Exposure Scale for Children (VESC; Fox & Leavitt, 1995)	1995	United States	Yes	No

The four measures that have been applied cross-culturally are discussed in further detail below and illustrated in Table 4.2, which also contains some key criteria from COSMIN PROMs (Prinsen et al., 2018), including an evaluation of content validity, internal consistency, cross-

cultural validity and construct validity, where this information was available. A full summary of indicators with relevant studies can be found within Table 4.2, and are summarised below:

- Cross-cultural validity was assessed for all measures, and all four have been applied within countries other than their origin.
- Information on content validity could not be found for the JVQ, but the CEDV, CPIC and VESC were all found to have content validity when compared with other measures.
- Internal consistency was assessed for all four measures, with the CEDV and JVQ reporting good internal consistency, and the CPIC and VESC reporting adequate to good internal consistency.
- Information on construct validity could not be found for the CPIC, and for the JVQ, construct validity was found but not for exposure to DVA. For the CEDV and VESC, convergent, concurrent and discriminant validity was found.
- The majority of studies exploring reliability used test-retest methods, and found correlations for all scales, with the highest correlation being found for the CEDV.

Despite not meeting the criterion for further discussion (due to not being applied cross-culturally), a measure the researchers thought was important to acknowledge from Table 4.1 is the Things I Have Seen and Heard Scale (TISH; Richters & Martinez, 1990). This measure was designed to measure the level of direct and indirect exposure to violence that children experience at home, as well as in the wider community. The TISH has demonstrated relatively strong internal consistency, with Cronbach's Alpha between $\alpha = 0.74$ and $\alpha = 0.76$. High reliability has also been established through strong test-retest ($r = 0.67$) and inter-rater reliability results ($r = 0.81$) (Richters & Martinez, 1993). The TISH is an important measure within this area of research, with other researchers either using it as a foundation for the development of their own measure, or as a tool to establish validity of their own measure (as discussed below and in Table 4.2).

Table 4.2 Summary of DVA Measures Applied Cross-Culturally by COSMIN PROMs Indicators

Measure	Content Validity	Internal Consistency	Cross-cultural validity	Reliability	Construct validity
Child Exposure to Domestic Violence Scale (CEDV; Edleson et al., 2008)	A panel of nine experts who work with children exposed to parental IPV were asked to review the measure during the creation of the CEDV. The experts were asked to examine each item and suggest whether to keep the item “as is”, delete the item from the measure, or revise the question. This increases content validity (Ravi & Tonui, 2020).	Good levels of internal consistency have been reported, ranging from $\alpha = 0.79$ (Grip et al., 2013) to $\alpha = 0.97$ (Fainsilber Katz et al., 2016).	• Brazil (Pinto Junior et al., 2017) • India (Anitha & Venus, 2016) • Iran (Sajadi et al., 2014) • Iraqi-Kurdistan (Jumma & Çerkez, 2017) • Pakistan (Khatoon et al., 2014) • South Africa (Idemudia & Makhubela, 2011) • Spain (Díez et al., 2018) • Sweden (Cater et al., 2015; Grip et al., 2013, 2014)	Test-retest reliability was assessed by calculating Pearson’s correlation coefficients and paired t-tests between Week 1 and Week 2 (Edleson et al., 2008). Pearson’s correlation coefficients for each subscale ranged from 0.57 to 0.70 ($p < 0.001$), indicating relatively strong and statistically significant correlations between the two administrations. Non-significant differences on t-tests between administrations also showed that Week 1 and Week 2 test scores for the level of violence in the home, home exposure, community exposure, risk factors, and other victimization were very similar and stable over the two administrations. The exception was the “level of involvement” subscale, which produced highly correlated answers but showed significantly different test-retest scores in the paired t-test ($t = -2.154, p < 0.05$). Test-retest reliability in other studies has found Pearson’s correlation coefficients between the two administrations of $r = 0.58-0.89$	Convergent validity was assessed by asking each child to complete the TISH questionnaire (Richters & Martinez, 1990) along with the CEDV (Edleson et al., 2008). Correlations were found between violence in the home and violence in the community subscales (Edleson et al., 2008). Concurrent validity was explored by examining the correlation coefficients of scores on the CEDV and a questionnaire on exposure to physical aggression (Sajadi et al., 2014). Results indicated that subscales of exposure to parental IPV on each measure were positively correlated (Sajadi et al., 2014). Grip et al. (2013) examined the relationship between the CEDV, and the Strengths and Difficulties Questionnaire (SDQ) and the Trauma Symptoms Checklist for Children (TSCC). The TSCC included a post-traumatic

				and for the total scale, $r = 0.86$ (Jumma & Çerkez, 2017). None of the tests demonstrated significant differences between time one and time two.	stress scale, and the mean of the t-scores on the additional scales were used to operationalise psychological problems in general. The CEDV was not significantly related to any of the scales, indicating discriminant validity (Fainsilber Katz et al., 2016).
Children's Perception of Interparental Conflict Scale (CPIC; Grych et al., 1992)	The CPIC was developed against two established measures of parent-reported interparental conflict, the Conflict Tactics Scale (Straus, 1979) and the O'Leary Porter Scale (Porter & O'Leary, 1980). The CPIC has been found to be significantly related to these measures, with Pearson's correlation coefficients $r = 0.30$ and $r = 0.39$, respectively (Grych et al., 1992). Whilst these are moderate correlations, Grych et al. (1992) justified it as such measures do not assess child adjustment and are completed by parents and not the child (Grych et al., 1992).	Three factor analytically derived subscales (Conflict Properties, Threat, Self-Blame) were assessed in the original paper (Grych et al., 1992). Alpha coefficients were computed, and each subscale demonstrated good internal consistency across samples, with all value greater than $\alpha = 0.70$. Several studies have used the CPIC and, in most cases, have shown adequate internal consistency (Bickham & Fiese, 1997; Kline et al., 2003; Reese-Weber & Hesson-McInnis, 2008).	- China (Chi & Xin, 2002; He et al., 2021; Wang et al., 2021) - Pakistan (Bukhari & Masood, 2020) - Portugal (Moura et al., 2010) - Spain (Iraurgi et al., 2008)	To assess test-retest reliability, 44 children were measured for the three factor analytically derived subscales two weeks after the initial administration of the test (Grych et al., 1992). Conflict properties $r = 0.70$, Threat $r = 0.68$, and Self-Blame $r = 0.76$. Inter-scale correlations were also assessed, with the Conflict Properties scale, and Self-Blame scale items being highly correlated, and the Threat scale being moderately correlated.	No information found.
Juvenile Victimization Questionnaire (JVQ;	No information found.	Internal consistency not measured specifically for items related to exposure to DVA, but for the whole tool, internal consistency was	- Australia (Mathews et al., 2023) - China (Chan et al., 2011)	200 of the respondents were re-contacted and re-administered the JVQ within 3-4 weeks of its original administration. This re-test sample included both 100	Evidence of construct validity, but not from studies measuring exposure to DVA.

Finkelhor et al., 2005)		good, $\alpha = 0.80$ (Finklehor et al., 2005).	• Israel (Lev-Wiesel et al., 2018) • Pakistan (Bashir & Dasti, 2015) • Portugal (Almeida et al., 2020) • South Africa (Ward et al., 2018) • Spain (Pereda et al., 2018) • UK (Radford et al., 2013)	youth self-respondents and 100 caregiver proxy respondents. The instrument showed adequate test-retest reliability (Finkelhor et al., 2005). The mean κ was 0.59 with a range from 0.22 to 1.00. For the self-reporting youth, the mean κ was 0.63, with range of 0.22-1.00 and for the caregiver proxies the mean κ was 0.50, range -0.03 to 1.00 (Finkelhor et al., 2005).	
Violence Exposure Scale for Children (VESC; Fox & Leavitt, 1995)	The researchers describe the study as “face valid” and as having content validity as it was developed on the TISH questionnaire (Richters & Martinez, 1990) and asks about similar areas of violence exposure to other measures.	Internal consistency: $\alpha = 0.72$ to 0.86 (The National Child Trauma Stress Network, 2021).	• Israel (Raviv et al., 2001) • The measure is also available in Spanish (according to Stover & Berkowitz, 2005), although no studies using this measure could be found.	There are no interrater statistics for interviews. A study comparing parent’s and children’s reports of the child’s exposure to violence found a significant relationship (Shahinfar et al., 2000).	Convergent and concurrent validity was found in non-clinical and diverse samples, and discriminant validity found for diverse samples (The National Child Trauma Stress Network, 2021).

4.3.1 Child Exposure to Domestic Violence Scale

The CEDV scale, developed by Edleson, Shin and Armendariz (2008), is a 42-item self-administered measure. The measure was developed using several existing surveys and interview guides investigating childhood exposure to DVA, based on key content areas identified in a 2007 review by Edleson et al. (2007). Nine international experts working with children who have been exposed to DVA were then invited to review each item and suggest whether it should be kept without changes, deleted from the measure, or if the question should be revised. They were also offered the opportunity to advise any additional items or content that should be included in the measure. The CEDV asks children aged 10-16 to answer questions using a Likert-type scale, with the choices being “never”, “sometimes”, and “a lot”. If the child chose one of the latter two options, indicating that the violent event occurred at home, they were directed to another set of questions which asked how the child was exposed to the DVA, including five choices: “I saw the outcome (e.g., someone was hurt, something was broken, or the police came)”, “I heard about it afterwards”, “I heard it while it was happening”, “I saw it from far away while it was happening” and “I saw it and was near while it was happening”. The second section of the CEDV asks a series of 23 questions using the same three-point Likert-type scale, and they were asked about how often they intervened in violent events and about other risk factors present in their lives (e.g., substance use in the home), and the third section collected demographic information including age, gender, race, ethnicity, current living situation, and family composition. The questionnaire was tested amongst 65 children aged 10 to 16 ($M = 12.5$, $SD = 2.1$) staying in domestic abuse shelters with their mothers – a potential methodological issue as this sample is not representative of the general population. When compared to the TISH (Richters & Martinez, 1990) for convergent validity, the correlation between the CEDV and TISH indicated that a statistically significant and positive correlation existed both at the level of home violence exposure ($r = 0.494$, $p < 0.001$) and community violence exposure ($r = 0.397$, $p < 0.001$).

It was hoped that as a measure, the CEDV would be able to address the shortage of empirically validated measures for childhood exposure to domestic violence (Evans et al., 2008). When considering Holden’s taxonomy (Holden, 2003), the CEDV addresses several categories of exposure to DVA, including witnessing, overhearing, observing the initial effects, hearing about it, and intervening.

Ravi and Tonui (2020) conducted a systematic review to synthesise and summarise the psychometric properties of the CEDV to assess the reliability and validity of the measure. From an initial identification of 264 studies using the measure, 13 studies were used as the final sample in the review after removing duplicates and applying the inclusion criterion. The final

studies, when combined, had a total sample size of 2,546 children (Mean age = 12.70, $SD = 3.30$), that ranged across countries (including a mixture of HICs and LMICs), with the measure being translated and administered into several languages. This includes Sweden (Cater et al., 2015; Grip et al., 2013, 2014), India (Anitha & Venus, 2016), Spain (Díez et al., 2018), Brazil (Pinto Junior et al., 2017), Iraqi-Kurdistan (Jumma & Çerkez, 2017), Pakistan (Khatoon et al., 2014), South Africa (Idemudia & Makhubela, 2011) and Iran (Sajadi et al., 2014). Despite being translated into different languages for implementation in different countries and contexts, internal consistency remained when utilising the CEDV with diverse populations, and the results indicated that the CEDV demonstrated content, convergent, and discriminant validity (Ravi & Tonui, 2020). However, there were some inconsistencies regarding the association of childhood exposure to DVA with internalising problems such as mental health concerns or depression symptoms (Fainsilber Katz et al., 2016; Harding et al., 2013). Limitations with factor and concurrent validity were also identified, and Ravi and Tonui (2020) suggested that future research should employ exploratory factor analysis to examine the factor structure of the measure when it is used with various populations, and that future studies should use larger sample sizes to understand more about key correlates and latent variables.

4.3.2 Children's Perception of Interparental Conflict Scale

The CPIC, developed by Grych, Seid and Fincham (1992), is a 48-item self-report measure designed to assess multiple dimensions of marital conflict that might lead to child adjustment problems, and to obtain children's perspectives on the degree of the conflict to which they are exposed, including questions about witnessing, overhearing, and interfering in the conflict. The developers' motivations for developing this measure were based on the fact that "parent-report measures often underestimate children's exposure to conflict" (Grych et al., 1992). Children are given a statement, for example "my parents have pushed or shoved each other during an argument", and they are asked whether this statement is "false", "sort of true", or "true".

The CPIC was designed for children aged 9-17 years old (Grych et al., 1992), but further studies have found the measure to also be appropriate for young adults aged 18-25 years (Reese-Weber & Hesson-McInnis, 2008), and has also been implemented in countries other than its origin (United States), including China (Chi & Xin, 2002; He et al., 2021; Wang et al., 2021), Pakistan (Bukhari & Masood, 2020), Portugal (Moura et al., 2010), and Spain (Iraurgi et al., 2008). The measure and scoring manual are free and easily accessible online, which promotes wider use, especially in resource-restricted countries or locations.

The subscales of the CPIC assess frequency, intensity, resolution, content, perceived threat, coping efficacy, self-blame, triangulation and stability – a comprehensive and detailed

approach to understanding the DVA that a child is exposed to. Three broad-factor scales were developed using exploratory factor analysis and confirmatory factor analysis. The first of these is Conflict Properties, which reflects how often conflicts occur and the level of hostility and resolution and comprises of the frequency, intensity and resolution subscales. The second is Threat, which indicates the degree to which children feel threatened and able to cope when marital conflict occurs, which comprises of the threat and coping efficacy subscales. The final broad-factor scale is Self-Blame, which assesses the frequency of child-related conflict and the degree to which children blame themselves for marital conflict, and comprises of the content and self-blame subscales. The stability and triangulation subscales can be used as independent subscales.

Alpha coefficients were computed, and each subscale demonstrated good internal consistency across samples, with all value greater than $\alpha = 0.70$. Several studies have used the CPIC and, in most cases, have shown adequate internal consistency (Bickham & Fiese, 1997; Kline et al., 2003; Reese-Weber & Hesson-McInnis, 2008). Test-retest reliability was assessed in the original study, with 44 children being assessed for the three factor analytically derived subscales two weeks after the initial administration of the test (Grych et al., 1992). Conflict properties $r = 0.70$, Threat $r = 0.68$, and Self-Blame $r = 0.76$, indicating moderate to high correlations. Inter-scale correlations were also assessed, with the Conflict Properties scale and Self-Blame scale items being highly correlated, and the Threat scale being moderately correlated. This demonstrates that the CPIC is a reliable measure in assessing the child's perception of parental conflict, an important outcome that is often not assessed by other measures exploring childhood exposure to DVA. However, Pote, Ghiara, Stock and McBride (2020) found insufficient evidence that the CPIC is a valid measure when investigating changes in childhood exposure to DVA in short interventions (less than three months), which is a potential limitation of the measure.

4.3.3 Juvenile Victimization Questionnaire

The JVQ, developed by Finkelhor, Hamby, Omrod and Turner (2005) is a 37-item questionnaire exploring various forms of juvenile victimization, including witnessing violence and indirect victimization. The questionnaire aims to measure multiple forms of juvenile victimization to obtain a better estimate of the total rate of victimization, enhance the correspondence of juvenile victimization measurement with important social constructs such as crime and child protection categories, and to provide a means of studying the overlap among forms of juvenile victimization.

The JVQ can be used in an interview format for children 9-17 years old, and self-administered for juveniles aged 12 and over. There is also a caregiver version, where a caregiver can be

interviewed by proxy for a child, for example, if a child is under the age of eight. Additionally, it can be adapted for retrospect reporting of childhood events for completion by adult respondents, making the questionnaire versatile when exploring childhood exposure to domestic violence (Finkelhor et al., 2005). The authors argue that the JVQ offers enhanced opportunities to obtain accurate epidemiological data across childhood, because it can be administered in self-report form from the age of eight, which is younger than previous measures allowed (Hamby et al., 2005).

The JVQ consists of modules, including Conventional Crime, Child Maltreatment, Peer and Sibling victimization, Sexual Victimization, Witnessing and Indirect Victimization. Follow-up questions are asked for those questions in which a child or caregiver reports that a victimization occurred. Follow-up questions include the number of times a child has been victimized, who victimized the child, whether the child was hurt, and questions specific to the victimization reported (Finkelhor et al., 2005).

The questionnaire has good internal consistency ($\alpha = 0.80$) and has been administered in China (Chan et al., 2011), Israel (Lev-Wiesel et al., 2018), Pakistan (Bashir & Dasti, 2015), Portugal (Almeida et al., 2020), South Africa (Ward et al., 2018), Spain (Pereda et al., 2018), and the United Kingdom (Radford et al., 2013), and has recently been adapted for use in a national study in Australia (Mathews et al., 2023). The measure also demonstrates adequate test-retest reliability, with 200 of the respondents being re-contacted and re-administered the JVQ within 3-4 weeks of its original administration. This re-test sample included both 100 youth self-respondents and 100 caregiver proxy respondents (Finkelhor et al., 2005). The mean Cohen's kappa coefficient was $\kappa = 0.59$, with a range from $\kappa = 0.22$ to $\kappa = 1.00$. For the self-reporting youth, this was $\kappa = 0.63$, with a range of $\kappa = 0.22$ to $\kappa = 1.00$, and for the caregiver proxies, the mean was $\kappa = 0.50$, range $\kappa = -0.03$ to 1.00 (Finkelhor et al., 2005). There is also evidence of construct validity in studies comparing juvenile victimization with psychological and sociological constructs such as depression and neighbourhood crime rates (Hamby et al., 2005).

4.3.4 Violence Exposure Scale for Children

The VESC, developed by Fox and Leavitt (1995), is a 25-item self-report measure of violence exposure that includes drawings to accompany questions, and a Likert-type rating scale. The measure includes questions about minor and severe violence victimization and witnessing violence in the home, school and neighbourhood. Children are given a statement, for example, "Chris sees a person beat up another person. How many times have you seen a person beat up

another person?” and they are asked if, over the course of their lifetime, this has “never” happened, it has happened “one time”, “a few times”, or “lots of times”.

The VESC was designed by Fox and Leavitt (1995) for children aged 4-10 years old, with their initial sample consisting of 40 Caucasian, primarily suburban children (Fox & Leavitt, 1995). The measure has also been administered to 155 African American preschool aged children from low socio-economic status families in Washington DC (Shahinfar et al., 2000), and following translation to Hebrew, the measure has also been administered to 134 second and fourth-grade students in Israel (Raviv et al., 2001). The measure has also been translated to Spanish (Stover & Berkowitz, 2005), although no published studies using this adaptation could be found. An alternate version of the questionnaire is available, with the characters depicted as either male or female, and for the Israeli population, the name of the cartoon character was changed, and several items were altered (Raviv et al., 2001).

Despite this measure being applied in a country other than its origin, the psychometric data available is limited, meaning that it scores low on the COSMIN PROMs criterion (Prinsen et al., 2018). The researchers describe the study as “face valid” and as having content validity as it was developed on the TISH (Richters & Martinez, 1993) and asks about similar areas of violence exposure as other measures. Internal consistency was also reported to be between $\alpha = 0.72$ to $\alpha = 0.86$. There are no interrater statistics for interviews. Shahinfar et al. (2000) compared parent’s and children’s reports of the child’s exposure to violence and found a significant relationship, but found poor concordance between VESC parent and child reports. However, this may be due to differences in interpretation of items or lack of parental knowledge of their child’s exposure. Convergent and concurrent validity was found in non-clinical and diverse samples, and discriminant validity found for diverse samples (The National Child Trauma Stress Network, 2021).

4.4 Discussion

The four measures applied cross-culturally were compared using the COSMIN PROMs criterion (Prinsen et al., 2018). Information on structural validity, measurement invariance, measurement error, criterion validity, and responsiveness could not be found for any of the measures, so they were not included in the discussion or in Table 4.2. While this could be considered a potential limitation, it was expected that not all criteria would be used due to COSMIN PROMs being a tool to compare patient-reported outcomes, rather than one to compare measures for childhood exposure to DVA.

When considering the appropriateness of measures for gaining global estimates of childhood exposure to DVA, the researchers considered three main areas: firstly, which measure had been most commonly applied within LMICs, second, which was most acceptable according to the indicators covered in COSMIN PROMs, and finally, which measure covered aspects of exposure to DVA the closest, based on our current understanding. Three of the measures have been applied in LMICs – the CEDV, which has been implemented in Brazil (Pinto Junior et al., 2017), India (Anitha & Venus, 2016), Iran (Sajadi et al., 2014), Iraqi-Kurdistan (Jumma & Çerkez, 2017), Pakistan (Khatoon et al., 2014), and South Africa (Idemudia & Makhubela, 2011), the JVQ, which has been applied in China (Chan et al., 2011), Pakistan (Bashir & Dasti, 2015) and South Africa (Ward et al., 2018), and the CPIC, which has been applied in China (Chi & Xin, 2002; He et al., 2021; Wang et al., 2021), and Pakistan (Bukhari & Masood, 2020). Based on this information, it could be assumed that the CEDV is the most appropriate measure for assessing childhood exposure to DVA within LMICs, although it is still sparsely implemented.

However, just because a scale has been applied the most within a certain context does not mean that it is the most appropriate, and so, therefore, the measures need to be examined under the lens of the COSMIN PROMs indicators (Table 4.2). From this examination, there is heterogeneity in the information relating to the different types of validity, with the CEDV showing cross-cultural, content, internal and construct validity reported. The VESC also reports these measures, but had lower internal consistency. There were gaps in these aspects for the JVQ and CPIC, although these may be available in grey literature or other reports that were not included in this study.

These measures need to be considered in line with the current understanding of childhood exposure to DVA. As previously mentioned, this is a relatively new area of research, and there has already been changes in the way in which childhood exposure to DVA is understood and explored (for example, the change in terminology from ‘witnessed’ to ‘exposed’). Holden’s taxonomy (Holden, 2003) provides a comprehensive overview of how children can be exposed to DVA, and so each of the four measures should be explored to see how aligned they are with these definitions and categories, along with that of the current definition of DVA (Ellsberg & Heise, 2005; United Nations, 2023; Women’s Aid, 2018; World Health Organization, 2021; World Health Organization & Pan American Health Organization, 2012). Appendix A provides a summary of the measures, which includes the types of DVA and the type of exposure measured. The VESC has the most constrained definition of exposure to DVA, exploring only physical violence that a child witnesses. The JVQ explores only witnessing and indirect victimization, but measures physical, sexual, and psychological/emotional violence and abuse as types of violence a child can be exposed to. The CPIC measures the same types of DVA as the JVQ but allows for the exploration of a few more of Holden’s taxonomies – witnessing, overhearing, and

intervening. The measure which allows for the most comprehensive definition of both DVA and exposure is the CEDV. The CEDV investigates physical and psychological violence and abuse, and coercive control. It also has questions related to whether a child is an eyewitness, overhears, observes the initial effects, hears about, or intervenes with the violence or abuse.

Based upon the three criteria defined by the researchers, the most comprehensive scale is the CEDV, as this has been applied the most within LMICs, has the highest score using COSMIN PROMs indicators, and allows for exploration of childhood exposure to DVA in a way most closely aligned with the current understanding of the area. This could, in part, be due to the fact that it is the most recent out of the four scales discussed in further detail in this study, and so it was likely developed with a larger body of evidence in mind. However, its application is still sparse, and further research is needed to assess whether it would be applicable and valid across multiple LMICs, and if it could be used globally to gain estimates of childhood exposure to DVA.

Whilst all the measures discussed have strengths, there is no standardised approach to assessing the issue of childhood exposure to DVA, and rather than a consensus being discussed around the best measure for exposure to DVA, modifications to existing measures are often made instead to address the research questions or requirements. These modifications could reflect the changing nature and understanding of DVA within wider society, for example, making questions around perpetrators of violence non-gender specific, and recognising additional forms of DVA, including psychological, emotional and economic abuse (whereas earlier measures had a primary focus on physical and sexual violence), but it could also be because there is not one accepted measure which is fit for purpose. For larger, country-wide studies, such as the Violence Against Children Surveys (VACS; Chiang et al., 2016), researchers tend to create their own questionnaires, which contain sections on childhood exposure to DVA, rather than use existing measures. This may be due to space, as most of the above scales have a large number of items, which may make them unfeasible to be used in a broad multi-country survey when trying to gain a global overview of the issue.

The lack of a cross-culturally validated instrument to measure childhood exposure to DVA is likely to be compromising the development of interventions to reduce the burden of exposure or to mitigate the effects. The understanding of the scale of the issue alongside a validated method to assess the success of interventions will support policymakers, and further allow cross-national learning on the effectiveness of interventions that have been implemented. With the increasing number of laws that note childhood exposure to DVA, this is an urgent priority. Without validated baseline data, progress in this area is likely to be limited.

Limitations in measures and how well they are applied, particularly within the LMIC context, have implications on our ability to make accurate estimates of the number of children exposed to DVA. Whilst the increasing interest in exploring childhood exposure to DVA is a positive development, if a standardised measure was available, it would allow for international comparable statistics, ensuring that there is visibility within international bodies to identify countries underperforming in the reduction of childhood exposure to DVA. The most recent global data on child exposure to DVA was conducted in 2006, when it was estimated that between 133 and 275 million children are exposed to DVA worldwide (UNICEF, 2006). The estimates indicated a significantly higher number of children are exposed to DVA in LMICs in comparison to HICs, and revealed that there are currently no estimates for the regions of Northern Africa or South-Eastern Asia, accounting for the wide-ranging estimate (UNICEF, 2006). Accurate statistics also allow for the social impact of policies related to child protection and exposure to DVA to be observed and tracked, and without a credible indicator (baseline), then it is more difficult to argue for change and assess the need for interventions (Buse et al., 2012). A reliable measure for childhood exposure to DVA could encourage a move toward inclusion of this topic in international goals such as the Sustainable Development Goals, for example, under 5.2: “Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation” or 16.2: “End abuse, exploitation, trafficking and all forms of violence against children” (United Nations, 2015).

A major limitation in this area of research is that when compared to HICs, there is still a lack of studies measuring childhood exposure to DVA in LMICs. It is possible that some data has been collected in LMICs using the measures, but these studies have not led to peer review publication, and so, therefore, they have not been included in this review. Additionally, the use of these measures within the LMIC context has not been validated, and so results from these studies should be generalised with caution. Large-scale studies which measure childhood exposure to DVA (such as the VACS) also opt to use their own questions, as opposed to using measures specifically designed to explore childhood exposure to DVA, raising the question on whether the estimates we have for childhood exposure to DVA are valid and highlighting a need for additional research to be conducted in the field of childhood exposure to DVA. Future research should focus on collating studies measuring childhood exposure to DVA within LMICs to allow for a wider perspective on the measures used and their appropriateness in the LMIC context, along with further development of the measures mentioned (including those not yet applied or validated in LMICs, such as the TISH).

Whilst efforts were made to present a widespread and representative body of literature through database searches, given the increasing body of work on childhood exposure to DVA, it is

possible that not all measures for childhood exposure to DVA have been included and discussed, especially if only included in grey literature at the present time. Instead, those most commonly used within existing, published, peer reviewed literature were included. Another limitation of the present study is that only English language articles were included in the search process, potentially excluding any articles published in non-English language journals, which may be more likely to contain studies which have applied measures in LMIC settings. However, no references to any articles such as these were found during the search and review for this study.

4.5 Conclusion

Despite it being an urgent research priority, there is no standardised approach or measure for childhood exposure to DVA, a situation which is exacerbated in LMICs. Many of the measures have not been validated in LMICs, leading to gaps in data and practice, and to an understanding of the scale of the issue. For such a sensitive area which already experiences significant underreporting (Ellsberg et al., 2001), it is paramount that a measure which can be used globally (particularly within LMICs) is agreed upon. Out of the four measures explored, the CEDV had been implemented in the most LMICs (although application was still sparse), met the most criteria for COSMIN PROMs, and most closely aligned with the definition of exposure to DVA used for the purpose of this paper, and so further work should be done on assessing its validity within LMICs, and potential to accept this as a standardised scale.

An accepted standardised measure for childhood exposure to DVA would undoubtedly allow for a more effective, and empirically sound comparison of the number of children exposed to DVA across a wider range of populations. This would provide a more accurate estimate of both the number of children who are exposed to DVA globally, along with who is more likely to be exposed so interventions can be targeted to and implemented with those most at-risk.

Chapter 5 Paper Two: Prevalence and Risk Factors Associated with Childhood Exposure to Domestic Violence and Abuse in LMICs

Purpose: The most recent global data on exposure to domestic violence and abuse (DVA) was conducted in 2006 by UNICEF, when it was estimated that between 133 and 275 million children were exposed worldwide, with a significantly higher number of children estimated to be exposed in low- and middle-income countries (LMICs) compared to high-income countries. However, these estimates are nearly two decades old, and there is also a knowledge gap in what factors place a child at an increased risk of being exposed to DVA, particularly within LMICs. It is difficult to know who is affected by exposure to DVA if we do not have accurate statistics on the extent of the issue. This paper seeks to explore the prevalence of childhood exposure to DVA in ten LMICs, alongside identifying social and demographic factors that are associated with exposure.

Method: This paper uses quantitative methods to explore ten CDC Violence Against Children Surveys (VACS) to gain prevalence estimates of childhood exposure to DVA in ten LMICs across the regions of Sub-Saharan Africa, Latin America and the Caribbean, South-Eastern Asia, and Eastern Europe. Logistic regression was used to explore factors associated with DVA exposure within the ecological domains of individual, family, and community and society to explore what makes a child more likely to be exposed to DVA.

Results: Exposure to DVA ranged from 11.8% in Honduras to 30.7% in Malawi. Other countries with high prevalence included Zambia, Nigeria, and Lesotho. When compared with the World Population Prospects, this paper finds that over 19 million children have been exposed to DVA across the ten countries explored, accounting for 7.21-14.91% of the UNICEF (2006) global estimates available. This indicates that the UNICEF (2006) figures are underestimations of the true scale of childhood exposure to DVA globally. Regression analysis found that factors related to community and society to be most important, with individual and family factors less so. Individuals exposed to community violence had much higher levels of exposure to DVA, while a relationship with societal acceptance of violence was also seen. Females were at significantly higher risk of exposure to DVA in four of the ten countries, and at the family level, mixed results were observed for factors such as wealth.

Conclusion: This study highlights the urgent need for updated and reliable estimates of childhood exposure to DVA, which likely far exceed existing global statistics. Understanding the magnitude of this issue is crucial for tracking progress and implementing effective interventions. The findings underscore the critical role of community and societal factors in influencing childhood exposure to DVA in LMICs, suggesting that future policies and interventions should concentrate on these domains. Further research is needed to develop globally comparable statistics that can inform the protection of vulnerable children worldwide.

5.1 Introduction

In 2006, it was estimated that close to 300 million children had been exposed to DVA perpetrated by one caregiver or adult household member against another worldwide (UNICEF, 2006), with low- and middle-income countries (LMICs) estimated to have a much higher number of children exposed when compared to high-income countries (HICs). However, these estimates are now over 15 years old, and include gaps in crucial regions (Northern Africa and South-Eastern Asia), and so a true picture of the state of exposure to DVA in LMICs (and globally), cannot be captured. Without this information, a potentially large number of children will grow up without their experiences being acknowledged or recorded, limiting the potential interventions to reduce their risk of poor outcomes.

Whilst a number of studies have explored the impact of childhood exposure to DVA on a child's wellbeing and future outcomes, there is limited information available about *who* is more likely to be exposed, and whether there are any risk factors for exposure. Identification of risk factors, and those children most at risk, could lead to both targeted prevention, and early appropriate intervention for children exposed to DVA.

This paper will explore risk factors associated with childhood exposure to DVA in ten LMICs, utilising quantitative methods to first determine the estimated prevalence of childhood exposure to DVA across ten selected LMICs, followed by identification of risk factors associated with exposure to DVA. This will be explored using the CDC Violence Against Children Surveys (Chiang et al., 2016; referred to from now on as 'VACS') to answer the research question for this paper: *What is the prevalence of, and risk factors associated with, childhood exposure to domestic violence and abuse across selected low- and middle-income countries?*

5.1.1 Prevalence of Childhood Exposure to DVA in LMICs

As previously mentioned, the most recent global data on childhood exposure to DVA was published in 2006, when it was estimated that between 133 and 275 million children have been exposed to DVA perpetrated by caregivers or adults in the home worldwide (UNICEF, 2006), with a significantly higher number of children estimated to be exposed in LMICs compared to HICs (Figure 2.1). These estimates were obtained through reviewing existing studies that measure violence in the home in various countries, and did not use a standardised tool. Therefore, the figures in this report may not be comparable across countries or regions, thereby limiting the visibility of the issue within international bodies, and the ability to monitor the progress of countries attempting to reduce childhood exposure to DVA. In addition, these estimates are

over 15 years old, meaning that they may not be an accurate reflection on the global status of childhood exposure to DVA.

Whilst there is no further international data available on the prevalence of childhood exposure to DVA, Kieselbach et al. (2022) aimed to address the paucity of research on the prevalence of exposure in LMICs. They performed a systematic review to assess the proportion of children in LMICs exposed to intimate partner violence (IPV). Their review included primary quantitative studies that included a measure of self-reported exposure to IPV prior to the age of 18, and they found that the lifetime prevalence of childhood exposure to DVA perpetrated between caregivers or adults was 29% (95% CI: 26% - 31%), with prevalence rates ranging from 2% to 78% across the studies included in the analysis. Additionally, they found no statistically different prevalence estimates between males and females. Whilst they concluded that childhood exposure to IPV is highly prevalent in LMICs, they recommended caution in drawing conclusions from their research due to both the large heterogeneity across the studies, and because of the variability across the studies in how they defined and measured childhood exposure to DVA, as similarly to the UNICEF (2006) data, a standardised measure was not used²⁸. Despite these limitations, the high prevalence rate reported indicates a clear need for further research to be conducted on the prevalence of childhood exposure to DVA in LMICs, but using a consistent definition so that a better understanding of the state of exposure to DVA perpetrated between adults in LMICs can be obtained. This would allow for important epidemiological information to be collected, which could aid in both prevention and intervention and allow for better comparability across countries and regions.

5.1.2 What is a Risk Factor?

A risk factor can be defined as “a characteristic at the biological, psychological, family, community, or cultural level that precedes and is associated with a higher likelihood of problem outcomes” (O’Connell, Boat & Warner, 2009). In parallel, a protective factor can be defined as “a characteristic at the biological, psychological, family, or community (including peers and culture) that is associated with a lower likelihood of problem outcomes or that reduces the negative impact of a risk factor on problem outcomes”.

The issue of DVA, and childhood exposure to DVA perpetrated by one caregiver or adult against another, is one which affects all levels of analysis in this thesis, both in terms of the risk factors for exposure, and the outcomes associated with exposure to DVA. For the purpose of this paper,

²⁸ Kieselbach et al. (2022) also discuss how in most of the studies used within their systematic review, measures were used without an appropriate cross-cultural validation and adaption, linking to the findings of Paper One (Chapter 4).

risk factors have been divided into three ecological domains – individual risk factors, family risk factors, and community and societal risk factors.

Relatively little research has been conducted into the factors and characteristics that are associated with children’s exposure to DVA perpetrated between caregivers or adults in LMICs, and hardly any published papers explicitly explore risk, or risk factors associated with such exposure. Therefore, much of the literature reviewed on individual, family and community or society level risk factors has been drawn from research examining risk factors for violence within the home, risk factors for multiple adverse childhood experiences (ACEs; Felitti et al., 1998), or patterns observed within studies exploring exposure, such as gender differences.

5.1.2.1 Conceptual Framework for Paper Two

When considering the development of a conceptual framework for the risk factors of childhood exposure to DVA, existing frameworks for risk factors for childhood violence and what makes an adult more likely to be a victim of DVA were considered. This is due to there being limited literature on risk factors for childhood exposure to DVA. Therefore, existing frameworks on a related area were examined to inform the conceptual framework development seen in Figure 5.1.

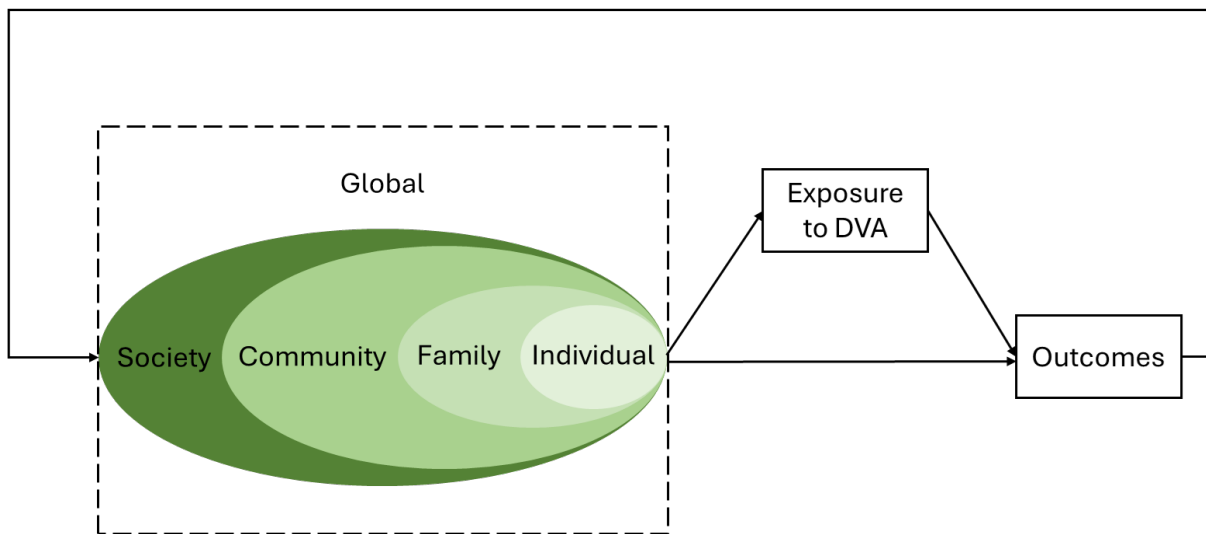


Figure 5.1 Conceptual framework for risk factors associated with childhood exposure to DVA

The framework illustrates how factors within a wider society feed into a community²⁹, which then feeds down into a family, and to an individual, in a similar way to how other ecological models explore health and behaviours, such as Bronfenbrenner (1979), and is akin to the Dahlgren-Whitehead rainbow, which demonstrates how broader factors filter through to

²⁹ The ecological domains within this thesis represent differences in scale, i.e., geographical/proximal categories. It considers geographical communities as opposed to interest communities (Poplin, 1979), and society is also considered in a geographical context, meaning wider (i.e., country-level) factors.

individual characteristics (Dahlgren & Whitehead, 1991). These ecological domains are represented by the circles on the left-hand side of the model, and as these factors could also have an adverse effect on a child, there is a solid arrow between these ecological domains and the ‘outcomes’ box. Additionally, global factors are recognised outside these four ecological domains as an indirect effect (therefore represented by a broken line).

Finally, the circular nature of violence and feedback loop is reflected in the framework, with arrows indicating that outcomes such as adverse effects on health and wellbeing can feedback into societies, communities, and families. This is explored further in Paper Three (Chapter 6), but within this model, it is represented by the ‘outcomes’ box. This conceptual framework and the categories within it guide both the literature review and analysis for this paper.

5.1.3 Individual Level Factors

A child’s level of education has been linked to a higher chance of a child being exposed to both DVA perpetrated between caregivers, and other types of violence. Breiding et al. (2011) found that children who had never attended school, or who had not completed primary school, were much more likely to be a direct victim of violence, and were more vulnerable to being exposed to violence in the home and community (a finding later supported in Breiding et al., 2013). This finding is supported by Fantuzzo and Mohr (1999), who found American children exposed to DVA were much likely to have poorer attainment at school, and Flynn-O’Brien and Rivara (2021), who found that children in Haiti who either had no primary schooling or incomplete primary schooling were at an increased risk of childhood physical violence, compared to those with complete primary schooling, who were more likely to report that no violence had occurred. Poor school attendance could increase a child’s likelihood of spending more time at home, thereby increasing their chances of being exposed to DVA if it is perpetrated within their home. There is also evidence that children who are exposed to DVA are reluctant to attend school, as they may fear about leaving a member of their family alone with the perpetrator due to concerns that violence may occur in their absence (Ward et al., 2001). This also highlights the issues with the cross-sectional survey data that is currently available to study exposure to DVA, with many factors potentially being both outcomes of, or risk factors for, exposure. However, these current studies do give an indication of further areas to explore and understanding if data becomes available which can temporally separate risk factors from outcomes.

Research in HICs has highlighted a range of other factors that are related to exposure, although there is minimal evidence from LMICs about this due to a lack of suitable data to explore this. These factors include an individual’s ability to talk to friends about important things and that they could “count on for support”, with those with poor peer relationships being found to be

more likely to be exposed to DVA perpetrated by adults in their home (Flynn-O'Brien, Rivara, Marcelin, Lea, & Mercy, 2015). However, similarly to a child's attendance at school, poor peer relationships could be an outcome of exposure, as opposed to a risk factor. For example, a meta-analysis exploring the outcomes of childhood exposure to DVA have found that children and adolescents who have experienced exposure have significantly poorer social outcomes when compared to children who have not been exposed to DVA (Chan & Yeung, 2009; Kitzmann et al., 2003). Both poor attendance at school and poor peer relationships could mean that a child is more likely to spend more time at home, increasing the likelihood of direct DVA exposure if DVA is being perpetrated in the household.

An important consideration in this area of research is the likelihood that someone who has been exposed to DVA between caregivers may have also been the victim of violence themselves ('co-occurring maltreatment'). This is supported by studies in both HICs and LMICs (Hamby, Finkelhor, Turner & Omrod, 2010; Krug et al., 2002; McKay, 1994). This co-occurrence of exposure to DVA perpetrated between caregivers with child maltreatment could mean that, in some reports, it may be difficult to separate exposure to DVA from those who have experienced direct violence themselves. Therefore, it may be difficult to state that any effects are purely due to exposure (Osofsky, 2003). Multiple theories exist as to why the co-occurrence of DVA and child abuse is so frequent, such as perpetrators not discriminating between family members, adult victims of DVA being unable to meet the needs of their children due to their own DVA, or children exposed to DVA trying to intervene (Devaney, 2015; Holden, 2003).

Similarly, exposure to multiple adverse childhood experiences (ACEs; Felitti et al., 1998) has been linked to a higher likelihood of being exposed to DVA perpetrated between caregivers or other adults in the home. Witnessing DVA is considered an ACE, as it is considered a stressful or traumatic event which affects a child through the environment in which they live (National Center for Injury Prevention and Control, 2022). Findings both in HICs and LMICs (including using the VACS – see Palermo et al., 2019) have found that those who have been exposed to DVA perpetrated between caregivers have a higher likelihood of being a victim of DVA or suffering abuse as a child (Hamby, Finkelhor & Turner, 2012; Palermo et al., 2019). This demonstrates that exposure to DVA is a common risk factor in both HICs and LMICs.

There appear to be gender differences in the ACEs reported alongside that of witnessing DVA. Guedes, Bott, Garcia-Moreno and Colombini (2016) found that girls who witness DVA are at a much greater risk of experiencing physical or sexual violence when compared to boys, who are more likely to report perpetrating physical or sexual violence later in life. Other researchers have highlighted gender differences in a child's likelihood to be exposed to DVA, citing that in some countries, females are more likely to spend time in the home and less likely to pursue work or

education, when compared to males (UNICEF, 2016). This means that if any violence is perpetrated in the home, females would be more susceptible to exposure. Due to this same reason, physical disabilities could also be considered a risk factor for exposure to DVA, as individuals may have less freedom in leaving their home without assistance from a caregiver, increasing the likelihood of exposure to violence if it is perpetrated within the home (Palermo et al., 2019).

5.1.4 Family Level Factors

An child's likelihood to be exposed to DVA can also be influenced by family factors. There is evidence suggesting that children from families with poorer economic conditions are more likely to be exposed to DVA. One study by Fantuzzo et al. (1997) examined the prevalence and risk of DVA and children in five major US cities. They found that the highest percentage of DVA was perpetrated in low-income families. This is supported by a study by Khan (2015), who found that DVA was more prevalent amongst those in lower-income homes in rural Bangladesh. Socioeconomic factors have also been identified as risk factors for children's exposure to DVA. Meltzer et al. (2009) found that amongst those in the UK, factors such as living in rented accommodation, poor neighbourhoods, and family dysfunction were independently associated with a greater likelihood of a child witnessing DVA, and "children from moderate means and hard-pressed families" are more likely to be exposed to DVA. Oğuztürk et al. (2019) also found that lower economic status was associated with a higher presence of DVA in a household amongst students in Turkey. In addition, studies have found that children exposed to DVA perpetrated between adults in their home are more likely to experience food insecurity (Chilton et al., 2013).

There are also a number of risk factors related specifically to a child's parents in HICs which are associated with an increased prevalence of DVA, therefore, an increased likelihood of exposure to DVA in childhood. These include poor parental psychopathology, parental drug or alcohol use (Levendosky, Huth-Bocks, Shapiro & Semel, 2003), parental unemployment and job loss (Bhalotra, Britto, Pinotti & Sampaio, 2021; Oğuztürk et al., 2019), educational differences between couples (Lasong et al., 2020). In addition, parental experience of childhood violence can increase the likelihood of that parent perpetrating or experiencing DVA in the future, with several studies both in HICs and LMICs finding a strong association between exposure to DVA as a child and perpetrating or experiencing violence in intimate relationships as an adult

(Roberts et al., 2010; Gupta et al., 2008; Widom, 2017; Crombach & Bambonye, 2015; Ludermit et al., 2017)³⁰. Therefore, this could increase the chance of a child being exposed to DVA.

The number of children in a household and increasing household size has also found to be a risk factor for DVA, and therefore, a child's likelihood of exposure. Cardenas and Cuesta (2022) used the data of mothers from the Colombian 2015 Demographic and Health Survey (DHS) and found some indication that the higher the number of children in a household (particularly those who are young), the greater the likelihood of their mother experiencing DVA. This could be linked to evidence that pregnancy can be a trigger for new or recurring episodes of DVA (Devries et al., 2010). A study based in India found that pregnant women with three or more children had 1.6 times higher odds of experiencing moderate to severe violence perpetrated by a partner during pregnancy than those who only had one child (Peedicayil et al., 2004). This is supported by a study in China, which found that women with more than two children had a significantly higher prevalence of DVA during pregnancy compared to those with a maximum of two children (Wang et al., 2017), and a study in the UK, who found that children in large families (with four or more children), were 50% more likely to have witnessed DVA perpetrated by one parent or caregiver against another (Meltzer et al., 2009). These studies suggest that in both HICs and LMICs, multiple children in a household puts a child at increased risk of exposure to DVA. This could, in turn, link to the fact that larger families are often more likely to be socioeconomically disadvantaged, an association found both in HICs (e.g., Stewart, Reeves & Patrick, 2023), and LMICs (Rose, Ishan & Adil, 2021).

Research suggests that the divorce or separation of parents can increase the likelihood of a child being exposed to DVA perpetrated between parents or caregivers, with Meltzer et al. (2009) finding that within a national UK survey, having divorced parents was independently associated with a greater likelihood of a child being exposed to DVA. This is supported by studies in other HICs, such as Doucet and Aseltine (2003), but the evidence for this in LMICs is low. Holden (2003) states in his taxonomy that separation of parents is a type of exposure ('experiences the aftermath'). In addition, the number of household moves prior to the age of 18 has been found to be a risk factor for violence (Breiding et al., 2011; Flynn-O'Brien & Rivara, 2021), which could be an outcome of the divorce or separation of a child's parents. Similarly, the death of a biological parent (in particular, maternal death prior to the age of 13) or not living with biological parents has been found to put children at greater risk of experiencing other forms of violence (Breiding et al., 2011; Breiding et al., 2013; Palermo et al., 2019), and so could also be a risk factor for childhood exposure to DVA. Again, this breakdown of family structures, or death of a

³⁰ This is often referred to as the 'intergenerational transmission of violence' (Widom, 1989), and is detailed further in Section 2.5.3.

parent could be due to the violence perpetrated by a parent or caregiver, and could be another way in which children are exposed to DVA. Finally, acceptable use of violence within a family to resolve conflict has been highlighted within research as a potential risk factor for a child's exposure to DVA. If a family regularly use, and normalise, violent strategies to resolve conflict within the home, then this increases a child's risk of exposure to DVA, as DVA is more likely to occur (Coleman & Straus, 1986; Kim & Emery, 2003). Similarly, interpretation of maltreatment by parents may vary according to what is personally acceptable as a disciplinary measure (Cyr, Michel, & Dumais, 2013), putting children at a greater risk of both exposure to DVA, and of being a victim of child abuse.

5.1.5 Community and Society Level Factors

Whilst there is limited literature focusing on risk factors for childhood exposure to DVA, many studies provide insights into the broader community, societal, and country-level factors which can contribute to DVA, thus increasing the potential for a child to be exposed. This section will take a brief overview at some of the factors most prevalent in the existing literature.

One such study suggests that neighbourhood characteristics such as concentrated disadvantages, low social cohesion, residential instability, and high levels of poverty and unemployment can increase the risk of DVA. These factors may create an environment that is conducive to violence and can potentially impact children's exposure to DVA perpetrated between adults (Gracia et al., 2018). This supports social disorganization theory (Shaw & McKay, 1942), which argues that concentrated neighbourhood violence and violence in the community are linked to higher levels of violence in the home³¹. This is supported by numerous studies, such as Kim et al. (2012) and McDowell and Reinhard (2022), who found that neighbourhoods with higher levels of social disorganization are more likely to have higher rates of DVA. Similarly, the prevalence of violence in the community, society or country is another factor which can increase a child's likelihood of being exposed to DVA. If DVA is more common and accepted within a society, it increases the likelihood that children will be exposed to such violence (Malik, 2008; Lourenço et al., 2013). This can be attributed to the fact that exposure to violence becomes normalised in such communities, increasing the likelihood of DVA occurring within households (Malik, 2008).

³¹ According to this theory, when a community lacks social control mechanisms and has weakened social bonds, it becomes more susceptible to criminal activities, including DVA. The theory suggests that there is a breakdown of informal social control in socially disorganized neighbourhoods, resulting in a higher likelihood of DVA. Factors such as poverty, unemployment, residential mobility, and a lack of community resources can contribute to the disorganization of social structures and weaken the ability of community members to intervene and prevent DVA.

Cultural norms and attitudes towards gender roles and violence can influence the prevalence of DVA within a society (Lourenço et al., 2013). For example, in societies where patriarchal norms are prevalent, there may be a higher acceptance of DVA and a belief that it is acceptable for men to exert control over women, which can perpetuate and normalise abusive behaviours perpetrated within relationships (Koenig et al., 2003), therefore increasing the likelihood of children being exposed to DVA. In addition to this, societal beliefs and values can contribute to the stigma and shame associated with being a victim of DVA (regardless of gender, but perhaps with an increased stigma for male victims). Victims may fear judgment, blame, or social isolation if they disclose their experiences, preventing them from seeking help or reporting the abuse, which can lead to a higher prevalence of DVA (Mshweshwe, 2020), but also increased underreporting. Gender inequality, national values, and societal beliefs can influence the awareness and understanding of DVA (Caprioli, 2005). In societies where there is limited awareness or education about the dynamics of abuse, victims may not recognise their experiences as DVA (Mshweshwe, 2020), and this lack of awareness can contribute to the perpetuation of abusive behaviours whilst hindering efforts to address the issue effectively. These cultural factors can shape attitudes and behaviours related to DVA, increasing the likelihood that children are exposed to such violence (Kim et al., 2012).

The availability and accessibility of resources and support services for victims of DVA can also affect a child's exposure to DVA (Sousa et al., 2010). Countries or societies with well-established support systems, such as shelters, hotlines, and counselling services, can provide assistance to victims and help them escape abusive situations (Sousa et al., 2010). In contrast, societies with limited resources and inadequate support services may make it more difficult for victims, including children, to seek help and protection from DVA (Sousa et al., 2010; Postmus, Severson Berry & Yoo, 2009). Similarly, communities with limited resources and support services may have fewer options for victims of DVA to seek help and escape abusive situations (Edwards, 2014). In some countries, these resources and support services can be concentrated, and some areas (for example, those living in rural areas) may not be able to easily access support (Peek-Asa et al., 2011; Zielewski & Macomber, 2007). If a parent experiencing DVA is unable to access shelter or support, then this can increase the likelihood of children being exposed to ongoing violence.

The legal and justice systems of a society or country also play a crucial role in addressing DVA and protecting children. The existence of laws and policies that criminalise DVA and provide legal support for victims can act as a deterrent and provide a sense of security for children and their families, and the enforcement of these laws (and effectiveness of the justice system in holding perpetrators accountable) can help reduce the likelihood of children being exposed to DVA (D'Ambrosio, 2008). In some societies, there may be a lack of comprehensive laws,

policies, and support services to address DVA (Dalal & Lindqvist, 2010). This can create barriers for victims seeking help and contribute to a higher prevalence of abuse. Similarly, the policing practices and responses to DVA can have a significant impact on a child's likelihood of being exposed to DVA. If there is a low conviction rate, or low policing of DVA cases, then this can increase a risk of a child's exposure to DVA (Winfield et al., 2023). Effective police intervention in cases of DVA can help mitigate the risk and reduce the likelihood of children being exposed to ongoing DVA (Foster et al., 2012). However, factors such as inconsistent policies, limited collaboration with child protection services, and procedural influences can impede police officers' response to children exposed to DVA (Winfield et al., 2023).

A recent war or conflict within a country or region has also been linked with an increased prevalence of DVA and, therefore, of a child being exposed to it. During times of war or conflict, perpetration of DVA may increase due to various factors, such as the breakdown of social structures and disruption of community support systems (Gray, 2018), stress, trauma and displacement caused by war exacerbating tensions within households (Kitzmann et al., 2003), and the presence of armed actors and the normalisation of violence in conflict settings can contribute towards a culture of violence perpetration which feeds down into households (Gray, 2018). Refugee populations and internally displaced people are particularly vulnerable to DVA in humanitarian settings, as displacement and the loss of social networks and support systems can increase the risk of violence within families (Betancourt et al., 2012). The trauma experienced during war and displacement can also contribute to mental health problems, which can further increase the risk of DVA (Klasen et al., 2010). Humanitarian responses can play a crucial role in mitigating the prevalence of DVA and can contribute to reducing the prevalence of DVA in post-conflict and humanitarian settings. Adequate support services, including counselling, safe shelters, and legal assistance, can help survivors of DVA access the help that they need (Rubenstein et al., 2017).

Furthermore, some research has shown that DVA is more prevalent in LMICs than in HICs, and this could be attributed to the countries' socioeconomic status, poverty, and economic inequality (Keynejad et al., 2020). Additionally, there is evidence to suggest that children in LMICs may spend more time at home, increasing their risk of exposure to DVA if it occurs (Grantham-McGregor et al., 2007). This may be due to various factors, such as poverty and limited access to early childhood education (Engle et al., 2011; Kamiya, 2021). The most recent global estimates available found that close to 300 million children are exposed to DVA worldwide, but only 4.6 to 11.3 million of these children are in HICs, suggesting a high number of children in LMICs are exposed (UNICEF, 2006). Whilst the available literature suggests that children in LMICs may have a higher likelihood of being exposed to DVA when compared to children in HICs, there is a distinct lack of evidence on the prevalence of exposure to DVA within

LMICs, or what makes a child more at risk of exposure in LMICs, which is why this is the chosen focus for this paper.

5.1.6 Aim and Purpose of Study

Despite research indicating that a high number of children are exposed to DVA, particularly in LMICS (Figure 2.1; UNICEF, 2016), there is a distinct lack of research into what makes a child more at risk of exposure. This, coupled with the fact that the existing estimates are nearly two decades out of date, means that we do not have a clear idea of the actual number of children exposed to DVA or how those children can be identified so that appropriate interventions can be targeted. While some research on childhood exposure to DVA within LMICs does exist, very few of these studies focus on risk factors, and those who look at LMIC populations generally have small sample sizes. The literature review highlighted a range of factors which could increase a child's likelihood of exposure to DVA, including individual, family, community, and society-level factors. The findings of the literature review suggest that an approach at each of these levels (i.e., a multi-faceted approach) is needed to address the issue of childhood exposure to DVA in LMICs, but that further research is required to assess this and to develop further the evidence base on childhood exposure to DVA in LMICs.

Therefore, this paper aims to analyse secondary data from a multi-country survey to determine the prevalence and variation of childhood exposure to DVA in selected low- and middle-income countries and identify any risk factors that may be associated with exposure. This will be done through answering the research question: *What is the prevalence of, and risk factors associated with childhood exposure to domestic violence and abuse across selected low- and middle-income countries?*

5.2 Methods

5.2.1 Selection of VACS Datasets for Analysis

Ethical approval to conduct secondary data analysis on the VACS was granted by the University of Southampton Ethics and Research Governance Committee, and a request for access to the VACS datasets made to the managing body, Together for Girls. Full datasets were received for the VACS for the following countries: Cambodia, Colombia (National and Priority Municipalities), Côte d'Ivoire, Eswatini, Haiti, Honduras, Kenya, Lesotho, Malawi, Moldova, Namibia, Nigeria, Tanzania, Zambia, and Zimbabwe.

The country questionnaires and datasets were examined prior to analysis, and the datasets of Eswatini, El Salvador, Haiti, Kenya, Tanzania and Zimbabwe were excluded from analysis, along

with the Colombia Priority Municipalities dataset, to allow for better comparability across questions (full justification of why each dataset was excluded can be found in Section 3.3). Therefore, ten VACS country datasets were used for analysis: Cambodia, Colombia National (referred to only as ‘Colombia’ from now on), Côte d’Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, and Zambia. Further details on the sampling methods and calculation of participation rates can be found within the VACS Country Reports (CDC, 2022, see also Section 3.3.1 and Table 3.4).

5.2.2 Assessing Risk Factors Associated with Childhood Exposure to DVA within the VACS

Due to the cross-sectional nature of the VACS, assessing temporality is difficult, and there is no way of knowing if the risk factor (e.g., death of a biological parent), happened before or after the exposure. This limitation is in addition to the general limitation that cross-sectional, correlational data cannot reveal causal relationships. Therefore, although the term ‘risk factors’ is used throughout this paper, the determination of these factors is based on prior literature and this study cannot ascertain any causality between these factors and exposure. These issues are acknowledged by other papers using the VACS (e.g., Annor et al., 2022; Kafuko et al., 2022). Whilst previous papers have focused on risk factors, protective factors, and outcomes, and acknowledged this as a limitation, for the purpose of this thesis the terms “risk factors associated with” or “associated risk factor” will instead be used. Looking instead for associations between exposure to DVA and potential background factors also allows for factors to cross-lag over time (Kearney, 2017) and both be risks, and outcomes of the exposure.

5.2.3 Selection and Creation of Variables for Analysis

The decision was made to look at the overall rates of childhood exposure to not only DVA (violence perpetrated between adults in the home), but also child abuse (adult perpetrated violence to a child under the age of 18 in the home), and community violence, to examine if there was a relationship between exposure to each of the three types of violence.

The impact of violence perpetrated in the community can be linked to both being a risk factor, and an outcome of exposure to DVA perpetrated by caregivers or adults within the home. Social disorganization theory (Shaw & McKay, 1942) argues that concentrated neighbourhood violence and violence in the community is linked to higher levels of violence in the home. As an outcome, studies have found that children exposed to DVA perpetrated by caregivers or family members are more likely to commit violent crimes (Fantuzzo & Mohr, 1999), which therefore contributes to community violence perpetrated by peers or adults, increasing the likelihood of exposure for

other children, creating a cycle of exposure to violence. Therefore, overall exposure rates to community violence were examined for each country.

Therefore the first stage of analysis was to create a “yes/no” variable to assess exposure for the three types of violence. Using Stata 17.0 (StataCorp, 2021), the variables were created using existing questions from within the VACS. Within the questionnaires, slight variations existed, such as the way in which the perpetrator and victim of the DVA were described (Table 3.5 displays the question asked and response options for each country). The datasets for Cambodia also included an additional question about exposure to DVA: “thinking about inside your home, have you ever seen an adult hurt or scare another adult by using or threatening to use a gun, stick, rock, or other similar weapon”, and the dataset for Colombia asked, “In a situation of combat within the internal conflict, how many times did you see anyone get attacked?”, but these questions were excluded from the creation of the variables to allow for better consistency and comparability across countries.

Any indication that there had been exposure to each type of violence, regardless of the frequency was coded as “yes”, to allow for an overall exposure statistic to be obtained to use in analysis of risk factors. For “don’t know/declined”, this was recoded as missing data, as it was considered a non-response which could obscure the ‘real’ level of exposure if calculated as “no”. Table 3.5 demonstrates how the exposure to DVA variable was recoded³². Risk factors associated with exposure to DVA were then examined in line with the three ecological domains of individual, family, and community and societal level. The majority of risk factors were explored through existing variables within the surveys, but some, such as death of a biological parent, were new variables derived from other questions (see Appendix B for how these variables were recoded). Some risk factors associated with DVA cited in the literature were not explored, either because the VACS questionnaire did not ask about them, or the way in which the surveys asked the questions varied too much between countries, meaning that it would have been difficult to standardise the variables and make country comparisons. Therefore, it was decided that these variables would not be explored within this paper. Response rates were examined for each risk factor variable prior to analysis, and if any variables had 5% or more missing data, then this was examined further. This decision was guided by literature from Schafer (1999) who asserted that a missing rate of 5% or less is inconsequential, and Bennet (2001), who stated that statistical analysis is likely to be biased when more than 10% of the data is missing.

³² A full table of how each exposure to violence types variable was created and recoded can be found in Appendix B.

5.2.4 Joint Variables and Collinearity

Consideration was given to issues of joint variables and collinearity. All variables were assessed to understand if there were common categories between variables, which may cause issues when using together in joint analyses. Joint variables were found to be: “death of biological mother” and “living with biological mother”, “death of biological father” and “living with biological father”, and “death of a biological parent” and “living with both biological parents”. However, cross tabulations of these variables revealed that some respondents’ parents died after they stopped living together, and so this is not an issue for analysis.

5.2.5 Weightings and Differences Between Estimates

Due to the complex sample design, weightings were applied using guidance within the Data File Summary provided by Together for Girls for each country dataset. During analysis, 95% confidence intervals will be included to indicate the degree of confidence in the accuracy of point estimates, within a specified margin of error.

5.2.6 Methods of Analysis

StataSE 17.0 was used for analysis of these datasets. Six of the country datasets were received from the data source as overall country data (i.e., combined male and female biological sex), and those of Cambodia, Malawi, Nigeria and Zambia were presented as two separate datasets – one for males, and one for females. Therefore, these were combined to allow for analysis of country prevalence of exposure to DVA and of risk factors associated with exposure to DVA.

Following creation of the exposure variables for each violence type, the overall exposure rate for each dataset was calculated, by cross-tabulating the various exposure variables by biological sex to gain an exposure statistic for DVA, child abuse, and community violence for the country, and then within this, male and female exposure rates. To explore risk factors, column percentages were created, and these were recorded in the form of a table to allow for analysis across countries to assess risk factors for exposure to DVA. Confidence intervals indicated that there was sufficient power in the data and in each group to allow for further analysis to be undertaken. This was demonstrated by the size of the confidence intervals and the care taken to ensure that there is no multicollinearity within the explanatory factors chosen for further analysis.

Individual level factors explored include biological sex, ever attended school, and education level. Family level factors consist of death of a biological parent (death of biological mother and death of biological father were also examined separately to explore whether there are any

differences), living with both biological parents (again, living with biological mother and living with biological father were also explored separately), along with family economic conditions. This was created using wealth tertiles constructed based on the DHS Wealth Index measurement approach, using principal components analysis of household survey items related to country-specific indicators of household wealth to generate a wealth score for each household (Filmer & Pritchett, 1998; Rutstein & Staveteig, 2014). The decision to use tertiles, rather than quintiles, was due to small sample sizes in some countries. Within the datasets for Colombia and Moldova, there were also a number of individuals for whom the household questionnaire had not been completed (which is where this variable was derived from). For these two countries, an additional category was created, “no household questionnaire”, so not to skew the data and distort analysis through the removal of individuals without this information. Societal and community factors explored included exposure to violence perpetrated in the community, and, and societal acceptance of DVA perpetrated by men against women. The variable ‘societal acceptance of domestic violence and abuse’ was constructed using one question within the VACS: “Do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA perpetrated by a man against his wife was acceptable, and if they answered “no” to all five scenarios, then they were coded as “no”. An additional category was created for this variable if someone did not fit into either of the previous categories and failed to answer all five scenarios (“incomplete answer”). Whilst the VACS collects responses at the individual level, a decision was made to include this as a societal risk factor³³. This is because an individual’s response is affected by societal views and what is occurring around them, and therefore, responses to this question can be used as a proxy for societal views, providing wider country context which the VACS data cannot.

Binary logistic regression analysis was conducted to assess which factors had the greatest influence on a child’s likelihood to be exposed to DVA. A regression model for each ecological domain was created within each country, followed by an overall additive model. Reference categories were selected with the literature review in mind, choosing the response which was least associated with exposure to DVA (for example, not completing primary school was found to be a risk factor, and so completion of primary school was chosen to be the reference category). Average marginal effects were used to calculate predicted probabilities for each

³³ A sensitivity analysis was conducted of the additive model to assess whether this variable should be excluded. The main difference within this model to that of the additive model was the predicted probabilities for females in Namibia. Even though this figure increased from 0.034 to 0.095, both of these predicted probabilities were non-significant, and so the decision was made to keep this variable within the analysis.

group, allowing for comparison in terms of absolute percentage-point differences rather than odds ratios (Mood, 2010). This approach allows for clearer interpretation of findings across different models and countries. The results of the logistic regression models³⁴ were expressed in terms of predicted probabilities using the following formula:

$$\log_e \left(\frac{p}{1-p} \right) = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n$$

To provide further insight into what makes a child more likely to be exposed to DVA, predicted probabilities were estimated using the final additive regression model. A probability scale was constructed (presented in Section 5.3.4) using the log-odds from this model and based on the significant risk factors. The first step involved calculating predicted probabilities for a baseline profile, using the same reference categories from the regression analysis (unless otherwise stated). These baseline characteristics included: having completed primary school (education), being in the ‘richer’ wealth category, having both biological parents alive, living with both biological parents, being the only child in the household³⁵, not having been exposed to community violence, and not believing that DVA is acceptable under any circumstance. Probabilities were then calculated using the following formula, where p is the probability of exposure to DVA, β_0 is constant and β_n is the list of potential explanatory variables.

$$p = \frac{e^{\beta_0 + \beta_1 + \beta_2 x_2}}{e^{\beta_0 + \beta_1 + \beta_2 x_2} + 1} = \frac{1}{1 + e^{-(\beta_0 + \beta_1 + \beta_2 x_2)}}$$

Probabilities were calculated for the overall baseline characteristics, and then specifically for the risk factors of education and wealth.

5.3 Results

5.3.1 Overall Exposure to Violence Statistics

Cross-tabulations revealed the percentages of children exposed to DVA, child abuse, and community violence across the ten VACS countries explored. These are presented in Table 5.1, along with confidence intervals, and displayed via a clustered bar graph in Figure 5.2.

³⁴ Interactions were tested where indicated in previous literature, but were not found to have a significant effect on the outcome.

³⁵ This factor was not possible to assess in Cambodia.

Table 5.1 Estimates of childhood exposure to violence types by VACS country (unweighted total number of participants, and weighted percentages)

MDG Region ³⁶	Country (Survey Year)	Type of Violence Children were Exposed to					
		Household				Community	
		Domestic Violence and Abuse		Child Abuse†			
		n	% (95% CI)	n	% (95% CI)	n	% (95% CI)
Sub-Saharan Africa	Côte d'Ivoire (2018)	2394	17.69 (15.48-20.15)	2393	42.02 (38.37-45.76)	2398	32.44 (28.88-36.22)
	Male	1200	17.77 (15.06-20.84)	1198	42.85 (37.52-48.36)	1203	38.88 (33.57-44.47)
	Female	1194	17.62 (14.27-21.55)	1195	41.18 (36.40-46.12)	1195	25.92 (21.46-30.95)
	Lesotho (2018)	8539	29.12 (26.83-31.52)	8530	24.15 (21.80-26.68)	8557	29.49 (26.25-32.96)
	Male	1458	26.23 (22.27-30.61)	1461	24.15 (19.44-29.59)	1465	37.96 (32.19-44.09)
	Female	7081	32.02 (30.31-34.10)	7069	24.16 (22.30-26.11)	7092	21.01 (19.20-22.95)
	Malawi (2013)	2147	30.68 (27.43-34.14)	2155	41.72 (38.47-45.04)	2159	33.52 (30.59-36.59)
	Male	1128	31.12 (27.13-35.41)	1132	46.96 (42.66-51.31)	1131	37.09 (32.83-41.57)
	Female	1019	30.29 (25.28-35.81)	1023	37.00 (33.07-41.10)	1028	30.31 (26.63-34.25)
	Namibia (2019)	792	15.45 (13.64-17.46)	1271	26.00 (22.98-29.26)	2205	49.07 (44.17-53.98)
	Male	162	15.05 (12.41-18.13)	256	24.90 (20.60-29.76)	525	52.82 (44.39-61.08)
	Female	630	15.95 (13.60-18.62)	1015	27.34 (23.28-31.82)	1680	44.49 (40.11-48.97)
	Nigeria (2014)	4098	29.60 (27.19-32.13)	4128	56.59 (54.07-59.07)	4044	41.42 (38.80-44.09)
	Male	2386	25.99 (23.09-29.12)	2415	52.65 (49.44-55.83)	2370	39.51 (36.52-42.58)
	Female	1712	33.10 (29.34-37.09)	1713	60.40 (56.62-64.07)	1674	43.27 (39.03-47.61)
	Zambia (2014)	1785	30.31 (27.97-32.76)	1789	40.70 (37.85-43.62)	1792	36.46 (33.64-39.38)
	Male	913	27.27 (24.44-30.30)	914	41.81 (38.28-45.43)	916	33.70 (30.28-37.31)
	Female	872	33.25 (30.27-36.36)	875	39.63 (36.00-43.39)	876	39.13 (35.90-42.46)
Latin America and the Caribbean	Colombia (2018)	2671	19.68 (16.21-23.68)	2682	23.96 (20.03-28.38)	2687	52.47 (48.04-56.85)
	Male	1281	16.12 (12.50-20.54)	1288	23.60 (18.05-30.22)	1292	54.12 (47.84-60.28)

³⁶ As discussed in Chapter 2, Millenium Development Goal (MDG) Regions are used throughout this thesis to allow for comparability with the latest global estimates for childhood exposure to DVA (UNICEF, 2006).

MDG Region ³⁶	Country (Survey Year)	Type of Violence Children were Exposed to					
		Household				Community	
		Domestic Violence and Abuse		Child Abuse†			
		n	% (95% CI)	n	% (95% CI)	n	% (95% CI)
	Female	1390	23.39 (17.73-30.21)	1394	24.33 (19.10-30.45)	1395	50.73 (44.52-56.92)
	Honduras (2017)	5176	11.80 (10.77-12.91)	5181	11.53 (10.37-12.81)	5186	32.99 (30.95-35.10)
	Male	2652	8.95 (7.70-10.39)	2654	9.61 (8.15-11.30)	2655	34.22 (31.38-37.17)
	Female	2524	14.54 (13.03-16.18)	2527	13.38 (11.65-15.32)	2531	31.82 (28.90-34.88)
South-Eastern Asia	Cambodia (2013)	2372	20.41 (18.32-22.68)			2373	58.49 (55.64-61.28)
	Male	1251	21.24 (18.50-24.28)	Not assessed in questionnaire		1254	59.53 (55.31-63.60)
	Female	1121	19.57 (16.47-23.09)			1119	57.43 (53.49-61.28)
Eastern Europe	Moldova (2019)	1912	17.36 (14.70-20.39)	1949	16.69 (14.07-19.70)	1913	56.67 (52.24-60.99)
	Male	939	12.82 (9.78-16.62)	951	13.42 (10.58-16.88)	945	62.67 (56.65-68.31)
	Female	973	21.92 (18.03-26.37)	998	19.97 (15.97-24.68)	968	50.66 (44.51-56.80)

† Parental physical violence towards a sibling of the respondent, although the questionnaires do not specify the age of the sibling.

These initial exposure statistics indicate that exposure to DVA perpetrated between adults is a prevalent issue, with Malawi having the highest overall percentage of childhood exposure to DVA (30.68%), and Honduras the lowest (11.80%), as illustrated in Figure 5.2.

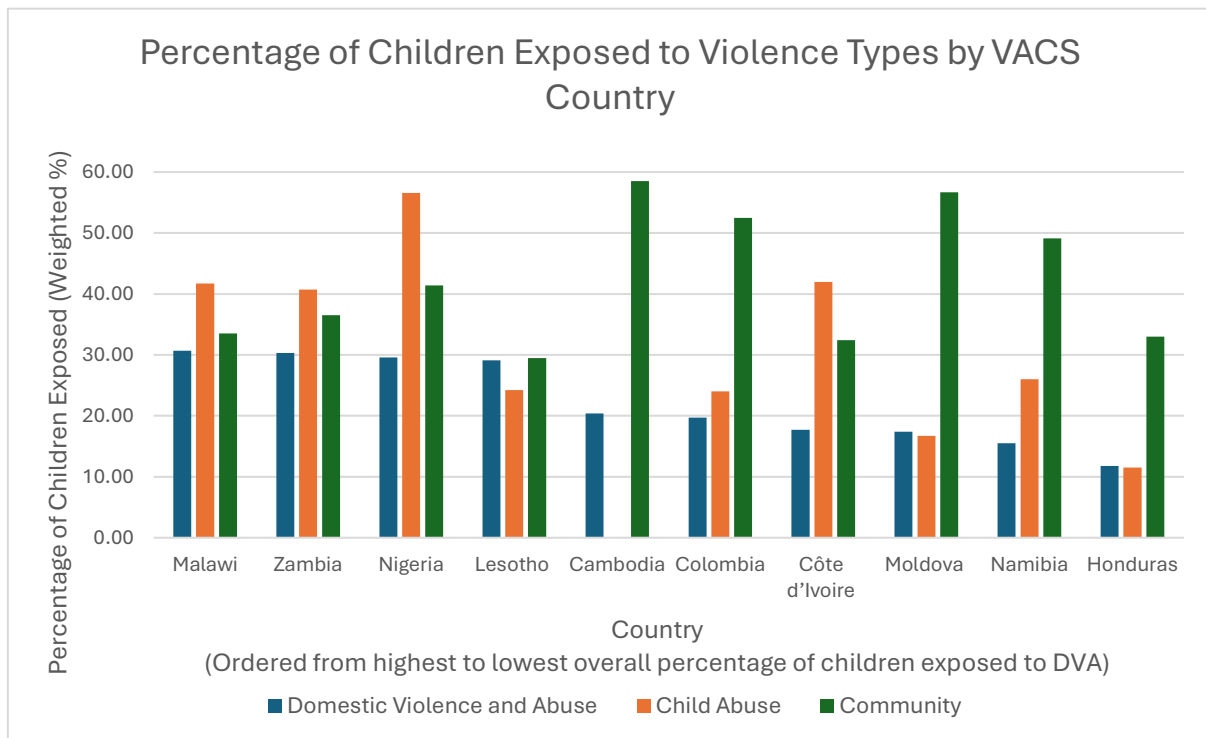


Figure 5.2 A clustered bar graph displaying the percentage of children exposed to violence types by VACS country (using weighted percentages)

Across all VACS countries included in this thesis, exposure to community violence is higher than exposure to DVA, supporting social disorganization theory (Shaw & McKay, 1942). However, this is not the case when split by sex, as there appears to be differences between population groups. For males, exposure to community violence is still higher than DVA in all countries, but for females, Lesotho and Malawi do not follow this pattern. Co-occurrence of exposure to DVA and exposure to child abuse is common (see Appendix C.2), although this was not asked in the questionnaire for Cambodia. When looking at overall country levels of exposure to child abuse, Nigeria reported the highest prevalence (56.59%), and Honduras the lowest (11.53%). Females appear to be more likely to be exposed to child abuse than males, except in the countries of Côte d'Ivoire, Malawi, and Zambia.

When looking at DVA alone, in general, females appear to be more likely to be exposed to DVA perpetrated between caregivers than males (see Figure 5.3). This was the case in seven of the ten countries, with the exceptions being Côte d'Ivoire, Malawi, and Cambodia, where males reported a higher prevalence of exposure to DVA. The largest absolute difference when

comparing males and females was in Moldova, where the prevalence rate for males was 12.82%, and females 21.92%.

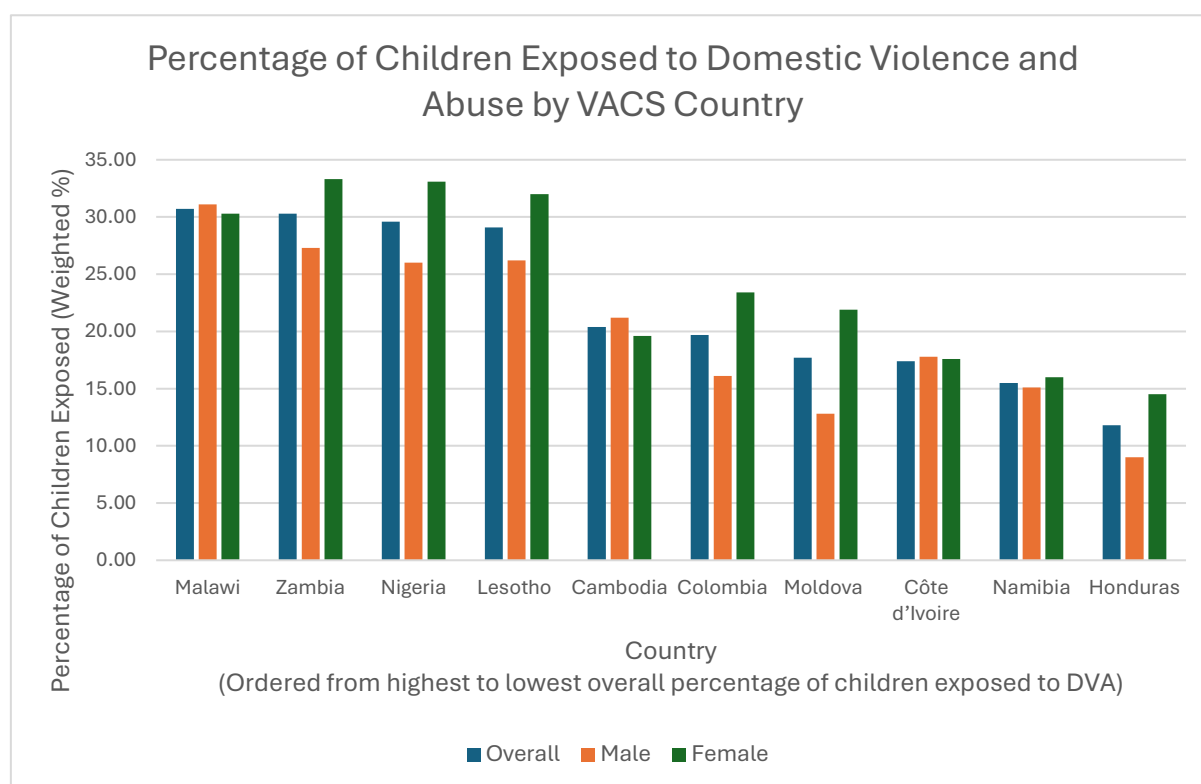


Figure 5.3 A clustered bar graph displaying estimates of children's exposure to domestic violence and abuse by VACS country (using weighted percentages)

To gain a better understanding of the number of children exposed to DVA in the ten LMICs explored, the figures presented in Table 5.1 were compared with the actual numbers of people aged 13-24 from each country at the time of the survey. This was done using the World Population Prospects³⁷ (United Nations Department of Economic and Social Affairs, Population Division, 2024). This allows for the weighted percentages to be actualised into numbers of children who have been exposed to DVA. The results from this can be found in Table 5.2.

³⁷ The World Population Prospects provides data by 1-year age groups and sex, through the annual population by single age and by sex (interpolated data based on 5-year age groups and 5-year periods). De facto population as of 1 July of the year indicated classified by single age (0, 1, ..., 99, 100+).

Table 5.2 Estimates of Children Exposed to DVA in Ten LMICs

MDG Region	Country (Survey Year)	Estimates of People Aged 13-24 Exposed to DVA before the age of 18 in Ten LMICs					
		Weighted Percentage (% , 95% CI)			Number of Children Exposed (rounded to the nearest person, 95% CI)		
		Overall	Male	Female	Overall	Male	Female
Sub-Saharan Africa	Côte d'Ivoire (2018)	17.69 (15.48-20.15)	17.77 (15.06-20.84)	17.62 (14.27-21.55)	1,101,036 (963,484-1,254,148)	569,582 (482,718-667,985)	531,905 (430,777-650,542)
	Lesotho (2018)	29.12 (26.83-31.52)	26.23 (22.27-30.61)	32.02 (30.31-34.10)	156,013 (143,744-168,871)	69,999 (59,431-81,687)	86,099 (81,501-91,692)
	Malawi (2013)	30.68 (27.43-34.14)	31.12 (27.13-35.41)	30.29 (25.28-35.81)	1,240,310 (1,108,922-1,380,189)	612,670 (534,118-697,129)	628,214 (524,307-742,699)
	Namibia (2019)	15.45 (13.64-17.46)	15.05 (12.41-18.13)	15.95 (13.60-18.62)	94,959 (83,834-107,313)	46,258 (38,144-55,725)	49,007 (41,787-57,211)
	Nigeria (2014)	29.60 (27.19-32.13)	25.99 (23.09-29.12)	33.10 (29.34-37.09)	12,893,849 (11,844,046-13,955,925)	5,760,249 (5,117,512-6,453,961)	7,082,398 (6,277,872-7,936,137)
	Zambia (2014)	30.31 (27.97-32.76)	27.27 (24.44-30.30)	33.25 (30.27-36.36)	1,209,234 (1,115,878-1,306,978)	539,857 (483,832-599,841)	668,285 (608,391-730,793)
Latin America and the Caribbean	Colombia (2018)	19.68 (16.21-23.68)	16.12 (12.50-20.54)	23.39 (17.73-30.21)	2,012,112 (1,657,334-2,421,078)	835,905 (648,189-1,065,105)	1,178,536 (893,350-1,522,171)
	Honduras (2017)	11.80 (10.77-12.91)	8.95 (7.70-10.39)	14.54 (13.03-16.18)	288,990 (263,765-316,175)	111,865 (96,254-129,863)	174,361 (156,253-194,028)
South-Eastern Asia	Cambodia (2013)	20.41 (18.32-22.68)	21.24 (18.50-24.28)	19.57 (16.47-23.09)	769,182 (690,417-854,731)	394,847 (343,911-451,359)	373,724 (314,524-440,944)
Eastern Europe	Moldova (2019)	17.36 (14.70-20.39)	12.82 (9.78-16.62)	21.92 (18.03-26.37)	70,860 (60,003-83,228)	25,767 (19,657-33,405)	45,415 (37,356-54,635)

These figures demonstrate that amongst the ten countries explored, it is estimated that over 19 million children have been exposed to DVA perpetrated between adults in their home³⁸. Whilst the existing figures are out of date and not directly comparable, the most recent global statistics estimate that 133 to 275 million children have been exposed to DVA (Figure 2.1; UNICEF, 2006), meaning that these ten countries alone account for 7.21-14.91% of the latest global estimates. We cannot be certain that these numbers would apply outside of the ten countries explored, but these figures indicate that exposure to DVA is a prevalent issue in LMICs. The figures from this

³⁸ The analysis within this paper estimates that the number of children exposed to DVA across the ten LMICs explored is 19,836,545 (17,931,427-21,888,634).

paper suggest that there is a need to gain accurate and updated global statistics, and for further research to be conducted into the prevalence of childhood exposure to DVA in LMICs.

5.3.2 Analysis of Risk Factors Associated with Childhood Exposure to DVA in LMICs

Risk factors associated with exposure to DVA were examined by ecological domain, the variables of which were guided by the literature review. Sex differences in exposure rates were examined as part of the initial analysis, and a summary of exposure to different types of violence depending on biological sex can be found in Table 5.1. As previously mentioned, initial analysis from the VACS suggested that females are generally more likely to be exposed to DVA.

The risk factors of ever attended school and education level were examined as part of the analysis of individual level risk factors, a summary of which can be found in Table 5.3 (Appendix D with confidence intervals). These cross tabulations revealed mixed results across the two education variables. In six of the ten countries, ever attending school was associated with a higher risk of being exposed to DVA perpetrated by adults in the home, but this is not the case when split by sex. For males, in five countries attending school was associated with a higher risk of being exposed to DVA, but in the other five, there was a lower risk. In some countries the percentage of children exposed were almost double between the categories, for example, for the male Côte d'Ivoire population, the exposure rate for those who had ever attended school was 18.82%, compared to those who had never attended school, which was 9.01%. This is compared to the male population of Honduras, where exposure to DVA was 22.50% amongst those who had never attended school, compared to 8.82% who had. In the female populations, in seven of the ten countries, attending school was associated with higher levels of exposure to DVA perpetrated between caregivers, with large differences existing between those who had and had never attended school in the female populations of Malawi, Honduras, Cambodia, and Moldova. Results were also mixed for education level, with four of the six countries in the Sub-Saharan Africa regional grouping having higher exposure rates had they completed primary school, compared to those who had not completed primary school, or were currently completing primary school. There is less variation between the populations of overall, male, and female within each country when compared to ever attended school, but this could in part be due to children attending school (and thus there is a higher overall percentage of children who would have been included in the “yes” category for ever attending school), but dropping out prior to completing certain levels of schooling, resulting in more variation in the latter variable.

Table 5.3 Estimates of childhood exposure to domestic violence and abuse by individual-level associated risk factor and VACS country (weighted percentages)

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Overall Percentage of Exposure to DVA		17.69	17.77	17.62	29.12	26.23	32.02	30.68	31.12	30.29	15.45	15.05	15.95	29.60	25.99	33.10
Ever Attended School	Yes	18.26	18.82	17.64	29.10	26.15	32.01	31.04	31.08	30.99	15.57	15.17	16.06	28.77	25.28	32.56
	No	14.39	9.01	17.51	30.13	28.72	33.58	22.35	32.27	16.50	11.82	10.09	14.39	33.53	30.76	35.08
Education Level	Completed primary	18.22	19.43	16.88	30.17	27.39	32.76	32.22	32.73	31.83	16.36	16.51	16.18	28.65	24.99	32.67
	Not completed primary	14.39	9.01	17.51	27.92	26.92	30.00	23.20	32.27	18.02	10.23	7.22	16.05	32.77	28.86	35.13
	Currently completing primary	18.73	12.41	25.82	23.18	20.30	27.09	28.97	28.92	29.03	12.41	10.80	15.26	29.68	29.39	29.97

Table 5.3 Cont.

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Overall Percentage of Exposure to DVA		30.31	27.27	33.25	19.68	16.12	23.39	11.80	8.95	14.54	20.41	21.24	19.57	17.36	12.82	21.92
Ever Attended School	Yes	30.58	27.37	33.63	19.71	16.18	22.43	11.80	8.82	14.65	20.66	21.21	20.09	17.23	12.85	21.66
	No	24.68	25.44	23.70	18.10	10.21	21.83	12.01	17.14	6.55	13.48	22.50	7.59	42.72	-	53.36
Education Level	Completed primary	30.83	27.58	33.84	19.82	16.18	23.66	11.65	8.86	14.34	19.05	21.16	17.51	17.18	12.82	21.60
	Not completed primary	24.78	23.41	26.21	15.80	8.68	19.30	15.46	11.63	18.35	23.71	22.64	24.84	42.72	0.00	53.36
	Currently completing primary	30.27	27.51	33.22	15.79	17.75	13.29	9.90	7.83	12.23	19.94	20.47	19.09	-	-	-

Table 5.4 Estimates of childhood exposure to domestic violence and abuse by family-level associated risk factor and VACS country (weighted percentages)

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Family Economic Conditions 'Wealth'	Poorer	15.38	15.16	15.56	24.79	19.95	29.40	31.46	31.74	31.23	17.02	17.44	16.65	25.33	23.02	27.30
	Middle	16.41	15.92	16.90	30.53	29.34	31.75	34.43	33.53	35.33	16.25	14.25	19.42	30.93	25.92	35.39
	Richer	21.83	21.67	22.05	31.27	28.27	34.41	25.02	26.93	23.40	13.39	14.25	12.32	32.32	28.24	36.84
	No household questionnaire †	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Death of a Biological Parent	Yes (a parent has died)	16.83	20.43	13.97	27.56	23.91	31.35	26.78	29.48	24.64	14.64	17.07	11.99	24.85	25.97	23.93
	No (both parents are alive)	18.04	16.99	19.21	30.54	28.41	32.60	32.17	31.69	32.63	15.84	14.38	17.72	30.78	25.90	35.68
Death of Biological Mother	Yes (mother has died)	16.81	19.52	14.67	28.80	24.91	32.63	27.75	33.20	23.60	13.52	15.98	11.10	26.73	30.64	23.20
	No (mother is alive)	17.85	17.59	18.13	29.23	26.63	31.85	31.12	30.87	31.35	15.74	15.00	16.67	29.84	25.53	34.02
Death of Biological Father	Yes (father has died)	16.00	20.22	12.62	26.73	23.15	30.36	27.39	29.53	25.75	15.01	17.90	11.91	24.02	21.96	25.64
	No (father is alive)	18.10	17.33	18.94	31.08	28.78	33.44	31.17	31.25	31.10	15.36	14.30	16.72	30.57	26.63	34.52
Living with both Biological Parents	Yes	18.03	17.14	19.20	28.13	26.10	30.32	30.57	29.00	32.94	13.67	12.01	15.54	30.23	26.05	36.10
	No	17.35	18.60	16.37	29.55	26.23	32.76	30.74	32.87	29.30	16.37	16.49	16.23	28.65	25.62	30.43
Living with Biological Mother	Yes	17.90	17.67	18.15	28.46	26.56	30.45	30.71	30.01	31.60	16.79	16.14	17.55	29.57	25.67	34.75
	No	17.38	18.00	16.88	30.05	25.68	34.15	30.65	33.00	29.25	13.12	13.30	12.86	29.50	26.80	30.79
Living with Biological Father	Yes	17.54	15.89	19.63	28.88	26.55	31.44	30.42	29.41	31.84	13.69	12.09	15.68	30.34	27.04	34.79
	No	17.97	21.68	15.31	29.32	26.06	32.37	30.55	31.98	29.59	16.88	17.30	16.36	28.30	22.86	31.15
Multiple Children in Household ††	Yes	17.85	17.90	17.79	28.45	25.65	31.20	30.96	31.13	30.80	15.98	15.70	16.31	30.00	25.91	34.08
	No	12.21	14.51	11.01	39.69	34.31	48.15	10.53	32.75	7.54	7.66	-	14.68	24.73	34.64	17.20

Table 5.4 Cont.

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa			Latin America and the Caribbean			South-Eastern Asia			Eastern Europe					
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Family Economic Conditions 'Wealth'	Poorer	29.50	27.31	31.58	16.97	12.17	21.93	12.86	8.79	15.86	21.61	23.14	20.18	17.63	9.61	25.03
	Middle	31.28	29.77	32.85	21.16	20.48	21.79	12.74	9.67	15.74	23.49	23.89	22.98	12.46	9.88	15.14
	Richer	30.21	24.81	35.10	23.66	18.92	29.04	9.86	7.58	12.34	16.34	16.59	16.12	19.63	17.70	21.66
	No household questionnaire †	-	-	-	15.97	11.46	21.46	-	-	-	-	-	-	22.94	16.86	29.24
Death of a Biological Parent	Yes (a parent has died)	28.15	23.68	31.64	14.58	9.23	19.88	11.97	10.42	13.31	24.96	24.64	25.23	27.14	18.91	32.03
	No (both parents are alive)	31.25	28.64	34.04	20.28	16.85	23.87	11.78	8.76	14.74	19.69	20.77	18.56	15.98	12.21	20.04
Death of Biological Mother	Yes (mother has died)	25.59	22.60	27.82	10.07	16.49	5.46	8.61	4.78	11.70	37.89	32.06	43.86	25.45	6.25	33.96
	No (mother is alive)	30.96	27.88	34.08	19.92	15.97	24.09	11.90	9.06	14.65	19.63	20.77	18.48	17.04	13.01	21.21
Death of Biological Father	Yes (father has died)	28.06	22.39	32.51	14.67	6.62	22.68	12.63	11.90	13.28	19.49	19.59	19.40	28.19	22.40	32.03
	No (father is alive)	30.69	28.21	33.28	20.03	16.91	23.31	11.69	8.64	14.67	20.53	21.41	19.60	16.29	11.98	20.87
Living with both Biological Parents	Yes	28.99	26.51	32.34	18.73	16.27	21.25	8.30	6.21	10.76	18.94	20.40	17.27	14.54	11.67	17.63
	No	31.34	28.22	33.67	20.92	15.12	27.41	15.12	12.23	17.43	24.38	24.03	24.64	21.95	15.56	27.39
Living with Biological Mother	Yes	29.92	26.65	34.01	19.66	16.48	23.32	10.74	8.30	13.39	19.50	20.66	18.26	16.45	13.56	19.39
	No	30.92	28.71	32.34	19.52	11.68	24.41	15.46	12.04	17.61	26.13	25.59	26.54	21.54	9.55	32.89
Living with Biological Father	Yes	30.18	27.32	33.72	19.21	16.05	22.46	8.66	6.58	11.09	19.68	20.90	18.28	15.36	11.10	19.97
	No	30.28	27.37	32.51	20.10	15.34	25.87	15.59	12.54	17.98	22.83	22.70	22.93	21.80	18.20	24.65
Multiple Children in Household ††	Yes	30.35	27.24	33.36	20.18	16.40	24.17	11.86	8.97	14.65	Not assessed in questionnaire			17.50	12.00	23.08
	No	40.48	49.57	28.65	13.20	12.65	13.59	9.87	8.82	10.88				17.06	19.49	14.89

† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

Table 5.5 Estimates of childhood exposure to domestic violence and abuse by community and societal level associated risk factor and VACS country (weighted percentages)

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Exposure to Violence in the Community	Yes	24.33	22.14	27.66	41.77	37.91	48.76	38.05	36.01	40.29	21.32	19.59	23.83	46.56	44.74	48.17
	No	14.56	15.06	14.14	23.86	19.11	27.59	27.03	28.35	25.95	10.30	10.62	9.98	17.46	13.04	22.25
Societal Acceptance of DVA †††	Yes, DVA is acceptable	22.14	21.53	22.86	33.83	31.29	35.98	38.89	38.04	39.46	22.72	27.51	17.87	35.79	33.91	37.12
	No, DVA is not acceptable	14.50	14.66	14.36	27.58	24.71	30.65	26.54	28.48	24.46	13.16	15.55	15.28	26.89	22.76	31.38
	Incomplete answer	3.06	3.03	3.10	25.00	23.75	25.85	11.40	14.46	8.97	10.56	7.32	14.28	23.09	24.90	19.78

Table 5.5 Cont.

Associated Risk Factor		Childhood exposure to domestic violence and abuse by associated risk factor and country (weighted %) by MDG Region <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Exposure to Violence in the Community	Yes	47.07	43.80	49.80	22.11	18.38	26.26	17.29	14.29	20.39	27.18	27.40	26.96	21.75	16.73	27.96
	No	20.72	18.91	22.64	17.06	13.61	20.40	9.12	6.19	11.84	10.83	12.22	9.48	10.52	4.02	15.69
Societal Acceptance of DVA †††	Yes, DVA is acceptable	35.18	30.17	39.31	32.79	36.54	25.11	14.01	9.05	18.87	20.64	22.44	18.70	32.60	27.18	38.89
	No, DVA is not acceptable	26.92	25.71	28.23	18.89	14.61	23.17	11.55	9.11	13.95	19.93	19.29	20.52	15.33	10.93	19.76
	Incomplete answer	25.23	22.62	27.85	24.27	21.30	28.71	10.33	4.06	13.85	23.22	28.15	14.71	16.61	10.99	21.44

††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

Family-level risk factors are summarised in Table 5.4, and indicate potential associations between exposure to DVA perpetrated between caregivers and family economic conditions, multiple children in household, death of biological parent (including death of biological mother and death of biological father so any differences can be examined), and living with both biological parents (again, also split into living with biological mother and living with biological father so any differences can be explored). There is no clear link between wealth and a child's likelihood of being exposed to DVA when examining wealth across all ten countries, but within countries, there are some patterns that can be observed. For example, within Cambodia, Honduras, Malawi and Namibia, a child's likelihood of being exposed to DVA perpetrated between adults in the home is higher for those of greater wealth. However, in Colombia, Côte d'Ivoire, Lesotho, Nigeria and Zambia, this pattern is reversed, and it is those who are poorer who are most likely to be exposed to DVA. In seven out of the ten countries explored, the death of a biological parent decreased a child's likelihood of being exposed to DVA (with children in Cambodia, Honduras and Moldova having an increased likelihood of exposure to DVA if a biological parent had died), and with differing results when looking at males and females alone (with the death of a biological parent having an increased likelihood of exposure in six of the ten countries for males, but only two in two countries for females). Results were also mixed when looking at the death of individual parent figures. When looking at the overall country populations, the death of a respondent's biological mother was associated with a decreased likelihood of exposure in eight of the ten countries (with the exceptions of Cambodia and Moldova, with Cambodia also having the largest differential). However, for males, the death of a biological mother is associated with increased exposure to DVA rates in six of the ten countries, but this is reversed in the female population, with seven of the ten countries reporting a decreased likelihood of exposure if their biological mother has died. There does not appear to be any patterns by MDG region in these results, nor in those for the death of a biological father, where results were similar across the population groups.

The other parental variable examined was whether someone lived with both of their biological parents. Those who did not live with both biological parents had an increased likelihood of being exposed to caregiver-perpetrated DVA in eight of the ten countries when looking at the overall populations (with Côte d'Ivoire and Nigeria being the exceptions), and nine out of the ten countries in the overall populations reporting higher levels of exposure to DVA when they did not live with their biological father when compared to those who did (seven of the male populations, and six of the female populations also reported this association). Finally, there appears to be a relationship between exposure to DVA perpetrated between adults in the home, and multiple children living in the household, with those with multiple children being more at risk of being

exposed to DVA than those who do not. The exception to this is Lesotho, where not living in a multiple-child household was associated with a higher risk of exposure to DVA.

Community and societal level associations are presented in Table 5.5. When considering community level risk factors, only one factor was explored – exposure to community violence. As previously mentioned, for all countries where exposure to DVA was reported, there were higher levels of exposure to community violence, supporting social disorganization theory (Shaw & McKay, 1942). Finally, amongst those exposed to community violence there were higher levels of exposure to DVA reported, when compared to those who did not report being exposed to violence in their community. This was the case across all countries, in both overall, and male and female datasets. When examining the overall datasets, the likelihood of being exposed to parental-perpetrated DVA was doubled when an individual was also exposed to community violence in five of the ten countries (Cambodia, Moldova, Namibia, Nigeria, and Zambia), and there were still differences of over 10% for the countries of Côte d'Ivoire, Lesotho, and Malawi. These differences, whilst still existing, were much smaller for Colombia and Honduras (4.77-5.86% for Colombia, and 8.10-8.55% for Honduras), suggesting that there may be a difference for the MDG region of Latin America and the Caribbean. In nine of the ten countries, there were higher levels of reported exposure to DVA amongst those where there was a general acceptance that it was okay for a husband to hit or beat his wife, when compared with those who did not think it was acceptable. However, similarly to some of the other risk factors explored, this could actually be an outcome of exposure, as opposed to a risk factor, as after seeing the perpetration of violence modelled in the home between parental figures, individuals could be more accepting of violence within a relationship.

Initial analysis of the Violence Against Children Surveys indicates that there are potential risk factors associated with childhood exposure to DVA, and that these should be explored further so that interventions can be planned to support those most likely to be exposed. Further research can help to build a picture of children who are most likely to have been exposed to DVA, so interventions can be targeted to both reduce the levels of exposure to DVA, but also reduce the negative health outcomes associated with it for those who have already been exposed to DVA.

5.3.3 Regression Analysis for Risk Factors Associated with Exposure to DVA in LMICs

After the data was checked and basic cross-tabulations generated, regression analysis was conducted at each ecological domain, and then as an overall additive model. Each country analysis was analysed separately, and then collated into a table to allow for cross-country comparisons to be made. Models are presented in the form of predicted probabilities by

ecological domain in Tables 5.6-5.9, grouped by MDG region (UN Stats, 2015; United Nations, 2015). Three levels of significance were assessed – $p < 0.1$ (weakly significant), $p < 0.05$ (moderately significant), and $p < 0.01$ (strongly significant).

5.3.3.1 Individual Level Factors Regression Model

Table 5.6 displays the results from Model 1, the model which includes only the individual level factors. In six of the ten countries, females had a significantly higher predicted probability of childhood exposure to DVA compared to males. This included both countries in the Latin America and Caribbean region, where the probability of exposure among females was 24.22% in Colombia and 14.39% in Honduras, compared to 16.45% and 8.92% among males, respectively. In three of the six Sub-Saharan African countries (Lesotho, Nigeria, and Zambia), predicted probabilities for females ranged from 33.01 to 34.43%, compared to 25.82 to 28.18% for males. Additionally, in Moldova, the predicted probability of exposure for females was 23.19%, notably higher than the 13.32% observed among males.

In comparison to respondent sex, education level showed fewer significant associations with childhood exposure to DVA. In Lesotho and Namibia, children currently in primary school had reduced predicted probabilities of exposure (21.15% and 12.76% respectively), compared to those who had completed primary education (27.38% and 16.60%). In contrast, children who had not completed primary school in Honduras and Cambodia had increased probabilities of exposure, at 11.65% and 24.71%, compared to 8.92% and 19.96% among those who had completed primary school. Although only Lesotho showed strong significance, these results suggest that in some countries, education level may be associated with differences in the likelihood of childhood exposure to DVA.

5.3.3.2 Family Level Factors Regression Model

Table 5.7 displays the results from Model 2, the regression model containing only the family level factors. The association between household wealth and childhood exposure to DVA varied across countries. In Malawi and Cambodia, those in the middle wealth category had significantly higher predicted probabilities of exposure than those in the richer category (11.00% vs 7.22% in Malawi and 21.84% vs 14.99% in Cambodia). In contrast, in Côte d'Ivoire and Moldova, individuals in the middle wealth category were significantly less likely to be exposed compared to the richer category (11.87% vs 16.25% in Côte d'Ivoire and 10.50% vs 15.86% in Moldova). A similar mixed pattern was found for the poorer category. In Côte d'Ivoire, Lesotho, and Nigeria, predicted probabilities of exposure were significantly lower for those in the poorer category compared to those in the richer category (10.98% vs 16.25% in Côte d'Ivoire, 33.10% vs 40.34% in Lesotho, and 23.96% vs 32.31% in Nigeria). However, in Malawi and Cambodia,

predicted probabilities were significantly higher for those in the poorer tertile (20.08% vs 14.99% in Cambodia and 9.58% vs 7.22% in Malawi), compared to those in the richer tertile. These findings suggest that the relationship between household wealth and childhood exposure to DVA varies across contexts.

The death of a biological parent was associated with a lower predicted probability of childhood exposure to DVA violence in the six countries where significant results were observed. Specifically, in Lesotho, Malawi, Zambia, Colombia, and Honduras, predicted probabilities of exposure were lower for individuals who had lost a parent, ranging from 3.77% to 21.64%, compared to 7.38% to 28.10% for those whose biological parents were both alive. The largest difference was seen in Nigeria, where the predicted probability of exposure among those with a deceased parent was 25.11%, compared to 32.31% for those whose parents were both alive. In contrast, not living with both biological parents was associated with a significantly higher predicted probability of childhood exposure to DVA in five countries. In Lesotho, Namibia, Zambia, Honduras, Cambodia, and Moldova, individuals not living with both biological parents had higher predicted probabilities of childhood exposure to DVA, ranging from 11.05% to 33.70%, compared to 8.57% to 25.05% among those living with both biological parents. In Zambia, the difference was particularly strong, with children not living with both biological parents having a predicted probability of exposure of 45.79%, compared to 38.27% for those who live with both biological parents. These two parental variables may reflect distinct and complex relationships with childhood exposure to DVA. While the death of a parent could be associated with reduced exposure due to the absence of the abusive partner, not living with both biological parents may reflect family separation, which can itself be a consequence of one parent perpetrating DVA against the other, and is also a way in which a child can be exposed to DVA according to Holden's (2003) taxonomy ('experiences the aftermath'). In such cases, family structure may be shaped by previous violence rather than operating purely as a risk or protective factor. These findings should therefore be interpreted with caution, acknowledging that family composition may be both a cause and consequence of violence. This complexity highlights the importance of avoiding overly deterministic interpretations of family variables in cross-sectional analysis.

Finally, the variable of whether there were multiple children living in a household was explored. This was unable to be explored in Cambodia as no questions about siblings were asked, and the variable was significantly associated with childhood exposure to DVA in only three countries. In Lesotho and Zambia, predicted probabilities were lower for children living in households with multiple children compared to those in only-child households (29.69% vs 40.34% in Lesotho and 28.62% vs 38.27% in Zambia). In contrast, the opposite pattern was found in Malawi, where children in households with multiple children had a predicted probability of 24.59%, compared

to 7.22% for children without siblings. These findings may reflect country-specific differences in household structure, family stressors, or unmeasured contextual factors.

5.3.3.3 Community and Societal Level Factors Regression Model

Table 5.8 displays the results from Model 3, the model which includes only the community and societal level factors. Exposure to community violence was significantly associated ($p < 0.01$) with a higher predicted probability of childhood exposure to DVA in all countries except Colombia. The largest difference was observed in Nigeria, where the predicted probability of childhood exposure to DVA amongst children exposed to community violence was 43.47%, compared to 15.92% among those not exposed to violence in the community. Similarly large differences were observed in Zambia (44.18% vs 19.03%), Honduras (50.00% vs 8.82), and Cambodia (26.80% vs 10.58%). In Lesotho and Namibia, children exposed to community violence had predicted probabilities of 40.13% and 18.29%, compared to 22.61% and 8.87% for those not exposed to community violence, respectively. In Moldova, predicted probabilities were also higher for those exposed to community violence (20.28% vs 9.50%), as well as in Malawi (33.28% vs 23.58%) and Côte d'Ivoire (20.13% vs 12.15%). These figures highlight a consistent association between childhood exposure to community violence and childhood DVA exposure, suggesting that community-level violence significantly elevates the risk of exposure to DVA exposure across diverse countries.

Societal acceptance of DVA was also associated with a significantly higher predicted probability of childhood exposure to DVA in several countries. In Moldova, children in societies where DVA was considered acceptable had a predicted probability of exposure of 20.86%, compared to 9.50% among those where it was not accepted. Similarly, in Malawi, Namibia and Lesotho, predicted probabilities were higher among those from societies with higher acceptance of DVA (35.12% vs 23.58% in Malawi, 15.18% vs 8.87% in Namibia, and 27.99% vs 22.61% in Lesotho). Other countries showing significant differences included Nigeria (22.59% vs 15.92%), Côte d'Ivoire (18.48% vs 12.15%), Zambia (24.02% vs 19.03%), and Honduras (11.35% vs 8.82%). Interestingly, in some countries, respondents who gave an incomplete answer (who despite not answering all parts of the question, had indicated that in some scenarios they indicated that DVA was unacceptable), had lower predicted probabilities of childhood exposure to DVA compared to those who stated that DVA was not acceptable. In Côte d'Ivoire and Malawi, these respondents had predicted probabilities of 2.76% and 10.26%, respectively, compared to 12.15% and 23.58% among those who clearly rejected DVA. These findings suggest that the way DVA is perceived and discussed within societies may be linked to varying patterns of risk for childhood exposure to DVA.

5.3.3.4 Overall Regression Model

Finally, Table 5.9 displays the results from Model 4, the overall regression model. This is the additive model containing all variables explored in this paper.

In the overall additive model, several individual-level factors remain significantly associated with childhood exposure to DVA, although some associations change in strength compared to the findings from Model 1. Respondent sex remains a significant correlate of childhood exposure to DVA in several countries. For example, in Moldova, the predicted probability of exposure for females was 12.99%, compared to 5.83% for males. Similarly, in Honduras, the predicted probability for females was 5.26%, compared to 3.07% for males. These findings align with earlier models and suggest that, even when accounting for other factors, biological sex remains an important characteristic associated with of childhood exposure to DVA. Education level also remained significantly associated with exposure in a few countries. In Moldova, those who had not completed primary education had a predicted probability of 23.39%, compared to 5.83% for those who had completed primary education³⁹. In Côte d'Ivoire, those who have not completed primary education had a lower predicted probability of exposure (10.03%) compared to those who completed primary education (13.70%). In Lesotho, those currently in primary school had a lower predicted probability of exposure (22.85%) than those who had completed primary education (28.10%). These results suggest that, even when accounting for a broader range of variables, biological sex and education remain important associative factors when considering the risk of childhood exposure to DVA, though the importance of these associations varies by country. In addition, education level may also act as a proxy for broader structural disadvantage, and should not be interpreted as a direct causal factor.

At the family level, wealth again produced mixed results when in the additive model. In Côte d'Ivoire, Lesotho, Nigeria, and Colombia, individuals in the middle or poorer wealth tertiles had lower predicted probabilities of exposure to DVA exposure compared to respondents in the richer tertile. For example, in Côte d'Ivoire, predicted probabilities for the middle and poorer groups were 9.60% and 8.40%, respectively, compared to 13.70% in the richer group. In contrast, in Malawi and Cambodia, predicted probabilities of childhood exposure to DVA were higher among respondents living in families in the middle and poorer wealth tertiles. In Malawi, the predicted probability for the middle group was 9.55%, compared to 6.33% in the richer group, and in Cambodia, the poorer group had a predicted probability of 10.68% compared to

³⁹ However, only 2.60% of the total population surveyed indicated that they hadn't yet completed primary school, and so whilst weakly significant, it is important to remember that the sample size is small, and therefore this may have inflated the predicted probability. In addition, this association is only significant at $p < 0.10$, and so is a weaker level of significance compared to conventional cutoffs (e.g., $p < 0.05$).

8.57% in the richer group. These results highlight the context-dependent nature of wealth as a factor in childhood exposure to DVA. The death of a biological parent maintains a consistent association with a lower predicted probability of exposure to DVA in five countries (Lesotho, Namibia, Nigeria, Colombia, and Honduras), mirroring findings from Model 2. For example, in Nigeria, the predicted probability of exposure among those who had lost a parent was 9.26%, compared to 12.98% among those whose parents were both alive. In Colombia, this difference was also notable (3.77% vs 7.38%). In contrast, not living with both biological parents was associated with a higher predicted probability of exposure to DVA in Lesotho, Zambia, Honduras, Cambodia, and Moldova. In Zambia, for example, the predicted probability was 31.08% for children not living with both biological parents, compared to 25.05% for those who were. In Honduras, the predicted probability increased from 3.07% to 5.78%. This suggests that family structure and stability continue to be crucial factors in childhood exposure to DVA. However, this relationship is complex. Not living with both biological parents may reflect separation or divorce, which in some cases could be a consequence of one parent's perpetration of DVA against the other, rather than a contributing factor to exposure. It is therefore important to interpret these findings cautiously, recognising the potential for reverse causality, where family composition is shaped by prior violence rather than functioning solely as a risk factor. The variable measuring whether there were multiple children in the household remained significant in Lesotho and Malawi. In Lesotho, the predicted probability was lower for those living with multiple siblings (19.13%) compared to those in only-child households (28.10%). In contrast, in Malawi, respondents in households with multiple children had a higher predicted probability of exposure (20.08%) than those without (6.33%), indicating the nuance of family-level factors, and how they may either elevate or reduce risks depending on broader familial or cultural dynamics.

Finally, at the community and societal level, both exposure to community violence and societal acceptance of DVA remained strongly associated with childhood exposure to DVA when placed in the additive model. Exposure to community violence continues to be a strong factor across nearly all countries, with predicted probabilities significant at $p < 0.01$ in all but Colombia (which is significant at the $p < 0.10$ level). In Nigeria, predicted probabilities rose from 12.98% (not exposed) to 40.88% (exposed). Similar increases were observed in Zambia (25.05% vs 53.24%) and Cambodia (8.57% vs 21.58%). In countries where the predicted probability of exposure to DVA amongst those not exposed to community violence was relatively low, such as Moldova (5.83%) and Namibia (3.11%), the predicted probability more than doubled among those who were exposed to community violence, highlighting the impact of exposure to community violence on childhood exposure to DVA across various countries. However, this may also reflect environments in which multiple forms of violence co-occur, rather than a

unidirectional pathway from community violence to household DVA. Societal acceptance of DVA also maintains a significant association with increased DVA exposure in several countries. In Moldova, children in countries with societal acceptance of DVA had a predicted probability of 13.40%, compared to 5.83% among those where DVA was considered unacceptable. Other countries with notable differences include Namibia (5.79% vs 3.11%) and Malawi (10.61% vs 6.33%), suggesting that societal norms continue to play a critical role. In Côte d'Ivoire and Malawi, individuals with incomplete responses (but who indicated DVA was acceptable in at least some scenarios) had much lower predicted probabilities than the reference group (3.07% vs. 13.70% in Côte d'Ivoire and 2.71% vs. 6.33% in Malawi), potentially indicating differing risk dynamics within these groups.

These findings reinforce the complexity and multi-level nature of childhood exposure to DVA across LMICs, with community and family contexts playing a key role in shaping risk.

Table 5.6 Regression Model 1: Individual Model for Childhood Exposure to DVA, presented as Predicted Probabilities

Explanatory Factors	MDG Region									
	Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Respondent sex										
Male (ref)	0.182	0.274	0.329	0.166	0.258	0.282	0.164	0.089	0.200	0.133
Female	0.184	0.330**	0.321	0.171	0.331***	0.344**	0.242**	0.144***	0.184	0.232***
Education level										
Completed primary (ref)	0.182	0.274	0.329	0.166	0.258	0.282	0.164	0.089	0.200	0.133
Not completed primary	0.145	0.264	0.237	0.104	0.297	0.229	0.118	0.116*	0.247*	0.301
Currently in primary †	0.186	0.211***	0.295	0.128*	0.277	0.276	0.129	0.077	0.205	-
<i>Number of Obs (n)</i>	<i>2394.00</i>	<i>8524</i>	<i>2146</i>	<i>5024</i>	<i>4085</i>	<i>1784</i>	<i>2760</i>	<i>5160</i>	<i>2372</i>	<i>1905</i>
<i>Number of Obs (% of total population)</i>	<i>99%</i>	<i>99%</i>	<i>99%</i>	<i>97%</i>	<i>97%</i>	<i>98%</i>	<i>99%</i>	<i>99%</i>	<i>100%</i>	<i>95%</i>

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

Table 5.7 Regression Model 2: Family Model for Childhood Exposure to DVA, presented as Predicted Probabilities

Explanatory Factors	MDG Region									
	Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Wealth										
Richer (ref)	0.162	0.403	0.072	0.057	0.323	0.383	0.157	0.058	0.150	0.159
Middle	0.119**	0.392	0.110**	0.070	0.293	0.404	0.146	0.068	0.218***	0.105**
Poorer	0.110**	0.331**	0.096*	0.076	0.240***	0.372	0.103*	0.066	0.201**	0.136
No household questionnaire †††	-	-	-	-	-	-	0.112	-	-	0.191
Death of a biological parent										
No, both parents are alive (ref)	0.162	0.403	0.072	0.057	0.323	0.383	0.157	0.058	0.150	0.159
Yes, a parent has died	0.151	0.332***	0.052*	0.048	0.251***	0.313**	0.088*	0.042**	0.156	0.212
Living with both biological parents										
Yes (ref)	0.162	0.403	0.072	0.057	0.323	0.383	0.157	0.058	0.150	0.159
No	0.163	0.472***	0.087	0.076*	0.351	0.458**	0.196	0.112***	0.195**	0.215**
Multiple children in household ††										
No (ref)	0.162	0.403	0.072	0.057	0.323	0.383	0.157	0.058	-	0.159
Yes	0.227	0.297***	0.246**	0.120	0.347	0.286*	0.233	0.076	-	0.174
<i>Number of Obs (n)</i>	<i>2341</i>	<i>8365</i>	<i>2125</i>	<i>4949</i>	<i>3956</i>	<i>1757</i>	<i>2568</i>	<i>5032</i>	<i>2359</i>	<i>1850</i>
<i>Number of Obs (% of total population)</i>	<i>97%</i>	<i>98%</i>	<i>98%</i>	<i>95%</i>	<i>94%</i>	<i>97%</i>	<i>95%</i>	<i>97%</i>	<i>99%</i>	<i>92%</i>

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

Table 5.8 Regression Model 3: Community and Societal Model for Childhood Exposure to DVA, presented as Predicted Probabilities

Explanatory Factors	MDG Region									
	Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Exposed to community violence										
No (ref)	0.122	0.226	0.236	0.089	0.159	0.190	0.162	0.088	0.106	0.095
Yes	0.201***	0.401***	0.333***	0.183***	0.435***	0.442***	0.219	0.500***	0.268***	0.203***
Societal acceptance of DVA ††††										
No, DVA is not acceptable (ref)	0.122	0.226	0.236	0.089	0.159	0.190	0.162	0.088	0.106	0.095
Yes, DVA is acceptable	0.185***	0.280***	0.351***	0.152***	0.226***	0.240**	0.293	0.113*	0.108	0.209***
Incomplete answer	0.028***	0.221	0.103***	0.099	0.159	0.194	0.234	0.087	0.131	0.114
<i>Number of Obs (n)</i>	2387	8530	2144	5010	3983	1769	2658	5170	2369	1838
<i>Number of Obs (% of total population)</i>	99%	100%	99%	97%	95%	97%	98%	99%	100%	92%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance, then they were coded as “incomplete answer”.

Table 5.9 Regression Model 4: Overall Additive Model for Childhood Exposure to DVA, presented as Predicted Probabilities

Ecological Domain	Explanatory Factors	MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
		Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Respondent sex										
	Male (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Female	0.166	0.383***	0.059	0.034	0.173***	0.286	0.127**	0.053***	0.078	0.130***
	Education level										
	Completed primary (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Not completed primary	0.100*	0.273	0.042	0.025	0.161	0.207	0.053	0.044**	0.098	0.234*
	Currently in primary †	0.127	0.229**	0.053	0.025	0.142	0.249	0.045	0.026	0.085	-
Family	Wealth										
	Richer (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Middle	0.096**	0.272	0.096**	0.035	0.106*	0.281	0.064	0.034	0.118**	0.035
	Poorer	0.084***	0.227**	0.084*	0.039	0.078***	0.273	0.045*	0.030	0.107*	0.044
	No Household questionnaire †††	-	-	-	-	-	-	0.048	-	-	0.075
	Death of biological parent										
	No, both parents are alive (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Yes, a parent has died	0.120	0.216***	0.048	0.027	0.093***	0.184***	0.038*	0.023*	0.086	0.076
	Living with both biological parents										
	Yes (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	No	0.138	0.337**	0.077	0.038	0.129	0.311**	0.097	0.058	0.111*	0.073
	Multiple children in household ††										
	No (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	-	0.058
	Yes	0.157	0.191***	0.201**	0.075	0.169	0.158	0.148	0.046	-	0.058
	Exposed to community violence										

Ecological Domain	Explanatory Factors	MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
		Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Community and Societal	No (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Yes	0.237***	0.501***	0.100***	0.065***	0.409***	0.532***	0.110*	0.062***	0.216***	0.151***
	Societal acceptance of DVA †††										
	No, DVA is not acceptable (ref)	0.137	0.281	0.063	0.031	0.130	0.251	0.074	0.031	0.086	0.058
	Yes, DVA is acceptable	0.201***	0.355***	0.106***	0.058***	0.174***	0.308**	0.153	0.041**	0.087	0.134***
	Incomplete answer	0.031***	0.264	0.027**	0.036	0.119	0.262	0.112	0.029	0.105	0.066
Number of Obs	<i>n</i>	2334	8346	2121	4931	3848	1744	2557	5011	2356	1778
	<i>% of total population</i>	97%	97%	98%	95%	92%	96%	95%	96%	99%	89%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance, then they were coded as “incomplete answer”.

5.3.4 A Probability Scale for Risk Factors Associated with Exposure to DVA in LMICs

To provide further insight into what makes a child more likely to be exposed to DVA perpetrated between adults, a probability scale was conducted using all the risk factors from this paper. First, an overall probability model was created, consisting of all baseline characteristics. These baseline characteristics were if someone had completed primary school (education), were part of the 'richer' wealth category, had not experienced the death of a biological parent (so both their biological parents were alive), were living with both biological parents, had grown up being the only child in the household (except in Cambodia, where this factor was not possible to assess), had not been exposed to community violence, and did not believe that it was ever acceptable for one partner to perpetrate DVA against the other. These reference categories were chosen in consultation with the existing literature on the topic, selecting the category associated with a lesser chance of exposure (for example, not completing primary school was found to be a risk factor, and so completion of primary school was chosen to be the reference category). This then formed the constant for the probability models.

Amongst this overall model, those in Lesotho had the greatest probability of being exposed to DVA (in both the male and female population, with a probability of 28.10% and 38.27% respectfully), with those in Namibia (3.11% for males and 3.37% for females) and Honduras (3.07% for males and 5.26% for females) being the least likely to be exposed. Honduras and Namibia being ranked the lowest probability could in part be due to the fact that these countries had the lowest overall percentage of children exposed to DVA amongst the ten countries analysed, but it indicates a need for further analysis, and does not explain why children in Lesotho have the highest probability of being exposed to DVA, when it has the third highest exposure to DVA statistic for both males, and females within the ten VACS countries analysed. The probabilities for all ten countries using the baseline characteristics are displayed in Figure 5.4. Females have a higher probability than males of being exposed to domestic violence except in Malawi and Cambodia (although differences in these two countries are very small and in the case of Malawi, only observed when the figures are more than two decimal places), although from the current analysis it is unclear if these are significant. Within all countries explored, there are also some differentials between males and females, with notable larger differences within Lesotho, Moldova, and Colombia (although these were still relatively small). Future analysis could explore further why these differences occur, although it is not possible to explore this using the current VACS datasets.

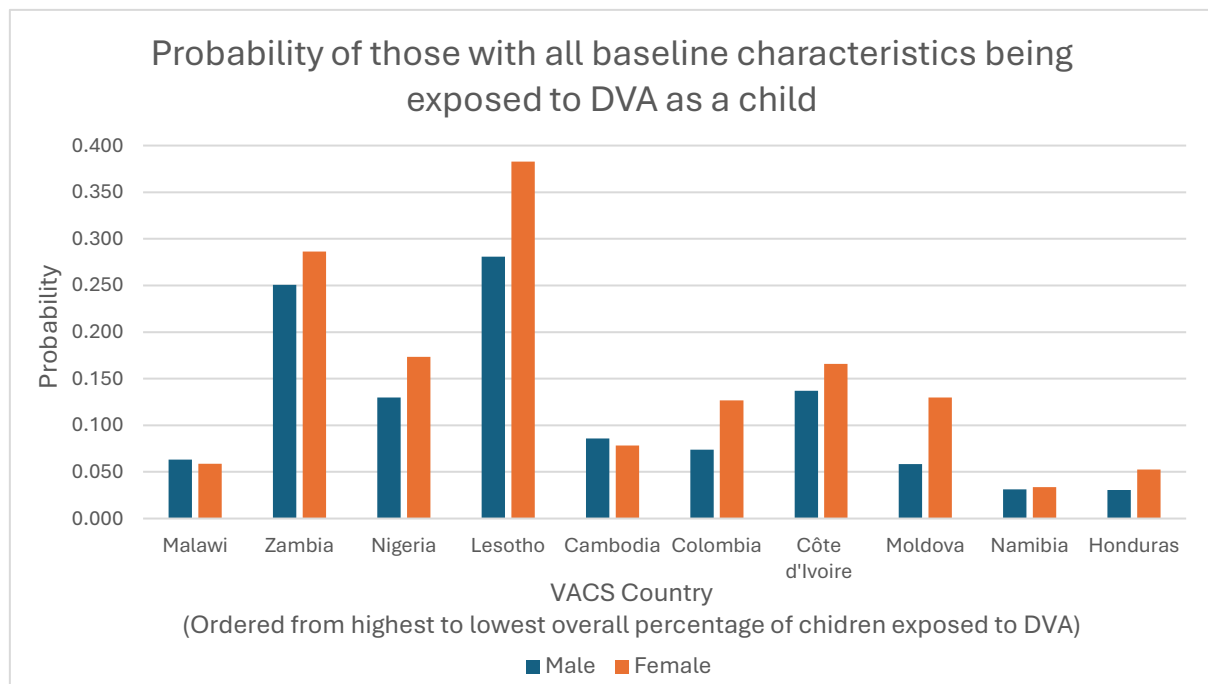


Figure 5.4 Probability of individuals with baseline characteristics being exposed to DVA as a child within the VACS

Following the overall probability model, the risk factors of Education Level and Wealth, and how this affects the probability of an individual being exposed to DVA were explored further.

The Education Level probability scale revealed that those who had completed primary school were most likely to be exposed in most countries explored. The male and female populations were examined separately, and all baseline characteristics kept the same as in the overall model and Figure 5.4.

Table 5.10 Probability of Exposure to DVA Amongst the VACS Surveys, Explored by Education Level

MDG Region	Country (Survey Year)	Male			Female		
		Not Completed Primary School	Currently Completing Primary School	Completed Primary School	Not Completed Primary School	Currently Completing Primary School	Completed Primary School
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.100	0.127	0.137	0.123	0.155	0.166
	Lesotho (2018)	0.273	0.229	0.281	0.374	0.320	0.383
	Malawi (2013)	0.042	0.053	0.063	0.039	0.049	0.059
	Namibia (2019)	0.025	0.025	0.031	0.027	0.027	0.034
	Nigeria (2014)	0.161	0.142	0.130	0.212	0.188	0.173
	Zambia (2014)	0.207	0.249	0.251	0.239	0.285	0.286
Latin America and the Caribbean	Colombia (2018)	0.053	0.045	0.074	0.093	0.080	0.127
	Honduras (2017)	0.044	0.026	0.031	0.074	0.044	0.053
South-Eastern Asia	Cambodia (2013)	0.098	0.085	0.086	0.090	0.078	0.078
Eastern Europe	Moldova (2019)	0.234	-	0.058	0.424	-	0.130

Amongst the male populations, those from Lesotho who had completed primary (28.10%) have the highest likelihood of childhood exposure to DVA, and amongst the female populations, those from Moldova who have not completed primary school (42.40%). Despite the large increase in Moldova, there was no significant difference due to small sample sizes, as the majority of Moldova's population had completed primary school. If these small sample sizes are ignored, then females at the highest risk of exposure are those from Lesotho who have completed primary school, with a probability of 38.27%. Those with the lowest likelihood of exposure (with all baseline characteristics the same) are those from Namibia who have not completed primary school, with males having a probability of 2.46%, and females 2.66%. Full results for education can be found in Table 5.10.

Finally, wealth was explored in more detail, and the same categories were used as within the bivariate and regression analyses (poorer, middle, richer, and, where relevant, no household questionnaire). It is important to note that for the 'wealth' category, only Colombia and Moldova had the additional 'no household (HH) questionnaire' category (as explained in Section 5.2.6). Again, the male and female populations were examined separately, and all other baseline

characteristics remained the same. Those with the highest probability of being exposed were those in Lesotho who belonged to the ‘richer’ wealth category. This was the case for both males (28.10%) and females (38.27%). Those with the lowest probability were those in Honduras in the ‘poorer’ category for males (3.03%), and in Namibia in the ‘richer’ category for females (3.37%). Full results for wealth can be found in Table 5.11.

Table 5.11 Probability of Exposure to DVA Amongst the VACS Surveys, Explored by Level of Wealth

MDG Region	Country (Survey Year)	Male				Female			
		Poorer	Middle	Richer	No HH Questionnaire	Poorer	Middle	Richer	No HH Questionnaire
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.084	0.096	0.137	-	0.103	0.117	0.166	-
	Lesotho (2018)	0.227	0.272	0.281	-	0.317	0.372	0.383	-
	Malawi (2013)	0.084	0.096	0.063	-	0.078	0.089	0.059	-
	Namibia (2019)	0.039	0.035	0.031	-	0.042	0.037	0.034	-
	Nigeria (2014)	0.078	0.106	0.130	-	0.107	0.143	0.173	-
	Zambia (2014)	0.273	0.281	0.251	-	0.311	0.319	0.286	-
Latin America and the Caribbean	Colombia (2018)	0.045	0.064	0.074	0.048	0.079	0.111	0.127	0.085
	Honduras (2017)	0.030	0.034	0.031	-	0.052	0.058	0.053	-
South-Eastern Asia	Cambodia (2013)	0.107	0.118	0.086	-	0.098	0.108	0.078	-
Eastern Europe	Moldova (2019)	0.044	0.035	0.058	0.075	0.099	0.079	0.130	0.164

These models add further context to the results of this paper, allowing for a demonstration of a probability of a particular group of people with certain baseline characteristics (the constant) of being exposed to DVA amongst the ten LMICs explored. It highlights a need for further research into this area to more comprehensively understand what makes a child more likely to be exposed to DVA in LMICs.

5.4 Discussion

This study uses the Violence Against Children Surveys (VACS; Chiang et al., 2016) to gain prevalence estimates and risk factors associated with childhood exposure to DVA in ten LMICs. The last prevalence estimates for the number of children exposed to DVA were by MDG region and were wide-ranging (UNICEF, 2006). This paper provides a more detailed look at exposure to DVA within distinct countries, also allowing for an insight into the estimated number of children exposed to both community violence and child abuse. The results from this paper indicate that childhood exposure to DVA is a significant issue within the ten LMICs explored, with females being more likely to be exposed to DVA than males, a finding inconsistent with Kieselbach et al. (2022). Some of these results are not as expected, for example, Honduras having such a low level of exposure to DVA, given the high reported rates of violence within the country. This could be due to the specific phrasing of questions asked within the survey and the interpretation of these questions. In addition to childhood exposure to DVA, exposure to other types of violence also appears to be prevalent, and analysis revealed that exposure to these three types of violence often co-occur. For all VACS countries used in this study, exposure to community violence is higher than exposure to DVA (Figure 5.2), a finding which supports social disorganization theory (Shaw & McKay, 1942). However, this is not the case when split by sex, as there appear to be differences between population groups. For males, community violence is still higher than DVA, but for females, Lesotho and Malawi do not follow this pattern (Table 5.1). This could be due to societal beliefs about gender and an increased expectation for females to spend more time in the home compared to males (UNICEF, 2016), which could also be why, in general, males seem to be exposed to community violence more than females in the countries surveyed. Exposure to community violence was also found to be a risk factor associated with childhood exposure to DVA perpetrated by caregivers or other adults within the home, and was the only factor which was significant across all ten countries when in the overall additive regression model (explored later in this discussion).

Co-occurrence of DVA and child abuse also appears to be common, which can be observed in the graphs, although this was not asked in the questionnaire for Cambodia. Although not explored in this paper, this parental violence towards a sibling could support the idea of co-occurring maltreatment, where a child exposed to DVA is more likely to be a direct victim of child abuse and multiple adverse childhood experiences (McKay, 1994; Felitti et al., 1998).

When looking at the prevalence figures estimated within this paper in more detail, it was found that the current estimates of childhood exposure to DVA (UNICEF, 2006) are much lower than the reality. Amongst the ten countries explored in this paper, it was estimated that over 19

million children have been exposed to DVA⁴⁰. Whilst not directly comparable, the latest global statistics estimate that 133 to 275 million children have been exposed to DVA (UNICEF, 2006; Figure 2.1), meaning that these ten countries alone account for 7.21-14.91% of the current global estimates. We cannot be certain that these numbers would apply outside the ten countries explored. However, these figures indicate that exposure to DVA is a prevalent issue in LMICs and that there is a need to gain accurate and updated global statistics.

Whilst comparative figures for the MDG estimates cannot be produced from the analysis within this paper (due to the number of countries within each MDG region used for analysis), the estimated number of children exposed in the six countries from the Sub-Saharan African region is 16,695,401 (15,259,908-18,213,423), meaning that these statistics cover 43.71-47.84% of all of the Sub-Saharan African region (46 countries) according to the UNICEF (2006) statistics. It could be possible that exposure to DVA in these countries is extremely high, or that the UNICEF estimates are low, or that there is something else which means that these figures are so extreme – or a combination of all three. However, it indicates that exposure to DVA within LMICs is a prevalent issue and highlights an urgent need for an accepted definition and measure of exposure to DVA so that accurate statistics can be obtained and monitored. This is a strength of the current research compared to previous attempts to gain prevalence of exposure to DVA in LMICs, such as Kieselbach et al. (2022), as a consistent question was used across all ten countries to assess exposure, allowing for comparability.

This study highlights the significant role that individual, family, community, and societal factors each play in shaping childhood exposure to DVA. The findings indicate that no single ecological domain is solely responsible for influencing exposure; rather, a combination of factors across these ecological domains interact to create complex pathways which can increase or decrease a child's likelihood of exposure. For instance, while individual factors like gender and education level are often predictive of exposure, family structure and broader community norms around violence also have substantial, independent impacts. These findings align with ecological models of violence, such as Bronfenbrenner's ecological systems theory (Bronfenbrenner, 1979), which states that individual behaviour and experiences are profoundly shaped by nested layers of influence – from immediate family dynamics to broader societal values and community safety. This reflects the conceptual framework of this paper (Figure 5.1). This multi-level perspective underscores the importance of comprehensive approaches when addressing childhood exposure to DVA. Focusing solely on individual or family-level interventions may overlook the critical influence of community environments and societal norms, such as the

⁴⁰ The current analysis within this paper estimates that the number of children exposed to DVA across the ten LMICs explored is 19,836,545 (17,931,427-21,888,634).

societal acceptance of DVA or exposure to community violence, both of which are strongly associated with increased risk of exposure in several countries. Therefore, an ecological approach that incorporates interventions across these multiple levels, supporting not just individuals and families but also addressing community safety and societal attitudes, may be more effective in both prevention, and intervention for childhood exposure to DVA in LMICs.

The analysis demonstrates that biological sex is consistently associated with an increased likelihood of childhood exposure to DVA, with females at a higher risk across multiple countries. This is observed in both the bivariate, and regression analyses. In particular, females in MDG regions such as Latin America and the Caribbean and Sub-Saharan Africa exhibit significantly increased predicted probabilities of exposure, suggesting potential gendered vulnerabilities rooted in broader social and cultural norms. This trend may reflect the intersection of gender inequality and violence, where societal power imbalances or traditional gender roles could place females at greater risk of experiencing or witnessing violence (Koenig et al., 2003). These findings align with literature suggesting that women and girls often face heightened vulnerabilities to violence within domestic settings (UNICEF, 2016), and suggest that policies and interventions aimed at reducing childhood exposure to DVA may benefit from a gender-sensitive approach, particularly in cultural contexts where gender norms contribute to these vulnerabilities.

Education level showed a mixed association with childhood exposure to DVA, varying significantly across the countries in this study. In several countries, children with lower educational attainment were more likely to be exposed to DVA, suggesting that access to education may serve as a protective factor, supporting findings by Breiding et al. (2011), Fantuzzo and Mohr (1999) and Flynn-O'Brien and Rivara (2021). However, in some countries, higher levels of education are associated with higher predicted probabilities of DVA exposure, possibly reflecting complex socioeconomic or cultural dynamics, such as the financial pressures or community-specific values related to schooling. It is also possible that exposure to DVA disrupts educational participation or attainment, for example through psychological distress, increased caregiving burdens, or disengagement from school, meaning that education level may reflect both a risk factor and a consequence of exposure. Future research could explore the mechanisms behind these varied associations, such as cultural attitudes towards education or economic pressures that influence both school attendance and family stability. When looking at the family-level ecological domain, the findings from this paper reveal the importance of family structure, particularly the presence or absence of both biological parents, as a consistent risk factor associated with childhood exposure to DVA. Children not living with both biological parents generally exhibit higher predicted probabilities of exposure, underscoring the role of family stability in protecting against violence. In contrast, children who

have experienced the death of a biological parent often show a reduced likelihood of exposure to DVA, which may reflect changes in family dynamics, added community support, or protective custody arrangements following parental loss, although these factors were not explored in the current analysis. This pattern may reflect both risk and consequence, as parental separation can both result from and contribute to household violence, particularly where children are exposed to DVA as part of broader familial instability (Holden, 2003). This is detailed further in Section 5.3.3.2.

The ecological domain of community and society was strongly associated with childhood exposure to DVA when examined both in a separate model (Model 3), and in the additive model (Model 4). Exposure to community violence was significant at the $p < 0.05$ level for all countries except Cambodia in both Model 3 and Model 4, with Cambodia displaying significance at the $p < 0.10$ level in Model 4, a finding which supports social disorganization theory (Shaw & McKay, 1942). Societal acceptance of DVA was also shown to play a significant role in childhood exposure to DVA across the ten LMICs explored, with children in communities that accept DVA facing elevated risks of childhood exposure to DVA. These findings support existing literature that these factors can increase DVA (e.g., Malik, 2008; Lourenço et al., 2013; Kim et al., 2012; McDowell & Reinhard, 2022), but provides new insight that these factors could also increase a child's likelihood of exposure to DVA – an area of research in which there is currently a gap, particularly for LMICs, which this paper addresses. Children growing up in violent communities may also be more likely to be exposed to violence perpetrated in the home due to broader environmental stressors or cultural normalisation of violence, making it difficult to determine directionality.

However, whilst there are some common factors across countries which either increase or decrease a child's likelihood of exposure to DVA, the findings from this paper reveal differences across countries and MDG regions, for example, wealth. This underscores the need for context and country specific research to be conducted, to allow for appropriate prevention and intervention strategies to be developed which acknowledge the cultural, economic, and social differences between countries.

It is important to acknowledge that statistics about exposure to DVA are based upon one question within a large survey. How respondents judged this based on the question asked means that the statistics could only capture a perception of violence rather than actual statistics of exposure to DVA. Therefore, whilst the variables were standardised, there may be differences in interpretation, which could distort the results. This links back to the idea previously mentioned that exposure to DVA, and what constitutes this, is a relatively unknown issue, that the definitions may not translate globally, and that there is currently no

internationally validated scale to measure exposure to DVA. Therefore, if any future research were to be conducted, perhaps a short definition of what exposure to DVA is could be provided, although this may not be possible if the questions are asked in the context of a larger survey where this topic is not the primary focus (as in the VACS).

A limitation of the data used for secondary data analysis within this paper is that the VACS uses a relatively narrow definition of exposure to DVA. With the exception of Cambodia, which asks about adult-to-adult violence within the home, the ten questionnaires do not allow exploration of exposure to DVA in multigenerational or multifamily households, where there could be other forms of DVA between people beyond those asked within the questions, e.g., grandmother to mother, or uncle to older cousin. In addition to this, the questions only ask about witnessing physical violence, and these statistics are likely to be a lot higher if other types of DVA were considered, for example, psychological violence or emotional abuse. The phrasing of the question highlights a potential limitation with the VACS and using them as a tool to get overall percentages of the number of children exposed to DVA. It also again highlights the need for a globally accepted measure for childhood exposure to DVA so that accurate statistics can be obtained. Similarly, specific phrasing for other questions and the variation of this across country could affect how someone interprets the question and, therefore, the answer given (Appendix B presents these differences).

In addition to this, differences exist in how exposure to domestic violence and abuse is defined and measured within the ten VACS datasets used for analysis within this paper (Table 3.5), notably with how the victim and perpetrator of the violence are specified. In six of the ten countries, the respondent's mother or stepmother is specified as the victim, with their father or stepfather as the perpetrator of the DVA. In three countries (Malawi, Nigeria and Zambia), respondents were asked if they had seen or heard their parent beaten up by their other parent, their boyfriend or girlfriend, and in Cambodia, the question was phrased to allow for any violence between adults in the home to be explored (and therefore allows for a broader definition of DVA to be explored). The questionnaire for Cambodia also contained another question on using a weapon, but it was excluded from the analysis to make it more comparable. Another limitation of the VACS datasets used is that exposure was not specified before the age of 18 in the country questionnaires for Cambodia and Zambia. This highlights the need for the measurement of exposure to be consistent, even within surveys commissioned by the same organisation.

The focus on witnessing and overhearing, rather than other types of exposure (Holden, 2003), could also mean that actual exposure statistics may be higher than reported. General limitations when exploring this topic also exist (as detailed in Section 2.3.1), which could lead to

underreporting amongst respondents. While some datasets may exist that could have perhaps provided information on childhood exposure to DVA better aligned with Holden's (2003) taxonomy of exposure; these data would only have been for specific countries. Instead, the VACS were chosen to allow for comparability and to obtain a better picture of childhood exposure to DVA in a range of LMICs so that any similarities could be identified. Whilst the VACS questions ask directly about whether a respondent saw or heard the violence (the fifth and sixth category of exposure in Holden's taxonomy), it could be assumed that children exposed to DVA may also have observed the initial effects, experienced the aftermath, and hears about the violence (the seventh, eighth, and ninth category), but this is not assessed as it is not explicitly asked. Therefore, according to Holden's (2003) taxonomy, some children who have been exposed to DVA may not have been captured using the questions asked within the VACS. However, despite these limitations, this paper gives a clear insight into exposure to DVA and that it is a highly prevalent issue across the ten LMICs explored. It also highlights how further work is required to ensure that more comparable statistics can be obtained so that the issue can be monitored and children protected from exposure to DVA and the adverse outcomes associated with it.

Whilst the narrow definition of exposure to DVA within the VACS is potentially a limitation, the high numbers of children found to be exposed to DVA within the ten countries within this analysis highlight that a large number of children are exposed to DVA in LMICs and that the actual number is likely to be a lot higher than the estimates presented in this paper if a broader definition of exposure to DVA was used. This, combined with the fact that there has been an increase in DVA cases as a result of the Covid-19 pandemic (Bradbury-Jones & Isham, 2020; Ertan et al., 2020; Kourti et al., 2021; Piquero et al., 2021), means that future research must focus on obtaining updated prevalence as an urgent priority.

As previously acknowledged, most risk factors associated with childhood exposure to DVA (along with the outcome variable, exposure to DVA) are not temporal (except for biological sex). This, combined with the broad age range of respondents to the survey (13-24), means that there is a possibility that the factors may not make a child more likely to be exposed to DVA, but instead, the factors explored could be an outcome of exposure. For example, not attending school could be an outcome rather than a risk factor, as exposure could affect this aspect of a child's life. Similarly, whether or not a child is living with both biological parents could be both a risk factor and an outcome of DVA perpetrated by one caregiver against another within the home, as the victim or perpetrator could leave the child's home. This is acknowledged within Holden's taxonomy of childhood exposure to DVA (Table 2.1; Holden, 2003) under the category "experiences the aftermath". This is why the phrase "risk factors associated with exposure to DVA" is used throughout this paper, as more complex analysis and data are required to

establish temporality and causality. This paper reveals that the ecological domains of community and societal factors is most important when considering exposure to DVA, demonstrating significance at both the overall, and community and societal levels. Again, though, these variables could be bi-directional, as high levels of violence in the community can often be seen reflected in high levels of violence in the home and vice versa (Shaw & McKay, 1942). Similarly, the variable assessing societal acceptance of DVA could both be a risk factor or outcome of exposure to DVA, as these views could be a result of general acceptance of violence within relationships within a country or society, or an outcome, if this is something which an individual has seen modelled between their parental figures. Despite these ecological domains only being associations, they proved to be significant, and so this is where future research should focus.

It is also important to acknowledge that whilst these ecological domains are distinct, factors across domains can interact to increase the likelihood of DVA being perpetrated between adults within a home, thus increasing the risk of a child being exposed to DVA. For example, societal beliefs and values can intersect with a family's socioeconomic status to influence the prevalence of DVA. For example, in a society where women have limited access to education, employment, and financial resources, they may be more vulnerable to abuse and less able to leave an abusive relationship (Koenig et al., 2003). Therefore, whilst the results of this study suggest a need for further research in the domains of community and society, a holistic approach to all potential risk areas within a child's life needs to be taken in an attempt to reduce exposure to DVA and adverse outcomes associated with exposure to DVA.

5.5 Conclusion

A high number of children are exposed to DVA within LMICs, and this study indicates that the existing global estimates (UNICEF, 2006) are likely to have underestimated the prevalence of childhood exposure to DVA. This indicates an urgent need for current estimates to be obtained so that the number of children exposed to DVA can be understood and progress monitored in order to reduce this.

When examining risk factors for exposure to DVA perpetrated within the home, this paper highlights the critical importance of contextual factors, particularly those occurring in the family, community, and society when considering the issue of childhood exposure to DVA in LMICs. While there are notable differences across countries, shared patterns, especially at the community and societal levels, suggest that suggesting that this ecological domain is where future research, policies, and interventions should focus.

To effectively reduce childhood exposure to DVA, multi-level strategies across all ecological domains should be explored, recognising that interventions solely focused on individuals or families are unlikely to address the full scope of risk. An integrated approach, incorporating agencies across the community, family and individual spheres could create a more comprehensive protective framework for children. Such an approach would not only support prevention but also provide the opportunity for more targeted interventions for those who have already been exposed to adult-perpetrated DVA.

However, as acknowledged throughout this paper, these are only associations, and further research is needed on this topic using surveys and tools that can assess temporality to obtain accurate global statistics and explore ‘true’ risk factors. Without these tools, there could be a delay in developing interventions and policies to both prevent exposure to DVA perpetrated by adults in their household, and help those children who have already been exposed.

Chapter 6 Paper Three: Mental Health Outcomes Associated with Childhood Exposure to Domestic Violence and Abuse in LMICs

Purpose: Research indicates that children exposed to domestic violence and abuse (DVA) are at an increased risk of adverse mental health outcomes. However, the majority of studies have predominantly focused on high-income countries (HICs), leaving a significant gap in the literature for those in low- and middle-income countries (LMICs). This paper aims to investigate the mental health outcomes in adolescence and early adulthood associated with childhood exposure to DVA, with a focus on internalising and externalising symptoms.

Method: Utilising ten CDC Violence Against Children Surveys (VACS), this paper applies quantitative methods, including bivariate analyses and binary logistic regression, to conduct a comprehensive multi-country analysis. The selected VACS encompass ten LMICs across the regions of Sub-Saharan Africa, Latin America and the Caribbean, South-Eastern Asia, and Eastern Europe. Internalising symptoms examined include psychological distress in the last 30 days, lifetime prevalence of intentional self-harm, suicidal thoughts, and suicide attempts; while externalising symptoms assessed involve risky behaviours in the last 30 days (any one of: binge drinking, drug use and smoking tobacco), and the lifetime prevalence of physical DVA and non-partnered violence perpetration.

Results: Bivariate analysis indicated a higher prevalence of both internalising and externalising symptoms amongst individuals with childhood exposure to DVA compared to those without. Regression analysis revealed that across all ten countries, those exposed to DVA had a 5.53%-19.80% percentage point higher predicted probability of experiencing psychological distress. Notably, in nine of the countries (all countries except Nigeria), individuals with childhood exposure has a higher predicted probability of having ever experienced suicidal thoughts. In five of ten countries, those exposed to DVA as a child were more likely to engage in risky behaviours and perpetrate DVA. Additionally, in six of the nine countries, non-partnered violence perpetration was more common amongst those exposed to DVA as a child. These findings suggest that childhood exposure to DVA is associated with a higher predicted probability of experiencing both internalising and externalising symptoms in adolescence and early adulthood than those who have not been exposed to DVA.

Conclusion: The findings from this paper demonstrate a significant association between childhood exposure to DVA and adverse mental health outcomes in adolescence and early adulthood across the ten LMICs explored, supporting existing literature from HICs. The consistent patterns observed regarding exposure across different countries, alongside certain exceptions that warrant further investigation, highlight an urgent need for additional research focused on childhood exposure to DVA in LMICs. This research is crucial to developing protective measures for vulnerable children.

6.1 Introduction

Despite the methodological issues associated with the measurement of exposure to domestic violence and abuse (DVA), and lack of research on risk factors, there is a wealth of evidence that suggests that exposure to DVA perpetrated by caregivers or adults within the home has adverse effects for both children and adolescents, in particular on their mental health. Evidence from high income countries (HICs) indicates that children exposed to DVA are at an increased risk of psychiatric disorders, substance misuse, and are more likely to commit violent crimes in adulthood, yet evidence on the impact of children exposed is limited in low- and middle-income countries (LMICs), despite there being a high number of children estimated to be exposed (UNICEF, 2006; Figure 2.1).

As discussed in Chapter 2, whilst some literature suggests an association between childhood exposure to DVA and outcomes which are non-mental health related (e.g., on future career opportunities, physical health or educational attainment), the greatest wealth of research on outcomes associated with exposure to DVA focuses on mental health outcomes, and therefore, this will be the focus of this study. Whilst there may be some positive outcomes of exposure to DVA depending on the context, these instances appear to be the exception, rather than the rule (Martinez-Torteya, Bogat, Von Eye & Levendosky, 2009).

This paper will utilise quantitative methods to explore mental health outcomes associated with childhood exposure to DVA in ten LMICs. This will be explored using the CDC Violence Against Children Surveys (Chiang et al., 2016; referred to from now on as ‘VACS’) to answer the research question for this paper: *How does childhood exposure to domestic violence and abuse influence mental health during adolescence and adulthood within LMICs?*

6.1.1 Conceptualising Mental Health

The term ‘mental health’ encompasses various aspects of an individual's life, including socialisation and interpersonal relationships. However, for the purpose of this thesis, the focus will be on internalising and externalising symptoms. Internalising and externalising symptoms provide a multidimensional perspective on mental health, covering emotional, behavioural, and contextual aspects (Nikstat & Riemann, 2020). These symptoms are valuable measures in assessing mental health across an individual's life due to their ability to predict both short and long-term mental health outcomes and capture a wide range of psychological distress and behavioural challenges (Kim et al., 2023; Thompson et al., 2015).

Internalising symptoms refer to inward-directed issues such as anxiety, depression, and withdrawal, while externalising symptoms involve outward-directed problems like aggression, conduct disorders, and impulsivity. These dimensions provide a comprehensive understanding of an individual's mental health status, covering both emotional and behavioural aspects (Masten et al., 2005). Research has shown that internalising and externalising symptoms are useful in predicting various mental health outcomes across developmental stages. Longitudinal studies have demonstrated that these symptoms in childhood can have implications for mental health trajectories in adolescence and young adulthood, influencing educational and employment outcomes (Veldman et al., 2015). Moreover, the presence of internalising and externalising symptoms has been linked to an increased risk for comorbid mental health disorders, highlighting the interconnected nature of these dimensions (Essau & Torre-Luque, 2021). Internalising and externalising symptoms have also been found to be associated with environmental factors and experiences such as homelessness, bullying, perpetration of violence, and family functioning (Kim et al., 2023; Kilpatrick et al., 2019; Schaub et al., 2014). This demonstrates that these symptoms can impact all four ecological domains explored within this thesis⁴¹, and mental health does not just affect an individual - these mental health outcomes can, in turn, affect family, community, and society. This highlights the significance of these measures in comprehending how social and contextual factors can affect mental health.

A plethora of studies have suggested a link between exposure to DVA and internalising and externalising symptoms (Evans, Davies, & DiLillo, 2008; McTavish, MacGregor, Grych, Jouriles, Swank, McDonald, & Norwood, 2000; Orr, Fisher, Preen, Glauert, & O'Donnell, 2020; Wathen, & MacMillan, 2016; Moylan et al., 2010; Vu, Jouriles, McDonald, & Rosenfield, 2016). However, the majority of these studies are based on research from HICs. Therefore, this thesis will focus on examining the mental health outcomes associated with exposure to DVA in LMICs, with a specific focus on internalising and externalising symptoms.

6.1.2 Internalising Symptoms Associated with Childhood Exposure to DVA

There is a wealth of research to support the link between exposure to DVA and internalising symptoms. Ellonen, Piispa, Peltonen and Oranen (2013) found that adults who had experienced

⁴¹ An explanation of the ecological domains used within this thesis and the literature from which they were developed can be found in Section 2.5.1. In summary, four ecological domains are explored which represent geographical/proximal categories: individual, family, community and society. It considers geographical communities and societies rather than those of interest (Poplin, 1979), representing differences in scale, but how each domain are interlinked.

exposure to DVA as a child demonstrate greater overall psychological distress including anxiety, depression and externalising symptoms, and more internalising symptoms. Meta-analyses have found effect sizes ranging from $d = .38$ to $.50$ for internalising symptoms (Chan & Yeung, 2009; Evans et al., 2008; Kitzmann et al., 2003; Wolfe et al., 2003), highlighting that this is a significant issue. These effects appear to be exacerbated in studies involving adolescents, with teenagers tending to exhibit greater levels of depression (Zinzow et al., 2009), anxiety (Mrug & Windle, 2010; Pelcovitz, Kaplan, DeRosa, Mandel, & Salzinger, 2000) and symptoms of post-traumatic stress disorder (Lang & Stover, 2008; Zinzow et al., 2009).

These differences present the idea of age as a factor which can cause differing outcomes, a consistent factor throughout the literature on this topic. In particular, two pathways should be considered: whether there are different outcomes predicted depending on the age of exposure to DVA, and whether the age that the person is asked to recall the experiences alters the outcomes. In addition to this, gender differences in internalising symptoms have been found among adolescents exposed to DVA (Moylan et al., 2010), with some research suggesting that both child and adolescent females may be more prone to experiencing internalising and trauma symptoms in response to exposure to DVA than males (Buka, Stichick, Birdthistle, & Earls, 2001; Moretti, Obsuth, Odgers, & Reebye, 2006). This highlights that alongside age, gender is another consideration for research in this area.

Whilst it is near impossible to say that exposure to DVA *causes* a particular mental health outcome, many studies have found a strong correlation between those who were exposed to DVA as a child, and those with clinically diagnosed mental health conditions (Bauer, Gilbert, Carroll, & Downs, 2013). Kitzmann et al. (2003) performed a meta-analyses of 118 studies, and found that children exposed to DVA are two to four times more likely to exhibit clinically significant problems than children from non-violent homes, with Fantuzzo and Mohr (1999) finding that these issues can manifest itself in the form of psychosomatic illnesses, depression, suicidal tendencies, and bed wetting.

Research by Orr, Fisher, Preen, Glauert and O'Donnell (2020) supports this association in their study based in Western Australia, with results revealing that children who are exposed to DVA are three times more likely to be hospitalised due to mental health issues than children who have not been exposed. Aboriginal children who had been exposed to DVA had a higher proportion of hospitalisations than non-Aboriginal children who had also experienced exposure to DVA, suggesting that these results differ by population grouping.

In particular, exposure to DVA perpetrated between caregivers as a child may lead to trauma symptoms, which can take the form of intrusive re-experiencing of the events in dreams or flashbacks, hyperarousal or an exaggerated startle response, and emotional withdrawal (Galano, Miller, & Graham-Bermann, 2014; Vickerman & Margolin, 2007). Prevalence rates of children who have been exposed to DVA who would also meet the clinical diagnostic criteria of post-traumatic stress disorder have been found to be as high as 50% (Vickerman & Margolin, 2007), indicating it is an extremely prevalent issue. However, this study failed to control for both the severity of the violence, or type of exposure – a significant methodological issue. Bauer et al. (2013) found that exposure to DVA before the age of three is also associated with pre-school onset of attention deficit hyperactivity disorder, suggesting that exposure to violence can have negative health outcomes from a very early age.

6.1.3 Externalising Symptoms Associated with Childhood Exposure to DVA

Another outcome commonly reported is that children who have been exposed to DVA perpetrated by one caregiver against another have an increased risk for developing a range of behavioural or externalising problems, and tend to exhibit more aggression towards parents, peers, and animals (Moretti et al., 2006). One such example is an Australian study, that found 40% of chronically violent teenagers had been exposed to extreme DVA in their home before the age of 18 (James, 1994). Children exposed to violence perpetrated in their home are also more likely to exhibit physical aggression in social situations and have higher levels of general behaviour problems compared to their non-exposed peers, when rated by teachers (Sternberg, Lamb, Guterman, & Abbott, 2006). They are also up to three times more likely to be involved in fighting and bullying behaviours during adolescence (Baldry, 2003; Herrera & McCloskey, 2001).

There is also evidence that exposure to DVA is associated with partaking in criminal, more risky behaviours, and behaviours harmful to health (Copeland et al., 2018; UNICEF, 2006). An example of this is in a study by Felitti et al. (1998), who found that adult participants who had been exposed to four or more categories of childhood exposure had a four-to-twelve-fold increase in smoking, poor rated self-health, having more than 50 sexual partners, and were more likely to be severely obese. There was also a graded relationship noted between the number of categories of adverse childhood experiences with the presence of diseases attributed to risky or negative but preventable behaviours, such as ischemic heart disease, chronic lung disease, and liver disease. These trends are supported by research by Chung et al. (2010) and Jackson et al. (2019), who investigated drug and alcohol use during pregnancy, and

emergency contraception use respectively. This association between exposure to DVA and criminal and/or risky behaviour demonstrates how exposure not only has an impact on the individual, but can also impact the wider community, highlighting the importance of creating effective interventions for those exposed.

Many studies have also found an association between exposure to DVA as a child, and alcohol and substance misuse or dependency later in adolescence and adulthood, with problems related to these being significantly higher when compared to the general population (Zilberman & Blume, 2005). Fagan and Wright (2012) found that witnessing DVA during adolescence is associated with greater frequency of drug use amongst females, but not males, and an increased likelihood of problematic alcohol use in young adulthood has been found for women, but not for men (Smith, Elwyn, Ireland, & Thornberry, 2010). Adults exposed to DVA as a child have also been found to be more likely to develop a dependence on medicinal drugs (Howarth et al., 2016; Sáez, Ruiz, Delclós-López, Expósito, & Fernández-Artamendi, 2020). Several studies have suggested that males are more prone to experience externalising symptoms than females, who instead, are more likely to exhibit internalising symptoms (Baldry, 2007; Sternberg et al., 2006). However, this is not a consistent finding across all research.

Research also suggests a strong likelihood that children exposed to DVA perpetrated between caregivers or other adults in their home will be caught in a continuing cycle of violence for the next generation, referred to as the 'intergenerational transmission of violence' (Widom, 1989). The single best predictor for children becoming either perpetrators or victims of DVA later in life is whether they grew up in a home where they were exposed to DVA (UNICEF, 2006). Studies from various countries support the findings that rates of abuse are higher among women whose husbands were abused as children or who saw their mothers being abused (Indermaur, 2001), and there is evidence that children who were exposed to DVA are more likely to be involved in a violent relationship as an adolescent, either as a perpetrator or as a victim (Ireland & Smith, 2009).

6.1.4 Theoretical Considerations

Exposure to DVA and how this can lead to negative health outcomes can be explored through a number of theories, with some of the most pertinent discussed below. It is important to note the wide range of theories, and that they are not necessarily competing, but can be complementary when investigating the negative outcomes related to childhood exposure to DVA.

Attachment Theory (Ainsworth & Bowlby, 1991) states that children develop mental representations and working models of themselves and their worthiness through interacting with caregivers, and other family members or role models. The style of attachment is formed early in an individual's life and can significantly affect a child's personality development and the relationships they form later in life (Bowlby, 1969). If a child has a family environment which is violent and hostile, with childcare potentially not prioritised, then their working models are compromised, resulting in the child developing poor quality attachments, such as insecure or disorganised attachments. This can cause a chain reaction where the child manifests this poor attachment through their behaviour, leading to aggression and interpersonal problems in childhood, adolescence and adulthood (Shemmings & Shemmings, 2011). However, having a secure attachment style to a non-violent parent or other significant carer (e.g. a grandparent) has been cited consistently across research as an important protective factor in mitigating the distress associated with exposure to DVA, with these children appearing to have more positive outcomes (Holt et al., 2008).

Another theory to consider is that of Social Learning Theory, proposed by Bandura and McClelland (1977). This theory emphasises the importance of observing, modelling and imitating the behaviours, attitudes and emotional reactions of a child's caregivers or role models (often termed 'observational learning'). If a child observes violence between their caregivers, it can lead to them learning to use aggression as a means of resolving conflict (Hotelling & Sugarman, 1986). Within research concerning DVA, Social Learning Theory has been used to explain externalising and behavioural symptoms (such as aggression and dating violence) in adolescents that have grown up exposed to DVA, however it is less useful when explaining internalising sequelae (Anderson & Kras, 2005). Social Learning Theory has been used by researchers to explain the intergenerational transmission of violence, with many children who are exposed to DVA being more likely to imitate or tolerate these behaviours than children from non-violent homes, with Margolin (1998) saying:

“the intergenerational data, taken as a whole, indicate that the childhood experience of witnessing interparental violence can lay the foundation for aggressively orientated behavioural repertoire as well as different expectations regarding aggression in adult intimate relationships”
(p 63).

Margolin (2005) also presented how Family Systems Theory can be used to explain the association between exposure to DVA perpetrated by one caregiver or adult in the home against another, and negative health outcomes. She argues that exposure to DVA creates a paradox that

leads children to interpret their families as chaotic, rather than somewhere where they are provided safety and protection (Margolin, 2005). This in turn causes them to behave in a chaotic manner, exhibiting externalising symptoms such as aggression. She argues that caregiver-perpetrated violence may result in an increased psychopathology for the victimised caregiver, causing strain to the family unit which in turn could increase stress levels and lead to psychopathology within the child who has been exposed (Margolin, 1998).

Trauma Theory is another theory which has been used to explain the association. This argues that exposure to DVA perpetrated by one caregiver against another is an environmental stressor that threatens a child's sense of personal safety and security (De Bellis, 2001). These perceived threats lead to cognitive, biological and psychological disturbances, and these disturbances at a young age can 'set the stage' for the development of additional emotional and behavioural disturbances as the individual matures (Margolin, 2005). Similarly, Stress Theory (Mistry, Vandewater, Huston & McLoyd, 2002) proposes that continued exposure to caregiver-perpetrated violence can increase psychopathologies such as psychological distress, mood and anxiety disorders, risk behaviours, and alcohol and other substance use to cope with negative emotions, which can in turn increase the risk of subsequent violence perpetration.

Finally, Ecological Theories such as the Bioecological model (Bronfenbrenner, 1979) argues that there is a relationship between the context a child grows up in, and the individual characteristics that a child develops. This theory explains the role of violence across multiple levels or contexts (for example, family, school and society), with studies finding that a child who is exposed to DVA typically faces additional adversities such as poverty, low parental education and a high crime rate in the area in which they live, which can increase the risk of adolescent psychopathology (Wong et al., 2009). This final theory suggests that social determinants can affect both a child's risk to experiencing exposure to DVA, but also, affect the outcomes experienced and their severity. This links to the work in Paper Three (Chapter 5), where ecological domains are explored to assess risk factors for childhood exposure to DVA. These risk factors and ecological domains are also used within the regression analysis of this paper, to assess whether the mental health outcomes explored are associated with these pre-existing risk factors, or if there is an association with childhood exposure to DVA.

6.1.5 Conceptual Framework for Paper Three

The conceptual framework for this paper can be seen in Figure 6.1. This builds upon that of Paper Two (Chapter 5; Figure 5.1), illustrating how factors within a wider society feed into a

community⁴², which then feeds down into a family, and to an individual, in a similar way to how other ecological models explore health and behaviours, such as Bronfenbrenner (1979), and is akin to the Dahlgren-Whitehead rainbow, which demonstrates how broader factors filter through to individual characteristics (Dahlgren & Whitehead, 1991). These explanatory factors are represented by the circles on the left-hand side of the conceptual framework, and as these factors could also influence mental health, there is a solid arrow between these ecological domains and mental health outcomes. Additionally, global factors are recognised outside these four ecological domains as an indirect effect (therefore represented by a broken line).

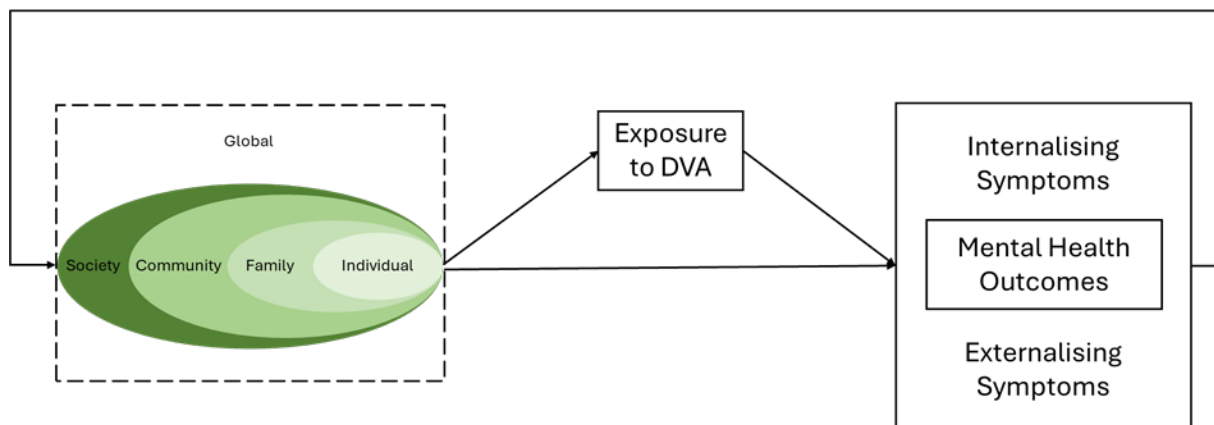


Figure 6.1 Conceptual framework for mental health outcomes associated with childhood exposure to DVA

Exposure to DVA directly feeds into mental health outcomes, which can manifest as internalising symptoms and/or externalising symptoms. Finally, the circular nature of exposure to DVA and a feedback loop is reflected in the framework, with arrows indicating that outcomes such as adverse effects on health and wellbeing can influence societies, communities, and families. This conceptual framework and the categories within it guide both the literature review and analysis for this paper.

6.1.6 Aim and Purpose of Study

Therefore, this paper explores adolescent and young adult mental health associations from childhood exposure to DVA, with a particular focus on a range of internalising and externalising

⁴² The ecological domains within this thesis represent differences in scale, i.e., geographical/proximal categories. It considers geographical communities as opposed to interest communities (Poplin, 1979), and society is also considered in a geographical context, meaning wider (i.e., country-level) factors.

symptoms. Using the Violence Against Children Surveys (VACS; Chiang et al., 2016), the following research question will be explored: *How does childhood exposure to domestic violence and abuse influence mental health during adolescence and adulthood within LMICs?*

6.2 Methods

6.2.1 Selection of VACS Datasets for Analysis

Ethical approval to conduct secondary data analysis on the VACS was granted by the University of Southampton Ethics and Research Governance Committee, and a request to access the VACS datasets made to the managing body, Together for Girls. Full datasets were received for the VACS for the following countries: Cambodia, Colombia (National and Priority Municipalities), Côte d'Ivoire, Eswatini, Haiti, Honduras, Kenya, Lesotho, Malawi, Moldova, Namibia, Nigeria, Tanzania, Zambia, and Zimbabwe.

The country questionnaires and datasets were examined prior to analysis, and the datasets of Eswatini, El Salvador, Haiti, Kenya, Tanzania and Zimbabwe were excluded from analysis, along with the Colombia Priority Municipalities dataset, to allow for better comparability across questions (full justification of why each dataset was excluded can be found in Section 3.3). Therefore, ten VACS country datasets were used for analysis: Cambodia, Colombia National (referred to only as 'Colombia' from now on), Côte d'Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, and Zambia. Further details on the sampling methods and calculation of participation rates can be found within the VACS Country Reports (CDC, 2022, see also Section 3.3.1 and Table 3.4).

6.2.2 Assessing the Relationship between Childhood Exposure to DVA and Adolescent and Adult Mental Health within the VACS

Due to the cross-sectional nature of the VACS, assessing temporality is difficult, and therefore, there is no way of knowing if some of the lifetime associated outcomes (e.g., suicidal thoughts), happened before, during, and/or after exposure to DVA. This limitation is in addition to the broader limitation that correlational data cannot reveal causal relationships. These are issues acknowledged by other papers using the VACS (e.g., Annor et al., 2022; Kafuko et al., 2022). Therefore, only associational relationships can be implied from the VACS data.

6.2.2.1 Childhood Exposure to DVA in the VACS

The prevalence of childhood exposure to physical DVA was assessed by asking VACS participants aged 13-24 how many times they saw or heard their parent punched, kicked, or beaten up by their other parent, or their boyfriend or girlfriend prior to the age of 18. Whilst this definition is relatively constricted when considered with the emerging body of literature about exposure, this was the only question the VACS asked about childhood exposure to DVA, and so this is what was used for the purpose of this study.

For the purpose of the analysis, the results were dichotomised, and an exposure “yes/no” variable was created to allow for analysis of childhood exposure to DVA. Within the VACS questionnaires, slight variations existed in the way in which the perpetrators and victims of DVA were described. The dataset for Cambodia also included an additional question about exposure to DVA: “thinking about inside your home, have you ever seen an adult hurt or scare another adult by using or threatening to use a gun, stick, rock, or other similar weapon?”. However, this question was excluded from the creation of the stimuli variable to allow for better consistency and comparability across countries.

Respondents’ answers to the VACS question regarding childhood exposure to DVA were recoded depending on whether the answer had indicated there had been any exposure, regardless of the frequency, to allow for an overall exposure statistic to be obtained. For “don’t know/declined”, this was recoded as missing data, as it was considered a non-response which could obscure accurate exposure if treated as equivalent to “no”.

Table 3.5 details the country specific questions and response options for each questionnaire, along with how each response was recoded. Response rates for exposure to DVA were examined prior to analysis, a summary of which can be found in Table 3.6.

6.2.3 Selection and Creation of Adolescent and Adult Mental Health Variables for Analysis

After careful consideration of the literature review and conceptual framework, the VACS datasets were examined for appropriate variables to assess which elements of mental health could be explored. Variables relating to mental health were searched for within the VACS questionnaires that would allow for comparison across all ten countries. The phrasing of the questions and their appropriateness under the definition and conceptualisation of mental health used within this paper was also considered. Variables measuring aspects of adolescent

and adult mental health were considered under the two categories of internalising symptoms and externalising symptoms, in line with the literature review. A summary of the variables explored within this paper can be found in Table 6.1.

Table 6.1 A summary of adolescent and adult variables relating to mental health within the VACS

Category of Mental Health	Possible Outcome	Time Period within VACS
Internalising Symptoms	Psychological distress	Last 30 days
	Intentional self-harm	Ever
	Suicidal thoughts	Ever
	Suicide attempt	Ever
Externalising Symptoms	Risky Behaviour: Binge drinking	Last 30 days
	Risky Behaviour: Drug use	Last 30 days
	Risky Behaviour: Smoking cigarettes/tobacco	Last 30 days/currently (depending on country specific phrasing)
	Perpetration of [Physical] DVA	Ever
	Perpetration of [Physical] Non-Partnered Violence ⁴³	Ever

The majority of outcomes were explored through existing variables within the surveys, but some, such as perpetration of physical DVA, were new variables derived from other questions.

Appendix E illustrates the way in which the variables were recoded within Stata (using the phrasing and coding in Côte d'Ivoire as an example), and the following section details how the variables used for analysis were formed.

6.2.3.1 Internalising Symptoms

Psychological distress: Psychological distress was assessed using the Kessler 6 (K6) scale (Kessler et al., 2003), which consists of six questions exploring feelings of hopelessness, restlessness, worthlessness, depression, effort, and sadness by the respondent during the previous 30 days. The K6 is an instrument that measures psychological distress and includes items that assess anxiety and depression, and it has demonstrated excellent internal consistency and reliability across different cultures and ethnic groups, including in many LMICs

⁴³ This question was not asked in the Cambodian questionnaire, and so was only explored in nine of the ten VACS datasets used within this thesis.

(Easton, Safadi, Wang, & Hasson, 2017; Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011; Van der Auwera, Debacker & Hubloue, 2012; Vissoci et al., 2018). Each item uses a scale response format from 1 to 5, where 1 corresponds to experiencing a mental health symptom “all the time” and 5 corresponds to “never”. The reference time frame is the past 30 days. The scores of the individual items were reversed and summed to form a unidimensional summary score of psychological distress on an index ranging from 0 to 24, following the approach used in previous studies (e.g., Furukawa, Kessler, Slade & Andres, 2003; Swartz & Lurigio, 2006). Respondents scoring 0 to 4 were defined as having no psychological distress, scores of 5 to 12 indicated mild to moderate psychological distress, and scores of 13 or higher indicated severe psychological distress (Prochaska, Sung, Max, Shi, & Ong, 2012). If there were any missing responses on any of the six questions then the respondent were classed as having a missing overall K6 score. This approach was taken due to the difficulty of imputing any missing scores, whilst relying on only the questions for which there was a response may lead to an over-reliance on one or two questions for the overall score.

Intentional Self-Harm: Within all of the VACS country questionnaires, a question asked respondents “Have you ever intentionally hurt yourself in any way?”, and respondents were able to answer yes, no, or don’t know/declined. This was used to construct a dichotomous variable indicating if the respondent had ever intentionally harmed themselves. While the psychological distress variable reflects the situation of the respondent at the time of the interview, the intentional self-harm outcome (along with others, such as suicidal thoughts, suicide attempt, perpetration of DVA, and perpetration of [physical] non-partnered violence) measure reflects lifetime experience.

Suicidal Thoughts: Suicidal thoughts was measured using the following question: “Have you ever thought about killing yourself?”, or in the case of Moldova, “Have you ever seriously considered ending your life?”. This was used to construct a dichotomous variable indicating if the respondent had ever had suicidal thoughts.

Suicide Attempt: For respondents who indicated that they had ever had suicidal thoughts, they were then asked, “Have you ever tried to kill yourself?”, or in the case of Moldova, “Have you ever tried ending your life?”. Again, from this, a dichotomous variable was constructed to indicate whether the respondent had ever had a suicide attempt.

6.2.3.2 Externalising Symptoms

Engaging in Behaviours Harmful to Health ('Risky Behaviours'): Respondents were asked the frequency over the past 30 days that they had engaged with three behaviours: binge drinking⁴⁴, smoking tobacco (in some countries respondents were asked whether they currently smoke), and drug use (in some questionnaires, some specific drugs were specified, such as yama⁴⁵ in Cambodia). Similarly to some other outcome variables explored, whilst the questions asked about frequency of the behaviour, for the purpose of analysis these were dichotomised. Even though when done in moderation some of these behaviours may not indicate poor mental health, for the purpose of this variable, anyone doing anything which could be harmful for their health has been considered. Therefore, if someone has partaken in binge drinking, smoking, or taking drugs at all in the past 30 days, then they have been coded as having engaged with the behaviour, no matter what the frequency was. From this, an overall 'risky behaviours' variable was created, where if anyone had indicated that they engage with any of the three behaviours, they were coded as yes, whereas respondents were coded as no if they answered no to the three behaviours.

Perpetration of [physical] Domestic Violence and Abuse: Research suggests a likelihood that those exposed to DVA as children can be at increased risk of perpetrating DVA later in life – thus fostering an 'intergenerational transmission of violence' (Widom, 1989). UNICEF (2006) stated, for example, that the strongest correlate of both DVA perpetration and victimhood later in life is whether an individual grew up in a home where they were exposed to DVA. An investigation of the reasons for this strong association between exposure and both perpetration and victimhood are multiple, complicated, and beyond the scope of this investigation.

Therefore, adolescence or adult perpetration of DVA (as recorded within the VACS) was explored as an externalising symptom that may be a possible later occurring associated outcome of childhood exposure to DVA. For those who indicated that they had ever had a relationship, respondents were asked a range of questions about types of violence that they have perpetrated towards a current or former husband, wife, partner, girlfriend, or boyfriend. In some countries, these included questions about perpetration of sexual violence or economic or

⁴⁴ Binge drinking is defined as consuming 5 or more drinks on an occasion for men or 4 or more drinks on an occasion for women (Centers for Disease Control and Prevention, 2022a).

⁴⁵ Yama is now more commonly known as ya ba/yaba and is a drug containing a mixture of methamphetamine and caffeine. Whilst it is illegal, it has considerable use in Southeast Asia (Hogan, 2018).

coercive control, however, these were not consistent across all ten countries. Therefore, only those behaviours which were consistently asked across all ten countries were included, which all relate to perpetration of physical violence:

1. Punching, kicking, whipping, or beating a current or previous partner with an object.
2. Choking, smothering, trying to drown, or intentionally burning or scalding a current or previous partner.
3. Using or threatening to use a knife or other weapon against a current or previous partner.

Whilst this perhaps does not encompass the full definition of DVA, for the purpose of this paper using behaviours that were consistent across all ten countries allowed for direct comparisons to be drawn. If a respondent answered “yes” to any of these, then they were coded as having perpetrated DVA. If they answered “no” to all three categories, then they were categorised as not having perpetrated DVA.

Perpetration of [Physical] Non-Partnered Violence: Respondents were also asked whether had perpetrated any of the violent acts to someone who was not a current or previous partner. Again, within some country questionnaires a variety of violent acts were explored, but only three were consistent across all ten datasets (the same three explored within the DVA Perpetration variable), and so these were what were explored for this variable. Again, each violent act was recoded to form a binary variable, and then if statements were used to form two groups – those who had ever perpetrated any of the three types of physical violence explored, and those who had never perpetrated those violent acts towards others.

6.2.4 Methods of Analysis

StataSE 17.0 (StataCorp, 2021) was used to analyse these datasets. Six of the country datasets were presented as overall country data (i.e., combined male and female biological sex), and those of Cambodia, Malawi, Nigeria, and Zambia were presented as two separate datasets – one for males and one for females. Therefore, these were combined to allow for analysis of the country's prevalence of exposure to DVA and associated mental health outcomes.

Due to the complex sample design, weightings were applied using guidance within the Data File Summary provided by Together for Girls for each country dataset. During analysis, 95% confidence intervals were included to indicate the degree of confidence in the accuracy of point estimates within a specified margin of error.

Following the creation of the exposure to DVA variable and the mental health outcomes variables (detailed in Section 6.2.3 and Appendix E), bivariate analyses through cross tabulations were performed. To explore mental health outcomes associated with childhood exposure to DVA, row percentages were created, and these were recorded in the form of a table to allow for analysis across countries. These percentages enable comparison of mental health outcomes between those who were, and those who were not exposed to DVA as a child. Confidence intervals indicated that there was sufficient power in the data and in each group to allow for further analysis to be undertaken. This was demonstrated by the size of the confidence intervals and the care taken to ensure that there was no multicollinearity within the independent explanatory factors chosen for regression analysis.

Regression analysis was then conducted to assess which of the potential explanatory factors from Paper Two (Chapter 5)⁴⁶ (including exposure to DVA) had a significant relationship with each of the mental health outcomes explored in this paper. Consideration was given to issues of joint variables and collinearity (as detailed in Section 6.2.4), and following the bivariate analysis, the variable ‘suicide attempt’ was removed from further analysis⁴⁷. The individual risky behaviours (binge drinking, smoking tobacco, and drug use) were also not explored further after conducting the bivariate analyses, with the focus instead placed on the overall ‘risky behaviours’ variable, which combined the three⁴⁸.

Binary logistic regression was applied as the most appropriate method of analysis. A regression model for each mental health outcome associated with exposure to DVA was estimated for each country. For presentational reasons, results are displayed for all mental health outcomes together, with a table for each individual explanatory variable to allow for easier comparisons across the ten countries of investigation. For psychological distress (the only variable which was not already binary), the variable was recoded, where if a respondent had experienced any psychological distress (be this mild/moderate or severe), then they were coded as having

⁴⁶ The explanatory factors used within this analysis are exposure to DVA, respondent sex, education level, wealth, death of a biological parent, living with both biological parents, multiple children in household, exposure to community violence, and societal acceptance of DVA. Further information about how each of these variables were conceptualized and created can be found in Paper Two (Chapter 5).

⁴⁷ The decision was made to remove this variable from the regression analysis as everyone within this variable would have also been included under the ‘suicidal thoughts’ variable. The ‘suicide attempt’ variable also had relatively low sample sizes across some countries.

⁴⁸ This variable takes the value of 1 if any risky behaviour is reported, and 0 if a respondent answered that they didn’t engage with all three risky behaviours. A full explanation of how this variable was recoded is available in Appendix E.3.2.

experienced psychological distress (1), and if they had experienced no psychological distress, then they remained in this category (0). This decision was made in line with other studies (e.g., Fan et al., 2017; Kieselbach, Kress, MacMillan & Perneger, 2011). Reference categories were selected with the literature review in mind, choosing the response which was least associated with exposure to DVA (for example, not completing primary school was found to be a risk factor, and so completion of primary school was chosen to be the reference category).

The results of the logistic regression models are presented as predicted probabilities using the following formula:

$$\log_e \left(\frac{p}{1-p} \right) = \beta_0 + \beta_1 x_1 + \beta_2 x_2 + \dots + \beta_n x_n$$

$$p = \frac{e^{\beta_0 + \beta_1 + \beta_2 x_2}}{e^{\beta_0 + \beta_1 + \beta_2 x_2} + 1} = \frac{1}{1 + e^{-(\beta_0 + \beta_1 + \beta_2 x_2)}}$$

Average marginal effects were used to calculate predicted probabilities for each group. These allow for comparison between groups in terms of absolute percentage-point differences, rather than odds ratios (Mood, 2010).

Some models had no variation, and so categories were removed from the risk factor variables, where appropriate. Where this is the case, details have been provided beneath the tables presenting the regression models (Appendix G).

The bivariate and regression analyses are presented in tables grouped by MDG Region⁴⁹ to allow for the examination of similarities and differences between and within regions.

6.3 Results

This section explores the simple bivariate relationships between the mental health outcomes and the factors that might be related to them, including exposure. To allow for full exploration of the data, this results section is split into three sections: bivariate analysis of internalising symptoms, bivariate analysis of externalising symptoms, and regression analysis.

⁴⁹ As discussed in Chapter 2, Millenium Development Goal (MDG) Regions are used throughout this thesis to allow for comparability with the latest global estimates for childhood exposure to DVA (UNICEF, 2006).

6.3.1 Bivariate Analysis of Internalising Symptoms Associated with Exposure to DVA in LMICs

6.3.1.1 Psychological Distress

Within the psychological distress variable, four categories were created in line with Kessler's K6 Level of Psychological Distress (Kessler et al., 2003): no psychological distress, mild/moderate psychological distress, severe psychological distress, and missing K6 score. Table 6.2 shows the levels of psychological distress reported amongst respondents in the past 30 days.

Table 6.2 Levels of psychological distress reported amongst adults exposed and not exposed to DVA as children within the VACS (last 30 days)

MDG Region	Country (Survey Year)	Kessler K6 Level of Psychological Distress (Weighted %)							
		No Psychological Distress (0-4)		Mild/Moderate Psychological Distress (5-12)		Severe Psychological Distress (13+)		Missing K6 Score	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	37.03	46.79	50.29	42.23	10.71	7.89	1.96	3.09
	Male	39.82	49.92	48.83	41.45	9.97	5.09	1.39	3.55
	Female	34.18	43.63	51.78	43.03	11.48	10.73	2.56	2.62
	Lesotho (2018)	63.75	75.65	32.22	21.60	3.59	2.23	0.45	0.51
	Male	63.11	74.37	35.92	24.10	0.97	1.37	0.00	0.16
	Female	64.27	77.05	29.18	18.89	5.73	3.16	0.81	0.90
	Malawi (2013)	53.54	70.18	36.22	23.73	8.48	5.04	1.76	1.05
	Male	56.85	68.57	34.34	24.29	6.79	5.77	2.02	1.36
	Female	50.48	71.63	37.96	23.22	10.04	4.39	1.52	0.76
	Namibia (2019)	58.20	70.49	33.45	25.16	4.99	2.53	3.36	1.83
	Male	66.71	78.64	25.79	19.00	4.34	0.94	3.16	1.43
	Female	48.41	60.55	42.26	32.68	5.73	4.46	3.60	2.32
	Nigeria (2014)	61.42	68.23	27.27	24.19	5.89	3.00	5.42	4.58
	Male	53.75	71.12	34.45	22.08	4.12	1.69	7.69	5.10
	Female	67.26	65.07	21.80	26.50	7.25	4.43	3.69	4.00
	Zambia (2014)	51.20	60.10	33.10	27.98	12.06	6.70	3.64	5.23
	Male	52.52	59.84	32.59	28.08	10.28	6.68	4.61	5.40
	Female	50.15	60.38	33.49	27.87	13.48	6.71	2.88	5.04
Latin America and the Caribbean	Colombia (2018)	34.72	60.01	51.18	34.81	11.87	3.04	2.23	2.14
	Male	37.77	67.85	52.21	28.86	6.47	1.64	3.55	1.64
	Female	32.54	50.88	50.44	41.73	15.76	4.67	1.27	2.72
	Honduras (2017)	33.72	49.61	51.62	42.53	14.04	7.10	0.62	0.76
	Male	42.86	53.49	45.20	41.40	11.94	4.57	0.00	0.46
	Female	28.31	45.61	55.42	43.61	15.29	9.71	0.98	1.07
South-Eastern Asia	Cambodia (2013)	46.34	67.38	41.32	29.13	10.27	2.76	2.08	0.72
	Male	55.21	72.43	36.71	24.18	4.81	2.00	3.27	1.40
	Female	36.54	62.37	46.41	34.05	16.29	3.52	0.75	0.06
Eastern Europe	Moldova (2019)	33.03	58.53	48.64	33.79	10.20	2.87	8.13	4.80
	Male	42.85	63.31	43.00	31.89	4.02	1.57	10.13	3.23
	Female	27.29	52.98	51.94	36.01	13.82	4.38	6.96	6.63

When examining the overall populations, in all ten countries, the prevalence of no psychological distress was higher among individuals not exposed to DVA between parents or caregivers than those who were exposed. The 'missing K6' category (those who did not answer one of the six questions) was mixed, containing an equal number of cases across both the exposed and non-exposed groups.

When looking at the overall population groups, the prevalence of mild/moderate psychological distress was higher among individuals exposed to DVA than those not exposed to DVA in all ten countries. In general, those in the exposed category had a 10-15% higher prevalence of mild/moderate psychological distress when compared to their non-exposed counterparts within each country, with slightly smaller differences reported in Namibia (33.45% for exposed vs 25.16% for non-exposed), Nigeria (27.27% for exposed vs 24.19 for non-exposed), and Zambia (33.10% for exposed vs 27.98 for non-exposed).

Within the overall country populations, for those experiencing severe psychological distress, the prevalence was higher among individuals exposed to DVA in all countries. This is particularly pronounced in Zambia, where the prevalence of severe psychological distress was higher among individuals exposed to DVA (12.06%) compared to those not exposed to caregiver-perpetrated DVA (6.70%) – a similar differential to that reported in Colombia (11.87% amongst those exposed to DVA vs 3.04% amongst those not exposed to DVA), Honduras (14.04% for those exposed vs 7.10% for those not exposed), Cambodia (10.27% for exposed vs 2.76% for non-exposed) and Moldova (10.20% for those exposed to DVA vs 2.87 amongst those not exposed to DVA).

Gender differences were also observed in some countries, although the general pattern is the same. Mild/moderate psychological distress was higher among females exposed to DVA in six of the ten countries (Côte d'Ivoire, Malawi, Namibia, Honduras, Cambodia and Moldova), but was higher amongst males who had been exposed to DVA in Lesotho, Nigeria, Zambia and Colombia. In the Nigerian female population, higher levels of psychological distress were also reported amongst those who had not been exposed to DVA (26.50%) when compared to those who had been exposed to DVA (21.80%), although this is the only exception. When examining male and female populations separately, a higher prevalence of mild/moderate psychological distress was reported amongst those who had been exposed to DVA as a child when comparing to those who had not been exposed. Amongst those who had been exposed to DVA, females reported higher levels of severe psychological distress when compared to males in all ten LMICs explored.

Further analysis revealed that when looking at whether an individual has experienced any psychological distress⁵⁰ in the last 30 days (whether that be mild/moderate, or severe), there are

⁵⁰ Any psychological distress is indicated by using a cut-off of ≥ 5 to classify persons into the category of moderate or severe mental distress (Fan et al., 2017). This was the method also applied to form the binary variable used in the regression models.

higher levels of psychological distress reported amongst those exposed to DVA in all ten of the LMICs explored (Figure 6.2 demonstrates this for the overall country populations). This suggests that there appears to be an association between childhood exposure to DVA and psychological distress in adolescence and early adulthood.

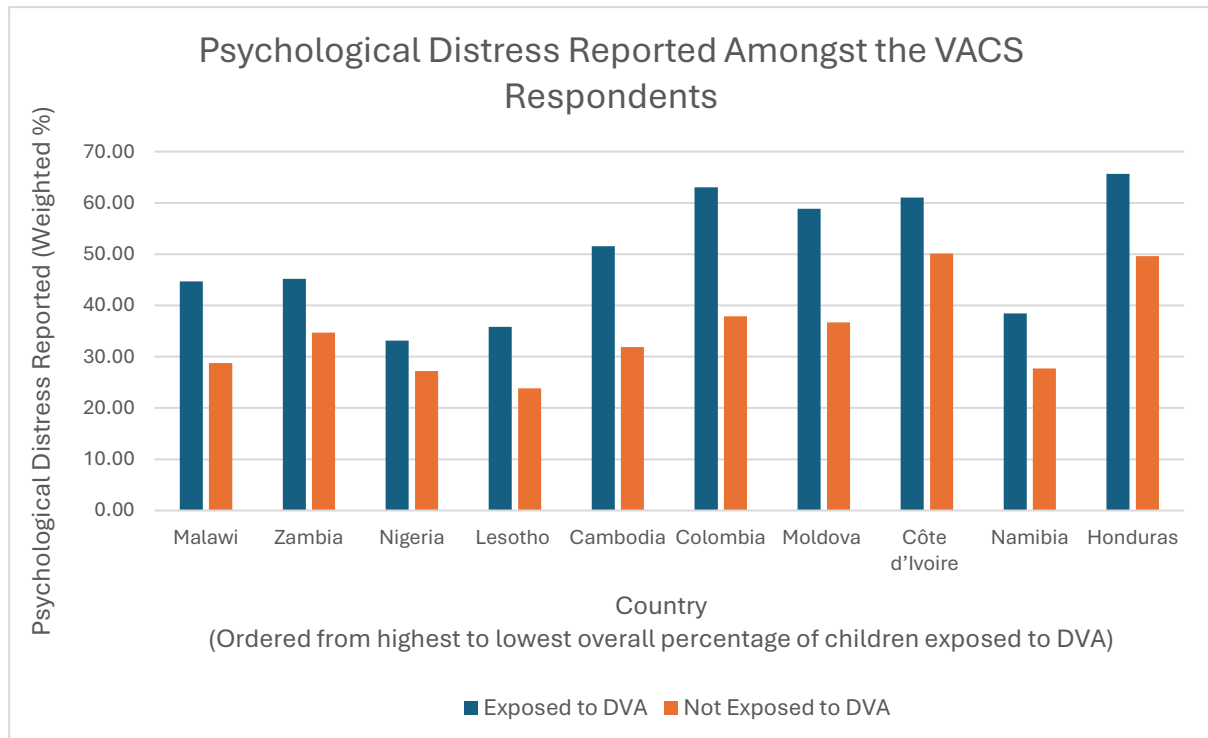


Figure 6.2 A clustered bar graph displaying the percentage of respondents reporting any psychological distress by VACS country (using weighted percentages)

6.3.1.2 Intentional Self-harm

Table 6.3 demonstrates internalising symptoms reported amongst adults exposed and not exposed to DVA as children within the VACS over their lifetime, including intentional self-harm behaviour. Those who have reported ever intentionally self-harming within the overall population can also be seen in Figure 6.3.

In almost all countries, there was higher prevalence of lifetime self-harm reported amongst the group exposed to DVA as a child, when compared to those who had not been exposed. The only exception to this is Zambia. The largest absolute difference is seen in Honduras, where the overall prevalence of intentional self-harm among exposed individuals (17.02%) was much higher compared to those who were not exposed (10.41%). This trend was also observed in Côte

d'Ivoire (15.97% vs 13.78%), Malawi (6.30% vs 3.87%) and Namibia (13.46% vs 8.65%), Colombia (14.52% vs 10.62%), Cambodia (11.09% vs 4.56%) and Moldova (10.79% vs 7.15%), but was not present in Zambia (where those exposed to DVA had a prevalence rate of 10.39% , and those who had not been exposed 10.42%), but these differences are small.

In terms of sex differences, the prevalence of intentional self-harm was generally higher among females compared to males, with the notable exception of Nigeria, where the prevalence rate of self-harm amongst females was 6.24% for those exposed to DVA and 5.11% for those not exposed to DVA, compared to 8.75% and 6.48% for males, for those and not exposed to DVA, respectively. In Malawi, amongst the exposed group females had a higher prevalence of lifetime self-harm (6.80% compared to 5.75% for males), but amongst those not exposed to DVA, males reported a higher prevalence of intentional self-harm (5.76% vs 2.18%). This pattern is reversed in Lesotho, with males reporting higher levels of intentional self-harm amongst the exposed population when compared to females (3.72% vs 2.56%), but lower levels amongst the not exposed group (2.07% vs 1.91%).

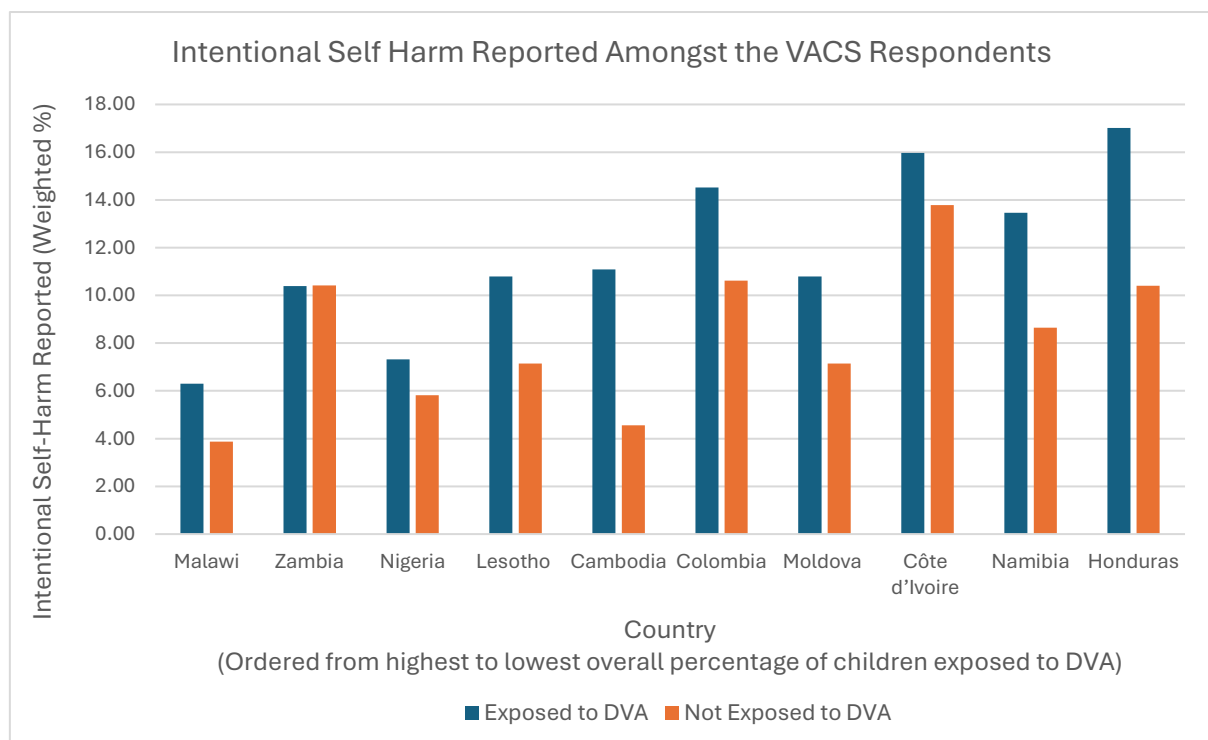


Figure 6.3 A clustered bar graph displaying the percentage of respondents reporting intentional self-harm by VACS country (using weighted percentages)

Overall, the findings suggest that exposure to DVA perpetrated between caregivers (or other adults in the home) may be associated with a higher likelihood of intentional self-harm

behaviour, although this relationship may vary across different countries and demographic groups.

Table 6.3 Internalising symptoms reported amongst adults exposed and not exposed to DVA as children within the VACS (lifetime)

MDG Region	Country (Survey Year)	Internalising Symptoms Experienced Throughout Respondent's Lifetime (Weighted %)					
		Intentional Self-Harm		Suicidal Thoughts		Attempted Suicide	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	15.97	13.78	7.63	4.43	2.88	2.14
	Male	13.18	9.12	2.40	1.88	0.30	1.03
	Female	18.83	18.50	12.97	7.01	5.52	3.26
	Lesotho (2018)	3.08	1.99	9.04	4.09	2.15	1.21
	Male	3.72	1.91	4.32	2.38	0.58	0.81
	Female	2.56	2.07	12.88	5.94	3.43	1.65
	Malawi (2013)	6.30	3.87	6.28	3.69	1.56	0.30
	Male	5.75	5.76	3.99	2.87	0.65	0.62
	Female	6.80	2.18	8.39	4.42	2.39	0.00
	Namibia (2019)	13.46	8.65	12.13	6.02	4.68	1.74
	Male	11.14	8.16	5.22	2.87	1.30	0.49
	Female	16.13	9.25	20.07	9.87	8.57	3.28
	Nigeria (2014)	7.32	5.82	4.90	4.81	3.10	1.48
	Male	8.75	6.48	2.61	3.41	1.05	0.74
	Female	6.24	5.11	6.64	6.35	4.65	2.29
Latin America and the Caribbean	Zambia (2014)	10.39	10.42	13.71	8.24	3.69	2.55
	Male	10.39	10.36	12.24	5.51	1.97	1.28
	Female	10.38	10.48	14.88	11.15	5.06	3.89
	Colombia (2018)	14.52	10.62	19.25	10.00	12.89	5.58
	Male	12.60	8.72	10.25	3.64	6.97	2.25
South-Eastern Asia	Female	15.91	12.83	25.72	17.40	17.15	9.44
	Honduras (2017)	17.02	10.41	20.60	7.90	12.25	4.54
	Male	14.15	8.53	7.65	3.45	2.44	1.65
Eastern Europe	Female	18.72	12.35	28.27	12.48	18.07	7.51
	Cambodia (2013)	11.09	4.56	10.66	3.24	4.75	1.34
	Male	7.41	4.14	3.69	1.23	1.30	0.40
Eastern Europe	Female	15.17	4.97	18.37	5.24	8.56	2.28
	Moldova (2019)	10.79	7.15	13.37	4.52	6.43	2.11
	Male	8.65	6.76	6.02	2.63	2.31	1.18
	Female	12.04	7.60	17.67	6.72	8.84	3.19

6.3.1.3 Suicidal Thoughts

Figure 6.4 illustrates the prevalence of suicidal thoughts reported amongst the overall populations within the VACS Surveys. Table 6.3 demonstrates internalising symptoms reported amongst adults exposed and not exposed to DVA as children within the VACS over their lifetime, including suicidal thoughts.

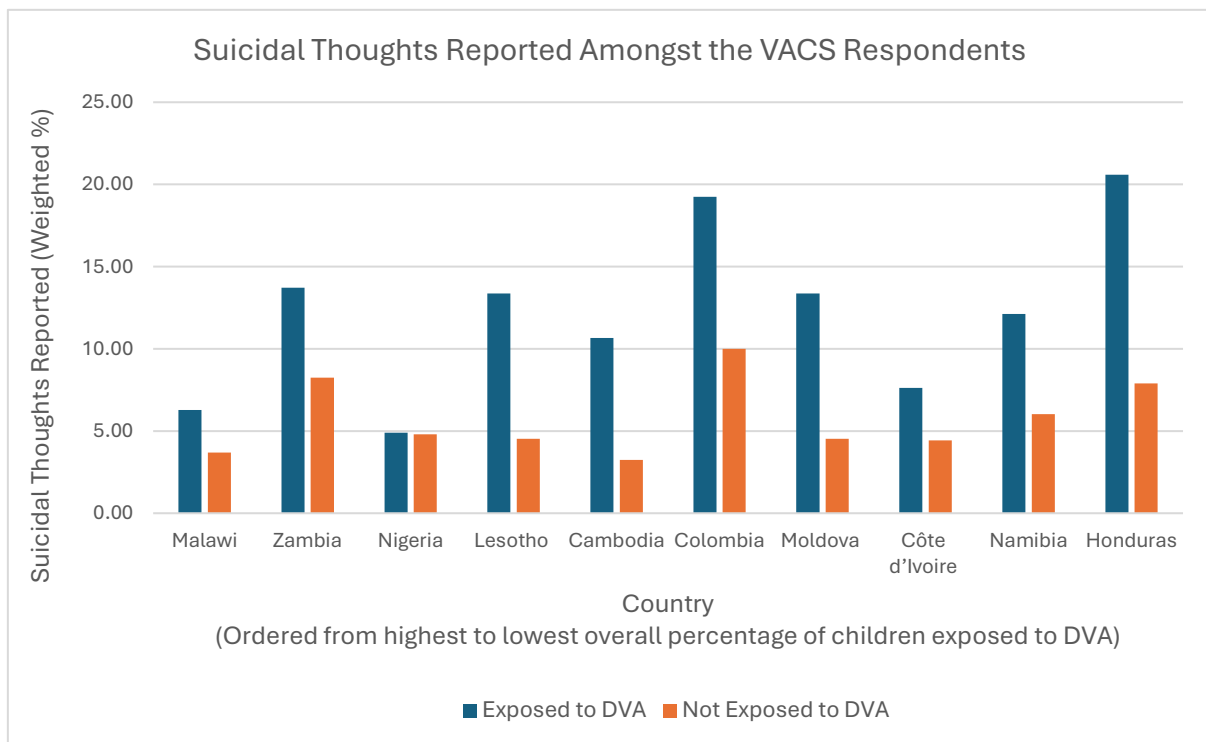


Figure 6.4 A clustered bar graph displaying the percentage of respondents reporting having ever experienced suicidal thoughts by VACS country (using weighted percentages)

In all countries, there was a higher lifetime prevalence of reported suicidal thoughts amongst those who had been exposed to DVA perpetrated between caregivers, when compared to those who had not (across males, females, and the overall population groups). The one exception to this is amongst males in Nigeria, where there was a higher prevalence of reported suicidal thoughts amongst those who had not been exposed to DVA (3.41%) as a child when compared to those who had (2.61%).

Sex differences were also observed in the prevalence of suicidal thoughts across all countries, with females reporting a higher lifetime prevalence of suicidal thoughts compared to males. This was common across both the exposed and non-exposed groups, suggesting that females may be more likely to exhibit this behaviour. However, as with all of these mental health outcomes (particularly with internalising symptoms), it is important to consider the stigma

around mental health, which is particularly prevalent for males. Therefore, males may find it more difficult to disclose if they have ever had suicidal thoughts, which could account for the higher prevalence amongst females.

6.3.1.4 Suicide Attempt

Respondents who indicated that they had experienced suicidal thoughts at some point in their lives were then asked if they had ever attempted to end their life. Figure 6.5 illustrates the prevalence of an individual having attempted suicide at some point prior to the survey⁵¹, reported amongst the overall populations within the VACS, with the full results available in Table 6.3.

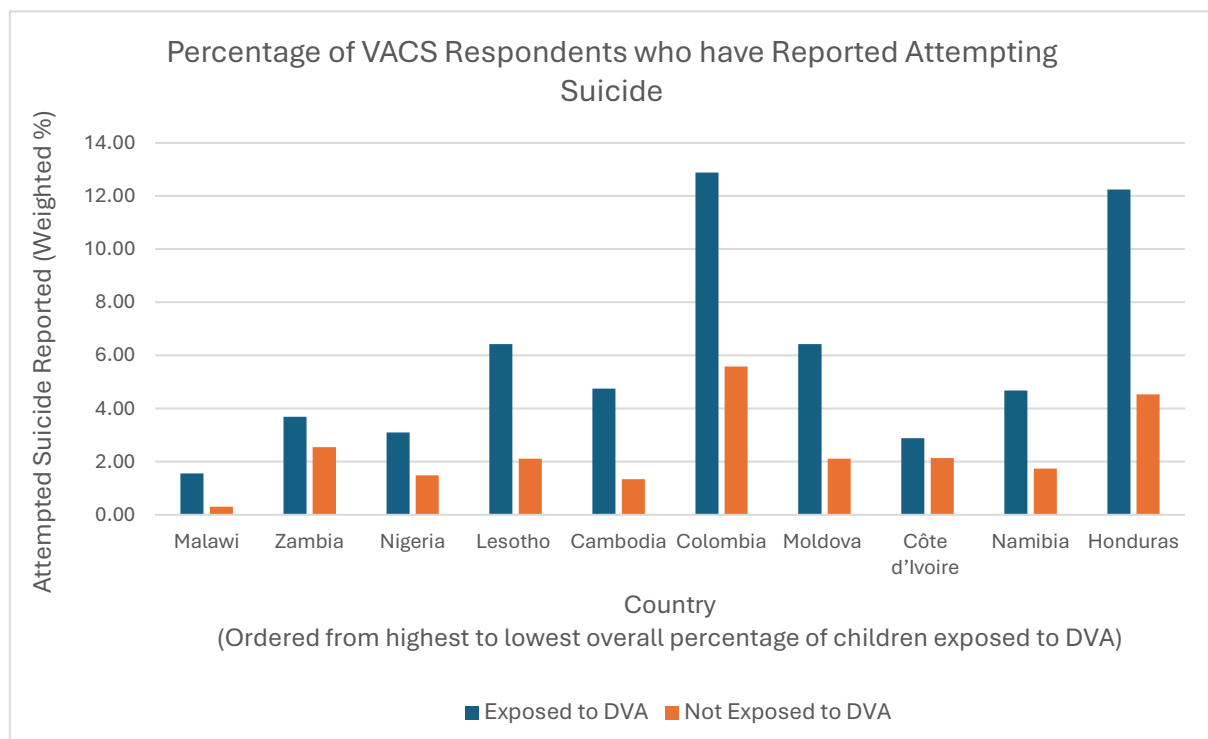


Figure 6.5 A clustered bar graph displaying the percentage of respondents reporting that they have attempted suicide by VACS country (using weighted percentages)

In general, prevalence of whether someone had ever attempted suicide were higher in those who had been exposed to DVA perpetrated between caregivers as children when compared to those who had not been exposed. However, similarly to suicidal thoughts, there are some exceptions to this – males in Côte d'Ivoire and Lesotho who had not been exposed to DVA as a

⁵¹ It is also important to acknowledge that this dataset does not include those who have committed suicide. Therefore, this difference may be even more pronounced if those who were successful in their attempt were included.

child had higher prevalence of reported suicide attempts (1.03% and 0.81% respectively) when compared to those who had been exposed (0.30% and 0.58%), but these differences are very small.

In addition, in some countries the sample sizes within categories were small for this variable, which may account for some of the differentials, and so results should be interpreted with caution. For this reason, and because of joint variables and collinearity with suicidal thoughts, this variable will not be included in the regression analysis.

6.3.2 Bivariate Analysis of Externalising Symptoms Associated with Exposure to DVA in LMICs

6.3.2.1 Engaging in Behaviours Harmful to Health ('Risky Behaviours')

For this variable, three behaviours were explored: binge drinking, smoking tobacco, and drug use over the past 30 days/currently. If anyone answered yes to engaging in any of these behaviours, then they were coded as yes, no matter what the reported frequency was. The results of these outcomes can be found in Table 6.4. A separate variable was then created which combined all three behaviours into one variable, termed 'risky behaviours'. If a respondent answered yes to any of – engaging with binge drinking, smoking tobacco, or taking drugs in the past 30 days/currently – then they were coded as yes for the new risky behaviours variable. Figure 6.6 illustrates the prevalence of those who have engaged in a risky behaviour in the overall population of the ten VACS countries explored in this paper.

Prevalence of smoking in the last 30 days was more common amongst those exposed to DVA perpetrated between caregivers in eight of the ten countries when looking at an overall population level (with the two exceptions being Côte d'Ivoire and Cambodia, where those who had not been exposed to DVA had a higher prevalence of smoking). When looking at the male and female populations separately, they also follow this same pattern, with the one exception of Cambodian males who had been exposed to DVA as a child, who reported higher prevalence of smoking in the last 30 days when compared to their non-exposed peers (14.65% for exposed, 15.21% for non-exposed). Across all ten countries, prevalence of smoking was higher for males than females, in both the exposed to DVA group and the non-exposed group.

Binge drinking over the last 30 days was more common amongst those exposed to DVA in nine of the ten countries when looking at the overall population level (with the exception of Colombia, when there was a higher prevalence of binge drinking in those who had not been

exposed to DVA compared to those who have – 28.52% for those exposed, and 33.31% for those not exposed). In the majority of countries, the male and female populations followed the same trend as the overall populations, with the exceptions of males in Côte d'Ivoire, and females in Colombia and Cambodia. In all countries except Côte d'Ivoire, prevalence of binge drinking was higher for males than females, in both the exposed to DVA group and the non-exposed group. For Côte d'Ivoire, the prevalence of binge drinking was higher in the exposed DVA group for females, and higher amongst the non-exposed group for males.

Drug use in the last 30 days was more common amongst those exposed to DVA perpetrated by a caregiver or other adult in the home, in eight of the ten countries when looking at an overall population level (with the two exceptions being Côte d'Ivoire and Zambia). In the majority of countries, the male and female populations followed the same trend as the overall populations, with the exception of Zambian males, who had a higher prevalence of drug use amongst those who had been exposed to DVA as a child (34.43% compared to 16.81% amongst females). Additionally, there were no respondents in Malawi or Zambia who were female and had taken drugs in the last 30 days (in either the exposed or non-exposed group), and no females in Cambodia who had been exposed to DVA and had taken drugs in the last 30 days. Across all ten countries, prevalence of drug use in the last 30 days was higher for males than females, in both the exposed to DVA group and the non-exposed group.

Table 6.4 Demonstration of risky behaviours harmful to health reported amongst adults exposed and not exposed to DVA as children within the VACS (last 30 days)

MDG Region	Country (Survey Year)	Engagement with Behaviours Harmful to Health in the Last 30 Days (Weighted %)							
		Smoking Tobacco		Binge Drinking		Using Drugs		Engaged in at least one Risky Behaviour	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	4.57	4.74	21.77	16.46	0.41	0.66	24.42	19.65
	Male	9.05	9.14	21.48	21.99	0.81	1.15	26.71	28.15
	Female	0.00	0.28	22.07	10.85	0.00	0.16	22.07	11.04
	Lesotho (2018)	15.74	12.47	13.22	8.87	6.70	3.71	22.27	17.08
	Male	31.53	22.30	21.60	13.41	13.36	6.18	38.38	27.60
	Female	2.79	1.81	6.34	3.94	1.25	1.02	9.05	5.66
	Malawi (2013)	8.59	7.73	16.22	13.82	1.61	0.70	19.61	15.69
	Male	11.73	10.36	21.60	18.95	3.34	1.49	26.53	21.70
	Female	5.68	5.35	11.24	9.20	0.00	0.00	13.21	10.29
	Namibia (2019)	7.29	4.35	22.02	14.78	1.59	0.13	26.33	17.34
	Male	11.08	6.88	29.45	17.57	2.49	0.17	35.48	21.83
	Female	2.94	1.25	13.47	11.37	0.55	0.07	15.80	11.88
	Nigeria (2014)	12.29	7.93	17.75	10.85	2.46	1.00	22.30	14.10
	Male	20.71	11.79	26.19	14.33	5.20	1.72	35.76	19.93
	Female	5.87	4.51	11.33	8.46	0.37	0.26	12.05	9.21
Latin America and the Caribbean	Zambia (2014)	13.39	12.62	23.03	19.38	1.29	1.35	24.61	22.05
	Male	20.86	18.56	31.52	27.89	2.92	2.62	34.43	32.21
	Female	7.47	6.29	16.31	10.32	0.00	0.00	16.81	11.25
	Colombia (2018)	11.86	10.84	28.52	33.31	10.76	4.35	35.99	37.95
	Male	19.31	15.26	34.71	41.52	22.99	6.95	47.92	48.73
	Female	6.51	5.70	24.08	23.75	1.97	1.32	27.40	25.40
South-Eastern Asia	Honduras (2017)	11.28	9.64	13.65	8.39	3.75	1.87	20.86	15.35
	Male	17.26	14.89	21.91	11.91	6.63	2.65	31.54	21.88
	Female	7.74	4.25	8.75	4.78	2.04	1.06	14.54	8.64
Eastern Europe	Cambodia (2013)	14.65	15.21	54.56	52.77	3.29	0.98	55.74	54.00
	Male	22.08	20.56	62.91	55.76	6.26	1.32	64.59	57.43
	Female	6.44	9.89	45.33	49.79	0.00	0.64	45.97	50.58
Eastern Europe	Moldova (2019)	19.76	16.02	27.49	17.25	1.77	0.27	35.01	25.16
	Male	30.20	26.08	34.45	23.34	2.21	0.40	45.87	35.26
	Female	13.65	4.36	23.42	10.19	1.52	0.12	28.64	13.45

When looking at the overall population level, engaging in at least one risky behaviour in the last 30 days was more common amongst those exposed to DVA perpetrated by one caregiver or

adult against another in nine of the ten countries (with the exception of Colombia, where the prevalence amongst those exposed to DVA was 35.99% and those who had not been exposed was 37.95%). This can be observed in Figure 6.6. In the majority of countries, the male and female populations followed the same trend as the overall populations, with the exceptions of males in Côte d'Ivoire and females in Cambodia (who had a higher prevalence amongst the non-exposed group), and females in Colombia (who had a higher prevalence of engaging in risky behaviours amongst those who had been exposed to DVA). Across all ten countries explored using the VACS, the prevalence of engaging in risky behaviours in the last 30 days was higher for males than females, in both the exposed to DVA group and the non-exposed group.

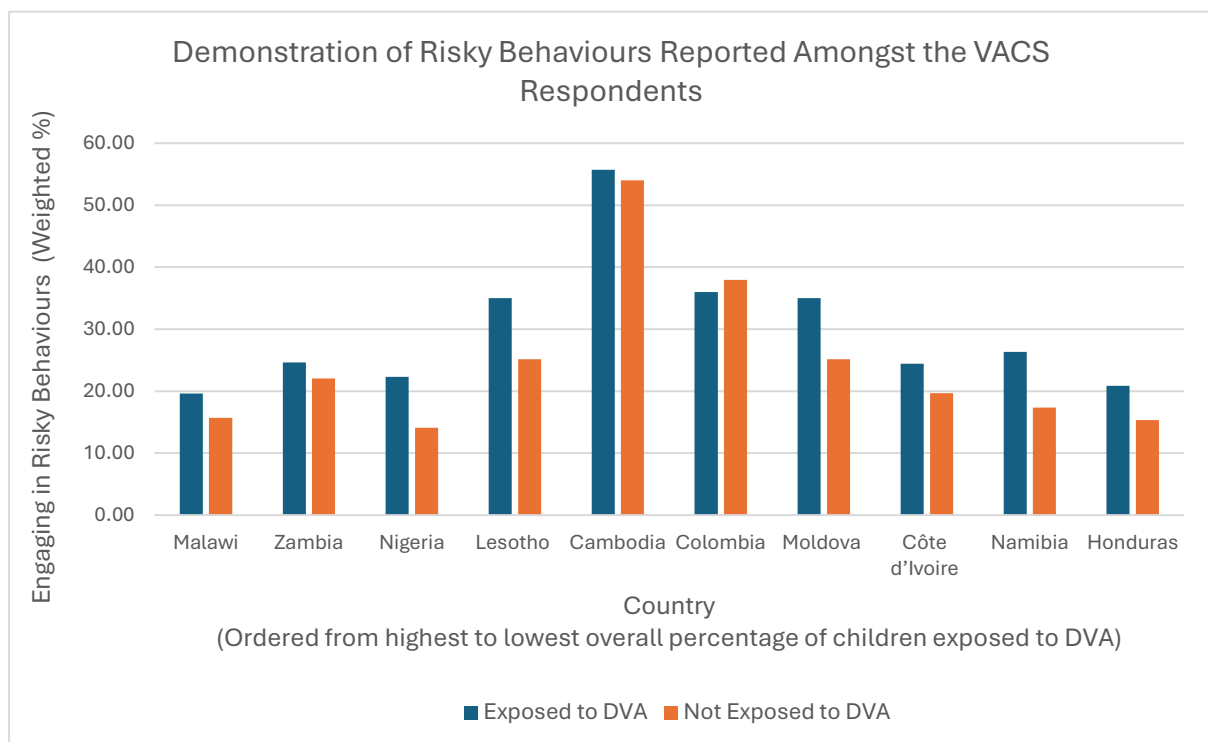


Figure 6.6 A clustered bar graph displaying the percentage of respondents reporting engaging in risky behaviours by VACS country (using weighted percentages)

Similarly to some other outcome variables explored, whilst the questions asked about frequency of the behaviour, for the purpose of analysis these were dichotomised. Even though when done in moderation some of these behaviours may not indicate poor mental health, for the purpose of this variable, anyone doing anything which could be harmful for their health has been considered. Therefore, if someone binge drinks, smokes, or takes drugs at all, then they have been coded as having engaged with the behaviour, no matter what the frequency was. Whilst this was essential for the purpose of this analysis, it is an important consideration to make when interpreting and generalising the results.

6.3.2.2 Perpetration of [Physical] DVA

Literature suggests that those exposed to DVA as a child can be caught in a ‘continuing cycle of violence’, and so therefore, perpetration of DVA was explored. For this variable, three types of physically violent acts were examined: 1) punching, kicking, whipping, or beating a current or previous partner with an object; 2) choking, smothering, trying to drown, or intentionally burning or scalding a current or previous partner, and 3) using or threatening to use a knife or other weapon against a current or previous partner. If a respondent answered “yes” to any of these, then they were coded as having perpetrated physical DVA. If they answered “no” to all three categories, then they were categorised as no.

Table 6.5 illustrates the reported lifetime perpetration of DVA, and allows for comparison between those respondents who had been exposed to DVA as a child, and those who had not.

In all countries, there was a higher level of perpetration of DVA reported amongst those who were exposed to DVA as a child, when compared to the group who had not been exposed (Figure 6.7). This is the case when looking at the overall population for each country, as well as the male and female populations separately. The exception to this is amongst Moldovan males, as there were no respondents in the Moldovan male category who had been exposed to DVA and had ever perpetrated DVA, as sample sizes for this variable were much smaller due to only those who had ever been in a relationship being included.

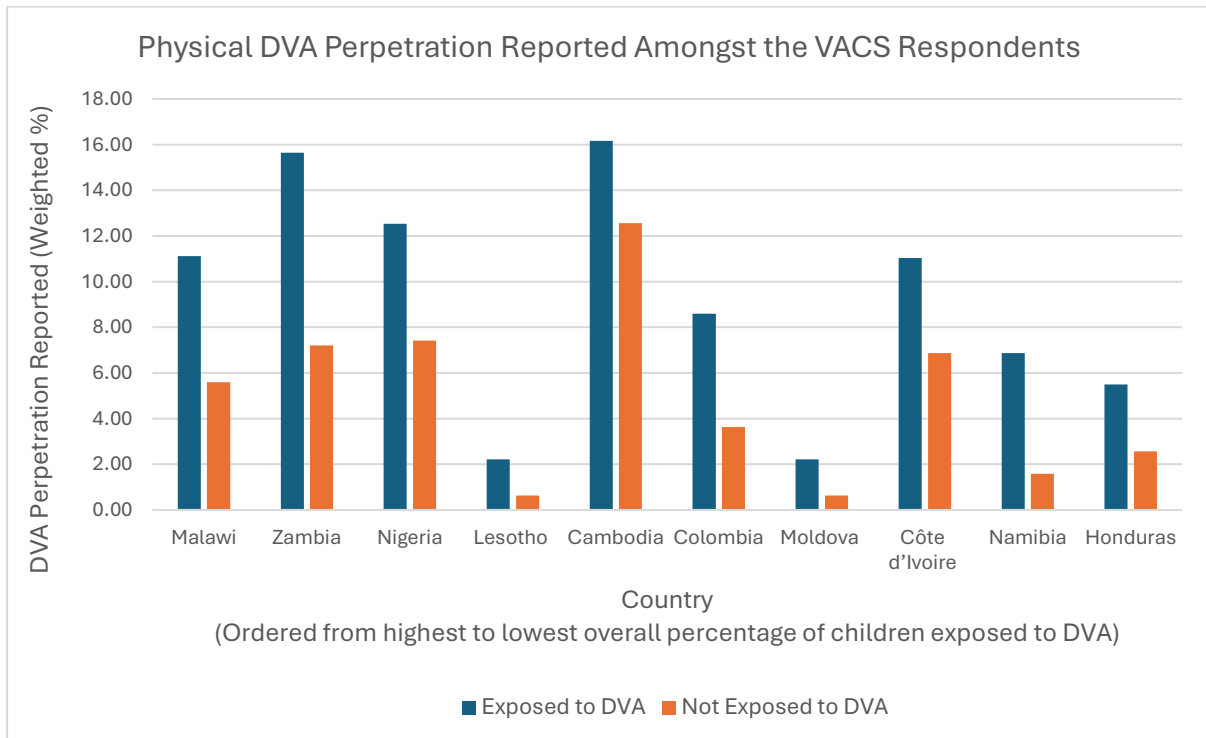


Figure 6.7 A clustered bar graph displaying the percentage of respondents reporting [Physical] DVA Perpetration by VACS country (using weighted percentages)

In four of the ten countries (Côte d'Ivoire, Lesotho, Nigeria and Zambia), prevalence rates for perpetration of DVA were higher amongst males compared to females, and the prevalence rate was higher for Colombia, Honduras, Cambodia, and Moldova (but again with Moldova, it is important to remember the small sample sizes within variable categories). There were mixed results in Malawi and Namibia depending on if the respondents had been exposed to DVA as a child.

Table 6.5 Perpetration of Physical Violence (both intimate partner, and non-partnered violence)
amongst adults exposed and not exposed to DVA as children within the VACS
(lifetime)

MDG Region	Country (Survey Year)	Perpetration of Physical Violence Throughout Respondent's Lifetime (Weighted %)			
		Violence Towards Partner		Violence Towards Others	
		Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	11.03	6.87	23.61	14.62
	Male	11.92	7.45	28.46	18.22
	Female	10.30	6.45	18.66	10.97
	Lesotho (2018)	4.76	2.48	12.70	7.17
	Male	8.22	3.73	21.52	11.37
	Female	1.89	1.22	5.46	2.61
	Malawi (2013)	11.12	5.60	28.80	14.76
	Male	10.10	6.04	36.11	20.30
	Female	11.97	5.25	22.04	9.77
	Namibia (2019)	6.87	1.58	9.79	5.79
	Male	7.10	1.08	13.12	7.92
	Female	6.59	2.14	5.95	3.19
Latin America and the Caribbean	Nigeria (2014)	12.54	7.41	11.78	8.63
	Male	21.92	9.50	14.81	7.62
	Female	6.98	5.72	9.47	9.73
	Zambia (2014)	15.64	7.20	11.36	6.04
	Male	19.62	10.66	15.24	8.06
	Female	12.93	4.54	8.28	3.88
Latin America and the Caribbean	Colombia (2018)	8.60	3.63	19.44	10.60
	Male	6.19	1.94	36.64	16.14
	Female	10.27	5.73	7.07	4.16
	Honduras (2017)	5.50	2.56	6.00	2.95
South- Eastern Asia	Male	1.67	1.24	4.31	2.82
	Female	7.64	3.88	7.00	3.10
	Cambodia (2013)	16.17	12.56	Not assessed in questionnaire	
Eastern Europe	Male	11.70	9.38		
	Female	20.01	14.69		
Eastern Europe	Moldova (2019)	2.22	0.63	2.55	1.56
	Male	0.00	0.33	5.12	2.70
	Female	3.24	0.95	1.05	0.24

6.3.2.3 Perpetration of [Physical] Non-Partnered Violence

Similarly to the perpetration of DVA variable, this variable examined three types of physical violence that the respondent could have perpetrated, but instead to someone who was not a current or previous partner. Again, if a respondent answered yes to any of the three types of violence, they were coded as having perpetrated physical non-partnered violence, and if they answered no to all three types, then they were coded as having not perpetrated non-partnered violence. These questions were not asked in the Cambodian questionnaire, and so therefore this outcome was not possible to assess in Cambodia.

Table 6.5 illustrates perpetration of [physical] non-partnered violence amongst both those exposed to DVA as a child, and those who hadn't been exposed. In all nine countries where this variable was explored, non-partnered violence perpetration was higher amongst respondents who had been exposed to DVA as a child when compared to their non exposed peers – and in some cases, these figures were doubled (Figure 6.8).

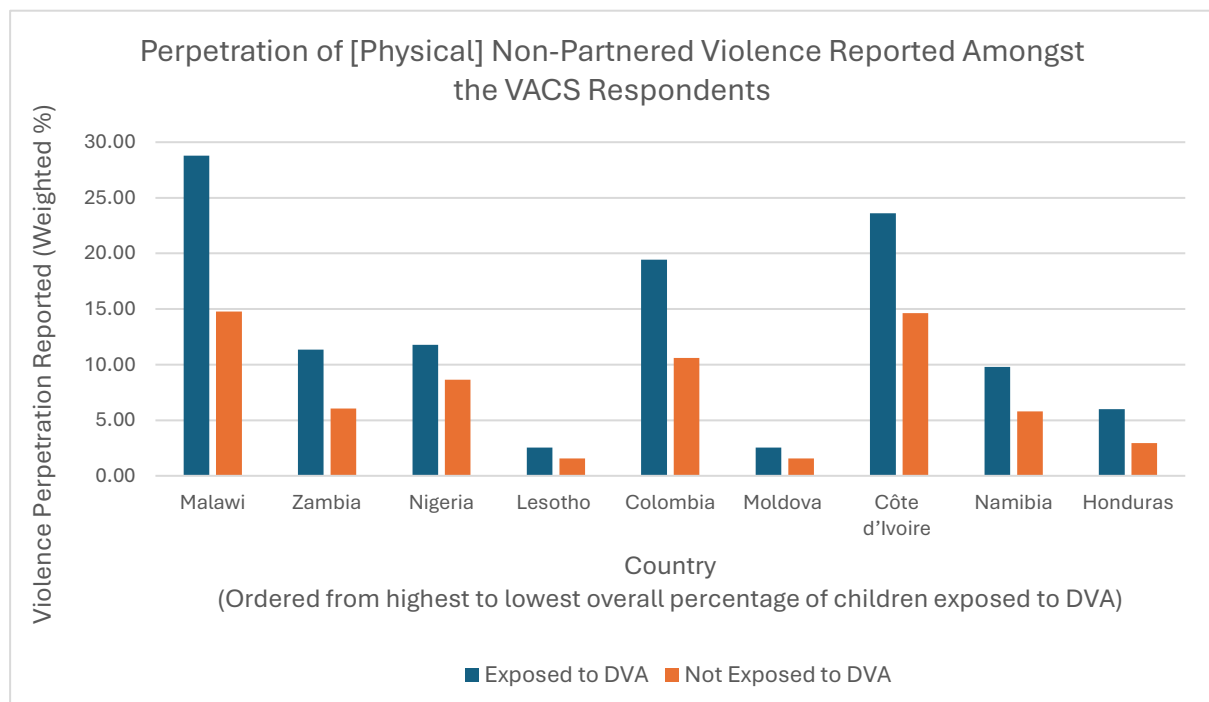


Figure 6.8 A clustered bar graph displaying the percentage of respondents reporting perpetration of [physical] non-partnered violence by VACS country (using weighted percentages)

This is the case when looking at the overall population for each country, as well as the male and female populations separately. The exception to this is amongst Nigerian females, where there was a higher prevalence of perpetration of non-partnered violence amongst those who had not been exposed to DVA as a child, although these differences are very small (9.47% for those who had been exposed to DVA, and 9.73% who had not been exposed).

In seven of the countries explored (Côte d'Ivoire, Lesotho, Malawi, Namibia, Zambia, Colombia, and Moldova), there was a higher prevalence of non-partnered violence perpetration amongst males compared to females. However, in Honduras, violence perpetration was more common amongst females (7.00% and 3.10% amongst the exposed and non-exposed populations) compared to males (4.31% and 2.82% amongst the exposed and non-exposed populations). In Nigeria, amongst those exposed to DVA as a child, males had a higher prevalence of violence perpetration (14.81%, compared to females, 9.47%), and amongst those who had not been exposed, females had a higher prevalence (9.73%, compared to males, 7.62%).

These initial cross tabulations suggest that there is a link between exposure to DVA as a child, and later perpetration of violence (both towards an intimate partner, and towards those who they have never had a relationship with) in adolescence and early adulthood. However, further analysis is required to assess the significance of the effect of childhood exposure to DVA on later violence perpetration.

6.3.3 Regression Analysis for Mental Health Outcomes Associated with Exposure to DVA in LMICs

Following cross-tabulations between exposure to DVA and mental health outcomes, logistic regression was conducted to assess the relationship between exposure to DVA and each potential outcome. Eight potential explanatory variables from the previous paper (respondent sex, education level, wealth, death of biological parent, living with both biological parents, multiple children living in household, exposure to community violence, and societal acceptance of DVA) were used, as literature suggested that all of these factors could have some influence on mental health outcomes⁵² and childhood exposure to DVA. These models are presented in Appendix G.

⁵² Further information about how each of these variables were conceptualised and coded can be found in Paper Two (Chapter 5) and Appendix B.

Models are presented in the form of predicted probabilities by ecological domain in Appendix G, grouped by MDG region (UN Stats, 2015; United Nations, 2015). Three levels of significance were assessed – $p < 0.1$ (weakly significant), $p < 0.05$ (moderately significant), and $p < 0.01$ (strongly significant).

In order to facilitate comparisons between countries on the different outcomes to assess the impact of exposure to DVA, the regression models below are organised by explanatory variable, rather than outcome.

6.3.3.1 The Association of Childhood Exposure to DVA with Mental Health Outcomes

As the primary focus of this paper, Table 6.6 presents the regression model findings for the explanatory variable of childhood exposure to DVA. This table illustrates the predicted probability of experiencing each of the six mental health outcomes for those exposed to DVA in childhood, across ten countries. For reference, Appendix G includes predicted probabilities for those not exposed to DVA, enabling comparisons between the two groups.

Table 6.6 Predicted Probabilities for Mental Health Outcomes Associated with Childhood Exposure to DVA

MDG Region	Country (Survey Year)	Mental Health Outcome					
		Internalising Symptom			Externalising Symptom		
		Psychological distress (last 30 days)	Intentional self-harm (lifetime)	Suicidal thoughts (lifetime)	Risky Behaviours (last 30 days)	Perpetration of [Physical] DVA (lifetime)	Perpetration of [Physical] Non-Partnered Violence (lifetime)
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.206***	0.109	0.027**	0.149	0.098	0.075*
	Lesotho (2018)	0.228***	0.009	0.027***	0.377***	0.002	0.180***
	Malawi (2013)	0.295***	0.028	0.005*	0.139	0.043***	0.788***
	Namibia (2019)	0.267**	0.055	0.031**	0.444***	0.004***	0.060
	Nigeria (2014)	0.349**	0.038	0.020	0.454***	0.199	0.063
	Zambia (2014)	0.464**	0.094	0.130***	0.113	0.121***	0.094***
Latin America and the Caribbean	Colombia (2018)	0.404***	0.104	0.016**	0.188	0.002	0.058**
	Honduras (2017)	0.421***	0.077***	0.045***	0.075***	0.005**	0.010***
South-Eastern Asia	Cambodia (2013)	0.377***	0.076***	0.022***	0.666	0.051	-
Eastern Europe	Moldova (2019)	0.413***	0.035	0.021***	0.234***	0.023	0.032

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

Regression analyses revealed that childhood exposure to DVA (where a child saw or overheard a caregiver or adult in their home perpetrate violence against another) was consistently associated with elevated predicted probabilities of both internalising and externalising symptoms of mental health across multiple countries.

In terms of internalising symptoms, childhood exposure to DVA is a strong predictor of increased psychological distress, intentional self-harm, and suicidal thoughts. For psychological distress, exposure to DVA was significantly associated with higher predicted probabilities in all ten countries, ranging from 20.61% in Côte d'Ivoire to 46.37% in Zambia. In each country, these probabilities were notably higher than amongst individuals not exposed to DVA. For example, in Cambodia, 37.70% of those exposed reported psychological distress, compared to 21.95% of those not exposed. Similarly, in Colombia and Moldova, predicted probabilities were 40.36% and 41.29% among those exposed, compared to 20.56% and 23.83% among the non-exposed, respectively. The highest predicted probabilities were observed in Latin America, South-Eastern Asia, and Eastern Europe, with exposed individuals in Colombia, Cambodia, and Moldova showing probabilities of 40.36%, 37.70%, and 41.29%, respectively.

Predicted probabilities for intentional self-harm were also elevated among those exposed to DVA when compared to those not exposed in several countries, with significant differences observed in Honduras (7.74% vs 5.55%) and Cambodia (7.62% vs 3.22%). While these were the only countries where associations reached statistical significance, predicted probabilities were generally higher amongst exposed individuals across most countries, suggesting a potential relationship between childhood exposure to DVA and later self-harming behaviour.

Suicidal thoughts are another internalising mental health symptom significantly associated with childhood exposure to DVA in nine out of the ten countries studied. In Cambodia, the predicted probability of suicidal thoughts was 2.24% among those exposed to DVA, compared to 0.66% among those not exposed. Similarly, in Côte d'Ivoire and Moldova, exposed individuals had higher predicted probabilities (2.72% vs 1.37% in Côte d'Ivoire; 2.12% vs 0.96% in Moldova). This pattern was consistent across most countries, with the largest differences observed in Zambia (13.05% vs 8.05%) and Honduras (4.52% vs 2.00%). These findings indicate a potential link between childhood exposure to DVA and increased likelihood of suicidal thoughts among adolescents and young adults.

In terms of externalising symptoms, childhood DVA exposure is significantly associated with increased engagement in risky behaviours and with the perpetration of physical domestic and

non-partnered violence. Risky behaviours were significantly more likely amongst those exposed to DVA in Nigeria (45.42% vs 25.91%), Namibia (44.41% vs 33.22%), Moldova (23.36% vs 15.20%), and Lesotho (37.67% vs 28.21%). In these countries, exposure to DVA appears to be a substantial risk factor for engagement in recent high-risk behaviours.

In addition to engaging in risky behaviours, perpetration of physical domestic violence was also elevated among individuals exposed to DVA in childhood, suggesting that early exposure to caregivers' use of violence may contribute to an intergenerational cycle of violence (Widom, 1989). In Zambia, the predicted probability of perpetration was 12.07% among those exposed, compared to 5.79% among the non-exposed. Similar patterns were observed in Malawi (4.28% vs 2.18%) and Namibia (0.40% vs 0.10%). While the overall prevalence of perpetration was relatively low in some countries, the consistent elevation among those exposed to DVA points to a meaningful association. These findings should also be interpreted in light of potential social desirability bias, as self-reported measures of perpetration may underestimate actual behaviours. This could affect both groups, potentially narrowing the observed differences between exposed and non-exposed individuals.

Finally, perpetration of physical non-partnered violence was also more likely among those exposed to DVA in six of the nine countries explored, indicating that early exposure to adult-perpetrated violence in the home may foster aggressive tendencies beyond intimate relationships. The largest absolute difference was observed in Malawi, where the predicted probability was 78.82% among those exposed compared to 60.89% among those not exposed. Notable differences were also seen in Lesotho (17.99% vs 10.35%), Zambia (9.40% vs 5.24%), Côte d'Ivoire (7.46% vs 5.22%), Colombia (5.82% vs 1.96%), and Honduras (0.95% vs 0.56%).

Together, these findings support a consistent association between childhood exposure to DVA and a wide range of adverse mental health outcomes in adolescence and early adulthood. While the magnitude of associations varies across countries and outcomes, the overall pattern underscores the importance of recognising and addressing childhood exposure to DVA as a significant public health concern.

6.3.3.2 The Association of Biological Sex with Mental Health Outcomes

Within the regression models presented in Appendix G, biological sex was found to have significant associations across the six mental health outcomes. Table 6.7 presents the predicted probabilities for female respondents, while the corresponding figures for males are

available in Appendix G. Together, these data illustrate the relationship between biological sex and the mental health outcomes explored in this paper.

Table 6.7 Predicted Probabilities for Mental Health Outcomes Associated with Being Female

MDG Region	Country (Survey Year)	Mental Health Outcome					
		Internalising Symptom			Externalising Symptom		
		Psychological distress (last 30 days)	Intentional self-harm (lifetime)	Suicidal thoughts (lifetime)	Risky Behaviours (last 30 days)	Perpetration of [Physical] DVA (lifetime)	Perpetration of [Physical] Non-Partnered Violence (lifetime)
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.191*	0.203***	0.053***	0.057***	0.060	0.036*
	Lesotho (2018)	0.149	0.008	0.039***	0.051***	0.000***	0.025***
	Malawi (2013)	0.177	0.013	0.005*	0.043***	0.017	0.414***
	Namibia (2019)	0.383***	0.050	0.069***	0.167***	0.001	0.019***
	Nigeria (2014)	0.284	0.020**	0.041***	0.078***	0.064***	0.052
	Zambia (2014)	0.371	0.097	0.130***	0.028***	0.026***	0.022***
Latin America and the Caribbean	Colombia (2018)	0.341***	0.131*	0.043***	0.106***	0.003**	0.003***
	Honduras (2017)	0.390***	0.080***	0.078***	0.017***	0.013***	0.006
South-Eastern Asia	Cambodia (2013)	0.321***	0.043	0.031***	0.539***	0.084***	-
Eastern Europe	Moldova (2019)	0.347***	0.034	0.027***	0.047***	0.023	0.003***

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

The regression analyses revealed a consistent association between biological sex and both internalising and externalising mental health outcomes, with clear gender-based differences across several countries.

For internalising symptoms, females generally had higher predicted probabilities of experiencing psychological distress, intentional self-harm, and suicidal thoughts compared to males. The largest absolute differences in predicted probabilities of psychological distress were observed in Namibia (38.32% for females, vs 20.64% for males), Colombia (34.11% vs 20.56%), and Moldova (34.69% vs 23.83%). Differences were also notable in Cambodia (32.12% vs 21.95%), Honduras (39.04% vs 31.13%), and Côte d'Ivoire (19.13% vs 15.08%), highlighting a consistent pattern across diverse countries.

While differences in intentional self-harm were generally smaller, significant disparities emerged in Côte d'Ivoire (20.26% for females vs 10.06% for males), Colombia (13.05% vs 8.29%), and Honduras (7.97% vs 5.55%). In Nigeria, the pattern was reversed, with males showing slightly higher predicted probabilities (2.89% vs 2.01%).

Suicidal thoughts were also more common amongst females across all ten countries explored, with the most pronounced differences seen in Honduras (7.79% vs 2.00%), Namibia (6.90% vs 1.87%), and Zambia (13.01% vs 8.05%). Substantial differences were also evident in Côte d'Ivoire, Colombia, and Lesotho, further indicating the elevated likelihood of suicidal thoughts among female respondents.

For externalising symptoms, being female was associated with substantially lower predicted probabilities of engaging in risky behaviours across all countries. The largest differences were observed in Lesotho (5.15% for females vs 28.21% for males), Nigeria (7.82% vs 25.91%), Namibia (16.72% vs 33.22%), Cambodia (53.95% vs 67.19%), and Colombia (10.58% vs 21.93%). This pattern was consistent across all ten countries, reflecting a widespread sex-based variation in engagement with recent high-risk behaviours.

The relationship between biological sex and perpetration of physical DVA (defined as the respondent's own use of violence against a partner) varied by country. In Lesotho (0.52% vs 1.71%), Nigeria (6.44% vs 14.93%), and Zambia (2.64% vs 5.79%), females had lower predicted probabilities of perpetrating physical DVA compared to males. In contrast, higher predicted probabilities for female respondents were observed in Colombia (0.32% vs 0.11%), Honduras (1.27% vs 0.33%), and Cambodia (8.37% vs 4.13%). These mixed patterns suggest that gendered dynamics around domestic violence perpetration may differ across contexts.

Finally, females consistently reported lower predicted probabilities of perpetrating physical non-partnered violence across nearly all countries where this was examined. The most pronounced differences were observed in Malawi (41.39% for females vs 60.89% for males), Lesotho (2.52% vs 10.35%), Zambia (2.24% vs 5.24%), and Namibia (1.93% vs 4.88%). Significant differences were also noted in Colombia, Côte d'Ivoire, and Moldova. These findings suggest that males are generally more likely to engage in non-partnered violence, although the extent of this difference varies by country.

Together, these findings underscore the significance of biological sex in shaping both internalising and externalising mental health outcomes, highlighting the need to consider sex-specific pathways and risks in intervention and policy responses.

6.3.3.3 The Association of Exposure to Community Violence with Mental Health Outcomes

Finally, the association between exposure to community violence and mental health outcomes is explored in greater depth due to the number of significant associations observed across the outcome variables. Table 6.8 presents the predicted probabilities for respondents exposed to community violence, while the corresponding figures for those not exposed are available in Appendix G. Together, these data illustrate the relationship between exposure to community violence and the six mental health outcomes examined in this paper.

Table 6.8 Predicted Probabilities for Mental Health Outcomes Associated with Exposure to Community Violence

MDG Region	Country (Survey Year)	Mental Health Outcome					
		Internalising Symptom			Externalising Symptom		
		Psychological distress (last 30 days)	Intentional self-harm (lifetime)	Suicidal thoughts (lifetime)	Risky Behaviours (last 30 days)	Perpetration of [Physical] DVA (lifetime)	Perpetration of [Physical] Non-Partnered Violence (lifetime)
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.230***	0.114	0.016	0.179**	0.106	0.095***
	Lesotho (2018)	0.260***	0.020***	0.019**	0.328	0.000***	0.150**
	Malawi (2013)	0.243***	0.073***	0.005**	0.103	0.022	0.687**
	Namibia (2019)	0.338***	0.067**	0.036***	0.431***	0.002**	0.156***
	Nigeria (2014)	0.315	0.031	0.032**	0.301	0.301***	0.106***
	Zambia (2014)	0.411	0.104	0.088	0.126*	0.076	0.083**
Latin America and the Caribbean	Colombia (2018)	0.279**	0.187***	0.018***	0.386***	0.003**	0.063***
	Honduras (2017)	0.465***	0.103***	0.039***	0.089***	0.008***	0.017***
South-Eastern Asia	Cambodia (2013)	0.329***	0.050*	0.013**	0.683	0.082***	-
Eastern Europe	Moldova (2019)	0.386***	0.037	0.018**	0.284***	0.001**	0.037

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

Across multiple countries, exposure to community violence was associated with elevated predicted probabilities of both internalising and externalising symptoms.

For internalising symptoms, exposure to community violence is associated with higher predicted probabilities of experiencing psychological distress, intentional self-harm, and

suicidal thoughts. For psychological distress, exposure to community violence was significantly associated with higher predicted probabilities in eight of the ten countries. The most pronounced differences were observed in Honduras (46.51% for exposed vs 31.13% for non-exposed), Moldova (38.64% vs 23.83%), Namibia (33.78% vs 20.64%), and Cambodia (32.89% vs 21.95%), with significant results also found in Lesotho, Côte d'Ivoire, Colombia, and Malawi. These results indicate a consistent relationship between community violence exposure and increased psychological distress.

Predicted probabilities for intentional self-harm were elevated among individuals exposed to community violence in several countries. Notable differences were observed in Colombia (18.70% vs 8.29%), Malawi (7.35% vs 2.03%), Honduras (10.35% vs 5.55%), and Namibia (6.73% vs 4.29%). Significantly higher predicted probabilities were also found amongst those exposed to community violence in Cambodia and Lesotho.

For suicidal thoughts, exposure to community violence was significantly associated with elevated predicted probabilities in eight of the ten countries. In Namibia, the predicted probability of suicidal thoughts was 3.55% among those exposed to community violence, compared to 1.87% among those not exposed. Similarly, in Honduras and Colombia, the figures were 3.86% vs 2.00% and 1.82% vs 0.87%, respectively. Smaller but still significant differences were seen in Moldova (1.85% vs 0.96%) and Cambodia (1.34% vs 0.66%). Côte d'Ivoire, Lesotho, and Malawi also showed modest but significant increases of 0.46, 0.21, and 1.68 percentage points, respectively. While the absolute levels were relatively low in some cases, the relative increases suggest an important association between exposure to violence in the community and suicidal thoughts.

With regard to externalising symptoms, exposure to community violence was significantly associated with increased engagement in risky behaviours and the perpetration of both physical DVA and non-partnered violence. Respondents who reported engaging in risky behaviours were significantly more likely to have been exposed to community violence in six of the ten countries examined. The largest differences were observed in Colombia (38.62% for exposed vs 21.93% for non-exposed), Moldova (28.39% vs 15.20%), Namibia (43.12% vs 33.22%), and Côte d'Ivoire (17.85% vs 13.21%), with significant differences also found in Honduras and Zambia. These results suggest that adolescents and young adults exposed to violence in their communities may be more likely to engage in high-risk behaviours.

For perpetration of physical DVA, predicted probabilities were higher among those exposed to community violence in six countries, including Nigeria (30.06% vs 14.93%), Cambodia (8.20% vs 4.13%), and Lesotho (3.48% vs 1.71%), with smaller differences also observed in Honduras, Colombia, and Namibia. In contrast, Moldova showed a small but statistically significant decrease in predicted probability amongst those exposed to community violence (0.08% vs 0.70%), suggesting that different contextual dynamics may influence this relationship. These findings point to a possible link between community and domestic environments in shaping violent behaviours.

Finally, exposure to community violence was associated with increased predicted probabilities of perpetrating physical non-partnered violence in eight of the nine countries where this was examined. The greatest differences were observed in Namibia (15.59% vs 4.88%), Malawi (68.67% vs 60.89%), Nigeria (10.65% vs 5.66%), Lesotho (14.97% vs 10.35%), and Colombia (6.35% vs 1.96%). Notable differences were also found in Zambia (8.31% vs 5.24%) and Honduras (0.85% vs 0.33%), reinforcing the association between community violence and broader patterns of aggression.

Together, these findings underscore the importance of community-level experiences in shaping mental health outcomes. The consistent pattern of elevated predicted probabilities across a range of outcomes highlights the potential for community violence exposure to affect both internal emotional wellbeing and outward behavioural responses among adolescents and young adults.

6.3.3.4 Key Associations across Ecological Domains

As previously mentioned, the full regression models in Appendix G are presented by ecological domain. Closer examination of these models reveals some interesting associations and patterns across the individual, family, and community and societal ecological domains in relation to internalising and externalising symptoms. This section highlights some of these key associations.

At the individual level, exposure to DVA and respondent sex emerged as key predictors across mental health outcomes, as discussed in Section 6.3.3.1 and Section 6.3.3.2. However, education level showed varied associations with both internalising and externalising symptoms. Currently attending primary school was generally associated with lower levels of psychological distress compared to those who had completed primary school. This pattern was evident in Côte d'Ivoire (6.39% vs 15.08%), Lesotho (10.48% vs 15.79%), Namibia (12.89% vs 20.64%), and

Cambodia (11.69% vs 21.95%), suggesting a potential protective effect of school attendance. In contrast, individuals who had not completed primary education were more likely to report psychological distress. For example, in Moldova, 44.46% of individuals with incomplete primary schooling experienced distress, compared to 23.83% of those who had completed it. For intentional self-harm, the probability was significantly higher among individuals who had not completed primary education in Moldova (15.14% vs 2.65%) and Lesotho (2.09% vs 0.68%). In contrast, in Namibia, those who had not completed primary school reported a lower probability of self-harm compared to those who had (1.59% vs 4.29%), suggesting that the direction of association varies by context. A similar pattern emerged for suicidal thoughts. In Lesotho, only 0.40% of those currently in primary school reported suicidal thoughts, compared to 1.40% of those who had completed it, and in Namibia, the figures were 0.76% and 1.87% respectively. In Malawi, the difference was small but in the same direction (0.09% vs 0.28%). For externalising symptoms, such as risky behaviours, individuals currently in primary school again reported lower levels of engagement when compared to their peers who had completed primary education. This can be observed in Colombia (1.04% vs 21.93%), Lesotho (2.05% vs 28.21%), Namibia (8.27% vs 33.22%) and Honduras (1.49% vs 5.27%). However, not completing primary education was associated with greater risk in some countries. In Zambia, those who had not completed primary school were more likely to report risky behaviours than those who had (14.13% vs 9.68%), whereas in Côte d'Ivoire, this pattern was reversed (9.54% vs 13.21%). For perpetration outcomes, associations varied across countries and education groups. In Nigeria, those who had not completed primary schooling were less likely to report perpetration of DVA than those who had completed it (8.56% vs 14.93%). A similar pattern was seen in Zambia (2.94% vs 5.79%). Meanwhile, individuals currently in primary school reported significantly lower perpetration rates in Malawi (1.22% vs 2.18%) and higher rates in Cambodia (11.38% vs 4.13%). For non-partnered violence, those currently attending primary school were more likely to report this behaviour in Côte d'Ivoire (8.32% vs 5.22%) and Malawi (67.85% vs 60.89%), although no significant differences were found between those who had and had not completed primary education in these countries. These mixed patterns suggest that the relationship between educational attainment and perpetration outcomes may be highly context specific.

At the family level, associations with internalising and externalising symptoms varied across countries. In terms of wealth, individuals from poorer households were more likely to experience psychological distress in Namibia (38.11% among those in the poorer tertile vs 20.64% in the richer tertile), while in Cambodia the pattern was reversed, with poorer individuals less likely to report psychological distress (17.33% vs 21.95%). In Honduras, distress was

slightly higher among those in the middle tertile (35.41%), indicating that the relationship between economic status and mental health may vary according to broader contextual factors. Patterns for intentional self-harm also differed across countries. In Namibia, poorer respondents were more likely to report self-harm compared to those in the richer group (8.68% vs 4.29%), whereas the opposite trend was observed in Lesotho and Malawi (0.21% vs 0.68% and 0.81% vs 2.03%, respectively). For suicidal thoughts, similar variability was evident. In Namibia, poorer individuals reported higher probabilities (6.35% vs 1.87%), whereas in Cambodia, the predicted probability was lower among poorer individuals (0.26% vs 0.66%). Similar variability was observed for externalising symptoms. For externalising symptoms, individuals from poorer households were more likely to report risky behaviours in Moldova (27.72% vs 15.20%) and Honduras (7.45% vs 5.27%), whereas in Malawi, poorer individuals were less likely to do so (7.31% vs 11.27%). Some associations were also observed for perpetration outcomes. In Zambia, poorer individuals had a lower predicted probability of perpetrating DVA compared to those in the richer group (3.23% vs 5.79%), while in Cambodia (6.97% vs 4.13%), Honduras (0.74% vs 0.33%), and Namibia (0.23% vs 0.10%), the probability was higher among those from poorer households. For perpetration of non-partnered violence, poorer individuals were more likely to report this behaviour in Colombia (4.11% vs 1.96%) and Honduras (2.30% vs 0.56%), whereas the reverse pattern was observed in Côte d'Ivoire (3.19% vs 5.22%), Malawi (43.30% vs 60.89%), and Zambia (2.02% vs 5.24%). The death of a biological parent is generally associated with increased risks across multiple outcomes, including elevated psychological distress in Côte d'Ivoire (19.77% vs 15.08%), Zambia (45.91% vs 38.10%), and Honduras (36.63% vs 31.13%), when compared to individuals with both parents alive. Suicidal thoughts were also more common among those who had experienced parental death in Malawi (0.67% vs 0.28%), Zambia (11.68% vs 8.05%), and Moldova (2.36% vs 0.96%). Similarly, those who had lost a parent had a higher predicted probability of engaging in risky behaviours in Lesotho (38.23% vs 28.21%), Namibia (43.49% vs 33.22%), Honduras (7.05% vs 5.27%), and Moldova (27.18% vs 15.20%). They were also more likely to report perpetrating DVA in Lesotho (4.37% vs 1.71%) and Malawi (4.36% vs 2.18%). Not living with both biological parents was associated with elevated risks across a range of internalising and externalising outcomes. For psychological distress, individuals not living with both parents were more likely to report this outcome in Côte d'Ivoire (23.23% vs 15.08%) and Nigeria (35.60% vs 29.08%). In Honduras, the probability of intentional self-harm was also significantly higher among those not living with both biological parents (7.43% vs 5.55%). Suicidal thoughts were also more common among this group in Côte d'Ivoire (3.64% vs 1.37%), Lesotho (1.93% vs 1.40%), Namibia (2.63%

vs 1.87%), Honduras (3.20% vs 2.00%), and Moldova (1.71% vs 0.96%). For externalising outcomes, risky behaviours were more likely among this group in Honduras (6.35% vs 5.27%). The predicted probability of perpetrating DVA was higher among individuals not living with both parents in Malawi (4.69% vs 2.18%) and Colombia (0.71% vs 0.11%). Finally, the presence of multiple children in the household was associated with a higher likelihood of adverse mental health outcomes in several countries. For psychological distress, individuals from larger households were more likely to report this outcome in Côte d'Ivoire (32.18% vs 15.08%), Lesotho (21.58% vs 15.79%), and Namibia (24.21% vs 20.64%). Suicidal thoughts were more common among individuals from larger households in Malawi (2.82% vs 0.28%) and Lesotho (2.41% vs 1.40%), whereas the opposite pattern was observed in Côte d'Ivoire (0.47% vs 1.37%). For externalising symptoms, the predicted probability of engaging in risky behaviours was higher among individuals from households with multiple children in Honduras (16.36% vs 5.27%) and Zambia (30.80% vs 9.68%). Similarly, perpetration of DVA was more likely among individuals from larger households in Namibia (0.49% vs 0.10%) and Colombia (0.71% vs 0.11%).

Finally, at the community and societal level, there are strong associations with mental health outcomes, with exposure to community violence standing out as a consistent predictor across multiple outcomes. This relationship, discussed previously in Section 6.3.3.3, highlights the impact of community violence on both internalising symptoms, such as psychological distress, and externalising behaviours, like risky behaviours and perpetration of violence. However, the other factor in this ecological domain, societal acceptance of DVA, was also associated with elevated risk across multiple outcomes. For internalising symptoms, psychological distress was more likely among individuals who believed DVA was acceptable, with differences observed in Zambia (50.77% vs 38.10%), Namibia (26.59% vs 20.64%), Cambodia (27.77% vs 21.95%), Honduras (36.16% vs 31.13%), Côte d'Ivoire (19.70% vs 15.08%), and Lesotho (19.20% vs 15.79%). Similar patterns were observed for intentional self-harm in Zambia (15.28% vs 9.81%), Honduras (8.64% vs 5.55%), Cambodia (5.66% vs 3.22%), and Nigeria (3.88% vs 2.89%). For suicidal thoughts, societal acceptance of DVA was associated higher predicted probabilities in Zambia (11.07% vs 8.05%), Honduras (2.90% vs 2.00%), and Cambodia (1.46% vs 0.66%). Societal acceptance of DVA also shows significant associations with externalising symptoms. In Colombia, for example, engaging in risky behaviours was more common among this group (41.57% vs 21.93%), as in Lesotho (34.81% vs 28.21%), Cambodia (72.87% vs 67.19%), and Côte d'Ivoire (17.40% vs 13.21%). Perpetration of DVA was also more likely in several countries, including Nigeria (22.98% vs 14.93%), Zambia (11.25% vs 5.79%), Moldova (4.11% vs 0.70%), Lesotho (4.30% vs 1.71%), Honduras (0.62% vs 0.33%), and Namibia (0.24% vs 0.10%). Societal

acceptance of DVA was additionally associated with greater predicted probabilities of perpetrating non-partnered violence, particularly in Lesotho (20.03% vs 10.35%), Namibia (9.58% vs 4.88%), Côte d'Ivoire (8.32% vs 5.22%), and Nigeria (7.32% vs 5.66%). In Colombia, however, the highest predicted probability of perpetrating non-partnered violence was observed among individuals who provided incomplete answers to the DVA acceptability question (6.44%), which was significantly higher than those who rejected DVA (1.96%). These findings suggest that societal norms surrounding the acceptability of domestic violence may shape broader patterns of mental health and behaviour, both within and beyond the household context.

6.4 Discussion

6.4.1 Discussion of the Key Findings

This study uses the Violence Against Children Surveys (VACS; Chiang et al., 2016) to explore mental health outcomes associated with childhood exposure to DVA in ten LMICs. This paper focuses on internalising and externalising symptoms of mental health as the outcomes. Whilst this is not an exhaustive list of mental health outcomes which could be associated with childhood exposure to DVA perpetrated between caregivers or other adults in the home, it gives an overview and a starting point from which further research can be conducted to explore further mental health outcomes associated with childhood exposure to DVA.

When looking at bivariate analysis, four outcomes were examined that fall under the category of internalising symptoms: psychological distress, intentional self-harm, suicidal thoughts, and attempted suicide. In general, all four of these variables had higher prevalence amongst those who had been exposed to DVA perpetrated by a caregiver or adult household member when compared to those who had not been exposed. For psychological distress, the exposed group had a higher prevalence of any psychological distress⁵³ (including mild/moderate and severe psychological distress) at the overall population level across all ten countries – a finding which remained in the regression analyses after controlling for a range of other factors. The same was found for the variable of intentional self-harm at the bivariate analysis stage, except for Zambia, but these differences were minimal. However, this link was only found for Honduras and Cambodia when looking at the regression analysis, indicating that other factors were more

⁵³ Respondents were classed as having any psychological distress if they fit into the 'mild/moderate psychological distress' or 'severe psychological distress' category. Further information on how this variable was conceptualised and recoded can be found in Section 6.2.3.1 And Appendix E.3.1.

important in explaining the relationships observed. For the variables of suicidal thoughts and attempted suicide, those who had been exposed to DVA had a higher lifetime prevalence when compared to the non-exposed groups at the overall population level, with the same finding when both the male and female populations are examined separately (except for Nigerian males, where those exposed to DVA had a prevalence rate of suicidal thoughts of 2.61%, but 3.41% if they had not been exposed to DVA – however, again, these differences are minor). When looking at regression analysis, in all countries except Nigeria, those who had been exposed to DVA as a child had a significantly higher likelihood of having ever had suicidal thoughts than those who had not been exposed to DVA. These findings suggest that those who have been exposed to caregiver-perpetrated DVA as a child are at a higher likelihood of experiencing internalising symptoms in adolescence and early adulthood than those who have not been exposed to DVA.

When examining gender differences in the bivariate analyses of internalising symptoms, it also appears that females may be more likely to experience internalising symptoms than their male counterparts in each country, supporting evidence from high-income countries (Baldry, 2007; Sternberg et al., 2006). In six of the ten countries, females are more likely than males to have any psychological distress. These six countries are Côte d'Ivoire, Namibia, Colombia, Honduras, Cambodia, and Moldova. In Lesotho, this is reversed, and males are more likely to experience psychological distress. In the countries of Malawi, Nigeria and Zambia, the results are mixed depending on whether the respondent has been exposed to DVA (in Malawi and Zambia, females are more likely to experience psychological distress if they have been exposed to DVA, and males are more likely if they have not been exposed, but in Nigeria the opposite is found – males are more likely to experience psychological distress if they have been exposed to DVA, and females are more likely to experience psychological distress if they have not been exposed). However, these results, in general, suggest that females are more likely to experience psychological distress when compared to males. These findings remain when exploring any psychological distress in regression analysis. In five of the ten countries explored (Côte d'Ivoire, Namibia, Colombia, Cambodia, and Moldova), the lifetime prevalence of intentional self-harm was higher in females than males across both the exposed to DVA and non-exposed groups, but the opposite was found in Nigeria, with males having a higher prevalence (again, across both the exposed to DVA and non-exposed groups). Lesotho, Malawi and Zambia had mixed results depending on whether the respondent had been exposed to DVA as a child. When placed in a regression model, respondent sex had mixed results, with females having an increased likelihood of having ever intentionally self-harmed in three countries but a decreased likelihood

in Nigeria. In bivariate analyses, females were more likely to experience suicidal thoughts than males across all ten countries in both the exposed to DVA and not-exposed groups. The same was found for the ever-attempted suicide variable, except for females in Malawi, as there were no respondents who had not been exposed to DVA as a child who had ever attempted suicide. When looking at regression analysis, in all ten countries, females had a significantly higher likelihood of having ever had suicidal thoughts when compared to males. While there is only a small selection of internalising symptoms, this analysis suggests that females may be more likely to experience the internalising symptoms reported in this paper. The timeframe within each variable explored also indicates that exposure to DVA as a child can have an impact on both long-term variables as well as on more recent measures of mental health.

Three variables were examined that fall under the category of externalising symptoms: engaging in behaviours harmful to health ('risky behaviours'), perpetration of DVA, and perpetration of physical non-partnered violence. In general, all three of these variables had higher prevalence amongst those who had been exposed perpetrated within the home to DVA when compared to those who had not been exposed when examining at the stage of bivariate analysis. For engaging in risky behaviour, the group who had been exposed to DVA as a child had a higher prevalence at the overall population level across nine of the ten countries explored. The same was found for the variable of perpetration of DVA and again for perpetration of physical non-partnered violence, with the exposed group having a higher prevalence in all of the countries in which these variables were assessed. These patterns remain when placing these mental health outcomes in regression models, although this was only significant in six of the nine countries explored. For engaging in risky behaviours, childhood exposure to DVA had a significantly higher likelihood than those who had not been exposed in five of the ten countries, a similar finding when looking at those who had perpetrated physical DVA. Similarly, in six of the nine countries where the outcome could be assessed⁵⁴, those who had been exposed to DVA as a child had a significantly higher likelihood of perpetrating non-partnered violence than those who had not been exposed. These findings suggest that those who have been exposed to DVA perpetrated during childhood have a higher likelihood of experiencing externalising symptoms in adolescence and early adulthood than those who have not been exposed to DVA.

When examining gender differences, it also appears that males may be more likely to experience externalising symptoms when compared to their female peers. In all ten countries,

⁵⁴ This outcome was not possible to assess in Cambodia, as the questions from which the variable was derived were not asked.

males were more likely to have engaged in risky behaviour (smoking/binge drinking/drug use) in the past 30 days when compared to females. This was common across both the exposed to DVA and non-exposed groups and was observed in both bivariate and regression analyses. For physical DVA perpetration, when looking at bivariate analyses, the prevalence was higher in four countries for males, and four for females (across both the exposed to DVA group and non-exposed group), and results were mixed in two of the countries dependent on whether someone had been exposed to DVA. This suggests that this relationship may be more nuanced, which is supported by the regression analysis, in which males had a higher likelihood of DVA perpetration in three countries, but females higher in another three (although it is important to note that there were small sample sizes within categories for this variable, particularly amongst females). For the perpetration of physical non-partnered violence variable, the prevalence was higher for males across both the exposed and non-exposed groups in seven of the nine countries explored in bivariate analysis, and only in one for females (Honduras). The remaining country (Nigeria) had mixed results depending on whether they had been exposed to DVA as a child. The regression model for non-partnered violence revealed that females were less likely to perpetrate non-partnered violence when compared to males in seven of the nine countries in which this variable was explored. While only a small selection of externalising symptoms is included, this analysis suggests that males may be slightly more likely to experience the externalising symptoms reported in this paper.

The findings of this paper support existing literature suggesting that childhood exposure to DVA perpetrated by caregivers or adult household members has an adverse effect on mental health in later life. Exposure to DVA during childhood and adolescence has been demonstrated to increase the risk of adverse mental health outcomes, with a moderate to strong association between childhood exposure to DVA and internalising symptoms, such as anxiety and depression, externalising behaviours (e.g. aggression) and trauma symptoms (Evans, Davies, & DiLillo, 2008; Kitzmann, Gaylord, Holt, & Kenny, 2003; Wolfe et al., 2003). In particular, the findings on psychological distress support the findings of Kieselbach et al. (2021), who explored the association between witnessing physical DVA between caregivers and other types of violence and the relationship between witnessing physical DVA in the past and current mental distress. To do this, they applied logistic regression to data from the VACS for the countries of Cambodia, Malawi and Nigeria to assess mental distress through the Kessler K6 mental health scale (Kessler et al., 2003). They found that between 22.4% and 34.3% of respondents across

the three countries had witnessed physical DVA between their caregivers during childhood⁵⁵. For Cambodia and Malawi, respondents who witnessed DVA were more likely to experience mental distress compared to those who hadn't, but in Nigeria, only male respondents who witnessed DVA had a higher chance of mental distress, but females had no significant association. These findings are consistent with the findings from the bivariate analysis within this paper, but in the analysis presented, the Nigerian overall and male populations were more likely to experience psychological distress if they had been exposed to DVA when compared to those who had not been exposed. Only the Nigerian female population were less likely to experience psychological distress if exposed to DVA compared to those who had not been exposed. However, these differences were small (29.05% for the exposed group and 30.93% for the non-exposed group). Regression analyses also revealed that those who had been exposed to DVA as a child in the three countries were associated with a substantially higher predicted probability of experiencing psychological distress as an adolescent or young adult. The analysis presented in this paper supports Kieselbach et al. (2021) while providing further insight into more LMICs in which the VACS was conducted. However, it is essential to remember that whilst the K6 has been validated in LMICs, psychological distress is based on the respondent's feelings over the past 30 days, so whilst there is an association, other factors could contribute to their levels of psychological distress reported.

6.4.2 Limitations and Recommendations for Future Research

There are some limitations to the present study that should be considered, most of which are due to the data used. This data uses the CDC Violence Against Children Surveys (VACS; Chiang et al., 2016). As previously mentioned, assessing the relationship between childhood exposure to DVA and adolescent and adult mental health within the VACS can be difficult due to the cross-sectional nature of the VACS. Because temporality cannot be assessed, there is, therefore, no way of knowing if some of the lifetime associated outcomes (e.g., suicidal thoughts) happened before, during, and/or after exposure to DVA perpetrated by caregivers or adult household members. This limitation is in addition to the broader limitation that correlational data cannot reveal causal relationships. These are issues acknowledged by other papers using the VACS (e.g., Annor et al., 2022; Kafuko et al., 2022). Therefore, only

⁵⁵ The prevalence rates found for these three countries in Paper Two are 19.68-30.68%, although as explained in 3.4, not all questions related to exposure to DVA were included in the creation of the main variable used in analysis to allow for comparison across all ten countries. Full exposure to DVA statistics for these three countries, along with the other seven focused on within this thesis can be found in Appendix C.1.

associational relationships can be implied from the VACS data, and to gain a more comprehensive understanding of the complex relationship between childhood exposure to DVA perpetrated within the home and future mental health outcomes, improved tools need to be developed to obtain data on this topic.

In addition, the question upon which the “Exposure to DVA” variable was created was relatively narrow (see Table 3.5) both in terms of how exposure is defined (seeing or hearing violence perpetrated by one parent or adult household member against another), and the DVA which is possible to explore (see, hit or kick – specific types of physical violence). Therefore, this variable may not have captured everybody exposed to DVA as a child. Despite this, the VACS provides one of the only opportunities to explore factors associated with childhood exposure to DVA within LMICs, and it offers a unique insight into mental health outcomes associated with childhood exposure to DVA across ten countries. However, as previously stated, better data is required to understand the issue fully. In addition to this, as the mental health outcomes explored are of a sensitive nature, it is important to consider the potential effects of the interviewer and social desirability. Respondents may be less likely to be honest about topics such as drug use, violence perpetration, or self-harm or suicide, for fear of either judgement or negative repercussions. Whilst respondents were reminded that everything would remain confidential, it is important to consider the potential impacts of this, which could lead to underreporting of both their exposure to DVA perpetrated by caregivers or family members and any adverse mental health associations (Levendosky, Bogat, & Von Eye, 2007). However, this is a common issue across research on such a sensitive topic.

A further limitation linked to the data, is that it was not possible to control for other violence types or ACEs which children may have experienced in the analysis. As the VACS is a survey about violence against children, the survey is about different forms of violence, and so it would be impossible to control for everything that could cause adverse mental health when looking at mental health outcomes. Notably, direct child abuse (or abuse perpetrated by a parent or caregiver) was not controlled for, nor respondent's own experiences of DVA. The effect of these other ACEs can perhaps be seen in the regression analyses for each mental health outcome, where exposure to community violence was significantly associated with at least six of the ten (or, in the case of the perpetration of physical non-partnered violence, nine) countries. In addition to this, factors which have been found in HICs to have a mediating, moderating, or protective effect on mental health following exposure were not possible to assess within this

analysis using the VACS data. Therefore, this is another area that future research could explore, if the data allows it.

This paper assessed mental health outcomes using six indicators (with the addition of attempted suicide when performing bivariate analysis). Whilst these results indicate that there does appear to be an association between childhood exposure to DVA and adverse mental health outcomes, only a narrow range of outcomes are explored, and further research is required to explore a broader range of internalising and externalising symptoms to fully understand the relationship between childhood exposure to DVA and mental health. In addition, the VACS interviewed respondents aged 13-24, and so whilst exposure is always before the age of 18, the longer-term impact that this can have on mental health cannot be assessed. In addition to this, the age range of the respondents can be a tumultuous time, and other aspects of an individual's life which could adversely affect mental health were not controlled for in the present study. Future research on this topic should have a clearly defined definition of exposure to DVA and should explore mental health over a more extended period of time. If future data allows, different methods, such as structural equation modelling, could also be beneficial in future research (alongside a more comprehensive definition of exposure to DVA) so that the true impact of exposure to DVA on mental health outcomes can be better understood.

6.5 Conclusion

In conclusion, this study highlights the increased likelihood of a range of adverse mental health outcomes associated with childhood exposure to DVA in LMICs, including internalising and externalising symptoms. A notable highlight is that within the ten LMICs explored, those who had been exposed to DVA as a child had significantly higher levels of psychological distress using a tool which has been validated in LMICs (Kessler et al., 2003) when compared to those who had not been exposed to DVA. This was a finding prevalent across all ten countries and remained significant even when controlling for other explanatory variables which could contribute towards adverse mental health.

The findings of this paper suggest that despite a lack of research, childhood exposure to DVA has many of the same adverse effects on mental health as has been found in research from HICs. However, it is important to note that they only demonstrate associations, and that the relationship between childhood exposure to DVA perpetrated within the home and associations with adverse mental health in adolescence and adulthood is more nuanced than this analysis

can explore. Perhaps the primary reason for this stems from the data available, which links to one of the central arguments of this thesis – that better data is required on childhood exposure to DVA in LMICs to allow for better analysis and a more comprehensive understanding of the complex issue.

This paper serves as a starting point for further research to better understand the relationship between childhood exposure to DVA and mental health in adolescence and early adulthood in LMICs. The lack of such research could delay the development of interventions and policies aimed at helping children exposed to DVA in LMICs, and is, therefore, an urgent research priority.

Chapter 7 Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal: Policymaker and Professional Perspectives

Purpose: Little is known about how childhood exposure to domestic violence and abuse (DVA) is viewed in Nepal, despite belonging to the region estimated to have the highest prevalence of exposure globally (UNICEF, 2006). Existing non-nationally representative surveys have found that 23-29% of respondents saw or heard their mother being beaten by their father or her male partner as a child, yet there does not appear to be acknowledgement of childhood exposure to DVA within policies related to either DVA or child protection in Nepal. This paper therefore firstly seeks to understand the current context and understanding of childhood exposure to DVA Nepal amongst professionals and policymakers in Nepal, the services in place to support children, before finally exploring potential improvements that can be made.

Method: In-depth interviews with 21 key informants were conducted in Nepal. Respondents included representatives from government, international non-government organisations, non-government organisations, academics, and freelancers working in the field of DVA or child protection.

Results: Thematic analysis revealed four main themes: (1) Understanding and Awareness of Childhood Exposure to DVA – indicating significant confusion among professionals regarding the distinction between exposure and child abuse, along with a general lack of awareness among policymakers about the specific needs of children exposed to DVA; (2) Barriers to Providing and Accessing Support – highlighting a lack of awareness of support amongst children alongside systemic issues such as the lack of resources, and geographical inaccessibility of services that hinder effective support; (3) Existing Support and Resources – exploring perceived responsibility for policy, provision and support along with identifying current interventions such as helplines and NGO networks, which, while present, are often insufficient or not tailored to the needs of children exposed to DVA and rely heavily on collaboration; and (4) Future Strategies and Interventions – emphasising the need for educational programs to empower children, multilevel interventions, and systemic reforms to improve policy and service delivery for children exposed to DVA.

Conclusion: The findings underscore a critical lack of recognition and support for childhood exposure to DVA in Nepal. Without a structured framework and clear policies, the unique vulnerabilities of these children remain overlooked. This research advocates for a national dialogue to address these gaps, suggesting that enhancing awareness, improving access to support, and implementing targeted interventions are essential for safeguarding the rights and wellbeing of children exposed to DVA in Nepal.

7.1 Introduction and Rationale

Evidence presented in the previous chapters show that children in low- and middle-income countries (LMICs) exposed to domestic violence and abuse (DVA) have a higher likelihood of experiencing adverse mental health outcomes later in life. In addition to this, there are high estimated prevalence rates of childhood exposure to DVA in LMICs, and Southern Asia is estimated to have the highest number of children exposed (Figure 2.1; UNICEF, 2006).

However, there is still limited knowledge about the full extent of the issue of exposure to DVA in many countries, the effectiveness of existing policies in these countries, and the level of awareness among those in power or providing support to children exposed to DVA perpetrated between caregivers or adults within the home. It is therefore important to assess the current knowledge, understanding, and provision for children who have been exposed to DVA, as well as any potential barriers to improving existing policies and support services to better protect children.

This paper will utilise qualitative methods to explore this issue through key informant interviews with those working in the field of DVA and child protection services within an LMIC, Nepal. It aims to examine the issue of childhood exposure to DVA on the ground in an LMIC, using the example of Nepal, to explore the current awareness and knowledge of childhood exposure to DVA amongst professionals and policymakers, describe the current policy landscape, and to identify gaps and opportunities for strengthening child protection.

7.1.1 Policy and Public Health Interventions for Childhood Exposure to DVA

Childhood violence encompasses many forms of maltreatment and violence which a child may experience in their homes or communities, including maltreatment, bullying, youth violence, intimate partner violence, sexual violence, and emotional or psychological violence (World Health Organization, 2022). However, the violence does not have to be direct, and childhood violence also encompasses exposure to violence, and this paper will focus on exposure to DVA. Despite the concept of childhood violence encompassing many different types of violence, there is rarely one comprehensive policy within a country to protect children from all forms of violence and maltreatment. To better protect children, there needs to be a comprehensive, holistic framework.

As more evidence emerges about the negative outcomes of childhood exposure to domestic violence (see Paper Three, Chapter 6), childhood exposure to DVA is becoming an increasingly recognised concept within policies around the world. These are not only country-specific, but the topic of exposure to DVA is mentioned (either explicitly, or implicitly) in some international

rights, treaties and conventions (Appendix I.1). An example of where this is explicitly mentioned is in the Istanbul Convention (2011), which contains “Article 26: Protection and support for child witnesses”. Article 56 also includes measures of protection for “child witness of violence against women and domestic violence”, and the preamble states that the convention recognises “that children are victims of domestic violence, including as witnesses of violence in the family”. The UN Convention on the Rights of the Child (UNCRC; 1989) implies protection for children exposed to DVA in “Article 19: Protection from violence, abuse and neglect”. This article details how children must be protected “from all forms of physical or mental violence, injury or abuse [...] while in the care of parent(s), legal guardian(s) or any person who has the care of the child”. The UNCRC has been complemented by various General Comments, and in “General Comment No. 13 (2011): The right of the child to freedom from all forms of violence”, childhood exposure to DVA is explicitly mentioned. It lists “children who experience and witness violence in the home and in communities” as children in potentially vulnerable situations, in Clause 72 “elements to be mainstreamed into national coordinating frameworks” (United Nations Committee on the Rights of the Child, 2011). In addition to the UNCRC, the Sustainable Development Goals (SDGs; 2015), particularly Targets 5.2 and 16.2⁵⁶, reinforces the commitment of nations to prioritise the protection of children and to implement effective measures to reduce DVA, under which childhood exposure could be considered. Despite the existence of these international frameworks, challenges remain in their implementation. Many countries have ratified these treaties but struggle with enforcement and the allocation of resources necessary to protect children effectively, an issue common when looking at other issues mentioned in these international frameworks.

Perhaps in part due to these international frameworks (which many countries have ratified and agreed to), a number of countries worldwide recognise childhood exposure to DVA as a significant form of harm⁵⁷. However, the way in which this is recognised varies across countries (Appendix I.2). For example, in the United Kingdom, the Domestic Abuse Act (2021) explicitly recognises children as victims of DVA if they see, hear, or experience its effects. The law acknowledges that children witnessing DVA suffer significant emotional and psychological harm, and it extends legal protections to them. Sweden’s child protection system includes provisions for intervening when children are exposed to DVA. Under the Swedish Social Services

⁵⁶ SDG 5.2 “Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation”; SDG 16.2 “End abuse, exploitation, trafficking and all forms of violence against children”.

⁵⁷ DVA Acts in many countries do mention children, but this is usually only in the context of including them in protection order for the victims (usually the mother), or when speaking about custody arrangements after DVA. The policies highlighted in this section are where childhood exposure to DVA is recognised independently due to the harm or impact of exposure.

Act (2001), children are considered in need of protection if they witness DVA within the home (Socialtjänstlag (2001:453), 2001), and in 2021, a law was introduced to the Swedish Criminal Code (The Violation of a Child's Integrity Act, or 'Barnfridsbrott'), which made it a criminal offence in Sweden to allow children to see or hear violence, threats or abuse between relatives (Swedish Prosecution Authority, 2022; Lag (2021:1500) Om Barnfridsbrott, 2021). In New Zealand, the Family Violence Act (2018) considers a child to be psychologically abused if they see or hear (or are at risk of seeing or hearing) abuse with whom the child has a family relationship. A few examples also exist within LMICs. For example, in Kenya's Protection Against Domestic Violence Act, a child is considered to have psychologically abused a child they cause or allow (or creates a risk of) a child to see or hear the physical, sexual or psychological abuse of a person with whom the child has a domestic relationship (Protection Against Domestic Violence Act, No. 2 of 2015 (Kenya)). In the Philippines under the Anti-Violence Against Women and Their Children Act (2004), psychological violence includes causing or allowing the victim to witness the physical, sexual or psychological abuse of a member of the family to which the victim belongs, thus encompassing childhood exposure to DVA. Finally, in South Africa, under the Domestic Violence Act (1998), a child under the care of a complainant, is also considered a complainant, and the Children's Act (2005) states the need to protect a child from any physical or psychological harm which may be caused by exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person.

Whilst a comprehensive policy analysis across all countries and settings has not been conducted and the above are only examples from certain countries, they illustrate how the topic of childhood exposure to DVA varies with where it sits within policies within countries. Figure 7.1 shows the relationship pictorially, with childhood exposure to DVA sitting across DVA and child protection policies, provisions, and services.

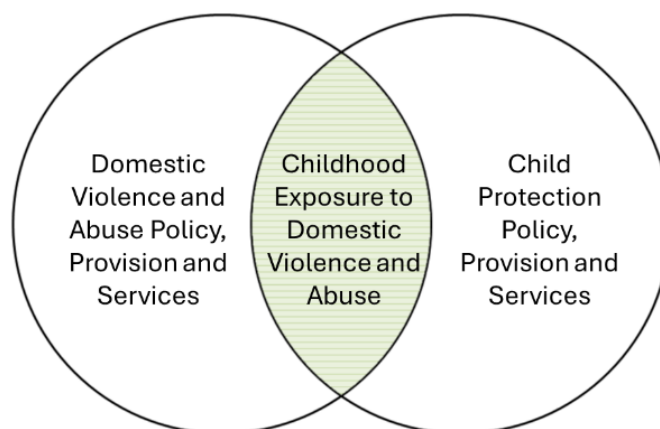


Figure 7.1 Standard placement of where childhood exposure to DVA sits within existing policy, provision and services, based on evidence from other countries

In addition to policy, public health interventions to both prevent and support childhood exposure to DVA are also important in protecting children. Whilst some of these stem from the introduction of policy, such as mandatory reporting, others arise from the awareness of the negative impact of exposure. Research has demonstrated that public health initiatives that span multiple sectors (such as health, education, and social services) and ecological domains⁵⁸ are essential for a comprehensive response to childhood exposure to DVA. Evidence suggests that multisectoral approaches can significantly reduce violence against children by addressing the issue at various levels of the socioecological model (Hillis et al., 2016). Such strategies not only focus on the immediate needs of children, but also aim to create systemic changes that promote long-term safety and wellbeing. The following section will give a brief overview of the public health and policy interventions found in existing literature for children exposed to DVA.

One significant approach at the community level includes school-based interventions, as schools can play a critical role in identifying at-risk children and providing them with the necessary resources and support (Laing, 2016). Including trauma-informed care and practices in school, and training members of staff within schools to recognise the signs of trauma and providing them with the tools to refer children to appropriate services is essential for timely intervention (Ponnamperuma & Kudagama, 2022; Armiento et al., 2016) and allows staff members to provide a compassionate and effective response (Pavlenko, 2023). Schools can also collaborate with local organisations that specialise in DVA prevention and intervention, and external agencies such as mental health services, facilitating access to additional resources, such as counselling services, support groups, legal assistance, and safe housing options for affected families (Adeyele & Makinde, 2021; Carnevale et al., 2020; Soron et al., 2021). Community awareness and education campaigns that aim to educate families about the impacts of DVA and provide them with tools to create a safer and more supportive home environment (Howard, 2021) have been found to encourage families to seek help and support, reduce the stigma associated with DVA (Ponnamperuma & Kudagama, 2022; Armiento et al., 2016).

Research demonstrates that family-focused interventions can enhance the protective factors for children and promote healthier family relationships (Cho, 2018; Lacasa et al., 2016). By addressing the needs of the entire family unit, these interventions can foster resilience and reduce the likelihood of future violence. Family therapy interventions (such as the Parents Accepting Responsibility that Kids are Safe initiative in Australia; Bunston, 2002) can be

⁵⁸ The concept of ecological domains is first introduced in Chapter 2, and are used throughout Paper Two (Chapter 5) and Paper Three (Chapter 6).

effective in addressing the dynamics of families experiencing DVA. These therapeutic approaches aim to improve communication and relationships within the family, helping to rebuild trust and safety (Armiento et al., 2016). Family therapy can also provide an opportunity for children to express their feelings about the violence they have witnessed in a safe space, which can help to facilitate healing and resilience (Pavlenko, 2023), enhancing protective factors for children and promoting healthier family relationships (Szilassy et al., 2016). Some interventions for childhood exposure to DVA are specifically related to parenting. For example, programmes that offer counselling, legal assistance, and resources for the victimised (non-abusive) parent can help them create safer environments for their children by reducing the ongoing risk posed by the perpetrating parent or caregiver (Zannettino & McLaren, 2012). Initiatives such as positive parenting programmes and conflict resolution training have also been found to be effective in providing support to at-risk families before violence escalates (UNICEF, 2020), therefore minimising the risk of childhood exposure to DVA⁵⁹.

Finally, individual level interventions have been found to be effective for children exposed to DVA. Research has demonstrated that preventative and early interventions for children exposed to DVA are critical in mitigating the adverse effects of such exposure on their mental health and overall development. Various forms of psychosocial support have been found to be particularly effective, for example, play therapy, cognitive behavioural therapy and counselling, which have been shown to help children process their experiences and develop coping mechanisms (Thompson & Trice-Black, 2012; Patterson et al., 2018; Stutey et al., 2017; Doroudchi, 2023), and some studies have found these interventions to significantly reduce symptoms of internalising and externalising symptoms amongst children (Lacasa et al., 2016; Hall, 2019) – symptoms which have been found within this thesis to be increased amongst those exposed to DVA (Paper Three, Chapter 6). Skill-building programmes, such as training in conflict resolution, emotional regulation, and communication skills, have also been found to enhance the social and emotional skills of children who have been exposed to DVA. By teaching children these skills, they can better navigate relationships, and reduce the likelihood of engaging in aggressive or maladaptive behaviours (Armiento et al., 2016; Russell et al., 2010). Finally, mindfulness and relaxation techniques such as deep breathing, meditation, and grounding exercises, can help children develop self-regulation skills and reduce emotional distress (Szilassy et al., 2016;

⁵⁹ Alongside ensuring that family support services and interventions are trauma-informed, the importance of ensuring that they are also culturally sensitive has also been highlighted. An example of this can be found in a study based in the Northern Territory of Australia, who found that incorporating the First Nations System of Needs was important in child protection and family support services (Reynolds, 2023). Ensuring that programmes and interventions are culturally sensitive programmes help to foster trust and encourage families to seek support, enhancing its effectiveness and reach.

Lapierre et al., 2017). These techniques can empower children to manage any psychological distress related to their exposure to DVA perpetrated within the household.

The importance of education, combined with psychosocial support has also been found to improve outcomes of children exposed to DVA. Through educating children about DVA and its effects, these programmes aim to help children understand that they are not responsible for the violence they have witnessed and that their feelings are valid (Doroudchi, 2023; Dargis & Koenigs, 2017). Psychoeducation can also provide children with coping strategies and resources to manage their emotions effectively, promoting resilience and emotional wellbeing. Closely linked to education is advocacy and empowerment. Advocacy services can help children navigate the complexities of their situations, including legal and social services. Advocates can assist children in accessing mental health services, educational support, and other resources necessary for their wellbeing (Zannettino & McLaren, 2012; Olofsson et al., 2010). By providing individualised support, advocates can empower children to voice their needs and ensure that they receive appropriate care.

A multifaceted approach that includes mental health support, safety measures, educational initiatives, and collaborative efforts among stakeholders is necessary to protect and support children who are exposed to DVA. By addressing the complex needs of these children, policies and public health interventions can significantly mitigate the long-term impacts of DVA on their development and wellbeing. Within all of these policies and public health interventions, it is important to include children's perspectives in the development, as it ensures that their specific needs and experiences are acknowledged and addressed (Noble-Carr et al., 2019; Callaghan et al., 2018).

Despite the evidence of the impact that policy and public health interventions can have in protecting children from, and supporting those who have been exposed to DVA, the majority of evidence is from HICs, rather than LMICs. Regarding policy, the countries which do acknowledge childhood exposure to DVA seem to be the exception, rather than the rule generally. Exploring the situation within a specific LMICs with regards to whether policymakers and professionals working in the sphere of DVA and child protection have an understanding of childhood exposure to DVA and appreciate its importance is an important first step in supporting the affected children. To explore this further, this paper will focus on one LMIC, Nepal, to understand the current understand and practice of exposure.

7.1.2 Nepal: Country Context and Background

Nepal, officially the Federal Democratic Republic of Nepal, is a landlocked country in South Asia (Figure 7.2), bordered by China to the north and India to the south, east, and west. In 2022,

the population of Nepal totalled almost 31 million people (World Bank, 2022). Nepal is renowned for its rich cultural diversity, where there are over 120 languages are spoken (Cole et al., 2017) and over 140 castes and ethnicities (Devkota et al., 2017; Kc et al., 2019; Government of Nepal National Statistics Office, 2023). In addition, Nepal also uses the Bikram Sambat (B.S.) calendar⁶⁰ as the official country calendar, which is approximately 57 years ahead of the Gregorian calendar, with the year beginning in mid-April. Official documents, national events, and festivals are often based on this calendar, reflecting Nepal's unique cultural and historical timeline (Cole et al., 2017; Mahaseth, 2023).

While Nepal's cultural and natural heritage attracts global attention, it faces numerous developmental challenges, including poverty, political instability, and social inequality (Bhandari, 2016; Ogino et al., 2019; Senarath & Gunawardena, 2009). In terms of development, Nepal is classed as a lower-middle income country, ranked 146th out of 193 nations with a human development index of 0.601, giving it the status of 'medium human development' (United Nations Development Programme, 2022).

Nepalese society has traditionally been structured by a rigid caste system, particularly among Hindu communities, which classifies individuals into hierarchical social groups (Sabri et al., 2015). Despite the legal framework officially abolishing caste-based discrimination, social practices and attitudes continue to perpetuate inequality, affecting access to education, healthcare, employment opportunities, and social mobility (Baek & Chitekwe, 2019; Devkota et al., 2017). It also reinforces cultural stigmas, as individuals from lower castes often face discrimination and social isolation (Subedi, 2022; Mainali et al., 2016). In addition to the caste system, Nepal's society is characterised by a patriarchal system that significantly influences gender roles and relationships (Pun et al., 2020; Patil & Khanna, 2022). Women often face systemic discrimination, which is evident in practices such as dowry, child marriage, and DVA, where societal acceptance of violence against women is prevalent (Thapa et al., 2020). This gender inequality is also reflected in educational disparities, with girls often facing barriers to schooling and higher dropout rates due to societal expectations (Dahal et al., 2021). Efforts toward social equality remain a significant part of Nepal's ongoing development, reflected through the country's improvement in the gender empowerment measurement from 0.391 in 2001 to 0.496 in 2006 (UNFPA, 2017).

This section will provide a brief overview of the country, including its geography, political structure, economy, and recent history.

⁶⁰ This means that the policies within Nepal are sometimes referred to in two different ways, the Gregorian Year, or the Nepali Year. For example, the Act Relating to Children 2018 / Act Relating to Children 2075.

7.1.2.1 Geography and Climate

Nepal runs approximately 500 miles from northwest to southeast, and is between 56 and 143 miles wide, covering an area of 56,827 square miles. Nepal's geography is characterised by diversity that encompasses three primary regions: the Terai (Madhesh), the Hills (Pahad), and the Mountains (Himal). Figure 7.2 illustrates the subdivision of Nepal into the three terrains (an enlarged map with districts noted can be found in Appendix H). Each of these regions presents unique geographical features, climatic conditions, and socio-economic dynamics, which significantly influence the lives of the people residing in these areas (Khanal & Shrestha, 2019).

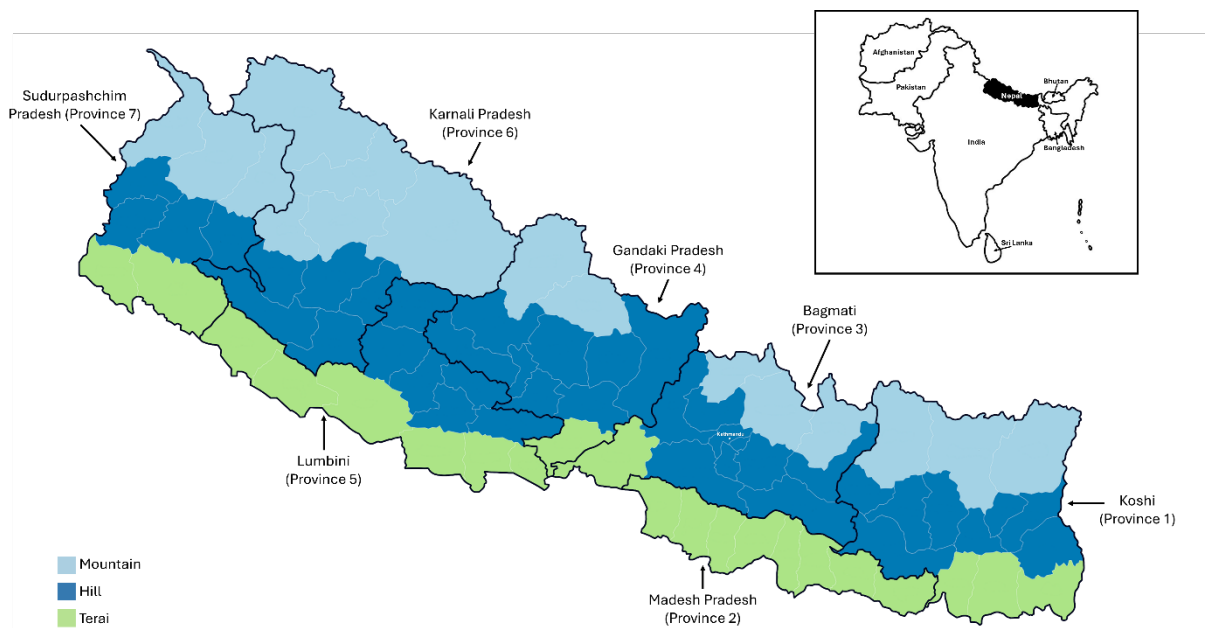


Figure 7.2 A map of Nepal showing the subdivision of the country into Mountain, Hill and Terai districts. Kathmandu is also noted. Inset is a thumbnail map showing the location of Nepal within South Asia

Kathmandu Valley (noted above in Figure 7.2) is located in the Hills. The topography of the Hills presents both opportunities and challenges; while it supports agriculture, particularly the cultivation of maize and millet, it also makes transportation and infrastructure development difficult due to the steep terrain (Paudel, 2012). The urban-rural divide is pronounced in this region, with urban areas experiencing more development and access to services compared to rural communities (Awasthi, 2019).

Nepal's climate is predominantly influenced by its diverse topography, and the country experiences a variety of climatic conditions but is primarily characterised by a monsoon climate. The monsoon season in Nepal typically occurs from June to September, and poses risks such as flooding, landslides, and soil erosion, particularly in the hilly and mountainous

regions (Ghimire, 2019; Kc et al., 2021). Climate change exacerbates these vulnerabilities, and Nepal is ranked as the fourth most vulnerable country to climate change according to the Climate Change Risk Index (Ghimire, 2019; Malla, 2024).

Approximately 79% of Nepal's population resides in rural areas, highlighting the significant rural character of the country (Singh Shah, 2023). Rural areas in Nepal face numerous challenges, including limited access to healthcare, education, and infrastructure, exacerbating social disparities between urban and rural communities. The geographical terrain often complicates transportation and communication, making it difficult for rural residents to access essential services (Chalise et al., 2019). Furthermore, economic opportunities in rural regions are often constrained, leading to higher levels of poverty compared to urban areas (Hirachan et al., 2010).

7.1.2.2 Political Structure, Economy and Development

Nepal operates as a federal democratic republic, a structure it adopted after the abolishment of its monarchy in 2008 (Dahal, 2020; Ghimire, 2022). The political landscape of Nepal has undergone significant transformations in recent years. The Constitution of 2015 marked a significant transition from a unitary state to a three-tier federal system, aiming to address the diverse needs of its multi-ethnic population (Pandey, 2021) and for Nepal to be an “independent, indivisible, sovereign, Hindu, inclusive, democratic republic state” (Article 4, Constitution of Nepal 2015). Part of this constitution resulted in the creation of Nepal’s current provinces, replacing the previous development regions, administrative zones, and districts. The seven provinces of Nepal are also noted on the map in Appendix H.

The Constitution of 2015 divided the country into three tiers of government: federal, provincial, and local (Dahal et al., 2020; Khadka, 2023). This structure includes seven provinces and 753 local governments, each endowed with legislative, executive, and judicial powers, allowing them to enact laws, formulate policies, and mobilise resources independently (Timsina, 2023; Dahal et al., 2020).

At the top of the hierarchy is the federal government (sometimes also referred to as central government), which is responsible for national governance and policymaking. It is led by the Prime Minister, who is the head of government, and the President, who serves as the ceremonial head of state. The federal government holds exclusive powers over areas such as defence, foreign affairs, and national economic policy, and it is tasked with ensuring the overall stability and security of the nation (Acharya & Zafarullah, 2020). Below the federal level are the seven provincial governments, each headed by a Chief Minister. The provinces have their own legislative assemblies and are responsible for managing regional affairs, including education, health, and infrastructure development. The provincial governments have the authority to enact

laws and policies specific to their regions, reflecting the unique needs and priorities of their constituents (Adhikari, 2023; Neupane & Jaishi, 2020). The provincial governments also play a crucial role in coordinating with local governments to implement development projects effectively (Sharma, 2014). The local government level consists of 753 local units, including municipalities and rural municipalities (known as *gaunpalika*), which are led by elected mayors or chairpersons. Local governments are responsible for delivering essential services such as education, health care, sanitation, and local infrastructure. They have the authority to formulate and implement local policies and budgets, making them the closest government tier to the citizens (Acharya, 2021; Neupane, 2019). The local government structure aims to enhance grassroots participation and ensure that local voices are heard in the decision-making process (Simkhada & Wasti, 2021).

This three-tiered system of governance in Nepal is designed to promote decentralisation, enhance local autonomy, and improve service delivery, although challenges remain in terms of capacity, resources, and intergovernmental coordination (Baral & K.C., 2023; Dahal, 2018; Jaishi et al., 2023; Pradhananga & ElZomor, 2021). The effectiveness of this federal system is often undermined by complex intergovernmental relationships, limited financial and human resources, and challenges in policy implementation at the local level (Baniya & Aryal, 2022; Regmi et al., 2023). Despite these efforts at decentralisation, political instability remains a concern, with issues such as corruption and lack of accountability affecting governance and public trust (Bhandari, 2016; Poudel, 2023). This instability hampers effective policy implementation and economic growth, as seen in various sectors, including health and education (Dahal, 2024).

Nepal faces significant developmental challenges, including poverty, political instability, and social inequality. Approximately 25% of the population lives below the national poverty line, with rural areas disproportionately affected due to limited access to resources and services (Shrestha, 2023). Furthermore, social inequality is deeply entrenched, with marginalised ethnic groups facing systemic barriers to economic opportunities and political representation (Senarath & Gunawardena, 2009). These interconnected challenges hinder Nepal's progress toward sustainable development and exacerbate the vulnerabilities of its population, particularly in the context of ongoing socio-economic transformations (Ogino et al., 2019).

In terms of social issues, healthcare is a pressing concern in Nepal, with a large portion of health expenditure being covered by households (Heydon, 2011). Access to healthcare services, particularly in rural areas, remains limited, affecting maternal and child health outcomes (Dhakal et al., 2011).

7.1.2.3 Recent History

Nepal's recent history has been shaped by significant events that have profoundly impacted its population and shaped the current socio-political landscape. One of the most critical events was the decade-long civil war from 1996 to 2006, primarily fought between Maoist insurgents and the government. This conflict led to the eventual abolition of the monarchy in 2008, and resulted in the deaths of over 17,000 people and left many more injured or displaced, creating a legacy of trauma that continues to affect survivors and their families (Basnet et al., 2017; Tol et al., 2010). The war also led to widespread human rights violations, including torture and disappearances, which have left deep psychological scars within communities (Tol et al., 2010).

Another major event was the 7.8 magnitude earthquake that struck Nepal on 25th April 2015. This caused extensive destruction, particularly in the Kathmandu Valley and surrounding areas, resulting in nearly 9,000 deaths and displacing hundreds of thousands of people (Karki et al., 2022). It is estimated that the disaster affected nearly a third of the Nepalese population (ActionAid, 2024). The aftermath of the earthquake saw a huge humanitarian response, but the recovery process has been slow and faced with challenges, including inadequate infrastructure, bureaucratic inefficiencies, and ongoing political instability (Karki et al., 2022). The psychological impact of the earthquake, coupled with the memories of the civil war, has contributed to a heightened prevalence of mental health issues among the population (Basnet et al., 2017; Breuer et al., 2018).

7.1.2.4 The Context of DVA within Nepal

The topic of exposure to DVA is closely tied to the general situation of DVA within a country, and therefore, understanding this within the context of Nepal is important. The context of DVA in Nepal⁶¹ is deeply rooted in the socio-cultural dynamics of the country, characterised by patriarchal norms, gender inequality, and traditional practices that perpetuate violence against women, with women frequently internalising these norms to justify their subordination and the violence they ensure (Patil & Khanna, 2022). Studies indicate that DVA is prevalent across various demographics, with significant implications for women's health and well-being. This section will briefly summarise this research, with a key focus on data from the Demographic and Health Survey (DHS).

According to the Nepal DHS (2022), 27% of women in Nepal aged 15-49 have experienced physical, sexual, or emotional violence from their current or most recent husband/intimate

⁶¹ An overview of how DVA is defined under Nepal's Domestic Violence (Crime and Punishment) Act, 2008 (2066 B.S.), can be found in Appendix I.3.

partner, and 23% have experienced physical violence since the age of 15, with 8% having experienced sexual violence (Ministry of Health and Population [Nepal] et al., 2023). The percentage of ever-married women who experienced DVA by any husband/partner in the last 12 months increased from 14% in 2016 to 17% in 2022 (Ministry of Health [Nepal] et al., 2016). The percentage of women who have experienced spousal physical, sexual, or emotional violence fell from 32% in 2011 to 26% in 2016 before increasing slightly to 27% in 2022 (Ministry of Health [Nepal] et al., 2016).

These figures highlight the persistent nature of DVA in Nepal, where cultural norms often perpetuate the acceptance of violence against women (Sapkota, 2024). In addition, the 2022 Nepal DHS reveals that there are differences in experiences of DVA dependent on demographics. For example, the survey found that women's experiences of physical or sexual violence increases with age, from 13% amongst those aged 15-19, to 30% amongst those age 40-49. There were also differences when looking at ethnic groups and regions, with the percentage of women who have experienced physical, sexual, or emotional violence by their current or most recent husband/intimate partner being higher among those in the Muslim (55%), Madhesi (43%), and Dalit (36%) ethnic groups than among those in the Janajati (21%) and Brahmin/Chhetri groups (18%) (Ministry of Health and Population [Nepal] et al., 2023). Women in Madhesh Province (46%) are more than twice as likely to experience DVA by their current or most recent husband/intimate partner as women in Sudurpashchim Province (20%), Bagmati Province (19%), and Gandaki Province (19%). These findings support a study conducted in rural Nepal, which found that more than half of young married women experienced some form of violence in their lifetime, with sexual violence being the most prevalent type (Lamichhane et al., 2011). Finally, within the 2022 Nepal DHS, DVA victimisation was reported to be the highest amongst those with no education (39%) and lowest among those with more than a secondary education (5%). A suggestion as to why this difference exists is that education provides individuals with greater awareness of their rights and access to resources (Kumar, 2021). Conversely, women with low educational levels are often trapped in cycles of violence due to economic dependency and lack of knowledge about available support systems (Paudel, 2007). Women who are pregnant are also highlighted to be a population more at risk of experiencing DVA, with reports indicating that nearly one in five pregnant women experience DVA in Nepal (Sapkota et al., 2019). A study in Chitwan reported that 27.9% of pregnant women faced physical, sexual, or emotional violence (Poudel et al., 2021). Another study indicated that 36.8% of pregnant women attending a hospital reported experiencing DVA during their pregnancy (Regmi et al., 2018). These findings highlight the vulnerability of women during pregnancy, a time when they are often subjected to increased risks of violence perpetrated by partners, which can have severe implications for both maternal and child health (Cengiz et al., 2014).

Another critical aspect highlighted by the Nepal DHS (2022) is the response of women to experiencing DVA. Only a small percentage of women who have ever experienced any type of physical or sexual abuse sought help from healthcare providers (Ministry of Health and Population [Nepal] et al., 2023), indicating a significant gap in support services and the stigma surrounding DVA (Deuba, 2024). This reluctance to seek help is compounded by societal norms that often view DVA as a taboo and private affair (Dahal et al., 2022), further isolating victims and limiting their access to necessary resources such as shelter in safe houses and legal aid. The COVID-19 pandemic has exacerbated the situation of DVA in Nepal, as lockdown measures confined women to their homes, increasing the threat of DVA whilst simultaneously disrupting support services (Dahal et al., 2020). The stigma surrounding DVA further complicates the issue, as many women are reluctant to disclose or report their experiences due to fear of social repercussions, further entrenching the issue within the community (Dangal et al., 2021). Women from lower socio-economic backgrounds are disproportionately affected, with the data indicating that those with limited financial independence are more likely to experience violence (Sapkota, 2024). This finding aligns with previous research that suggests economic dependency on male partners is a significant risk factor for DVA perpetrated by them in Nepal (Dhungel et al., 2017).

The intersection of DVA with other forms of abuse, such as elder abuse, is also notable. Elderly women, particularly those from marginalised communities like the Dalit caste, face significant risks of violence, often linked to their socio-economic status and lack of education (Acharya et al., 2021). This demographic is particularly vulnerable, as many elderly individuals do not seek healthcare despite having health issues, which can lead to increased susceptibility to abuse (Bhandari & Baral, 2020). In addition, women and girls in Nepal face various forms of gender-based violence beyond DVA, including sex trafficking and harmful traditional practices. Sex trafficking is a significant issue, with estimates suggesting that around 10,000 Nepali women and girls are trafficked annually to India for forced prostitution, contributing to a broader pattern of exploitation fuelled by poverty, lack of education, and gender inequality (Dahal et al., 2015; Adhikari, 2023). The societal norms that devalue women exacerbate their vulnerability, making them targets for traffickers who exploit their circumstances under the guise of marriage or employment opportunities (Shrestha et al., 2015; Sapkota, 2018). Additionally, the practice of Chhaupadi, which involves isolating menstruating women in sheds due to cultural beliefs, poses severe health risks and reinforces gender discrimination (Dahal et al., 2022). This practice not only endangers women's physical well-being but also perpetuates the stigma surrounding menstruation, further entrenching gender inequality in Nepalese society (Dahal et al., 2022). Collectively, these forms of violence highlight the urgent need for comprehensive interventions to protect women and girls from all forms of violence in Nepal.

7.1.2.5 Childhood Exposure to DVA in Nepal

As previously mentioned, Southern Asia is the MDG region estimated to have the highest prevalence of childhood exposure to DVA globally, but individual country estimates are not available (UNICEF, 2006). In addition, to the principal investigator's (PIs) knowledge, there are currently no plans to explore the issue of childhood exposure to DVA within Nepal, including any plans to implement the Violence Against Children Survey (VACS; Chiang et al., 2016). Very little data exists on childhood exposure to DVA within Nepal.

Only one large-scale survey exists which has briefly explored the issue of childhood exposure to DVA in Nepal, the International Men and Gender Equality Survey (IMAGES). In 2011, a modified version of a standardised survey (called IMAGES) was conducted in Nepal. IMAGES is a population-based, mixed-method multi-country study conducted in more than 40 countries, and within Nepal, it was carried out with 1000 men aged 18 to 60 years in in three districts: Saptari, Gorkha, and Dang⁶² (Equimundo, 2012). This survey contains the only existing data on the prevalence of childhood exposure to DVA in Nepal, as it asks respondents whether they witnessed their mother being subjected to DVA by her partner during their childhood. In response to this question, 29% of men reported seeing or hearing their mother being beaten by their father or her male partner as a child⁶³.

In 2021, the IMAGES was carried out again by Equimundo (formerly Promundo-US) in collaboration with the Center for Research on Environment Health and Population Activities (CREHPA) in two provinces, Madhesh Pradesh (Province 2) and Sudurpaschim Pradesh (Province 7)⁶⁴. This study used a mixed-method design and a stratified, multi-staged, cluster sampling approach to gather data on 850 men aged 18 to 60, irrespective of their marital status (Gupta et al., 2021). The 2021 iteration of the IMAGES found that 23.59% of men saw or heard their mother beaten by their father or her male partner as a child.

⁶² Due to the IMAGES Nepal (2012) being adapted to further understand men's attitude towards son preference, the three districts in Nepal were therefore selected with this in mind, using the sex ratio of children under the age of one. Therefore, the findings are representative at the district level, not the country level. Additional challenges noted were that the fieldwork coincided with the peak monsoon, so there were several barriers to physically accessing the target populations, and the high migration of men for employment, meaning that it was difficult to find the selected respondents. Despite these potential limitations, the IMAGES Nepal (2012) is valuable, as it provides the only data on childhood exposure to violence in the country to date.

⁶³ The prevalence rate of men who reported seeing or hearing their mother being beaten by their father or her male partner as a child, across other South Asian countries in which the IMAGES has been conducted is varied: India 2014 (20%), Bangladesh 2013 (28%), Afghanistan 2017 (29%), Sri Lanka 2013 (31%), India 2011 (38%), and Pakistan 2018 (76%) (Equimundo, 2022).

⁶⁴ The 2021 IMAGES was conducted in Madhesh Pradesh (Province 2) and Sudurpaschim Pradesh (Province 7). The 2011 iteration was conducted in individual districts within Madhesh Pradesh (Saptari; Province 2), Bagmati (Gorka; Province 4), and Lumbini (Dang; Province 5).

In addition, the 2021 IMAGES survey asked about their perpetration of DVA as an adult, and if a child was exposed to it. After asking the male respondents about perpetration of DVA, it asks, “We have asked about a lot of different bad moments. Did any of these acts take place in front of children?”. Amongst ever-partnered men ($n=691$)⁶⁵, 46.16% of men reported perpetrating DVA, and in 51.10% of these cases, there were children present. However, not all of these men had children, and among those with children at the time of the DVA perpetration ($n=279$), children were reported to be present in 58.42% of violent acts reported⁶⁶. However, as discussed in Section 2.3.1, relying on parental reports for childhood exposure to DVA is problematic, as they may think that their child is unaware of the DVA (DeVoe & Smith, 2002), and therefore this is likely to be an underestimation.

In 2020-2021, Gautam et al (2024) conducted a cross-sectional study among 225 female secondary level students in grades 9-12 (Age: 18.2% <15; 67.6% 15-20; 14.2% >20 years old) in Brahmpuri rural municipality of Sarlahi district (Madesh Pradesh/Province 2). They aimed to explore the prevalence and associated factors of gender-based violence (GBV), and one of their background characteristics explored was whether the respondent had witnessed GBV as a child. Whilst their study does not specify if this was DVA, it still provides some insight into children’s exposure to violence within Nepal. Amongst all students who completed the questionnaire, 28.9% reported witnessing GBV as a child, and amongst these respondents, 74.6% reported experiencing GBV themselves at some point in their lives (compared to 25.4% who had witnessed GBV as a child, but never experienced GBV themselves). Gautam et al (2024) reported that those who witnessed GBV as a child had higher odds of facing GBV themselves in later life compared who had not witnessed GBV (OR 5.99, 95% CI 3.01–11.57). Whilst a small and non-representative sample, this study supports research from high-income countries that children exposed to violence are more likely to be involved in a violent relationship as an adolescent, either as a perpetrator or victim (Ireland & Smith, 2009). This demonstrates that childhood exposure to DVA should be considered within policy, as there are potential public health implications for the children exposed, in adulthood, that would affect wider society.

Whilst both the two iterations of the Nepali IMAGES and the study by Gautam et al. (2023) consist of a relatively small sample and are not nationally representative, they provide an insight into the prevalence of childhood exposure to DVA within Nepal, and highlights that it has been a

⁶⁵ The violence against women module was only asked to ever-partnered men, except if they were widowed.

⁶⁶ These figures do not come from any peer reviewed literature, as this data was analysed whilst in Nepal at CREHPA, who hold the data.

prevalent issue amongst the country's population for many years. However, further data and exploration is required to understand the true extent and impact of the issue.

7.1.2.6 Existing Policies and Public Health Interventions for Childhood Exposure to DVA in Nepal

When reviewing legislation that may address childhood exposure to DVA, three particular Acts were identified: The Act Relating to Children (2018/2075), The Constitution of Nepal (2015/2072), and the Domestic Violence (Crime and Punishment) Act. An overview of the relevant provisions can be found in Appendix I.3.

While all these documents possess the potential to acknowledge childhood exposure to DVA, none explicitly state it. The Act Relating to Children (2018/2075) focuses on direct abuse towards children, rather than considering the psychological harm experienced by children who are exposed to DVA perpetrated within their homes, whereas the Domestic Violence (Crime and Punishment) Act (2009/2066) does not directly recognise children exposed to DVA as victims in their own right, and the only time in which children are mentioned is when mentioning interim protection orders. Although Article 39 of the Constitution of Nepal (2015/2072) provides broad protections for children, it does not specifically identify them as victims of DVA, despite this being potentially inferred from Clause 7, which states that “no child shall be subjected to physical, mental or any other form of torture in home, school or other places and situations whatsoever”.

Despite the absence of these considerations in national legislation, Nepal is a signatory to The UN Convention on the Rights of the Child (UNCRC; 1989). The General Comment No. 13 (2011), which specifically highlights the need to integrate the experiences of “children who experience and witness violence in the home and in communities” into national coordinating frameworks across various legislative, administrative, social, and educational measures, spanning all stages from prevention to recovery and intervention. This suggests that although the issue is not explicitly reflected in existing policies, it is possible that policymakers and professionals in Nepal are aware of it and are considering ways to address it.

7.1.2.7 Rationale for Exploring Childhood Exposure to DVA in Nepal

Nepal was selected as the focus country for this research based on empirical, conceptual, and practical considerations. At the regional level, Southern Asia is estimated to have the highest prevalence of childhood exposure to domestic violence globally (UNICEF, 2006). However, national-level data remains sparse, and there is limited understanding of how the issue is conceptualised or addressed within individual countries in the region. Nepal, like many other

LMICs, does not currently have plans to implement the Violence Against Children Surveys (VACS; Chiang et al., 2016), meaning that prevalence estimates for childhood exposure to DVA within the country are limited. Where data does exist, it suggests that childhood exposure to DVA is a prevalent but under-recognised issue. For example, both iterations of the IMAGES conducted in Nepal (Equimundo, 2012; Gupta et al., 2021) provide insight into the proportion of men who witnessed a parent perpetrating DVA during childhood. However, these studies are not nationally representative and only offer a narrow view of how childhood exposure to DVA is understood and experienced. Moreover, to date, no in-depth qualitative research has explored how the issue is understood by professionals and policymakers, or how existing policies and services respond to affected children. Given Nepal's commitments under the UN Convention on the Rights of the Child (UNCRC, 1989) and General Comment No. 13 (2011), which explicitly recognises children who witness violence in the home as rights-holders in need of protection, this exploration is both timely and important.

From a conceptual standpoint, Nepal represents a critical case for examining the early stages of institutional and policy recognition of childhood exposure to DVA. The country's legal and public health frameworks currently make limited or no reference to the issue, despite its international commitments. As such, Nepal provides a valuable context for exploring how awareness of childhood exposure to DVA emerges among policymakers and practitioners, what barriers exist to institutional engagement, and how these may be shaped by broader structural challenges such as federalisation, limited resources, and entrenched social norms. Nepal also presents a particularly valuable country to explore due to a clear disconnect between existing legislation on DVA and child protection, and the absence of recognition of children as victims in their own right when exposed to violence perpetrated between adults (see Sections 7.1.2.5 and 7.1.2.6). This disconnect provides a compelling rationale for examining both the current level of awareness and understanding of the issue, and the structural barriers and opportunities for policy and practice reform.

Finally, Nepal was selected in part due to the presence of established academic and research links with a trusted local partner organisation, the Centre for Research on Environment, Health and Population Activities (CREHPA). These existing relationships supported ethically responsible and culturally appropriate fieldwork, and enabled access to key informants working in the fields of child protection and DVA. Further details about the local partner and their role in the study are provided in Section 7.2.2.

Although findings are context-specific, Nepal also shares key structural and policy characteristics with other LMICs, such as underdeveloped support systems, competing policy priorities, and cultural norms that influence attitudes towards violence. Therefore, the insights

gained from this study have potential relevance beyond the Nepali context and contribute to the broader aim of this thesis: to advance understanding of childhood exposure to DVA in LMICs and identify areas for future research, intervention, and policy development.

7.1.3 Aim and Purpose of Study

There is a distinct lack of inclusion of childhood exposure to DVA within existing policies within Nepal, and there is no published literature available which discusses the current understanding, provision or support for children who have been exposed to DVA. It is important to gain an understanding of what is happening on the ground within a country, and especially an LMIC, to identify any key areas which require improvement in order to better protect children from exposure, and reduce the adverse outcomes for those already exposed.

The initial aim of this paper was to explore the initial research question “What are the barriers and facilitators to implementing public health interventions for children exposed to domestic violence and abuse in Nepal?”. However, upon conducting the interviews, it was realised that there was a lack of knowledge about the understanding of what exposure is, and that amongst the key informants interviewed, public health interventions were not being considered, because there was a general lack of understanding about what ‘exposure’ actually is. Therefore, the aims for this paper were changed. Further information is available in the discussion (Section 7.4).

Therefore, this paper utilises qualitative interviews with policymakers and professionals working in the areas of child protection and/or DVA, firstly seeking to understand the current context of Nepal, respondent’s understanding of children’s exposure to DVA and services which are in place to support them, before exploring the changes that can be made to better support children.

This will be done through addressing the following research questions:

1. What is the current level of awareness and understanding among policymakers and professionals in Nepal regarding childhood exposure to domestic violence and abuse?
2. What types of support and resources are currently available to children who are exposed to domestic violence and abuse in Nepal?
3. What policy changes, strategies, and interventions, can be implemented to improve the support for children exposed to domestic violence and abuse in Nepal?

These questions aim to cover a comprehensive exploration of the topic of exposure to DVA within Nepal, from understanding and evaluating the current situation, to proposing future improvements.

7.2 Methodology

7.2.1 Research Design

This paper utilised a semi-structured interview guide to examine the issue of childhood exposure to DVA in Nepal. In particular, this explored the current understanding of exposure and how this is reflected in the current policy landscape and support available to children affected. It further explored the gaps and opportunities for strengthening child protection.

Expert interviews with key informants⁶⁷ who work in the field of child protection or DVA policy or support were conducted to explore the current understanding, context and laws related to how Nepal is currently responding to childhood exposure to DVA. The interview guide was designed to focus on understanding the political, structural, and environmental context around policies and interventions at an organisational level (e.g., policymakers and professionals within organisations who work with victims). This was in order to gain an understanding around the structural context of intervention, provision and safety, and to identify barriers and facilitators for implementing public health policies for children exposed to DVA in Nepal.

The interview guide was informed by the quantitative analysis from the previous papers, as was the recruitment and sampling⁶⁸. The interview guide was developed in English and translated into Nepali, as was the participant information sheet, and informed consent form. All documents were discussed with a member of the local partner, and a trial interview conducted prior to formal data collection, to ensure that concepts and phrases translated well and were culturally sensitive. The interview guide was also reviewed throughout the interview process and reflected on with the local partner to ensure that the order of questions made sense. A copy of the final interview guide can be found in Appendix J.

7.2.2 Identifying a Local Partner and Seeking Ethical Approval and Funding for the Research

Due to the Principal Investigator (PI) being based in the UK and the sensitivity of the research topic, a local partner was identified to assist with the research. It was hoped that by working

⁶⁷ When conceptualising this paper, consideration was given as to whether the PI could speak to individuals who had been exposed to DVA as a child, to ensure that their views and opinions on the provision and support for childhood exposure to DVA were heard. However, it was decided that speaking directly to adults who were exposed to DVA as a child could be unsafe for the victim, and would be unlikely to give information on the current understanding and provision within Nepal that this paper seeks to explore, due to the exposure happening some time in the past and due to the changes in Nepal's political landscape in recent years (see Section 7.1.2.2).

⁶⁸ A full explanation of how the methods were mixed across papers can be found in Section 3.2. Whilst it was hoped that the PI would be able to speak to certain groups (such as those working in education), this was not possible due to an inability to identify key informants who had the time to partake in an interview during the data collection. Further information on the respondents is available in Section 7.2.3.

with a local non-governmental organisation (NGO), that the work would be more targeted, and would help with selection and recruitment access to potential respondents, help facilitate the smooth running of the research, and also help with the later dissemination of the research (McFayden & Rankin, 2016).

The Center for Research on Environment, Health and Population Activities (CREHPA) was approached to act as a gatekeeper organisation and to help make contact with key informants. CREHPA was chosen as the NGO for this study due to their extensive research within the field of DVA, and the fact that they have conducted both qualitative and quantitative research studies in sensitive research areas, including gender-based violence. They were also involved in the delivery of both iterations of the International Men and Gender Equality Survey (IMAGES) in Nepal, the only large-scale study which touches on the issue of exposure to DVA within Nepal. Existing links between CREHPA and The University of Southampton also existed, and CREHPA were not identified as a key informant when conducting a stakeholder map and so there was no conflict of interest. CREHPA were involved at all stages of the data collection.

Following discussions with CREHPA, an application to conduct the research was made to the University of Southampton Ethics and Research Governance Committee (ERGO: 80830.A1), and then to the Nepal Health Research Council (NHRC 324/2023). An application to conduct overseas fieldwork was also made to the South Coast Doctoral Training Partnership, who kindly funded the PI to travel to Kathmandu for a month to conduct this research.

7.2.3 Identification of Respondents, Sampling and Recruitment

As this paper is exploring the current understanding and consideration of childhood exposure to DVA within Nepal in policy and public health, the PI wanted to speak to a variety of people across different sectors and levels of seniority who are working in the sector. This included those in government who are involved in policy making, to NGOs and individuals in the community such as mental health workers. Therefore, to further ascertain what has, and could be done to support children further (and what barriers there are to implementing related policies and programmes), an initial stakeholder map was created to help identify potential key respondents. This was used in conjunction with conversations with CREHPA to help to pre-identify individuals who have a knowledge base in relation to the topics the PI sought to investigate. Findings from Masefield, Msosa, Chinguwo and Grugel's (2021) study were considered in the engagement of key informants, to ensure inclusive and meaningful engagement in policy process.

Non-governmental organisations (NGOs), international non-governmental organisations (INGOs), government agencies, along with freelancers, academics, and any other

recommended stakeholders, whose focus was on improving the lives and wellbeing of children who had faced violence or abuse, or adult victims of DVA were contacted via email by CREHPA with initial information about the study and its aims, along with contact details of the PI and Research Associate from CREHPA ('the research team') to find out more information. The research team aimed to speak to organisations whose focus was on children and child welfare, and also those working with women affected by DVA to assess whether they had an awareness of how DVA affects children. The final section of the interview guide (Appendix J) used snowball sampling to ask the respondent if they had any recommendations on who should be interviewed as part of the research, and these recommended key informants were also contacted.

Initially, it was hoped that 25-30 in-depth interviews (IDIs) with key informants could be conducted, but this was not feasible given the limited time that the PI was able to spend in Nepal. However, this number was tentative, and after 21 interviews the research team felt that data saturation had been reached. The 21 key respondents were either from federal level government departments, INGOs, NGOs, or were other recommended stakeholders (such as academics or freelancers, referred to as 'independent' in the research). The interviews conducted are summarised in Table 7.1. To maintain confidentiality, all identifying information has been removed. All respondents were interviewed in a private location, and in 19 interviews there was one key informant. On two occasions, the organisation asked for more than one representative to be interviewed together⁶⁹. Respondents were from varying levels of seniority within the organisation, and included directors, programme managers, team leaders, legal officers, and psychosocial counsellors. To maintain confidentiality and avoid potential identification, the job title of each respondent has not been identified in Table 7.1.

⁶⁹ Reflections on the implications and dynamics of conducting interviews with multiple participants are discussed in Section 7.2.6.

Table 7.1 A Summary of Interviews Conducted

ID Number (IDI)	Organisation Type	Language of Interview	Gender of Respondent
1	NGO	English	Female
2	INGO	English	Female
3	Government	English and Nepali	Female
4	NGO	English	Male
5	Government	English and Nepali	Female
6	Independent	Nepali	Male
7	NGO	English	Male
8	INGO	English	Male
9	Independent	English	Male
10	NGO	Nepali	Male
11	NGO	English	Female
12	NGO	English	Female
13	NGO	English	1 Male, 1 Female
14	Independent	English	Male
15	NGO	English	Female
16	NGO	English	Female
17	NGO	English	Female
18	NGO	Nepali	1 Male, 2 Females
19	Independent	English	Female
20	INGO	English	Female
21	NGO	English and Nepali	Female

Due to the limited time that the PI was able to spend in Nepal (one month), the fact that this period was during the monsoon season, and because the research team had a desire to conduct the interviews face to face, all organisations were based in the Kathmandu Valley. However, this was not viewed as an issue, as many NGOs and INGOs are based in Kathmandu, and have partners or sub-locations outside of Kathmandu Valley. In the responses given, many respondents also referred to specific examples and scenarios outside of Kathmandu Valley, including specific challenges and considerations required when exploring this issue in other areas of Nepal.

7.2.4 Data Collection

All interviews were conducted at a location chosen by the respondent, where they felt comfortable expressing their views. In the majority of cases, this was in an office at their organisation, but in three cases the respondent instead chose a café, where the interview was conducted in a private area to ensure that the respondent could not be overheard. Respondents

were offered the participant information sheet and consent form in both English and Nepali and were told that they could speak in either language, or a combination – whatever they felt most comfortable doing. Throughout the data collection process, a Research Associate from CREHPA accompanied the PI, aiding in the recruitment of interviews, and conducting them when in Nepali. Prior to the interview commencing, respondents were given time to re-read the participant information sheet, sign the consent form, and ask any questions prior to the recording starting. The participant information sheet also contained sources of support, should the respondent find the interview distressing, and they were also reminded of their right to withdraw from the study. All respondents who agreed to be interviewed conducted the interview in full, and consented for their quotes to be used within the reports for this study.

Field notes were taken throughout the interviews, to aid with reflexivity and reflection (Deggs & Hernandezs, 2018). For interviews conducted in Nepali, CREHPA's Research Associate made notes in English for the PI so that there was shared understanding of the interview, so appropriate follow up questions could be asked. Throughout the interview process, the PI continued to have in-depth conversations with CREHPA to ensure that the respondents being interviewed, and the topics under consideration were appropriate given the cultural context and their understanding of the issues of DVA and child protection in Nepal. The questions and interview guide were also adapted based on CREHPA's feedback, to ensure that the topic was explored in a culturally appropriate and sensitive way. Principles of COREQ were considered and incorporated throughout the research process to assess the reporting quality of the study (Tong, Sainsbury & Craig, 2007).

To ensure confidentiality and to protect the respondents, the audio recordings contained no names or identifying information other than a numerical ID. During the fieldwork, the participant details were stored on a password protected laptop within an encrypted file, as were the audio recordings and transcripts. Following transcription, the recordings were deleted, and as per the Data Management plan, participant details will also be deleted for confidentiality once all research activities have been completed.

7.2.5 Data Analysis

Interviews conducted in Nepali were translated into English by colleagues from CREHPA, and all data collected transcribed as verbatim. Thematic analysis was performed by the PI following the six stage, iterative, and reflective approach outlined by Braun and Clarke (2006; 2021), illustrated in Figure 7.3. NVivo 14 (Lumivero, 2023) was used to assist in storing and sorting data for analysis.



Figure 7.3 The Six Stages of Reflexive Thematic Analysis (Braun & Clarke, 2021)

Initially, parent codes were determined based on the literature review, research questions, and interview guide, as well as through inductive insights gained from the transcripts. Three of the transcripts were coded independently by a member of the research team and were then compared and discussed, before the subsequent rounds of coding to enhance understanding, interpretation and reflexivity (Braun & Clarke, 2021). The subsequent rounds of coding involved a more detailed iterative process, leading to the final themes presented in Table 7.2. This iterative process of identifying and refining themes within and between transcripts and field notes allowed for key themes occurring across interviews to be clearly identified in order to meet the aims for the paper (Gibson & Brown, 2009). Braun and Clarke's (2021) ten core assumptions of reflexive thematic analysis were considered and incorporated throughout the research process. Given the interpretive nature of the analysis, a reflexive approach was also taken to consider the researcher's positionality and the broader research context. These reflections are discussed in the following section.

7.2.6 Reflexivity and Researcher Positionality

In line with Braun and Clarke's (2021) approach to reflexive thematic analysis, it is important to reflect on the role of the researcher and the broader context in which data were collected and interpreted. Therefore, this section will focus on reflexivity and researcher positionality.

This paper is underpinned by an interpretivist epistemology, which assumes that knowledge is co-constructed through social interaction and shaped by cultural, institutional, and interpersonal contexts (Holmes, 2020). This approach recognises that participants' understandings of childhood exposure to DVA are not fixed or universal, but shaped by their social roles, professional experiences, and broader socio-cultural settings. Consequently, the positionality of the researcher, and the dynamics of the research encounter, play a critical role in shaping both the collection and interpretation of the data.

The researcher is based in a high-income country and holds academic and professional training in psychology, including experience working as an Assistant Psychologist in clinical settings in the United Kingdom. This background informed the research design and initial focus on child and adolescent wellbeing and psychological impacts of DVA. At the same time, it also required ongoing reflection to avoid imposing Western, individualised frameworks of harm. The potential

for culturally embedded assumptions was recognised from the outset of the research and helped inform the collaborative design of interview materials with the support of the local partner organisation, the Centre for Research on Environment Health and Population Activities (CREHPA).

All interviews were conducted in-person in Nepal with the support of a local translator where required, depending on participant preference and language needs. While this was essential for ethical and inclusive engagement, it introduced additional interpretive layers that influenced how participants' perspectives were understood and represented. Despite efforts to clarify terminology and maintain authenticity in translation, some nuance may have been lost or altered in the process. These dynamics were carefully considered during transcription and analysis, recognising that meaning was co-constructed during the interviews, with the translator playing an active role in helping participants understand the questions and convey their responses.

In addition, the interviews varied in format, with most conducted individually as intended, whilst others were in small groups. Group interviews⁷⁰ provided insights into collective views and institutional practices, but may have been affected by professional hierarchies or norms (e.g., gendered dynamics or role seniority). Individual interviews offered greater depth and personal reflection, though were more constrained by time and rapport. These contextual factors were documented in memos and considered during the analytic process to avoid overstating agreement in group settings and to ensure that more tentative or divergent perspectives were also taken into account.

Reflexive practices were embedded throughout the study. The researcher kept detailed field notes and analytic memos, recorded impressions during and after the interviews, and reflected regularly on personal assumptions and emerging challenges. One transcript was independently coded by a second researcher, with follow-up discussions to deepen interpretation and enhance transparency. These practices contributed to a more rigorous and transparent analytic process, in line with the principles of reflexive thematic analysis (Braun & Clarke, 2021).

These reflexive practices, alongside the interpretivist stance underpinning the research, informed how meaning was constructed and how themes were developed and interpreted. The thematic analysis revealed several important insights into how childhood exposure to DVA is understood and addressed in Nepal (presented in Table 7.2). The four main themes identified in the analysis, along with their corresponding subthemes, reflect the range of challenges, gaps,

⁷⁰ Although not originally planned, two organisations requested that more than one representative be interviewed together.

and potential interventions highlighted by the key informants. In the following Results section, these themes are explored in depth, with direct quotes from the interviews used to illustrate the perspectives and experiences of the respondents. The presentation of the results follows the structure of the themes outlined in the table, with each theme representing a critical dimension of the data related to childhood exposure to DVA in Nepal.

7.3 Thematic Findings

This section presents the key findings from the interviews conducted with 21 key informants working in the fields of child protection and DVA in Nepal. Using Braun and Clarke's thematic analysis approach (Braun & Clarke, 2006; 2021), outlined above in Section 7.2, four key themes emerged, each capturing distinct aspects of understanding, barriers, support systems, and future potential strategies related to childhood exposure to DVA in Nepal. Each theme is further broken down into subthemes that address specific dimensions of the data. Table 7.2 illustrates the themes and subthemes identified during thematic analysis, along with providing a definition for each subtheme. This table serves as an overview of the key findings, which will be explored in greater detail in this section.

Table 7.2 Themes and subthemes identified during thematic analysis

Theme	Subtheme	Definition
1. Understanding and Awareness of Childhood Exposure to DVA	1.1 (Mis)understanding and Confusion	This subtheme captures instances where respondents demonstrated confusion between exposure to DVA and child abuse. It reflects a lack of clarity in distinguishing childhood exposure to DVA from other forms of violence against children, leading to misunderstandings about the nature and effects of exposure.
	1.2 Lack of Awareness Among Policymakers	This subtheme addresses the lack of understanding and awareness among policymakers regarding childhood exposure to DVA. It includes the absence of specific policies for childhood exposure to DVA and a general failure to recognise the unique needs of children exposed to such violence.
	1.3 Cultural and Societal Influence	This subtheme highlights how cultural norms, societal views, and family structures in Nepal influence both the understanding of childhood exposure to DVA and the response to it. Issues such as patriarchy, stigma, and traditional family hierarchies shape attitudes towards DVA and limit the recognition of children's specific vulnerabilities.
2. Barriers to Providing and Accessing Support for Children Exposed to DVA	2.1 Awareness and Knowledge Gaps	This subtheme focuses on the lack of awareness among children about the support systems available to them and their rights – generally, not just regarding childhood exposure to DVA. It also includes how community dynamics, parental involvement, and societal attitudes hinder children's ability to seek help when exposed to DVA.

Theme	Subtheme	Definition
	2.2 Systemic and Organisational Barriers	This subtheme encompasses institutional challenges that prevent effective support for children, including the duplication of services by NGOs, short-term support structures, and limited resources or funding. Again, some of these barriers were not specific to exposure. It also highlights how organisational mandates may focus on adult victims of DVA, often overlooking the needs of children.
	2.3 Accessibility Issues for Support Services	This subtheme covers the logistical and systemic barriers that make it difficult for children to access support. Factors include the geographical inaccessibility of services, especially in rural areas, and exclusion from shelters or services primarily designed for adult victims. Socioeconomic status and poverty also contribute to limited access for vulnerable children.
3. Existing Support and Resources	3.1 Current Resources and Interventions	This subtheme identifies the existing support structures available for children, such as helplines and NGO networks, and the role these resources play in providing some form of assistance. However, the subtheme also acknowledges that these interventions are often insufficient or not child-centred.
	3.2 Institutional Collaboration and Challenges	This subtheme addresses the importance of collaboration between different sectors (government, NGOs, INGOs, schools) in providing support to children exposed to DVA. It also highlights the challenges in ensuring effective coordination and avoiding duplication of efforts, which often undermine the efficiency of existing interventions.
	3.3 Perceived Responsibility for Policy, Provision, and Support	This subtheme explores the varying opinions on who holds responsibility for addressing the issues of childhood exposure to DVA. It examines the perceptions that the obligation mainly lies with government, or if it is a shared responsibility amongst all stakeholders, including government, NGOs, and the community. The subtheme also discusses the implications of these perceptions on policy implementation, resource allocation, and the effectiveness of support systems for affected children.
4. Future Strategies and Interventions	4.1 Empowerment and Education	This subtheme emphasises the importance of educating children about their rights and empowering them to recognise and report violence. It reflects the need for capacity-building initiatives to help children develop the skills and knowledge to navigate complex situations like exposure to DVA.
	4.2 Multilevel Interventions	This subtheme reflects the need for interventions at multiple levels – individual, family, community, and societal. It includes efforts such as family counselling, community-based programs, and societal campaigns that aim to address DVA holistically and prevent childhood exposure.
	4.3 Policy and Structural Changes	This subtheme highlights the need for systemic reforms, including changes to policies related to childhood exposure to DVA, the strengthening of existing support systems, and the introduction of an independent oversight body (such as an ombudsperson) to ensure children's rights are protected. It underscores the role of government and societal responsibility in creating long-term solutions for children exposed to DVA.

In the following sections, the major themes identified in the data are discussed. Each theme is supported by illustrative quotes from the respondents, illustrating their perspectives and experiences. These themes are organised to reflect the key areas of inquiry of the interview (see Appendix J for the interview guide): (1) the understanding and awareness of childhood exposure to DVA, (2) barriers to providing and accessing support for children exposed to DVA, (3) existing support and resources, and (4) future strategies and interventions. The results provide a comprehensive overview of the current state of support for children exposed to DVA in Nepal, and suggests pathways for policy reform and improved interventions for children exposed.

Theme 1: Understanding and Awareness of Childhood Exposure to DVA

This theme explores how key informants understand the concept of childhood exposure to DVA and how this understanding (or misunderstanding) shapes the responses to the issue in Nepal. A critical finding is the widespread confusion between childhood exposure to DVA and other forms of child abuse, which points to a lack of conceptual clarity among both policymakers and practitioners. Additionally, respondents frequently emphasised the broader cultural and societal factors that contribute to this misunderstanding, such as entrenched patriarchal values and traditional family structures. These factors hinder the recognition of the unique impact of DVA on children.

The following subthemes delve deeper into specific aspects of this theme. Subtheme 1.1 addresses the common misunderstandings and confusion around childhood exposure to DVA, while Subtheme 1.2 highlights the lack of awareness among policymakers. Finally, Subtheme 1.3 examines how cultural and societal influences, including patriarchal norms and stigma, further complicate the recognition and response to childhood exposure to DVA in Nepal.

Subtheme 1.1: (Mis)understanding and Confusion

One of the clearest findings from the interviews was the widespread confusion and conflation between childhood exposure to DVA and other forms of violence, particularly direct experiences of child abuse. Many respondents struggled to differentiate between these two forms of harm, despite being provided with a definition of childhood exposure to DVA during the interview process. The lack of conceptual clarity has significant implications for recognition, prevention, and intervention for childhood exposure to DVA.

Several respondents responded to questions about childhood exposure to DVA by describing physical abuse directly inflicted on a child⁷¹, often by parents, guardians, or older family members:

“Their rights are violated by the adults ... Hence, at home, they are abused by guardians.”

IDI 03 (Government)

“It is of course physical abuse, either in domestic or in the school corporal punishment.”

IDI 20 (INGO)

These responses suggest that childhood exposure to DVA is often considered under general child abuse, without clear recognition of its unique impact. Some respondents continued to refer to child abuse when answering other questions within the interview, despite being provided with the definition of exposure to DVA used within the study.

This could, in part, be due to the fact that under Nepal’s Domestic Violence (Crime and Punishment) Act (2009/2066), DVA is considered any form of violence “by any person to the other person with whom he has a family relationship” (Appendix I.3). The Act goes on to state that “domestic relationship” includes anyone in a household, meaning that children could also be a victim of DVA. Therefore, there is tension between the definition of DVA used within this paper and thesis, and that of the Domestic Violence (Crime and Punishment) Act (2009/2066). The term “child-based domestic violence” was commonly used by respondents, reinforcing this ambiguity.

Even when respondents acknowledged that DVA between adults might place children in vulnerable situations (as they could become a direct victim of child abuse), they often failed to identify the indirect harm of childhood exposure to DVA :

“If it's between the adults then there could be the chances of violence, no? Yes, definitely there could be the chances of violence, yeah. It's a vulnerable situation for me.”

IDI 16 (NGO)

A few respondents from both INGO, NGO, and independent groups, however, did clearly understand childhood exposure to DVA as a distinct experience, even when the child is not the direct victim of violence:

⁷¹ Quite often, respondents would use the phrase “child-based domestic violence”, which under the definition used within this thesis, would be considered child abuse.

“They are now bound to observe, witness and face whatever is happening inside their household. And that means they are exposed to the domestic violence.”

IDI 14 (Independent)

Some also recognised the broader societal tendency to normalise DVA and overlook its effects on children in Nepal:

“The concept is...not so much heard here [in Nepal] ... the adult don't have any realisation that their behaviour is affecting the children.”

IDI 15 (NGO)

“This is hardly recognised or acknowledged issues. In my experience, you are the first person who is asking these questions, that how children are affected by the violence among adults.”

IDI 14 (Independent)

Several respondents became reflective during the interviews, sharing personal experiences of exposure to DVA either when they were a child, or as parents observing the impact of parental conflict on their own their children's:

“When I was a child, I used to see the fight between my mother and father. My father used to beat my mother ... I used to feel so low and I used to feel so weak ... that kind of anger and fear, that used to come a lot on me.”

IDI 15 (NGO)

“We all have grown up seeing violence and the majority of Nepali people have grown up seeing violence in their home.”

IDI 19 (Independent)

These moments of reflection were powerful, and alongside quotes about exposure to DVA being “normal” (IDI 11, NGO), suggest that many people have been exposed to DVA in their childhood, even if the concept is not widely understood or labelled as such in policy or practice.

Finally, some respondents recognised that childhood exposure to DVA could have both short- and long-term negative outcomes, including the potential for intergenerational transmission of violence (Widom, 1989), and the fact that the outcomes of exposure do not just affect an individual, but have the capacity to affect all ecological domains:

“Why we are having this kind of circle of violence continue? It's because people have grown up normalising violence as a part of the relationship. It has become normalised. It's a part of their childhood memory.”

IDI 19 (Independent)

Overall, the findings from this subtheme reveal a critical gap in conceptual understanding of childhood exposure to DVA among professionals and policymakers in Nepal. While some participants could articulate a definition aligned with international literature, many conflated childhood exposure to DVA with other forms of child abuse, or overlooked indirect forms of exposure altogether. This has practical implications for how interventions are designed and for whether children's needs are fully recognised in policy and service delivery. These issues are particularly acute at the policy level, which is explored further in Subtheme 1.2.

Subtheme 1.2: Lack of Awareness Among Policymakers

In addition to the conceptual confusion highlighted in Subtheme 1.1, many respondents described a general lack of awareness about childhood exposure to DVA among policymakers in Nepal. This was reflected in the absence of specific laws or frameworks recognising the issue, as well as perceived lack of political will or understanding to address it.

Several respondents confirmed that no current policy in Nepal explicitly acknowledges children as victims when exposed to DVA between adults. Whilst this was already noted during the review of policies (see Appendix I.3), respondents also described this absence as a form of systemic neglect:

“Children ... have been always ignored somewhat. They have been always neglected in some part. They have not been addressed how this should be addressed, how the act, how the regulations, how the child protection policy have been developed, and they have not been addressed accordingly. They have always been neglected at some point. Every kind of procedures and any kind of activities, they have been somewhere neglected.”

IDI 11 (NGO)

“There should be a holistic policy that covers the policies on domestic violence and protection of children from domestic violence as well.”

IDI 01 (NGO)

However, some respondents also described how the existing legislative frameworks exist to protect women from DVA and children from harm more broadly, such as the Domestic Violence (Crime and Punishment) Act (2009/2066) and the Act Relating to Children (2018/2075), but that

these do not intersect or work together coherently, leaving gaps in both recognition and response:

“There is no connection between the laws ... The policies don't always make up the gap.”

IDI 12 (NGO)

Others noted that even when laws exist, they are rarely implemented or enforced⁷². This was described as a structural challenge across all levels of government, and was a theme mentioned in all 21 interviews:

“Still ... very sensitive [cases] ... should be revised in regulations, in policies, in acts, but still it's been ignored, it's been neglected from the government level.”

IDI 11 (NGO)

In addition, some respondents felt that existing policies are outdated and did not reflect the evolving nature of violence or the changing needs of children. They expressed concern that laws had not kept pace with the realities and experiences faced by children exposed to DVA, or with broader societal changes:

“Even the policy, the existing policies are very, I think, obsolete now because the children have changed over time. And the type of violence, like you know, it's growing so much, the fast speed, but the law remains the same. It needs to be transformed according to what is happening.”

IDI 13 (NGO)

This perceived gap between policy and lived experience was seen as a barrier to effective recognition and response, and further reinforces the need for updated legislation and increased understanding among policymakers.

The capacity of policymakers themselves was also raised. Several respondents noted that there are few experts in child protection within governmental roles:

“The government has very few people who have worked with children ... they lack experts in this field.”

IDI 18 (NGO)

⁷² Issues with policy implementation is further explored in the context of the barrier that this poses to providing and accessing support in Subtheme 2.2.

There was also concern that gaps in policy awareness were particularly acute at the local level. Multiple participants noted that newly elected or appointed local officials often lacked understanding of child protection frameworks and were unfamiliar with federal policies:

“The local governments are also not aware about the policies formulated by the federal government ... They are not fully aware about child protection issues.”

IDI 01 (NGO)

This lack of awareness was linked to weak implementation. Some respondents believed that the lack of awareness amongst policymakers is due to the motivations within governments to include a certain topic. For example, several respondents described a top-down policy-process in which legislation may be adopted to align with international obligations (rather than out of genuine commitment), and therefore is rarely operationalised in ways that support children in practice:

“They make law because they are forced to make the law by ... international agency. It's not [them] feeling that they should have to bring law and protect women So that is so much necessary to work from a very grounding level.”

IDI 15 (NGO)

“The government attends different programs and signs the treaties. However, they have not done any work for the women and children.”

IDI 18 (NGO)

Whereas some felt that poor implementation stemmed from a lack of political will and technical expertise:

“How the government will implement unless and until they know about it? That's important. You know, like, especially the local government, they need to understand the child rights, why is it important ... They always say that we have a budget lacking, but they have a budget of everything, but they don't have a budget for anything related to children.”

IDI 20 (INGO)

Overall, this subtheme highlights an absence of awareness amongst policymakers, along with a gap in political and institutional recognition of childhood exposure to DVA. Respondents described a system where laws are outdated, fragmented, or poorly implemented, and where children's needs are not prioritised. This lack of awareness has tangible implications and consequences, as without formal policy recognition, there are no coordinated or sustainable

support systems in place for children exposed to DVA. These structural barriers are explored further in Subtheme 2.2.

Subtheme 1.3: Cultural and Societal Influence

Beyond conceptual confusion and limited policy awareness, cultural and societal norms play a significant role in shaping how childhood exposure to DVA is understood (and often overlooked) in Nepal. Deeply embedded patriarchal values, traditional family hierarchies, and societal attitudes towards children all contribute to a limited recognition of childhood exposure to DVA between adults.

A recurring theme in interviews was that violence against women and children is normalised across many settings in Nepal⁷³. Respondents frequently described how both physical and emotional abuse occur not only in the home, but also in schools and communities:

“The multi-indicator cluster survey conducted by UNICEF with Nepal government it shows that 82% of children face violence, physical or and humiliating punishment.. in the school and home, both settings.”

IDI 08 (INGO)

While respondents were discussing childhood exposure to DVA, many broadened their responses to include related issues such as Chhaupadi, school corporal punishment, caste-based violence, and lack of safety for girls within families:

“There are problems related to Chhaupadi, parents not allowing their daughters to go to school, and safety concerns of girls from their fathers, brothers, and other family members. Women aren't safe within their own families; how can they be safe anywhere else?”

IDI 18 (NGO)

These reflections help contextualise the broader range of issues which some respondents considered under “domestic violence and abuse”, and the potential spectrum of violence and abuse across a child’s life. In addition, it provides information on the cultural and societal context upon which this study is based, and gives some insight and understanding of some of the additional challenges that professional and policymakers in Nepal are having to consider when prioritising policy and provision. It also demonstrates that despite some harmful practices

⁷³ Those most commonly mentioned include: caste-based violence and discrimination; Chhaupadi; child and sex trafficking; child labour and labour exploitation; child marriage; child sexual abuse; corporal punishment; cyber bullying; dowry-related violence forced work in the entertainment sector; online sexual exploitation of children; sexual exploitation; sexual violence; violence perpetrated by teachers at school; and violence within childcare homes and orphanages.

being illegal (e.g., Chhaupadi, caste-based discrimination, corporal punishment in schools), these forms of violence and abuse are still prevalent amongst society.

DVA itself (between adults) was seen as a prevalent yet poorly acknowledged issue in practice. Respondents emphasised that abuse within relationships is often minimised, justified, or concealed within Nepal:

“Instances of domestic violence are too prevalent ... most cases of domestic violence haven't been registered because of stigma and other social situations.”

IDI 03 (Government)

“People just think it so and take it so easily that yeah, it's a normal thing. Like the husband can beat his wife or husband can say something to his wife and the women have to accept it. So that kind of like feeling is there all the time. Being a woman I have to accept that much.”

IDI 15 (NGO)

These perceptions intersect with dominant social views about women, marriage, and family harmony, which can discourage victims from reporting or seeking help (an important consideration when exploring childhood exposure to DVA in Nepali society):

“A large number of women believe that the husband has the right to beat a wife ... they think it's a normalised thing.”

IDI 13 (NGO)

“That is where the Nepali society is. It's [domestic violence] an individual woman's problem. It is caused because of her individual problem and the effect is also her individual problem.”

IDI 19 (Independent)

This acceptance of violence within the home has implications for how childhood exposure to DVA is understood. Family is often viewed as a private, sacred space in Nepal, making it difficult to acknowledge harm occurring within it, especially when it affects children indirectly⁷⁴.

Another cultural barrier identified was how children themselves are viewed within Nepali society. Respondents described children as being seen more as dependents or property, rather than as rights-holders:

⁷⁴ How this specifically links to childhood exposure to DVA as a barrier for children seeking help is explored in Subtheme 2.2.

“No one sees children as a human being, it's just like ... they are my property. And when you feel like take them as a property you cannot like think of giving them their rights.”

IDI 15 (NGO)

These views contribute to a lack of space for children's voices and reinforce their vulnerability. They also help explain why childhood exposure to DVA has not gained recognition as a distinct policy or service priority.

The cultural and societal elements discussed within this subtheme clearly influence the understanding and awareness of childhood exposure to DVA, not only amongst the respondents (who due to their work, will likely have an enhanced understanding of child protection or DVA issues compared to the general population), but across Nepali society more broadly. From the multitude of threats children may face, which compete for attention in to policy and practice, to the way in which DVA and children themselves are perceived, these contextual factors undoubtedly influence how childhood exposure to DVA is recognised and prioritised. These are important considerations when exploring the issue and developing effective responses.

Theme 1 highlights how understanding of childhood exposure to DVA is shaped by confusion and cultural influences, further compounded by structural and practical barriers. These factors collectively prevent children from accessing the support they need. The next theme explores these barriers, ranging from knowledge gaps to systemic challenges, that hinder the effectiveness of support services for children exposed to DVA.

Theme 2: Barriers to Providing and Accessing Support

Despite the limited awareness of childhood exposure to DVA in Nepal, it is clear that children who are exposed DVA face significant barriers in accessing the support they need. These barriers exist at multiple levels, from individual knowledge gaps to systemic institutional failures, and are compounded by wider cultural and societal factors outlined in Theme 1. A lack of awareness among children and families regarding available services, coupled with logistical and structural challenges, means that many children do not receive the support they require.

The following subthemes examine the key barriers to both providing and accessing support for children exposed to DVA in Nepal. Subtheme 2.1 explores the lack of awareness and knowledge of childhood exposure to DVA among families, professionals, and communities, which limits recognition and response. Subtheme 2.2 considers systemic and organisational constraints, including limited funding, poor implementation, and a lack of trained personnel. Finally, Subtheme 2.3 focuses on accessibility challenges, particularly for children in rural or

marginalised communities, where geographical, social, and economic factors further hinder access to support.

Subtheme 2.1: Awareness and Knowledge Gaps Amongst Children

A major barrier to accessing support for children exposed to DVA is a fundamental lack of awareness. Many children (and their families) are unaware of their rights or the services available to them, which prevents them from seeking help. This issue is shaped by broader societal norms around children's roles and status, as highlighted in Subtheme 1.3, where one respondent noted that "no one sees children as a human being" (IDI 15, NGO) in Nepali society.

Several respondents described how children in Nepal are not taught about their rights or the systems in place to support them:

"I think first of all the children they don't know how the Nepalese government law they provide, what type of the service for them, because they don't have knowledge about that right? ... a barrier children face is partly understanding."

IDI 04 (NGO)

This lack of awareness is shaped by broader disconnection between individuals and the state. As one respondent explained, children are rarely engaged with government systems or civic processes::

"We are not that much state-linked citizens ... Like even up to 18 years, hardly children know where is their local government. They hardly know how to make their citizenship identity ... They are not aware of all these systems."

IDI 14 (Independent)

These gaps may be especially pronounced in rural areas, where both awareness and service provision are limited:

"The children and women who live in the rural areas are not aware of these policies and don't know how they can share their sufferings and seek help from the concerned agencies."

IDI 03 (Government)

As a result, children may internalise the belief that seeking help is either too futile or risky:

"They think why should I go outside and then tell people and seek help? If I am not getting adequate support or if I am not assured that I will get justice. So instead of that, let me handle my problem by myself."

IDI 14 (Independent)

This is particularly complex when the perpetrator of violence is a parent, as this is a dynamic which goes against prevailing views of children and their relationship with their family in Nepal (Subtheme 1.3):

“Children don’t know how to seek help, or how to protect themselves from their parents because parents are their primary guardians. They don’t view their parents as threats. They were never taught to.”

IDI 03 (Government)

Even when children are supported to understand their rights, exercising those rights can be difficult:

“So mostly like the children though they understand their rights it's quite hard for them to like seek it from their parents, from their guardians and from the people in the community.”

IDI 15 (NGO)

Overall, this subtheme highlights how a lack of awareness amongst children about their rights, the systems available to support them, and how to seek help, creates a significant barrier to accessing support. These gaps are further complicated by cultural views of children, family and authority within Nepali society. The importance of addressing this through empowerment and education is discussed further in Subtheme 4.1.

Subtheme 2.2: Systemic and Organisational Barriers

While knowledge gaps are a critical barrier, systemic and organisational challenges also play a significant role in limiting children’s access to support services.

Respondents described how policies and systems designed to support children affected by violence are not child-centred and lack meaningful engagement with children’s experiences or needs.

Some respondents felt that this was partly due to a lack of child protection expertise within government bodies:

“They [the government] are not so sensitive for child issues. They are ignoring the child voice.”

IDI 11 (NGO)

“[The government] organise programs ... only to utilise the budget. They don't try to understand the feelings and needs of children.”

IDI 18 (NGO)

Others pointed out that government policies are sometimes developed without consultation with child protection specialists, leading to unintended harm:

“There is a policy ... girls who don't have parents are not allowed to stay in the organisation but should stay in their relative's house This leads to more violence against those children. The government has just been conducting programs without proper plans and policies for children.”

IDI 18 (NGO)

Nepal's transition to a federal system⁷⁵ was also identified as a structural barrier. Some respondents noted that previously functioning local committees⁷⁶ had ceased to operate, and new agencies lacked clarity in their mandates:

“Earlier it was better coordinated, but ... during the Federation, we have created new agencies. And there's no clarity among these agencies about their roles and responsibilities that has also affected in this coordination thing. Because they are new, and they don't know their limitations. They don't know their responsibility.”

IDI 13 (Independent)

Implementation was repeatedly raised as a barrier in all 21 interviews. While laws exist on paper, they are not consistently applied:

“There's the Domestic Violence Act, adopted by the government in 2009; we have Children Act and Regulation. Additionally, there are also provisions for domestic violence where the government should provide free treatment and lawyers to the needy in order to seek justice. However, the implementation is very poor.”

IDI 03 (Government)

“There is a policy that talks about child rights, they have defined it very clearly, they even have the guideline and the framework. The major part is the implementation part. It's not happening.”

IDI 20 (INGO)

⁷⁵ Further information on the country's 2015 restructure from a unitary state to a three-tier federal system can be found in Section 7.1.2.2.

⁷⁶ Whilst the specific example given in this case related to child trafficking, the respondent clarified afterwards that other local child committees, some of which deal with violence against children are also no longer working within the new government structure.

Implementation is further hindered by confusion about who is responsible for delivering services, especially at local levels:

“Who are the legal implementing body? Who is doing the legal implement? And what is their priority?”

IDI 04 (NGO)

“There is no agency to monitor the performance of this local government.”

IDI 08, INGO

Even policies intended to ensure local child protection services often go unfulfilled:

“The Act Relating to Children, 2018, has provisioned every local government must have a roster of local child psychologists or social workers ... I think less than 10 municipalities have done that, out of 753.”

IDI 14 (Independent)

Whilst these structures are not to do with childhood exposure to DVA, these illustrative quotes demonstrate how the lack of implementation has a direct impact on the support available to children who are facing violence or living in families where they are exposed to DVA. These particular quotes also touch on the unequal distribution of support services for children, which is explored in further detail in Subtheme 2.3.

Respondents also noted the absence of standardised national referral mechanisms:

“The formal referral mechanism ... is not established. And that has been very much challenging ... One formal national level refer mechanism should be there.”

IDI 13 (NGO)

“What I've heard from children ... is like, if I take up the courage and go [and seek help from the state systems] ... the police or the person will say, oh, we are not that right person or authority, ... and they give up.”

IDI 12 (NGO)

In addition, there was a widespread view that existing systems lack the resources to provide meaningful support. This was raised by all organisation types:

“The NGOs and the INGOs we are supporting for the temporary, right? ... We are doing just humanitarian support. That is not long-lasting.”

IDI 04 (NGO)

“It is very, very difficult to get funding for shelter program, because it’s a long-term program ... It’s not a project, you know.”

IDI 13 (NGO)

NGO respondents described being caught between insufficient government support and short-term donor expectations, often leading to short-term and unsustainable interventions:

“If we refer cases to NCRC [National Child Rights Council], they say that, please don’t refer just the cases, please come with the resources as well, come with the fund as well.”

IDI 01 (NGO)

“They don’t have human resources, particularly in remote or rural area ... Who is able to provide those services?”

IDI 14 (Independent)

Some respondents described the impact that scarcity of resources is having on NGOs, as competition for funding hinders collaboration:

“Funding competition creates some sort of gaps on the cooperation among them.”

IDI 14 (Independent)

Finally, respondents described how societal stigma and cultural attitudes act as barriers to both reporting and support-seeking. These intersect with systemic barriers to further isolate children:

“I think stigma. Stigma is the major barrier.”

IDI 01 (NGO)

“It’s beginning from the family, then after it comes to the society. They don’t let their children to come forward and speak about the violence they have been facing.”

IDI 11 (NGO)

Taken together, these findings highlight how children exposed to DVA are let down by systems that lack coordination, resources, and long-term planning. Structural barriers are deeply embedded and cannot be addressed by policy alone. These systemic issues are compounded by logistical access problems, which are explored in more detail in Subtheme 2.3.

Subtheme 2.3: Accessibility Issues for Support Services

Another important barrier is the logistical and geographical inaccessibility of services, particularly in rural or marginalised areas. Many children, especially those in remote regions or from disadvantaged groups, face significant challenges in accessing the limited support systems that do exist. This subtheme explores how geography, poverty, infrastructure, and socio-economic status create unequal access to support services for children exposed to DVA.

Across interviews, respondents acknowledged that services for children are not widely available or accessible:

“Although they are formed, the system and mechanism are formed, but it is not accessible to the children and beneficiaries. So that should be accessible.”

IDI 16 (Independent)

“[Services] are running ... in a very limited area. It's not available like in every district or in every area.”

IDI 19 (Independent)

Several respondents described a centralisation of services around Kathmandu and larger cities, limiting access for children in rural or remote areas:

“Actually, we do not have a child protection system properly existing in the local levels. So the services is centralised in Kathmandu or in the headquarter of the states or big municipalities.”

IDI 09 (Independent)

“Facilities provided by the government and NGOs are centralised, though ... People from the remote areas of Nepal still don't have access to services.”

IDI 17 (NGO)

Geography itself was frequently cited as a structural barrier:

“If you see the geographical context of Nepal, even one helpline in one municipality is not enough. You have to walk for a day to reach your local government office or local police stations.”

IDI 14 (Independent)

This is particularly problematic considering that approximately 79% of Nepal's population live in rural areas (Singh Shah, 2023)⁷⁷. The challenge is not only service availability, but also communication infrastructure such as helplines, which were frequently cited by respondents as the sources of support:

“In Karnali, in some rural areas there is no internet, even mobile services, ... 1098⁷⁸ doesn't work ... OCMC, One Step Crisis Management Center ... is also located in district headquarters, not in all of the municipalities.”

IDI 08 (INGO)

“Children who are living in villages ... do not have access to the internet or media ... there is a lot of communication and information gap.”

IDI 03 (Government)

Even where services are technically present, government and justice mechanisms may be absent or inactive:

“There is no presence of government in some areas and there is no support for the victims.”

IDI 18 (NGO)

Respondents also noted how inequality within communities affects access. Children from more privileged or vocal families may have more opportunity to access, and engage with support services:

“The access is also for those children who speak more, who are from a good family, so they have more access. So not all the children have access.”

IDI 15 (NGO)

In some cases due to funding, NGOs could not meet the specific needs of marginalised groups, including children with disabilities:

⁷⁷ In addition, when speaking about DVA in Nepal, some respondents highlighted that children in rural areas may be at a heightened risk of exploitation for trafficking, e.g., “There is a big issue of violence in remote areas as well. There is exploitation of children in those areas.” (IDI 18, INGO).

⁷⁸ The toll-free number 1098 is the Child Helpline in Nepal, run by an NGO and supported by the government. The helpline strives “strive to create a safe environment where every child is shielded from abuse, exploitation, and neglect”. Childhood exposure to DVA is not explicitly listed as one of their priority issues, but their website says that the helpline can be utilised by “Children experiencing violence, torture, discrimination, labor exploitation, and abuses”, “Children requiring psychosocial counselling”, “Children affected by violence and conflict”, and “Children in challenging circumstances and at risk” – all elements which childhood exposure to DVA could come under (Child Workers in Nepal Concerned Centre (CWIN-Nepal, 2024).

“But we are unable to provide the services to the children with disability, they need the service with mental status, we are unable to provide.”

IDI 13 (NGO)

Respondents highlighted how the specific nature of childhood exposure to DVA makes accessing support particularly difficult. For example, children may fear that disclosing abuse will escalate the violence that their victimised parent experiences:

“If he or she happens to complain about it, and if the parents or the adults come to know about it, then the more violence will develop.”

IDI 20 (INGO)

Others described the difficulty of engaging children in environments where abuse is common and often hidden within families:

“It was very hard to reach out to them first ... all of those abusers are already there in the family and community itself.”

IDI 12 (NGO)

In practice, children often lack the agency to seek help independently, and usually rely on adults to advocate on their behalf:

“We have never had a child reporting something by themselves ... The children don't have that sort of agency in Nepal to report their cases.”

IDI 13 (NGO)

Legal requirements further restrict access. One government official described how children must obtain written consent from a guardian to attend some support services, something that may not be possible when a guardian is the perpetrator, as this could put the child or victimised parent at a heightened risk of violence:

“If children who are minors want to attend a service or go to the court or a service centre, they have to take guardianship ... It is a type of written consent that comes from their guardians ... It poses a barrier ... The parents are supposed to be the guardians and should try and help their children by seeking such services. But they don't because the parents themselves are making mistakes.”

IDI 03 (Government)

Finally, some respondents noted that children are often excluded from DVA shelters:

“Often children are not allowed ... in the safe houses together with the mother ... Where is the child to go? It has to be a safe place for both women and the children.”

IDI 19 (Independent)

However, there were early signs of change:

“We had ... the first national shelter conference ... where inclusivity was also discussed ... potential children inclusivity in these shelters was also discussed very extensively.”

IDI 13 (NGO)

In summary, accessibility issues are not only shaped by geography and infrastructure, but also by societal norms, legal requirements, and the specific dynamics of childhood exposure to DVA. Children may be unable to access services due to physical distance, lack of information, or the need for guardian consent – factors which are particularly problematic when the guardian is the perpetrator of violence. These challenges are further compounded by the perception of children as dependents rather than rights-holders, and by services that often fail to recognise the indirect forms of harm experienced by children. Taken together, these barriers create a complex and unequal system, in which many children (particularly those living in rural or marginalised communities) are unable to access the support they need.

Theme 2 illustrates how a range of barriers, including limited awareness, systemic constraints, and accessibility challenges, restrict children’s ability to receive timely and appropriate support. Whilst these barriers limit access, it is also important to consider the availability and nature of the support that does exist. The next theme explores existing services and interventions for children exposed to DVA, and how these are perceived and experienced by policymakers and professionals working in the field.

Theme 3: Existing Support and Resources

This theme explores the existing support systems and resources currently available to children exposed to DVA in Nepal. Although some services exist, such as helplines and NGO-led interventions, these are often fragmented, short-term, and not sufficiently child-centred. Respondents consistently emphasised the importance of strengthening support structures, whilst also highlighting limitations including weak government engagement, poor inter-agency collaboration, and significant resource constraints.

The following subthemes examine the nature and effectiveness of existing services, and the barriers that limit their impact. Subtheme 3.1 outlines current interventions, such as child helplines, shelters, and NGO activities, while assessing the extent to which they address the

needs of children exposed to DVA. Subtheme 3.2 explores the challenges of institutional collaboration and coordination, which often results in duplication of efforts and fragmented service delivery. Finally, Subtheme 3.3 examines perceptions of responsibility for responding to childhood exposure to DVA, highlighting the tensions between government responsibility and the role of NGOs, as well as the need for shared, collective approaches.

Subtheme 3.1: Current Resources and Interventions

Although significant barriers exist, there are services currently available to children in Nepal, such as helplines and NGO-led support, that may offer assistance, even if not specifically designed for those children exposed to DVA. These services, however, are often constrained by limited resources, inconsistent implementation, and a lack of child-centred approaches. This subtheme explores the types of support available and assesses their relevance and effectiveness in addressing the needs of children exposed to DVA perpetrated between adults in their household.

Most respondents stated that there are no specific programmes or interventions that directly address childhood exposure to DVA in Nepal. One NGO respondent explained:

“I can say that there is not be any kind of program for such children, focusing on such children. And we have programs focusing only for children, but not like to those children who are exposed to domestic violence. So I should say that there are not enough programs.”

IDI 15 (NGO)

Others echoed this view, highlighting that while some support exists for children more generally, children exposed to DVA are often overlooked:

“Every kind of procedures and any kind of activities [for DVA], they [children] have been somewhere neglected.”

IDI 11 (NGO)

As one independent respondent noted, support for children exposed to DVA is rarely the primary focus, and is usually only considered incidentally:

“It’s just something that comes up as an issue among children receiving support for another issue.”

IDI 14 (Independent)

However, two NGOs described efforts to consider childhood exposure to DVA within their broader services. This included building children's perspectives into their programming, and providing shelter for at-risk children alongside non-abusing parents:

"We have children's centres and we are demarcated and sensitised on the issues. We implement women's training, child agency building, or children's perspectives in domestic violence or violence against women."

IDI 13 (NGO)

"We are taking the shelters in our safe house. There are 106 survivors. And among them, dependent children are 42 ... because they are also in risk."

IDI 11 (NGO)

However, this awareness appears to be inconsistent across (and within) sectors. As noted in Subtheme 2.3, several respondents believed that children were often excluded from safe houses, highlighting a disconnect between policy, practice, and perception, even amongst professionals working in the same field. This fragmentation underscores a wider issue: the lack of shared knowledge and consistent practices in addressing childhood exposure to DVA.

This knowledge gap was further illustrated by responses relating to one stop crisis management centres (OCMCs). Although these centres are written into Nepal's Domestic Violence (Crime and Punishment) Act (2009/2066), their remit is limited to adult survivors of physical or sexual violence. Nonetheless, several respondents incorrectly identified them as appropriate services for children, again indicating a lack of understanding about how children exposed to DVA are (or are not) currently supported.

Critiques of OCMCs were common, and several respondents highlighted that even when services are accessed, they often prioritise physical health over psychological or psychosocial recovery:

"Once the violence is reported ... they provide some medical treatment and all but the psychological, you know, healing the psychological impact is really challenging."

IDI 13 (NGO)

This lack of psychosocial care was frequently raised as a concern across multiple respondents and organisation types:

"We try to give the services related to physical health and all these things, but we avoid the issues of mental health. We are ignoring the issues even these days."

IDI 16 (NGO)

Respondents also raised concerns about the absence of child-centred practices in existing interventions. While some policy and support structures claim to include children, respondents reported that in reality, most interventions were not designed with children's specific needs in mind:

"I mean, dealing with the adult and dealing with the children is a completely different thing ... So the mechanism is not there as far as we know to deal with the children."

IDI 20 (INGO)

In the absence of formal services, several respondents recommended community-based alternatives such as children's clubs or child networks. Although not explicitly intended to address childhood exposure to DVA, these were seen as safe spaces where children could build agency or express themselves:

"We have child agency, child clubs, child networks. Those children are very active and they are promoting all these, fighting against all sort of these harmful practices of the community. So these children are the change-maker for us as well."

IDI 20 (INGO)

Similarly, whilst not specific to childhood exposure to DVA, child helplines were frequently cited as a support mechanism, although respondents acknowledged that these are limited in reach, especially in rural areas:

"The child helpline is one of the effective child protection mechanisms in the countries, which is supporting for the children who are victimised."

IDI 09 (Independent)

Some respondents also described how support for children exposed to DVA may be provided indirectly through parental counselling offered to adult survivors of DVA:

"Parental counselling also, then how they have to take care of their children ... because somehow, directly, indirectly ... they are affected by those domestic violence ... We mainly focus on how the caretakers should address the child's safety ... physical safety, educational, economic, all kinds of safety."

IDI 11 (NGO)

Overall, while some existing services could potentially be adapted to address childhood exposure to DVA, there are currently no dedicated interventions in place, and there remains a significant gap in formal, coordinated, and child-centred responses to childhood exposure to DVA. Current support is fragmented, often indirect, and lacking in psychosocial or developmental focus. These findings reinforce the need for investment in child-specific, trauma-informed services and clearer protocols. The next subtheme explores the challenges of institutional collaboration, which can further limit the effectiveness of current support systems for children exposed to DVA.

Subtheme 3.2: Institutional Collaboration and Challenges

Whilst some support and resources exist (even if not specific to childhood exposure to DVA), many respondents highlighted the lack of institutional collaboration as a major barrier to providing effective services. NGOs, government agencies, and schools often work in silos, leading to duplication of efforts, inefficiencies, and fragmented provision. This next subtheme explores the challenges related to institutional collaboration and the consequences for children's support and protection.

Collaboration across sectors was widely acknowledged as essential. Respondents consistently emphasised the importance of unified, multi-agency approaches to support children:

“At the end of the day, it's not something that you can resolve by one particular sector, it has to come together.”

IDI 19 (Independent)

The need for collaboration was not limited to NGOs and INGOs, but extended to government ministries, educators, legal actors, and other stakeholders involved in a child's life:

“Very much collaboration is needed. From grassroots to the national to the international level ... The collaboration between Teachers Association and Parents Association. The collaboration between legal counselling and police counselling. The collaboration between the Ministry of Women and Children and different CSOs or NGOs that they have been working directly with the children.”

IDI 20 (INGO)

Despite widespread recognition of its importance, respondents identified several barriers to effective collaboration. One key issue was a lack of mutual respect and power struggles between organisations:

“There is some ego. Ego with the civil society, ego with the government systems ... Civil society say, oh, ‘we are the expert, we are working for this issue for a long time’ ... And the government say, ‘we have authority’ ... So how to minimise this ego and collaborate to achieve the result, that is the challenging part.”

IDI 09 (Independent)

This tension was compounded by competition for limited funding, which respondents felt discouraged openness and mutual support:

“The coordination is very low as per my experience. Before I think there was a kind of good coordination among NGOs, but lately because of lack of funds ... there is kind of competition among the NGOs for getting projects.”

IDI 01 (NGO)

Even when opportunities for collaboration exist, some respondents felt these were tokenistic or lacked follow-through or long-term commitments:

“The collaboration should be meaningful. It should not be for the sake of the collaboration ... government agencies should take us, our other agencies as collaborators, not as a souvenir type of thing.”

IDI 16 (NGO)

Structural limitations also played a role. Some respondents noted the absence of shared forums, strategy-setting spaces, or joint planning mechanisms:

“There is a lack of coordination on sitting together, trying to figure out what really is the problem, what we can do. And that is very less likely to happen because NGO relies on funding and then they apply for the funding based on what's available from INGO ... so it's not very much bottom up, it's top down, very, very top down.”

IDI 19 (Independent)

Even when collaboration was improving, it was seen as fragile and vulnerable to funding cycles:

“There's good coordination among the civil society organisers and recently the cooperation and collaboration between the government and the civil society is also better now comparing to the past. But again ... NGOs are very much dependent on funding. So funding competition creates some sort of gaps on the cooperation among them.”

IDI 14 (Independent)

Some respondents described how this lack of collaboration leads to missed opportunities, duplicated services, and a general lack of clarity around who is doing what:

“So, like, everybody is doing almost the same thing, but we don't know what we are doing, you know.”

IDI 12 (NGO)

Ultimately, the lack of coordinated, long-term collaboration not only limits the reach and quality of services for children exposed to DVA, but also undermines opportunities to share learning and pool limited resources. The next subtheme explores how responsibility for these issues is perceived across institutions and stakeholders.

Subtheme 3.3: Perceived Responsibility for Policy, Provision, and Support

Respondents expressed differing views on who holds responsibility for addressing childhood exposure to DVA in Nepal. While many identified the government as the primary duty-bearer, others emphasised that responsibility is shared across sectors – including NGOs, INGOs, and civil society. These perspectives reflect broader tensions in Nepal’s social protection landscape, particularly regarding state capacity and accountability.

A significant number of respondents felt that the government should lead efforts to protect and support children exposed to DVA, citing both moral and legal obligations. This view was often framed in relation to Nepal’s existing legal frameworks and decentralised governance structure, along with several respondents referencing The Act Relating to Children (2018/2075) and the authority of local governments to establish protection standards. One respondent explained:

“The government should ensure the safety of children who are exposed to domestic violence.”

IDI 18 (NGO)

Others emphasised that local governments have both the power and responsibility to implement child protection measures, though they often lack the capacity or political will to do so:

“Even [local governments] have authority to set the child protection standard in their local levels ... but for that, the people, those who are in the decision making levels, they should be sensitised to these issues.”

IDI 09 (Independent)

Despite this expectation, many respondents were sceptical about the government's willingness or ability to act. As in earlier subthemes, a disconnect was noted between legislation and implementation. One respondent summarised this limitation by stating:

"The government is the most efficient entity for enforcing laws ... But they cannot do social and normative changes."

IDI 14 (Independent)

This frustration with the gap between policy and practice was common across interviews. Respondents often described the government as symbolically present but practically absent, particularly in service delivery:

"The state is nowhere, nowhere at all. It is just there, it pretends to perform, its capacity is very, very limited. Even when they have capacity, they don't perform."

IDI 19 (Independent)

In response to these gaps, NGOs were widely seen as filling a critical role. Some respondents described non-governmental actors as the only organisations actively engaging with communities or delivering support on the ground:

"NGOs in Nepal have sort of become almost essential for our community because the government is not doing its job."

IDI 19 (Independent)

At the same time, several respondents acknowledged that NGOs cannot work in isolation. As one NGO respondent noted:

"Organisations like ours can't solve the problem without active support from the government."

IDI 18 (NGO)

This dual recognition, that the government has ultimate responsibility, but that NGOs play a vital role, led many to argue for a more collaborative approach. While respondents differed in emphasis, there was broad agreement that addressing childhood exposure to DVA requires a shared commitment across sectors:

"I think everyone is responsible, actually. Because everyone has a role to play."

IDI 12 (NGO)

However, these ideals of shared responsibility were often undercut by structural realities. Participants described limited coordination, weak political engagement, and a persistent disconnect between responsibilities and resources. One respondent reflected on the roles that NGOs play, rather than the government:

“We are working, we are on the ground, we are not writing. We are actually doing.”

IDI 21 (NGO)

Ultimately, whilst the government is widely seen as having the formal responsibility for policy, provision, and support, practical limitations mean that NGOs often take the lead in implementation. This imbalance creates frustration, contributes to fragmented service delivery, and highlights the urgent need for more coordinated, long-term strategies.

Taken together, the findings in Theme 3 reveal that while some services and resources exist, these are limited in scope, inconsistently implemented, and not tailored to the needs of children exposed to DVA. The absence of dedicated interventions, weak institutional collaboration, and unclear responsibilities have created a fragmented and often unsustainable support system. In light of these challenges, Theme 4 explores how childhood exposure to DVA could be more effectively addressed in future.

Theme 4: Future Strategies and Interventions to Improve Support for Children

This theme explores the strategies and interventions that respondents believed could improve support for children exposed to DVA in Nepal. While earlier themes highlighted the limited availability of current resources, poor institutional coordination, and unclear responsibilities, respondents also offered constructive recommendations for future action. These focused on three key areas: empowering children through education and awareness, designing interventions at multiple levels of society, and implementing structural and policy reforms to support long-term, sustainable change.

The subthemes that follow reflect these priorities. Subtheme 4.1 explores how education and empowerment (particularly through schools) can equip children with knowledge, confidence, and supportive environments to recognise and respond to violence. Subtheme 4.2 considers the importance of interventions that operate across individual, family, community, and societal levels, aiming to shift norms and build supportive ecosystems. Finally, Subtheme 4.3 highlights structural and policy changes needed to address existing gaps, strengthen coordination, and ensure that childhood exposure to DVA is recognised and prioritised at all levels of governance.

Subtheme 4.1: Empowerment and Education

Respondents consistently emphasised the importance of empowering children through education, framing this as both a preventative measure and a means of enabling children to seek help. Education was viewed as central to building children's knowledge, agency and confidence, particularly when embedded within school systems that are safe, inclusive, and child-focused. The following subtheme examines the role of education and empowerment programs in providing children with the tools they need to navigate difficult situations.

Schools were commonly described as key sites for prevention and early intervention by a range of respondents, including those working in government, NGOs, and independently. Several respondents highlighted their potential role in helping children recognise abuse, access support, and build resilience. However, they also acknowledged existing gaps in access and retention, especially for children from marginalised or poorer families:

"School has to fill that gap ... the school should be a safe zone."

IDI 19 (Independent)

Compulsory and accessible schooling was considered essential, not only for educational development but also for preventing violence and identifying children at risk. Some respondents linked non-attendance to wider family vulnerabilities, noting that children in violent households were often disengaged from school or unable to attend regularly.

Beyond access, respondents emphasised the need for reforms to the school curriculum. They advocated for content that fosters critical thinking about violence, challenges gender norms, and promotes children's rights. Several respondents noted that existing materials tend to be overly prescriptive or didactic, failing to engage children in meaningful ways:

"The education curriculum ... tends to be very top-down, hierarchical and very preachy."

IDI 19 (Independent)

Promoting children's agency was seen as central to prevention and support. Respondents described a need to equip children with the skills and confidence to speak out, both individually and collectively:

"Building the agency is the core."

IDI 20 (INGO)

Peer-to-peer support was identified as a particularly effective route for empowerment, with several respondents noting that children are often more likely to confide in friends than adults.

Encouraging peer networks and youth-led initiatives was seen as a promising area for intervention:

“The effective one is their peers, their friends. Because they are the most trusted group ... rather than your family and parents.”

IDI 14 (Independent)

Training for teachers was also described as critical. Respondents believed that teachers could play a vital role in recognising early signs of harm, offering support, and creating safe classroom environments, provided they received adequate training in child protection, trauma-informed practices, and communication:

“Train the teachers about the child protection issues and how to identify the children ... give them some sort of psychological first aid.”

IDI 09 (Independent)

Some respondents also extended this recommendation to social workers and psychosocial counsellors, advocating for training that emphasises children’s rights and needs in service delivery.

In addition to child-focused approaches, respondents described the need to empower parents (particularly mothers), through awareness-raising, parenting support, and economic empowerment. This was viewed as having a dual benefit: improving outcomes for children while also enabling women to leave abusive situations more safely and confidently:

“Economical empowerment of women is really bringing women in the forefront to fight against violence ... empowered women get resilient faster, and that helps their children.”

IDI 20 (INGO)

Whilst some respondents proposed familiar interventions such as economic empowerment for women, this often reflected a continued tendency to focus on adult survivors rather than directly recognising children as victims of DVA in their own right through exposure. This pattern reinforces earlier findings that children are often viewed only in relation to their parents’ experiences.

In summary, respondents identified education and empowerment as key to improving support for children exposed to DVA. This includes strengthening support systems, building children’s agency, equipping educators with the skills to respond appropriately, and ensuring parents are

supported to play an active role. Together, these strategies were seen as foundational to a more child-centred and proactive approach to prevention and protection.

Subtheme 4.2: Multilevel Interventions

In addition to empowering children individually, respondents consistently emphasised the need for multilevel interventions to address childhood exposure to DVA, highlighting the importance of targeting not only the individual child, but also families, communities, and wider society. These strategies were viewed as essential for building environments that are protective, responsive, and capable of fostering resilience. This subtheme explores how could more effectively address childhood exposure to DVA in Nepal. A shift in societal attitudes is needed to reduce stigma and foster greater recognition of childhood exposure to DVA. Respondents reflected on how stigma and silence surrounding DVA prevents children from accessing support, while limiting public understanding of its broader impact on children:

“There is a stigma around talking about violence, and until we break that stigma, change will be slow.”

IDI 12 (NGO)

Others highlighted how societal minimisation of DVA, often treated as a “women’s issue,” further obscures its impact on children and limits collective responsibility.

“The trivialising of the subject matter ... it's just like the women's issue, and again, women are considered accountable to raise the issue.”

IDI 19 (Independent)

Community education was identified as a key tool for challenging harmful cultural norms and building awareness. Several respondents noted that societal acceptance of violence, particularly against women, remains widespread, which in turn limits the visibility of its impact on children:

“Awareness is still low among the community people about domestic violence ... a large number of women believe that the husband has the right to beat a wife.”

IDI 13 (NGO)

As part of this, some respondents recommended targeted awareness programmes and workshops that specifically include marginalised or excluded children, particularly in rural or underserved areas:

“Holding workshops and awareness programs in neighbourhoods, particularly focusing on children who may be excluded from traditional programs, can further reinforce community support systems.”

IDI 03 (Government)

Some respondents emphasised the need to promote supportive norms and reframe expectations about children’s presence in adult spaces, linking to broader cultural values:

“We need to reinforce positive cultural values ... when adults are talking, it's better for children to not stay there.”

IDI 14 (Independent)

Respondents also emphasised the importance of building local support structures, such as child clubs and peer groups. These were seen as promising spaces for awareness-raising, support, and expression:

“At the community level, they must create a child club where children can play and share their feelings.”

IDI 18 (NGO)

Family-level interventions also considered essential. Respondents viewed families as both a risk context and critical area for prevention, intervention, and recovery⁷⁹. As one participant summarised:

“No matter what policies there are, if that particular home is not empowered to understand the child rights perspective, then it will definitely not be safe.”

IDI 20 (INGO)

The strongest consensus, however, was that interventions must occur across all ecological domains – individual, family, community, and society. Respondents consistently described childhood exposure to DVA as a multifaceted issue requiring integrated responses:

“I would say it's not only one aspect, we really need to work on all the aspects, from an individual to the policy level.”

IDI 20 (INGO)

⁷⁹ When asked about who they thought was responsible for providing support to children exposed to DVA, most respondents said parents (with the majority specifying mothers).

Media campaigns were also highlighted as a valuable strategy for shifting norms and reaching broader audiences, particularly at countering the normalisation of violence:

“What kind of stories our children hear ... violence is normalised, sexual violence is very much eroticised.”

IDI 19 (Independent)

“We need civil society and media.”

IDI 14 (Independent)

Respondents described multi-agency collaboration as fundamental. They called for coordination across sectors including education, health, child protection, and justice to ensure children’s needs are met holistically:

“We must advocate for the holistic protection of children.”

IDI 01 (NGO)

“At the end of the day, it's not something that you can resolve by one particular sector; it has to come together.”

IDI 19 (Independent)

Some respondents highlighted the value of learning from successful models and adapting them for local use, including peer education programmes and youth-level initiatives:

“[World Vision] have this sort of national level intervention ... they build the capacity of young peer educators ... who are the change makers, agents in their community. I think I see that as the most effective tool that we could learn from.”

IDI 12 (NGO)

However, others stressed the importance of grounding interventions in local evidence and social contexts, warning against uncritical adoption of external frameworks:

“Most of our development partners come up with all these stories from the northern, western world, and that's a very big threat for us ... we need to understand the local social context.”

IDI 14 (Independent)

“One cannot work alone for the children ... They should share their experience, identify the needs of children, conduct research, and design programs accordingly.”

Respondents saw multilevel interventions as crucial to tackling the complexity of childhood exposure to DVA. By integrating strategies across ecological domains and sectors, it is possible to build more responsive, resilient systems of support, however, these efforts must be underpinned by clear policies, structural reform, and sustained government investment. The next subtheme explores the policy and systemic changes that respondents believe are necessary to achieve lasting, meaningful support for children exposed to DVA.

Subtheme 4.3: Policy and Structural Changes

Finally, respondents emphasised that meaningful and sustained progress on childhood exposure to DVA in Nepal depends on significant policy and structural changes. Without government prioritisation, increased funding, and coherent frameworks, earlier recommendations around prevention and support are unlikely to be realised. Many of the proposed changes align with barriers raised in Subtheme 2.2, including a lack of child-centred services, weak implementation, and limited coordination across sectors. The following subtheme focuses on the policy and structural changes that are necessary to ensure long-term, sustainable solutions for children exposed to DVA.

One of the most frequently cited concerns was the absence of child-focused services, Respondents called for a shift in both attitudes and approaches to ensure children's needs and experiences are prioritised in practice, not just in policy:

“The organisation and the teams working with children should be child-friendly. One should take training to understand the feelings of a child and try living like children again to understand them.”

IDI 18 (NGO)

There was a strong consensus that the government must play a more proactive role in addressing childhood exposure to DVA. This included strengthening implementation of existing legislation and allocating dedicated financial and human resources:

“The first of all, what we envision in our policy and act, the government should give priority to enact all those things.”

IDI 09 (Independent)

“If the municipality office has only a designated person, then it will be easier to coordinate with all that.”

IDI 13 (NGO)

In addition to better coordination, respondents advocated for stable, permanent funding streams, not just project-based support, to ensure continuity and sustainability of services:

“The government should set up one fund, one committed fund to address these issues.”

IDI 13 (NGO)

“If cases come, we have to support through our whole fund and that is not sustainable in the long run. So we need some kind of permanent kind of support for supporting the children.”

IDI 01 (NGO)

To support enforcement, respondents recommended the establishment of a national child protection body or ombudsperson to oversee progress and hold duty bearers accountable:

“There should be a high-level children's mechanism. Either a high-level mechanism or an ombudsperson.”

IDI 08 (INGO)

The importance of implementation at the local level was also stressed. Respondents highlighted the gap between policy and practice, calling for greater attention to district-level infrastructure and stronger engagement from decision-makers:

“Sometimes dealing with children's cases, if there is a child case, there is no infrastructure at district level to comply with the provisions of laws and policies. So that needs to be maintained from government side. Government should invest in these areas.”

IDI 08 (INGO)

Some respondents argued for a shift from top-down policymaking to a bottom-up model that reflects local needs and contexts. This included consulting local communities, survivors, academics, experts, and crucially, children:

“We still are in a top-down model ... it is important to have a bottom-up model.”

IDI 14 (Independent)

“I think listening to survivors' stories, their experiences is very much fundamental ... that's where you get the insight of where exactly the system is broken.”

IDI 19 (Independent)

Respondents also emphasised the need to involve children directly in programme and policy development, not only as beneficiaries but as stakeholders:

“The participation of children in these interventions is very low ... the programme is designed from the adult's perspective ... We need to build agency for children, and we need to recognise them as stakeholders.”

IDI 13 (NGO)

In addition to stronger legislation, several respondents called for clearer integration across legal and policy domains. They recommended that a policy specifically for childhood exposure to DVA is required, that addresses both DVA and child protection together:

“I think there should be a holistic policy that covers the policies on domestic violence and protection of children from domestic violence as well.”

IDI 01 (NGO)

Fragmented responsibilities across ministries and agencies were frequently raised as barriers to effective action. Respondents described poor coordination, even between government departments, and urged more joined-up systems:

“There is also difficulty collaborating with each other ... the police doesn't want to collaborate with the local body, or the municipality, even with the government agencies and the other government agencies. We need to react and improve that.”

IDI 09 (Independent)

“The federal government should also coordinate with the local government.”

IDI 01 (NGO)

Respondents recommended several practical steps to improve coordination. These included service mapping, shared reviews, and role clarity amongst NGOs and government stakeholders:

“There should be service mapping so that there won't be duplication of services.”

IDI 01 (NGO)

“The local government should map the available resources in their area and coordinate with other authorities to rescue and rehabilitate children.”

IDI 10 (NGO)

Education and training for policymakers and frontline workers, particularly police, legal professionals, and doctors, was also viewed as essential to ensure appropriate responses to children exposed to DVA:

“This is a kind of cross-cutting agenda ... it needs to have some package to be included in a government employees training course.”

IDI 08 (INGO)

Finally, respondents highlighted that current systems often lack cohesion and fail to respond adequately when children disclose abuse. One interviewee stressed the need for legal alignment and structured case management, while another pointed to systemic failure in immediate responses:

“The most urgent for me is actually to strengthen our first response to the survivor when they come to seek help. That is where we are failing terribly.”

IDI 19 (Independent)

In summary, respondents saw policy and structural reform as central for addressing childhood exposure to DVA in Nepal. Their recommendations included child-focused services, stronger local implementation, collaborative policymaking, and robust accountability. While progress requires government leadership, it also depends on the collective engagement of NGOs, civil society, and communities to build a coordinated and sustainable system of protection for children exposed to DVA in Nepal.

Theme 4 highlights a strong consensus among respondents that improving support for children exposed to DVA in Nepal requires both targeted interventions and wider structural reform. While community and individual-level efforts are essential, sustained progress depends on coordinated action, policy change, and long-term government investment. The final chapter discusses how these findings contribute to the wider evidence base and considers key implications for research, policy, and practice.

7.4 Discussion

The original aim of this paper was to explore the barriers and facilitators that exist when implementing public health interventions for children exposed to DVA in Nepal. It aimed to do this through speaking to respondents working in the field of child protection, or DVA prevention and support. This included representatives from the federal government, INGOs, NGOs, and freelancers, academics, and any other recommended stakeholders (referred to as

'independent' within the analysis and discussion). However, upon conducting the interviews, it was quickly realised that many of the respondents did not have knowledge and understanding of childhood exposure to DVA, and therefore, elements such as these needed to be understood before potential interventions could be designed and implemented. This led to the aim of the paper being changed to firstly seeking to understand the current context of Nepal, respondents' understandings of children's exposure to DVA and services which are in place to support them, before finally exploring the changes that can be made to better support children. This shift in focus is important to highlight as part of this paper in order to show the early stage of research and support in this area within Nepal. The new focus is still part of the overall research process previously highlighted (Figure 1.1), and shows the adaptability that is needed when researching on this topic.

This research spoke to 21 key informants, and their responses to the interview guide varied depending on the focus of their organisation, for example, focusing more on direct victims of DVA (which was primarily women/mothers), or children, who had been affected by some form of violence or abuse (e.g., child abuse or trafficking). None of the respondents interviewed worked in an organisation with the primary area of support of childhood exposure to DVA, and the respondents were unaware of any organisations operating in Nepal who had this as their focus (or who even incorporated it into their service or provision).

Before presenting the four key themes, it is important to reflect on how the researcher's earlier analyses shaped the lens through which this qualitative work was initially approached. The previous papers in this thesis used quantitative data to examine the prevalence, risk factors, and mental health outcomes associated with childhood exposure to DVA in ten LMICs. These analyses drew on standardised survey definitions, which positioned exposure to DVA as a distinct form of violence against children. As a result, there was an implicit expectation that stakeholders in Nepal would share a similar understanding of exposure as separate from direct abuse. However, during interviews, it became apparent that this conceptual distinction was not consistently recognised by participants. Despite clarifications during the interviews, many respondents continued to equate childhood exposure to DVA with other forms of violence against children, such as direct physical abuse or neglect. This revealed a fundamental divergence in understanding that significantly shaped the analysis and interpretation of findings. Rather than applying predefined Western conceptual categories, the analytic process required a more open and inductive approach, recognising how participants' social, cultural, and legal framings influenced their responses. This shift was essential in ensuring that the thematic findings reflected participants' lived realities, rather than being constrained by external definitions.

7.4.1 Summary of Key Findings

Four main themes were identified through thematic analysis (Braun & Clarke, 2006; 2021): (1) the understanding and awareness of childhood exposure to DVA, (2) barriers to providing and accessing support for children exposed to DVA, (3) existing support and resources, and (4) future strategies and interventions. There is some overlap between themes and subthemes, which is natural and expected, especially when dealing with complex issues like childhood exposure to DVA (Maguire & Delahunt, 2017)⁸⁰. These themes and the key findings that arise from them directly address the research questions of this paper, providing a comprehensive overview of the current state of understanding and support available for children exposed to DVA in Nepal, along with exploring potential policy changes, strategies and interventions in order to improve this. The following section will summarise the key findings from this research, placing them in the context of existing knowledge and literature.

First, it is evident that there is a lack of clarity and comprehensive understanding of childhood exposure to DVA among professionals and policymakers in Nepal. Many respondents conflated childhood exposure to DVA with other forms of child abuse, revealing that the distinct impact of exposure to DVA on children is not fully grasped. Many respondents referred to “child-based domestic violence”, and despite reminders from the interviewers that the research was about a child being exposed to, or witnessing or overhearing, violence perpetrated by one adult against another in their home, they continued to revert back to talking about direct abuse towards a child in their answers. This is perhaps linked to the definition of domestic violence in the Domestic Violence (Crime and Punishment) Act (2009/2066), where “domestic relationship means a relationship between two persons who live or have, at any point of time, lived together in a shared household and are related by consanguinity, marriage, adoption or are family members living together as a joint family; or a dependent domestic help living in the same family” (Appendix I.3). Under this definition, children would be included as a victim or perpetrator. This in part this could explain some of the confusion when respondents were initially asked to explain what they understood by the phrase “children’s exposure to domestic violence”. Furthermore, the Act Relating to Children (2018/2075) is a key policy which provides the framework for the protection of children as a victim of abuse. When considered alongside the Domestic Violence (Crime and Punishment) Act (2009/2066), this highlights a potential issue, in that the same actions or crimes are present in two Acts, potentially making protection for children harder to implement.

⁸⁰ Whilst the PI has made every effort to minimise this as much as possible so that the themes are distinct, acknowledging that these overlaps exist is important because it reflects the interconnected nature of the challenges and solutions.

A further potential consideration relating to the way in which respondents continued to return to speaking about direct abuse towards children, rather than exposure, perhaps highlights a general tendency to overlook the specific impacts of exposure to DVA perpetrated by adults against each other in a home, as distinct from being a direct victim, and that in general, the unique impact of exposure is not yet recognised. This limited understanding among key stakeholders impairs the development of targeted interventions and policies, highlighting a significant gap in addressing childhood exposure to DVA specifically. This confusion is symptomatic of a broader lack of attention to the issue at the national level. Within Subtheme 1.2, additional awareness and knowledge gaps were also highlighted within government, including knowledge about the existing policies in relation to child rights and protection, but also a gap in understanding federal laws among local government which highlights a broader issue with the three-tier federal system which has been noted by other researchers (Khadka et al., 2024). This is an area which was discussed in further depth in Subtheme 2.2, where systemic and organisational barriers to providing and accessing support were discussed. The broader context of childhood exposure to DVA in Nepal was also discussed in-depth by respondents, which supported existing literature, such as the societal acceptance of violence against women (Thapa et al., 2020), and the internalisation of harmful social norms by women and children (Patil & Khanna, 2022). From Subtheme 1.3, it is clear that the wider perceptions of both DVA, and of children influence the wider society's lack of acknowledgement, awareness, and understanding of the issue and impact of childhood exposure to DVA, and, perhaps, is why it is considered "normal" (IDI 11, NGO) within Nepal. Societal education around reducing these cultural norms to reduce stigma is one of the interventions suggested in Subtheme 4.2, suggesting that education and awareness not only influences understanding of an issue, but also serves as a possible avenue from which interventions can be developed.

A second finding is that significant barriers prevent children from accessing the support they need. Along with lack of awareness generally about childhood exposure to DVA, the fact that children are unaware of their rights or of the support available to them also acts as a barrier, again demonstrating the need for education, which was addressed in Subtheme 4.2. Perhaps the most prevalent barriers identified, however, were systemic and organisational barriers, which affect not only children accessing support, but also for organisations to be able to provide it. Specific issues with policy, such as the fact that they do not link together, are outdated, and the issues with implementation were also discussed. One such example of this is linked to the country restructure from a unitary state to a three-tier federal system. Some support mechanisms no longer work with Acts or vice versa, meaning that support systems which were previously operating are no longer valid or work properly. In addition, issues were raised about collaboration between the different levels of government, along with government agencies

knowing their responsibilities. This reflects findings from other research conducted in Nepal, such as Khadka et al. (2024) and demonstrates an urgent need for this to be addressed, and for the systems to be strengthened, as highlighted by respondents in Subtheme 4.3. Part of this need is determining the responsibility of implementation and ensuring a comprehensive way of monitoring and evaluating policies, programmes, and provision of services. The scarcity of resources and funding was also found in previous research to hinder the effectiveness of the federal system (Baniya & Aryal, 2022; Regmi et al., 2023), something which was prevalent in the findings of this study. The scarcity of resources generally was a barrier mentioned across most themes, as it means that funding is short-term, unsustainable, and presents long-term issues for both children seeking support, and for the organisations trying to deliver it. One respondent said that the scarcity of funds meant that their organisation had started to sell handmade crafts to raise additional funds so that they could keep their DVA shelter open. Many respondents also described how the lack of available resources has created competition between NGOs, impacting collaboration (Subtheme 2.2 and Subtheme 3.2).

Third, the existing support structures, though valuable, are insufficient, poorly coordinated, and do not acknowledge the unique needs of children exposed to DVA between adults in their home, instead focusing on children who are direct victims of violence. The two respondents who did mention that their organisation provided support for children (through providing them shelter in the safehouse alongside their victimised parent seeking support for DVA) were exceptions, and no other respondents interviewed were aware that this support was provided. This again raised the issue of collaboration and the need to strengthen it to better support children. There are existing helplines and child protection networks within Nepal who provide essential services for children, but are not exposure-specific, and are often short-term and unsustainable (due to issues with funding and resources), or fail to reach the most vulnerable children, particularly those in rural or marginalised communities. This is especially concerning given that approximately 79% of Nepal's population lives in rural areas (Singh Shah, 2023), and therefore, addressing the unique needs and challenges faced by these communities should be on policymakers' agendas. One respondent spoke about how access to support services were only for "those children who speak more, who are from a good family" (IDI 15, NGO), highlighting how sociodemographic factors can also be a barrier for children accessing support. Education levels and the socioeconomic status of a family have previously been found to affect a child's likelihood of exposure (Paper Two, Chapter 5), and therefore, those most at risk could be the ones who are least able to access services. Additionally, the lack of integration between DVA services for women subjected to DVA and child protection further weakens the support system, leaving children without adequate help or pathways to recovery. This is further complicated by the differing perceptions of who is responsible for policy, provision, and support for childhood

exposure to DVA, which directly affects the effectiveness of support systems for children exposed to DVA. Prior to conducting this research, it was expected that childhood exposure to DVA would be acknowledged across DVA and child protection policies, provisions and services (Figure 7.1) based on evidence from other countries, when, in fact, it is perhaps represented better by Figure 7.4.

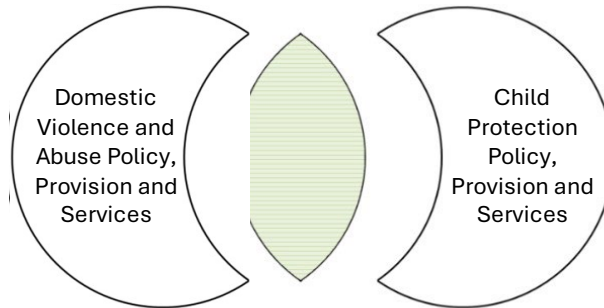


Figure 7.4 Reflection on the position of childhood exposure to DVA within existing policy, provision and services in Nepal. This diagram highlights that exposure is not acknowledged anywhere, and there is also disconnect between DVA and child protection

Despite Nepal being a signatory to the UN Convention on the Rights of the Child (UNCRC; 1989). The General Comment No. 13 (2011), which specifically states the need to integrate the experiences of “children who experience and witness violence in the home and in communities” into national coordinating frameworks across various legislative, administrative, social, and educational measures, spanning all stages from prevention to recovery and intervention”, Figure 7.4 pictorially illustrates the reality of the current situation in Nepal – that childhood exposure to DVA currently sits neither in DVA policy, provision or services, nor those for child protection (which also, do not link up), instead it is not even considered in the policy, provision and services landscape. Currently, there is a distinct lack of awareness of the issue, and, consequently, no resources are being allocated to tackle this issue in Nepal. This, again, enhances the need for both education amongst professionals and policymakers, and for that of collaboration, to ensure that childhood exposure to DVA can be built into existing frameworks so that children can be better protected.

Finally, the findings from this study underscore the urgent need for more comprehensive and sustainable strategies to address childhood exposure to DVA in Nepal. Future interventions must prioritise child-centric approaches, focusing on capacity building, empowerment, and education about children’s rights (Morris et al., 2020; Angelöw & Psouni, 2025). Respondents

spoke about the importance of including children in the development of policies and interventions to ensure that their specific needs and experiences are acknowledged and addressed, supporting findings by Noble-Carr et al. (2019) and Callaghan et al. (2018). Many of the future strategies and interventions suggested by respondents are supported by existing literature in high-income countries. For example, the focus on using school as a focus for interventions (Laing, 2016) and training teachers to identify children exposed to DVA and provide them with psychological first aid (Ponnamperuma & Kudagama, 2022; Armiento et al., 2016). However, respondents mentioned that accessing children in marginalised groups through school-based interventions may be challenging, as non-attendance at school disproportionately affects those in rural areas and those from poor backgrounds⁸¹ – both groups of children who were noted by respondents as being harder to reach with existing support systems⁸². This demonstrates that the issue of childhood exposure to DVA requires a multilevel and multisectoral approach, to ensure that all children (including those with additional vulnerabilities) can access support. This supports findings by Hillis et al. (2016), who suggested that a multisectoral approach across different levels of socioecological models can significantly reduce childhood violence, both addressing the short-term impacts, and promoting changes which provide long-term safety and wellbeing for children. When discussing interventions, the most common recommendation from respondents was that interventions are required at all ecological domains – operating at the individual, family, community, and societal levels (supporting ideas by Wessells, 2015). In order to do this, collaboration between the government, NGOs, schools, and other institutions is essential to strengthen the support systems and ensure that this multilevel intervention is achievable. Across the four themes, there are many instances where certain elements (such as collaboration, resources and education) are noticeably prevalent. This shows the interconnected nature of the issue of childhood exposure to DVA, and how one approach to address it will not adequately address it, therefore supporting the idea of a multilevel, multisectoral approach to tackling the issue of childhood exposure to DVA in Nepal. Additionally, national-level reforms are required, including greater prioritisation of childhood exposure to DVA by the government, increased funding, policy changes, and a coordinated effort to raise awareness of the issue of childhood exposure to DVA.

⁸¹ In addition, when speaking about the impact of childhood exposure to DVA, two respondents described how it may affect school attendance: “it might also affect their academic performance and it might also lead to absenteeism in the school” (IDI 01, NGO) and “everything, their educational status, everything will be affected” (IDI 10, NGO). If this is an outcome of exposure, it may mean that the children who need the support the most, are not attending school and so may not be reachable using this approach.

⁸² Research has also found that girls in Nepal face barriers to schooling and have higher dropout rates (Dahal et al., 2021). In Paper Two (Chapter 5), females were found to be more likely to be exposed to DVA, again highlighting how children who need support the most may not be able to access the interventions unless a multisectoral approach is taken and consideration given to these important societal factors.

7.4.2 Implications for Policy and Practice

The findings from this study underscore critical areas where policy and practice changes are necessary to better support children exposed to DVA in Nepal. One of the most pressing issues is the formal recognition of childhood exposure to DVA as a distinct form of harm. Currently, there is significant confusion between exposure to DVA – where a child witnesses or otherwise experiences violence perpetrated by one caregiver or adult in their home towards another – and direct child abuse amongst professionals and policymakers, with the impact of exposure not yet being recognised within policies and interventions. Research is needed on the context of childhood exposure to DVA within Nepal so that policies and interventions can be developed that adequately address the unique needs of affected children. Policymakers must collaborate with DVA and child protection experts to develop and establish clear policies that integrate this understanding into existing child protection and DVA Acts, in line with the requirements of the UN Convention on the Rights of the Child (UNCRC; 1989). The General Comment No. 13 (2011), to which Nepal is a signatory.

The current disconnects between DVA and child protection services must be addressed, and demands policy-driven integration to ensure that organisations supporting adult survivors of DVA are also equipped to meet the needs of their children – and the resources need to be made available by government or INGOs so that organisations can provide these services. Policies should mandate that all DVA shelters and services include provisions for children and provide necessary training for staff on the impact of childhood exposure to DVA. As education and schooling were highlighted as such a critical area for interventions, it should also be ensured that within these shelters, children are given education and schooling in line with their education level, as respondents from existing shelters that also house children are currently not providing this (due to resource constraints), which could expose children to further vulnerabilities in later life. Psychosocial counselling should also be included for children in these shelters so that a holistic approach to children's welfare is provided.

Moreover, current services often face challenges due to a lack of resources and short-term funding. This is the case generally in Nepal for child protection and DVA services, and so therefore, requesting additional resources to tackle the issue of childhood exposure to DVA is challenging. However, existing research demonstrates that children exposed to DVA perpetrated between adults in their home are at risk of developing some of the same adverse outcomes as those who experience direct abuse (see Paper Three, Chapter 6). Therefore, it should be considered an urgent priority in terms of policy and resource prioritisation. To effectively address childhood exposure to DVA, the government must prioritise this issue by allocating increased financial and human resources to child protection services, NGOs, and

DVA shelters. Developing long-term funding strategies is essential for creating sustainable support systems that extend beyond immediate crisis interventions and allow organisations to provide ongoing care. The findings also highlight the need for a focused approach to policy enforcement and accountability. Many existing policies unrelated to childhood exposure to DVA are not currently implemented as intended, leaving many children facing direct abuse unsupported. Setting up monitoring and evaluation bodies or appointing independent ombudspersons can help oversee the implementation and effectiveness of policies related to child protection and DVA. Increased resources and funding combined with better application, are therefore, urgent priorities which need to be addressed.

Additionally, children from vulnerable and marginalised groups, such as those from lower castes, children with disabilities, and those in rural areas, face additional barriers in accessing support. Policymakers and practitioners must create inclusive interventions that reach these vulnerable populations, establishing support structures that consider geographic, social, and economic challenges. This includes developing outreach programmes targeting rural areas, offering mobile services, and creating support systems that do not rely on parental consent for children to access help. Children from these groups should be consulted and involved to ensure that they address their unique needs and that the services are designed with inclusivity and accessibility in mind. The presence of child protection agencies and support services across all of Nepal at the local level is also essential, along with having a clear reporting procedure embedded into existing areas of a child's life (such as at school or child clubs). This reporting procedure, follow-on process, and care should include clear and consistent communication across government departments and agencies to ensure that all aspects of a child's life can be supported.

Awareness and education programmes should be developed to educate children, parents, and communities about childhood exposure to DVA and its impacts. Schools, in particular, can play a pivotal role in delivering child-focused education about rights and support mechanisms, and information such as healthy relationships and violence should be incorporated into the curriculum so that children are able to recognise situations where they may need further support. Training for teachers on recognising signs of childhood exposure to DVA and skills in psychosocial care should also be incorporated.

Several key areas for improvement emerged from the findings, which are particularly relevant for practitioners. Training and capacity building is crucial, with professionals in both child protection and DVA services requiring training on the specific dynamics of childhood exposure to DVA, including both the short-term and long-term psychological and emotional impacts. Development of child-centric interventions should be prioritised, designing therapeutic and

psychosocial interventions tailored to the needs of children exposed to DVA, alongside creating safe spaces for children to express their experiences.

Collaboration both within and across sectors and organisations is also essential, including collaboration between practitioners in child protection and DVA support work to ensure that a child receives holistic care. Regular workshops that bring together policymakers and organisations in Nepal to share best practices, receive training, and ensure consistency across the delivery of services can help ensure a more streamlined referral process. Regular workshops such as these would also provide the opportunity to identify and address any specific gaps or opportunities for inter-agency collaborations, leading to better utilisation of resources and more comprehensive care for children exposed to DVA.

By addressing these interconnected dimensions, Nepal can move towards a more comprehensive and effective framework for supporting children exposed to DVA, enhancing both policy and practice in this critical area, whilst also establishing better support more widely for children facing other forms of violence and abuse.

7.4.3 Suggestions for Future Research

Findings from the in-depth interviews conducted revealed that the topic of childhood exposure to DVA is still in its infancy in Nepal, even amongst policymakers and professionals working in the field of child protection and DVA in Nepal.

Therefore, there is a critical need for research within Nepal to gain a more comprehensive understanding of childhood exposure to DVA, including the prevalence, risk factors, and how children are affected by witnessing or living with violence perpetrated by adults in the home, within Nepal's unique context (representing the first few stages of the research process illustrated in Figure 1.1⁸³). Respondents acknowledged this need for research in Subtheme 4.2. Appropriate, context-specific research is required to ensure that policies and interventions can be designed to address the specific needs of children in Nepal facing exposure. Having context-specific information about childhood exposure to DVA in Nepal would be a helpful tool to provide to policymakers and professionals, to enhance their understanding of the issue so that their responses can be more targeted. Misunderstanding and confusion were a key theme within this research, and respondents highlighted that without understanding and education about an issue, the government cannot effectively prioritise it, which, in turn, affects the resources

⁸³ As explained in Section 7.1.3 and Section 7.4, this paper initially intended to explore the fifth stage of the research process ('What is being done?'), and the interview guide was designed with this in mind. However, upon conducting the first few interviews, it became apparent that the earlier stages in this research process (Figure 1.1) have not yet been completed, so research that addresses these stages first needs to be explored within the context of Nepal.

allocated – which was identified as a key barrier, which in turn affects other essential factors like collaboration amongst NGOs. Therefore, obtaining this country-specific data is an urgent research priority.

Additionally, future research should include children's perspectives in developing policies and interventions (highlighted in Subtheme 4.3). Utilising participatory methods to gain a better understanding of children's experiences and perceived needs could help shape more child-centric policies and practices, ensuring that the policies, provisions, and services are designed to best protect children (Morris et al., 2020; Angelöw & Psouni, 2025). Once support mechanisms for children are established, including improved policies and interventions specific to childhood exposure, further research could focus on the effectiveness of these mechanisms so that the issue can be monitored and, hopefully, a reduction in childhood exposure to DVA in Nepal can be observed.

7.4.4 Limitations

There are a few limitations of this study. Firstly, it was not possible to speak to everyone involved in the provision and support of services for children exposed to DVA across the whole of Nepal, due to the restrictions of this research project, and lack of a centralised point of support for children who had been exposed to DVA between caregivers or other adult household members. However, it was felt that amongst the interviews that were conducted, valuable information was provided about others who are involved in the support of children (even informally), such as teachers, and it was felt that data saturation was reached after 20 interviews. Secondly, as people are being interviewed in their role within their workplace (rather than as an individual), they may not feel that they can speak freely. However, this was mitigated by reminding respondents that their data would be kept confidential, and any identifying information (including the name of their organisation) would be kept anonymous. For respondents who preferred to meet at a location outside of their workplace, an alternate, private location was arranged, to try to mitigate this potential limitation and to ensure that the respondent felt comfortable at all times during the interview.

Due to the amount of time that the PI spent in Nepal, combined with the fact that this period was during the rainy season, and because the research team had a desire to conduct the interviews face to face, all organisations were based in Kathmandu Valley. Whilst this is where most services are based, future research could focus on speaking to people in rural areas to explore the support (if any) available there. However, many of the respondents within this study had offices or partner organisations across Nepal, or had worked in rural areas in previous roles, and so could speak to the unique challenges for children living in these communities.

This paper set out to explore the context of childhood exposure to DVA within an LMIC, Nepal. Whilst some findings, particularly around the lack of awareness, resource constraints, and societal barriers are likely generalisable to other LMICs, the study's findings should be adapted to account for the specific cultural, social, and political contexts of each country. The broader themes of inadequate support for children exposed to DVA perpetrated within the home, systemic barriers to accessing help, and the need for coordinated, sustainable interventions are highly relevant across many LMICs, but the exact nature of these challenges and potential solutions will vary. Therefore, whilst this is a demonstration of the current understanding and support for childhood exposure to DVA in Nepal, it may not be reflective of what is happening in other LMICs.

7.5 Conclusion

This study sought to explore the level of understanding, existing support systems, barriers, and future strategies related to childhood exposure to DVA in Nepal, as perceived by key informants working in the fields of child protection and DVA. The findings reveal critical gaps in awareness, a fragmented support landscape, multiple barriers to accessing help, and an urgent need for coordinated interventions and a national conversation on childhood exposure to DVA.

Childhood exposure to DVA remains an under-recognised and inadequately addressed issue in Nepal, as evidenced by widespread confusion, fragmented services, and policy gaps identified in this study.

There is a clear lack of understanding amongst professionals and policymakers regarding what constitutes childhood exposure to DVA, along with the unique impacts it can have on affected children. This hinders the development of targeted policies and interventions. Existing support structures, while valuable for children, are not specific to exposure, are insufficient and poorly coordinated, and often fail to reach vulnerable populations, particularly in rural areas.

Significant barriers, including societal stigma and structural limitations, further obstruct children's access to services. Therefore, comprehensive, multifaceted, and sustainable strategies are urgently needed, with an emphasis on child-centric approaches that prioritise empowerment, education, and collaboration between government, NGOs, and institutions such as schools. Furthermore, national reforms must also prioritise childhood exposure to DVA through increased funding, policy revisions, and public awareness campaigns to foster a supportive environment for affected children.

The findings also underscore the importance of reflexivity when conducting research across cultural and policy contexts. Earlier stages of this research shaped certain expectations around the understanding of childhood exposure to DVA; however, the qualitative findings emphasised

the need to remain open to local conceptualisations and lived experiences. This highlights the importance and value of culturally grounded, collaborative approaches to both research and intervention development.

Without a deeper understanding of the specific needs of children exposed to DVA perpetrated within the home, and a concerted effort to address structural, systemic, and societal barriers, children in Nepal will continue to face significant challenges in accessing the care and protection they need. By focusing on inclusive policies, sustainable support systems, and local engagement, Nepal can take essential steps towards protecting children from the often overlooked but significant harm of exposure to DVA.

Chapter 8 Discussion and Conclusion

Childhood exposure to domestic violence and abuse (DVA) perpetrated by caregivers or other adults in the household has been found to have an increased risk of an individual experiencing adverse outcomes in later life. However, the majority of this research has been conducted in high-income countries (HICs), with very little research or evidence on the context of childhood exposure to DVA in low- and middle-income countries (LMICs). Without this information, a potentially large number of children will grow up without their experiences being acknowledged or recorded, thereby limiting the potential interventions to reduce their risk of poor outcomes. In addition to this, the knowledge that we have may not be transferable from HICs to LMICs, and so even existing interventions that are designed, may not be applicable. The paucity of research does not just relate to one element of the topic of exposure within LMICs but is at every stage of the research process (Figure 1.1). Exploring the topic of childhood exposure to DVA in LMICs is, therefore, an urgent research priority, and this thesis provides a valuable contribution to enhancing our knowledge on this topic.

This thesis takes a four-paper format, with each of the empirical papers presented contributing to advancing our understanding of children's exposure to DVA in LMICs. It achieved this through distinct, but closely linked papers, representing essential stages of the process of conducting research in an emerging area (Figure 1.1). When the findings in these papers are taken together, they present an exceptionally detailed account of the current understanding of children's exposure to DVA within LMICs, advancing our understanding, and suggesting where further work is required.

This concluding chapter begins by summarising the research objectives of this thesis and how they have been addressed in the empirical papers. Section 8.1 explains how these papers contribute to advancing our understanding of childhood exposure to DVA in LMICs. Section 8.2 highlights the key conclusions drawn from the body of work presented in this thesis and discusses how they enhance our understanding of childhood exposure to DVA in LMICs. Section 8.3 then offer reflections on the strengths and limitations of the empirical research conducted for this thesis, which includes the implications of these novel findings. Following this, Section 8.4 presents a set of recommendations for future research that is necessary to achieve a comprehensive understanding of childhood exposure to DVA in LMICs. This discussion is informed by the limitations identified in this thesis. This chapter then ends with Section 8.5, which provides some final concluding remarks for the thesis.

8.1 Revisiting the Research Design

The overarching aim of this thesis was to enhance and develop the knowledge and understanding of childhood exposure to DVA in LMICs, by looking at the issue at all stages of the research process (Figure 1.1), from the start of the research process (defining the issue, how to measure it, and its scale), to the end, looking at approaches to policy responses to the issue, via the prevalence, risk factors, and implications. Using a mixed-methods approach (detailed in Chapter 3), each empirical paper contributes to this overall aim by investigating research questions linked to a stage of the research process, thereby fostering a more thorough understanding of childhood exposure to DVA in LMICs. The novel research findings presented in this thesis, when taken together, presents the first comprehensive overview of the current state of understanding of childhood exposure to DVA in LMICs, highlighting areas where further research and understanding are needed to ensure that children's experiences are recognised.

The first paper presented in this thesis, Paper One (Chapter 4) addressed the second stage of the research process: “How can it be measured?”. This paper addressed a critical research gap: whether existing tools that measure childhood exposure to DVA can be used to obtain estimates on the global scale of exposure. Following a review of scales using an existing framework for evaluating the methodological quality of measures, the scales were assessed based on current understanding of both DVA, and of exposure. The findings from this paper found that there are multiple measures for childhood exposure DVA, but there is no standardised approach, and they are sparsely used in LMICs. In addition, the language used within some of the accepted measures is outdated and does not reflect the current understanding of childhood exposure to DVA. Paper One provided the first published attempt to assess measures of exposure cross-culturally and question if they are applicable in a global context, and argues that gaining a global consensus on a measure is an urgent research priority to obtain country-level or global prevalence rates of childhood exposure to DVA.

Paper Two (Chapter 5) addressed the third stage of the research process: “How can it be measured?” and Paper Three (Chapter 6), the fourth stage: “How are people affected?”. These two chapters both used ten CDC Violence Against Children Surveys⁸⁴ (VACS, Chiang et al., 2016) and utilise quantitative methods to perform secondary data analysis to address the respective research questions. The aims of Paper Two (Chapter 5) were twofold: firstly, to assess the prevalence of childhood exposure to DVA across the ten LMICs; and secondly, to explore the risk factors associated with childhood exposure. Bivariate analysis and binary

⁸⁴ The ten VACS datasets used within the quantitative papers of this thesis (Paper Two and Paper Three) are Cambodia, Colombia, Côte d'Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, and Zambia.

logistic regression were utilised to assess the research questions, and identified that the existing estimates of childhood exposure to DVA (UNICEF, 2006) are likely outdated, as the paper revealed that over 19 million children have been exposed to DVA across the ten LMICs explored. In addition, it found that females are more likely to be exposed to DVA, and that exposure to DVA not only commonly occurs with exposure to other violence types, but is most commonly associated with the ecological domain of community and society. These novel findings provide the first multi-country comparative analysis looking at risk factors for exposure, and highlight specific groups at-risk of exposure. Paper Three (Chapter 6) builds explicitly on this, utilising bivariate analysis and binary logistic regression to explore mental health outcomes associated with childhood exposure to DVA in the same ten LMICs. The findings from this paper support existing research in HICs that childhood exposure to DVA is associated with adverse mental health outcomes in adolescence and early adulthood, and also highlighted how variables in the ecological domain of community and society also lead to an increased risk of adverse mental health.

The final paper of this thesis, Paper Four (Chapter 7), shifted the focus from a multi-country comparative analysis, to look at a specific country to address the fifth stage of the research process: “What is being done?”. This paper spoke to policymakers and professionals in Nepal working in the field of child protection or DVA, and explored the current understanding of childhood exposure to DVA amongst policymakers and professionals, and what is currently being done to support children who have been exposed to violence perpetrated between caregivers or other adults within their home. Thematic analysis revealed that there is a distinct lack of understanding, and there is confusion around childhood exposure to DVA in Nepal, which impacts children’s recognition within policy and programmes. In addition, the current support structures for children facing violence is fragmented, insufficient, and poorly coordinated. Finally, it argued for further research to understand the country-specific context of childhood exposure to DVA within Nepal to initiate a national conversation, to work towards the inclusion of childhood exposure to DVA in national policies, provision, and support.

The selection of data and methods used in each paper was guided by their suitability for answering the research questions. Table 8.1 provides an overview of the research questions that guided the research of each paper presented in this thesis. This develops Table 3.1 further, which detailed the objectives, stage of the research process it explored (Figure 1.1), data sources, and methods used within this thesis. In this table, data and methods are combined, and there is the additional column detailing the key findings produced by each paper. This table serves as a reminder of the papers within this thesis, from which the discussion and conclusions in this chapter follow.

Table 8.1 A table summarising the key findings of this research, in relation to the questions posed and the stage of the research process it addresses

Paper	Research Questions	Stage of Research Process (Figure 1.1)	Data and Methods	Key Findings
Paper One (Chapter 4)	- What current tools are available to measure childhood exposure to domestic violence and abuse? - Can existing measures of childhood exposure to domestic violence and abuse be used to obtain global estimates on the scale of exposure?	This paper links to the second stage of the research process: How can it be measured?	- Abstracts in electronic databases were searched for terms related to age, exposure, DVA, and those related to measurement. - Measures mentioned in formally peer-reviewed articles published in indexed journals were included, and grey literature were excluded. Measures exploring childhood exposure to DVA in any capacity were considered, including self-reported and caregiver reported measures, and if the measure looked at additional forms of violence. Modifications of established measures were examined individually and were included only if the modifications that had been made were related to the aims of the study. - The four measures applied cross-culturally were compared using the Consensus-based Standards for the selection of health Measurement Instruments approach and criterion for Patient-Reported	- Multiple measures for childhood exposure to DVA exist, but there is no standardised approach, and they are sparsely used in LMICs. - The language used within some of the accepted measures is outdated and does not reflect the current understanding of childhood exposure to DVA. - Global consensus on a measure is an urgent research priority to obtain country-level or global prevalence rates of childhood exposure to DVA.

Paper	Research Questions	Stage of Research Process (Figure 1.1)	Data and Methods	Key Findings
			Outcome Measures (COSMIN PROMs; Prinsen et al., 2018). - Information on structural validity, measurement invariance, measurement error, criterion validity, and responsiveness could not be found for any of the measures, and so these were not included in the comparison of the scales. - The four measures were then considered in line with the definition of DVA and of exposure used within this thesis.	
Paper Two (Chapter 5)	What is the prevalence of, and risk factors associated with, childhood exposure to domestic violence and abuse across selected low- and middle-income countries?	This paper links to the third stage of the research process: Who is affected?	- Secondary data analysis of ten CDC Violence Against Children Surveys (VACS). - Quantitative methods were applied through bivariate analysis and binary logistic regression.	- Over 19 million children have been exposed to DVA across the ten LMICs explored – meaning current estimates are much lower than reality. - Females are more likely to be exposed to DVA than females in the ten LMICs explored - Exposure to DVA often co-occurs with exposure to other violence types - Exposure to DVA was most associated with the ecological domain of community and society
Paper Three (Chapter 6)	How does childhood exposure to domestic violence and abuse influence mental health during	This paper links to the fourth stage of the research process: How are people affected?	Secondary data analysis of ten CDC Violence Against Children Surveys (VACS).	Childhood exposure to DVA is strongly associated with poorer

Paper	Research Questions	Stage of Research Process (Figure 1.1)	Data and Methods	Key Findings
	adolescence and adulthood within LMICs?		Quantitative methods were applied through bivariate analysis and binary logistic regression.	mental health in adolescence and early adulthood - There are differences in mental health outcomes by biological sex, with females more likely to experience internalising symptoms - Variables in the ecological domains of community and society also impact mental health outcomes
Paper Four (Chapter 7)	- What is the current level of awareness and understanding among policymakers and professionals in Nepal regarding childhood exposure to domestic violence and abuse? - What types of support and resources are currently available to children who are exposed to domestic violence and abuse in Nepal? - What policy changes, strategies, and interventions, can be implemented to improve the support for children exposed to domestic violence and abuse in Nepal?	This paper links to the fifth stage of the research process: What is being done?	- A semi-structured interview guide was used to conduct 21 in-depth interviews with key informants. - The key informants consisted of 21 respondents from either federal level government departments, international non-governmental organisations (INGOs), non-governmental organisations (NGOs), or were other recommended stakeholders (such as academics or freelancers, referred to as 'independent' in the paper). - Interviews were transcribed as verbatim, and thematic analysis performed following the six stage iterative and reflexive approach outlined by Braun and Clarke (2006; 2021).	- There is misunderstanding and confusion around childhood exposure to DVA in Nepal, impacting children's recognition within policy and programmes. - The current support structures for children facing violence is fragmented, insufficient, and poorly coordinated - Further research is required to understand the country-specific context of childhood exposure to DVA within Nepal to initiate a national conversation and work towards the inclusion of childhood exposure to DVA in national policies, provision, and support

Paper	Research Questions	Stage of Research Process (Figure 1.1)	Data and Methods	Key Findings
			This led to the development of four major themes: (1) the understanding and awareness of childhood exposure to DVA, (2) barriers to providing and accessing support for children exposed to DVA, (3) existing support and resources, and (4) future strategies and interventions.	

8.2 Discussion of the Key Findings of this Research

This thesis contributes to the understanding of children's exposure to DVA within LMICs – an emerging and relatively under-researched, but essential, topic. It does this by taking the topic of exposure to DVA in LMICs from the start of the research process (defining the issue, how to measure it, and its scale) to the end, looking at policy responses to the issue, via the prevalence, risk factors, and implications – a piece of work which, before this thesis, had not yet been presented as a coherent whole.

When read in its entirety, this thesis presents a comprehensive overview of the current understanding of children's exposure to DVA in LMICs, highlighting where further research is required to ensure that children's voices are heard, and appropriate policies and interventions are developed to ensure their protection. The following section discusses the key findings and contributions of each of the four empirical papers of this thesis in turn.

Paper One: Measuring Exposure to DVA

Key Finding 1: Multiple measures for children's exposure to DVA exist, but there is no standardised approach, and they are sparsely used in LMICs

Prior to this research, numerous measures existed to assess children's exposure to DVA, but there was little consensus on which tools were most valid or appropriate for use in LMICs. Existing reviews (e.g., Latzman et al., 2017) tended to focus on high-income settings and rarely engaged with questions of cross-cultural applicability or psychometric rigour. This thesis addressed that gap by conducting a review and critical appraisal of ten identified measures using the COSMIN (CONsensus-based Standards for the selection of health Measurement INstruments) approach and criterion for Patient-Reported Outcome Measures (PROMs; Prinsen et al., 2018) framework – a methodological approach not previously applied in this context.

Of the ten measures identified, only four had been employed cross-culturally⁸⁵. These measures were the Child Exposure to Domestic Violence Scale (CEDV; Edleson, Shin & Armendariz, 2008), Children's Perception of Interparental Conflict Scale (CPIC; Grych, Seid & Fincham, 1992), Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Omrod & Turner, 2005), and the Violence Exposure Scale for Children (VESC; Fox & Leavitt, 1995). However, of these measures,

⁸⁵ Amongst the databases searched, for inclusion criteria see Section 4.2.2.

only three (the CEDV, JVQ, and CPIC) had been implemented in LMICs, and even these applications were limited, often lacking formal cross-cultural adaptation. The CEDV emerged as the most comprehensive and promising tool, based on its breadth of coverage, some use in LMICs, alignment with the COSMIN PROMs indicators, and consistency with current conceptualisations of childhood exposure to DVA (Holden, 2003; Callaghan et al., 2017).

This analysis made three significant contributions. First, it is the first known study to systematically evaluate the psychometric quality and conceptual fit of DVA exposure measures for children using COSMIN criteria. Second, it explicitly centres the question of LMIC applicability, which is a major gap in the existing literature. Third, it demonstrates how current practices, including the modification of existing tools or creation of bespoke survey items (for example, in the VACS), reflect not only conceptual developments such as gender-neutral framing or expanded abuse typologies, but also a lack of standardisation that hampers cross-national research and global monitoring.

These adaptations are often motivated by evolving understandings of DVA, for example to include non-gendered perpetrators or recognise forms of abuse beyond the physical, such as emotional or economic abuse. However, without consensus or validated guidance, such adaptations vary widely, which undermines the validity and comparability of findings. This has serious implications. Without standardised and validated measures that are appropriate across diverse cultural contexts, the true prevalence of childhood exposure to DVA cannot be accurately estimated. This not only limits stage two of the research process (see Figure 1.1) in understanding the scale of the problem, but also undermines stage three: identifying which children are most at risk and in need of support.

Furthermore, the sparse use of formal measures in LMICs raises broader concerns about global equity in knowledge production and monitoring. It reflects both methodological and ethical issues around whose experiences are counted, and highlights the urgent need for a coordinated, globally-informed consensus on how childhood exposure to DVA should be defined and measured.

Key Finding 2: The language used within some of the accepted measures is outdated and does not reflect the current understanding of exposure to DVA

As research into children's experiences of DVA has advanced, so too has the conceptualisation of what constitutes exposure. Early studies often referred to children as "witnesses" to DVA, implying a passive role limited to visual observation of physical violence (Holt, Buckley, &

Whelan, 2008). However, contemporary research increasingly recognises that children may be exposed in more complex, indirect, and harmful ways – including overhearing violence, being aware of its effects, living in an atmosphere of ongoing fear, experiencing impaired caregiving, or intervening during incidents (Evans et al., 2008; Callaghan et al., 2017; Øverlien, 2010). Such exposure can result in psychological harm even when children do not directly see the violence occur. This evolution reflects a broader shift in child-focused research and rights-based approaches, which increasingly acknowledge children as active social agents whose experiences and interpretations of violence matter (Callaghan et al., 2018; Øverlien, 2013).

This shift in understanding is reflected in frameworks like Holden’s (2003) taxonomy, which outlines ten distinct modes of exposure beyond direct witnessing. In Paper One (Chapter 4), the four reviewed measures that had been used in LMICs – the Child Exposure to Domestic Violence Scale (CEDV; Edleson, Shin & Armendariz, 2008), the Children’s Perception of Interparental Conflict Scale (CPIC; Grych, Seid & Fincham, 1992), the Juvenile Victimization Questionnaire (JVQ; Finkelhor, Hamby, Omrod & Turner, 2005), and the Violence Exposure Scale for Children (VESC; Fox & Leavitt, 1995) – were assessed against Holden’s taxonomy, as well as current definitions of DVA that emphasise coercive control, psychological abuse, and post-separation harm (Ellsberg & Heise, 2005; Women’s Aid, 2018; WHO, 2021).

This analysis revealed that many of the measures in use still reflect outdated conceptualisations. Several tools prioritised visible acts of physical violence and neglected less overt but equally harmful forms of exposure. Only the CEDV captured a wide range of both exposure types (e.g. overhearing, intervening, observing consequences) and abuse types (e.g. emotional, psychological, coercive control), making it the most conceptually aligned with contemporary understandings.

These outdated framings raise concerns about both validity and comprehensiveness. If measures do not fully capture the different ways in which children experience DVA, they risk underestimating prevalence, misrepresenting who is affected, and overlooking key pathways of harm (Hester et al., 2007). This is particularly problematic when such tools are used in large-scale data collection efforts in LMICs, where these nuances are already under-researched. Such challenges are compounded in LMICs, where resource constraints and contextual variation hinder the adaptation and validation of existing tools. This also has practical implications: if definitions embedded in tools fail to capture more hidden or indirect forms of exposure, affected children may be overlooked by professionals and policymakers, limiting access to appropriate interventions.

While researchers may attempt to adapt existing measures to better reflect contemporary definitions (for example, by including gender-neutral language or adding items on psychological abuse) these adaptations vary considerably. In the absence of clear guidance or agreed standards, such modifications can further compromise comparability across studies and settings. These findings therefore underscore the urgent need to revisit and revise existing measures to ensure they are conceptually current, psychometrically robust, and suitable for use across diverse cultural contexts. Together with Key Finding 1, this reinforces the case for a globally agreed, standardised measure of childhood exposure to DVA. Without such tools, research will continue to rely on partial indicators that fail to reflect the full spectrum of children's lived experiences and may ultimately misguide policy and intervention design. These findings also directly inform Key Finding 3, which highlights the urgent need for global consensus on how childhood exposure to DVA should be measured.

Key Finding 3: Global consensus on a measure is an urgent research priority to obtain country-level or global prevalence rates of childhood exposure to DVA

As established in Key Findings 1 and 2, the measurement of childhood exposure to DVA lacks standardisation, conceptual clarity, and consistency across settings. The conclusions of Paper One, and, as a result, Key Finding 3 builds on this by arguing that the absence of a globally accepted, cross-culturally validated tool represents a fundamental barrier to understanding the scale and nature of childhood exposure to DVA – and, by extension, to designing effective prevention and response strategies.

While other forms of violence against children have received increasing attention in global monitoring systems (such as physical punishment, sexual abuse, and bullying), exposure to DVA has not been similarly prioritised or consistently measured (Finkelhor, 2008; Hillis et al., 2016; Devries et al., 2018). Even within internationally recognised survey programmes, such as the VACS, inconsistencies exist in how exposure is defined, operationalised, and recorded (Chiang et al., 2016). This compromises comparability, undermines data quality, and risks masking the true scope of the issue across countries and contexts.

Paper One provides the first systematic, comparative evaluation of tools used to measure children's exposure to DVA in LMICs, addressing a major gap in the literature. Four tools were assessed against Holden's (2003) taxonomy and contemporary definitions of both DVA and exposure, including psychological abuse and coercive control. The Child Exposure to Domestic Violence Scale (CEDV; Edleson, Shin & Armendariz, 2008) emerged as the most conceptually

aligned with current understandings, but no measure fully captured the breadth of children's experiences or had been validated for widespread cross-national use. By assessing these tools through a child-centred lens that foregrounds conceptual relevance, contextual suitability, and alignment with children's lived experiences, the paper contributes new evidence to support measurement consensus and global efforts to address childhood exposure to DVA. This finding directly supports calls for harmonisation in child protection indicators used in global research and development monitoring (Hujo & Carter, 2019; UNICEF Office of Research – Innocenti, 2019).

The implications extend beyond prevalence estimation. A validated, standardised tool would allow researchers and policymakers to monitor intervention effectiveness, track trends over time, and conduct cross-country comparisons. It would also facilitate inclusion of childhood exposure to DVA in global development frameworks, such as the Sustainable Development Goals (SDGs; United Nations, 2015). For example, exposure could be more explicitly integrated into SDG 5.2 ("Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation") and SDG 16.2 ("End abuse, exploitation, trafficking and all forms of violence against children"). This would help ensure that the hidden experiences of children living with DVA are made statistically visible, ethically acknowledged, and politically actionable.

The need for consensus is especially urgent given growing legal recognition of children's exposure to DVA as a form of harm in its own right (e.g., Home Office & Ministry of Justice, 2021). However, without reliable baseline data, efforts to enforce accountability or measure progress are limited. Moreover, the lack of clear definitions and measurement standards risks reinforcing fragmentation in global and national policy responses.

Taken together, the findings of Paper One make three key contributions to the evidence base on childhood exposure to DVA in LMICs. First, the paper highlights the lack of a standardised, cross-culturally validated tool for measuring exposure, and demonstrates how current approaches lack conceptual clarity and consistency (Key Finding 1). Second, it shows that existing measures often rely on outdated or narrow definitions that fail to reflect evolving understandings of DVA and children's experiences of harm, underscoring the need for more inclusive and theoretically grounded tools (Key Finding 2). Third, by conducting the first systematic, multi-tool evaluation of measures used in LMICs, the paper generates new empirical evidence to inform global measurement consensus, strengthen prevalence monitoring, and advocate for the integration of exposure to DVA into international development

frameworks (Key Finding 3). Collectively, these contributions provide a critical foundation for future research, measurement harmonisation, and child-centred policymaking.

Paper Two: Prevalence and Risk Factors for Exposure to DVA

Key Finding 4: Over 19 million children have been exposed to DVA across the ten LMICs explored – meaning current estimates are much lower than reality

Perhaps the most important contribution of Paper Two (Chapter 5) is the finding that current global estimates of childhood exposure to DVA are significantly underestimated. Despite long-standing recognition that such exposure is both widespread and harmful (UNICEF, 2006; World Health Organization, 2024a), robust prevalence data remain limited, particularly in LMICs. Existing global estimates often rely on extrapolations from small-scale studies, indirect proxy indicators, or inconsistent definitions of violence (UNICEF, 2017; Devries et al., 2013). Previous reviews have also highlighted the lack of standardised tools for cross-country comparisons (Kieselbach et al., 2022). Paper Two addresses this evidence gap by generating the first cross-national, standardised prevalence estimates of childhood exposure to parental DVA across ten LMICs, using nationally representative VACS data. Due to the consistent measurement approach employed across countries, these estimates are directly comparable and provide an empirical foundation for future cross-national work.

The results indicate that more than 19 million adolescents and young adults across the ten countries were exposed to DVA⁸⁶ before the age of 18, accounting for 7.21-14.91% of the existing UNICEF (2006) global estimate of 275 million children (Figure 2.1). As previously mentioned, we cannot be certain that the exposure estimates within this paper would apply outside the ten countries explored. However, we can take a closer look at the region of Sub-Saharan Africa (a region with 46 countries), where UNICEF placed the number of children exposed to DVA at 34.9 to 38.2 million. In contrast, the six Sub-Saharan African countries included in this study alone accounted for nearly 17 million exposed children⁸⁷, equating to 43.71-47.84% of UNICEF's regional estimate. This suggests that in comparison to other countries, either these six countries have very high prevalence rates for children's exposure to

⁸⁶ The analysis within Paper Two estimates that the number of children exposed to DVA across the ten LMICs explored is 19,836,545 (17,931,427-21,888,634).

⁸⁷ The analysis within Paper Two estimates that the number of children exposed to DVA in the region of Sub-Saharan Africa (six countries) is 16,695,401 (15,259,908-18,213,423).

DVA in comparison to other countries in the region, the UNICEF statistics are extremely low, or there are other factors at play. UNICEF's estimates were derived from a review of existing studies that measured violence in the home across various countries but did not use a standardised tool. This inconsistency in measurement may have led to under- or over-reporting, further limiting the accuracy of those figures (UNICEF, 2006). These figures and comparisons strongly suggest that current global figures are likely to be significant underestimates, reinforcing the urgent need for updated global statistics and standardised data collection efforts (supporting Key Finding 3).

Several factors may explain this disparity. First, the estimates provided in Paper Two are based on a consistent, nationally representative methodology – an important advance over earlier global estimates derived from diverse sources and variable methods. Second, even the 19 million figure presented here is likely conservative. The VACS questions used in this analysis measure only two of Holden's (2003) ten modes of exposure (seeing and hearing) and focus solely on acts of physical violence (e.g. hitting, kicking, or beating). Other forms of abuse, including psychological and economic coercion, coercive control, post-separation violence, and impaired caregiving, are not captured, despite their recognised harm (Ellsberg & Heise, 2005; Callaghan et al., 2018; United Nations, 2023). This contrasts with a growing body of research calling for broader conceptualisations of harm that account for emotional and developmental impacts (Øverlien, 2010; Orr et al., 2020). If other types of violence encompassed under the definition of DVA (for example, physical, sexual, or psychological, as well as involving violence such as economic coercion⁸⁸) and all ten types of exposure (Holden, 2003) were included, the estimates of children's exposure to DVA would almost certainly exceed the figures presented in this paper.

This highlights a key tension between data availability and the evolving conceptual framing of childhood exposure to DVA (Øverlien, 2013). As in Key Findings 2 and 3, the findings underscore the need for a globally agreed measurement tool that reflects contemporary understandings of both DVA and the multiple ways in which children experience its effects. Without such tools, prevalence estimates will continue to underestimate the scale of exposure, and affected

⁸⁸ Examples of physical aggression include slapping, hitting, shaking, kicking, burning, or threatening someone with a dangerous object, such as a knife; sexual abuse includes coerced sex through threats or intimidation or through physical force, forcing unwanted sexual acts, forcing sex in front of others, and forcing sex with others (UNICEF, 2006). Finally, psychological violence involves acts such as humiliation, intimidation, excessive jealousy, control of a victim's activities, verbal aggression, constant belittling and humiliation, and behaviours such as stalking or isolating a victim from friends or family (Evans, Davies, & DiLillo, 2008).

children may remain invisible to policymakers and service providers. This study contributes new comparative evidence from LMICs to inform that process, supporting efforts to better define, measure, and ultimately prevent children's exposure to domestic violence globally. Therefore, while the headline figure of 19 million exposed children across the ten countries is striking, it should be understood as a minimum estimate, and one that points to a much larger, unmeasured burden of harm.

Key Finding 5: Females are more likely to be exposed to DVA than males in the ten LMICs explored

Paper Two (Chapter 5) found that, across the ten countries included in this study, females were more likely than males to report exposure to DVA before the age of 18. This sex-based difference was evident in bivariate analyses, and remained significant in both the individual-level regression model (Model 1, Table 5.6) and the full additive model (Model 4, Table 5.9), although the size of this difference varied across countries.

In the individual-level model, predicted probabilities of childhood exposure to DVA were consistently higher for females than males in six countries. For example, in Colombia, 24.22% of females reported exposure, compared to 16.45% of males; in Honduras, 14.39% of females versus 8.92% of males. Similar disparities were observed in Lesotho, Nigeria, and Zambia, where predicted probabilities for females ranged from 33.01% to 34.43%, compared to 25.82% to 28.18% for males. In Moldova, the gap was especially pronounced: 23.19% of females were exposed, compared to just 13.32% of males. These patterns largely persisted in the full additive model. For example, even after adjusting for all other individual, family, community, and societal-level variables, the predicted probability of exposure in Moldova remained notably higher for females (12.99%) than for males (5.83%). A similar pattern was found in Honduras (5.26% for females versus 3.07% for males). Across both models, sex was the only individual-level factor that remained statistically significant in every country, suggesting that biological sex remains a significant correlate of exposure to DVA, even when broader contextual factors are taken into account.

This gender disparity aligns with longstanding global evidence suggesting that women and girls face a disproportionate burden of violence within the home (Koenig et al., 2003; UNICEF, 2016). It also reflects deeply embedded gender norms that shape both the perpetration and intergenerational transmission of violence (Widom, 1989; Jewkes et al., 2015; Fulu et al., 2017). Girls may be more likely to be exposed to DVA because they are more likely to reside with

mothers who experience partner violence, or to take on caregiving roles that increase their proximity to, or awareness of, abuse (Hamby et al., 2011; Katz, 2016; UNICEF, 2016). In addition, they may also be more likely to report or recognise such experiences. In some contexts, gendered socialisation may encourage girls to adopt protective or empathetic roles within the family, making them more likely to witness inter-parental conflict or provide emotional support to the non-abusing parent (Callaghan et al., 2018). These patterns are shaped by prevailing gender norms that influence both the distribution of violence and children's roles within the household (Jewkes et al., 2015).

While reporting bias cannot be ruled out, the consistency of findings across countries with differing cultural contexts suggests that the observed patterns are not solely due to differences in disclosure. These findings also align with wider literature showing that girls are more likely than boys to be exposed to interpersonal violence within the home (UNICEF, 2006; Palermo et al., 2019). Several mechanisms may contribute to this disparity. Gendered expectations and household power dynamics may place girls in closer proximity to violence or caregiving roles that increase exposure (Koenig et al., 2003; Palermo et al., 2019), and in settings where violence against women is normalised, girls may internalise or replicate relational patterns shaped by exposure to abuse perpetrated toward a caregiver. This study adds to existing evidence by demonstrating that these patterns hold true even when using harmonised, nationally representative data across ten LMICs – a contribution not yet reflected in prior multi-country analyses.

These findings also speak directly to international policy frameworks. Gender-based violence is a global public health priority, and tackling children's exposure to DVA is central to achieving Sustainable Development Goal (SDG) 5.2: "Eliminate all forms of violence against all women and girls in the public and private spheres." Children's exposure also relates to SDG 16.2: "End abuse, exploitation, trafficking and all forms of violence against children" (United Nations, 2015). Understanding the gendered dimensions of exposure to DVA is therefore critical for meeting these commitments and ensuring that prevention and response strategies are appropriately tailored. The findings presented here provide a strong evidence base to inform that aim.

However, while females were more likely to report exposure overall, this does not mean that males are unaffected. These findings reinforce the importance of gender-sensitive but inclusive approaches to prevention and support, recognising that DVA impacts children of all genders, but that patterns of risk, recognition, and help-seeking may differ. They also underscore the

need for more nuanced and disaggregated data to understand how intersecting factors such as gender, age, and household dynamics influence children's exposure and resilience. This analysis provides a starting point for such disaggregation, using a large, standardised dataset to highlight persistent gender disparities across diverse settings.

Key Finding 6: Exposure to DVA often co-occurs with exposure to other violence types

The findings from Paper Two (Chapter 5) demonstrate that childhood exposure to DVA frequently co-occurs with exposure to other forms of violence both within and beyond the household, such as community violence and child abuse. As shown in Table 5.1, exposure to community violence had the highest prevalence across all ten VACS countries, ranging from 21.01% (females in Lesotho) to 62.67% (males in Moldova). Exposure to child abuse was also widespread, with over half of children in Nigeria (56.59%) reporting exposure, alongside 42.02% in Côte d'Ivoire and 41.72% in Malawi.

While DVA exposure was generally less common than community violence, this pattern diverged in some settings, particularly for females. In Lesotho, 32.02% of females reported exposure to DVA, compared to only 21.01% for community violence. Similarly, in Malawi, the gap between DVA (30.29%) and community violence (30.31%) among females was minimal. These trends may reflect societal norms and gendered expectations around girls' domestic roles and greater time spent in the home. This may increase their exposure to household-level violence while reducing community-level risk, echoing existing research on gendered vulnerability and mobility constraints (Callaghan et al., 2018; Jewkes et al., 2015).

The overall additive regression model (Model 4, Table 5.9) supports these patterns of co-occurrence. Exposure to community violence was the only factor found to be significant across all ten countries, underscoring its robust association with childhood exposure to DVA. For example, the predicted probability of DVA exposure among children who had also experienced community violence was 50.13% in Lesotho, 53.24% in Zambia, and 40.88% in Nigeria, compared to 28.10%, 25.05%, and 12.98% respectively for those not exposed to community violence. These stark differences illustrate the clustering of violence types within children's lives and support social disorganisation theory, which posits that structural instability and weakened community cohesion can increase vulnerability to violence both inside and outside the home (Shaw & McKay, 1942). While it is widely recognised that adversities tend to cluster, few studies have quantified the strength of this association across multiple LMICs using nationally

representative data. This study provides new evidence that community violence is not only prevalent but systematically associated with increased risk of childhood exposure to DVA across diverse cultural contexts.

While co-occurrence with exposure to child abuse was not modelled due to questionnaire limitations (notably in Cambodia), high rates of exposure to child abuse in countries like Nigeria and Côte d'Ivoire further could suggest that many children exposed to DVA are also directly victimised themselves. Although the variable within the analysis captured physical violence directed at siblings rather than against the respondent⁸⁹, it may function as a proxy for a broader violent or unsafe household environment. This resonates with literature on Adverse Childhood Experiences (ACEs), which highlights that childhood adversities rarely occur in isolation and that polyvictimisation is common (Felitti et al., 1998; McKay, 1994).

These findings highlight that childhood exposure to DVA rarely occurs in isolation. Instead, it often forms part of a broader ecology of risk and violence within children's lives. This reinforces the importance of integrated, whole-systems approaches to violence prevention that move beyond siloed interventions focused solely on the family or household. Addressing community- and societal-level factors (discussed further in Key Finding 7) and acknowledging polyvictimisation are essential for developing effective responses to childhood violence.

Key Finding 7: Exposure to DVA was most associated with the ecological domain of community and society

Prior research on childhood exposure to DVA has largely focused on individual and family-level risk factors, including biological sex, parental absence, and household poverty (Fantuzzo & Mohr, 1999; Hindin & Gultiano, 2006; Carlson, 2000). While previous research has rarely examined community and societal risk factors of childhood exposure to DVA in LMICs, this paper makes a novel contribution by modelling multiple ecological domains simultaneously. It demonstrates that community and societal factors (not individual or family factors) are the most consistent and robust predictors across ten diverse countries.

The findings from Paper Two (Chapter 5) demonstrate that risk factors for childhood exposure to DVA span multiple ecological domains, including individual, family, and community and societal levels. At the individual level variables, biological sex remained a consistent predictor

⁸⁹ The VACS does ask questions related to direct experiences of child abuse, but these were not explored in analysis within this thesis. This limitation is acknowledged and discussed in further detail in Sections 6.4.2 and 8.3.

of exposure to DVA in both bivariate and multivariate models, with females consistently showing higher predicted probabilities of exposure than males across most countries (Key Finding 5). However, other factors such as educational attainment, were less consistently associated with DVA exposure than prior studies might suggest (although prior to this paper, these were not explored in a multi-country study of LMICs in the context of childhood exposure to DVA). Although prior research has identified school attendance as a protective factor (Breiding et al., 2011; Fantuzzo & Mohr, 1999; Flynn-O'Brien & Rivara, 2021), education level did not emerge as a strong or consistent predictor in the full additive model. At the family level, some associations were observed, although they varied by country. For example, the death of a biological parent was linked to lower predicted probabilities of DVA exposure in six of the ten countries, although this association was not consistently significant in the full additive model (Model 4, Table 5.9). Similarly, not living with both biological parents was associated with higher predicted probabilities of exposure in several countries, consistent with literature linking non-traditional family structures to increased risk of violence⁹⁰ (Meltzer et al., 2009; Breiding et al., 2013; Flynn-O'Brien & Rivara, 2021). However, these findings were not universal and suggest that while family structure can shape exposure, it does not fully explain children's vulnerability to exposure to DVA.

In contrast, the most consistent and robust associations were found at the ecological domain of community and society, where two factors were examined: exposure to community violence and societal acceptance of DVA. In Model 3 (Table 5.8), which focused solely on this ecological domain, exposure to community violence was significantly associated with higher predicted probabilities of childhood exposure to DVA in nine of the ten countries (all $p < 0.01$ except Colombia). For example, in Nigeria, the predicted probability of childhood exposure to DVA was 43.47% among children exposed to community violence, compared to 15.92% for those unexposed. Similar strong differences were observed in Zambia (44.18% vs. 19.03%) and Lesotho (40.13% vs. 22.61%). These patterns illustrate a consistent association between exposure to violence in the community and being exposed to DVA at home.

Crucially, exposure to community violence was the only variable that remained significantly associated with DVA exposure across all ten countries in the full additive model (Model 4, Table 5.9). This provides strong cross-national evidence in support of social disorganisation theory (Shaw & McKay, 1942), which posits that structural disadvantage, community fragmentation,

⁹⁰ When considering family structure, it is important to acknowledge that family composition and structure may both be a cause, and/or a consequence of violence. This is reflected on in further detail in Section 5.3.3.2.

and weakened informal social controls can increase vulnerability to multiple, overlapping forms of violence. These findings align with the broader literature on violence clustering, whereby different forms of violence co-occur within the same contexts or families (Finkelhor et al., 2007; Hamby et al., 2010). This advances our understanding by showing that community-level risk is not only prevalent but systematically linked to household DVA across diverse contexts – an association previously assumed but not empirically established at this scale.

Societal acceptance of DVA was also significantly associated with childhood exposure to DVA in several countries, including in both the community and societal model (Model 3, Table 5.8) and full additive model (Model 4, Table 5.9). For instance, in Malawi, respondents who believed that DVA was acceptable had a predicted probability of DVA exposure of 35.12%, compared to 23.58% among those who did not. In Moldova and Namibia, the differences were also pronounced (20.86% vs. 9.50%, and 15.18% vs. 8.87% respectively; all $p < 0.01$). These results reinforce the role of normative environments in shaping whether DVA is likely to occur and be visible to children (Caprioli, 2005; Kim et al., 2012; Lourenço et al., 2013). Some respondents failed to answer all elements of the question when asked about DVA acceptability (therefore being noted as “incomplete answer”), and in countries such as Côte d’Ivoire, this group had lower predicted probabilities of exposure. This may reflect differing patterns of disengagement, social desirability bias, or discomfort in discussing sensitive issues, highlighting the importance of measurement sensitivity in global DVA research (Paper One, Chapter 4) and the need for a global consensus on a culturally appropriate and conceptually aligned measure (Key Finding 3).

Taken together, these findings establish the community and societal ecological domain as the most salient in predicting children’s risk of exposure to DVA. While individual and family-level factors showed variable associations, exposure to community violence remained significant in all ten countries, even after controlling for other variables. This is one of the first studies to demonstrate this pattern across multiple LMICs using standardised data.

Importantly, these domains do not operate in isolation. As discussed in Paper Four (Chapter 7), structural and cultural forces (such as poverty, gender inequality, and intergenerational trauma) intersect with family and individual-level factors to shape children’s experiences. For example, in settings where DVA is more widely accepted, this may amplify the risk associated with family separation or bereavement. Similarly, professional stakeholders in Nepal highlighted how weak community systems and limited institutional coordination contributed to inadequate support for children exposed to violence (Paper Four, Chapter 7). It is crucial to recognise that while these ecological domains are analytically distinct, factors across them interact to create

environments where DVA is more likely to occur. For instance, societal beliefs and values may intersect with a family's economic status to affect risk. In contexts where women lack access to education, employment, or financial independence, they may be more susceptible to abuse and less able to leave abusive relationships (Fantuzzo et al., 1997; Koenig et al., 2003). The findings of this study therefore reinforce calls for multi-level, whole-systems approaches to prevention, addressing not only family-level risk factors, but also the broader structural and normative conditions in which DVA occurs. These findings reinforce the value of ecological models and strengthen calls for multi-level, whole-systems approaches to prevention that move beyond treating the family in isolation. To be effective and equitable across diverse global settings, interventions must also engage with the broader conditions that shape risk, including social norms, neighbourhood disorganisation, poverty, and gender inequality.

Taken together, the findings of Paper Two make four key contributions to the evidence base on childhood exposure to DVA in LMICs. First, they provide the first cross-national prevalence estimates using nationally representative data and a consistent measurement approach, showing that over 19 million children across the ten study countries have been exposed to parental DVA (Key Finding 4). This suggests that global estimates may substantially understate the true scale of the issue. Second, the analysis confirms gendered patterns of exposure, with females consistently more likely than males to report exposure across most countries (Key Finding 5). This reinforces existing literature on gendered vulnerability while highlighting the need for further research into contextual variation and the role of gender norms. Third, the study demonstrates that DVA rarely occurs in isolation, frequently co-occurring with other forms of violence such as community violence and child abuse (Key Finding 6). These findings support the concept of polyvictimisation and underscore the need for integrated violence prevention strategies. Finally, the paper identifies community and societal factors, particularly exposure to community violence and societal acceptance of DVA, as the strongest and most consistent predictors of childhood exposure across all ten countries (Key Finding 7). This shifts the analytical and policy focus beyond the family unit, providing robust support for whole-systems approaches that address structural and normative drivers of violence. Collectively, these contributions offer new empirical insights that challenge assumptions about where risk resides and can inform more effective, contextually grounded interventions.

Paper Three: Mental Health Outcomes for Exposure to DVA

Key Finding 8: Childhood exposure to DVA is strongly associated with poorer mental health in adolescence and early adulthood

There is a well-established body of literature from HICs linking childhood exposure to DVA with adverse mental health outcomes, including internalising symptoms such as depression and anxiety, and externalising symptoms such as aggression and risk-taking behaviours (Kitzmann et al., 2003; Wolfe et al., 2003; Margolin & Vickerman, 2007; Evans et al., 2008). However, the vast majority of this literature is drawn from HIC contexts, and population-level analyses from LMICs remain extremely limited, particularly using nationally representative data. Paper Three (Chapter 6) addresses this critical gap by presenting the first cross-national analysis of predicted probabilities for mental health outcomes associated with childhood exposure to DVA across ten LMICs, using harmonised VACS data. These findings are also consistent with an earlier VACS-based study in Cambodia, Malawi, and Nigeria (Kieselbach et al., 2021), although this study expands the evidence base to ten LMICs and incorporates adjusted predicted probabilities.

Across almost all countries, those who had been exposed to DVA in childhood had significantly higher predicted probabilities of experiencing both internalising and externalising mental health symptoms across multiple countries. These associations remained significant even after adjusting for a range of individual, family, and community-level factors.

When looking at internalising symptoms, psychological distress was substantially higher in all ten countries explored. For example, the probability of psychological distress was 46.37% among exposed individuals in Zambia, compared to 38.10% among their non-exposed peers; in Honduras, the figures were 42.05% and 31.13%, respectively. The association was even more pronounced in Colombia (37.70% vs. 21.95%) and Moldova (41.29% vs. 23.83%), where the predicted probability of psychological distress was nearly twice as high among those exposed to DVA. Similarly, intentional self-harm was elevated in Honduras (7.74% vs. 5.55%) and Cambodia (7.62% vs. 3.22%). Suicidal thoughts were significantly more common among those exposed to DVA in nine of the ten countries, including Cambodia, where the predicted probability was more than three times higher (2.24% vs. 0.66%), and Zambia (13.05% vs. 8.05%). These findings echo earlier research on the psychological impact of exposure to DVA, including disrupted emotional regulation, increased fear and helplessness, and chronic stress (Galano et al., 2014; Sternberg et al., 2006).

Childhood exposure to DVA was also significantly associated with externalising symptoms, including engaging in risky behaviours and perpetrating both physical DVA and non-partnered violence. In Namibia, the predicted probability of engaging in risky behaviours of 44.41%, compared to 33.22% for their non-exposed peers, and similar gaps were observed in Nigeria (45.42% vs. 25.91%) and Lesotho (37.67% vs. 28.21%). Perpetration of physical DVA was notably higher in Zambia (12.07% vs. 5.79%) and Malawi (4.28% vs. 2.18%), while perpetration of non-partnered violence was elevated in Lesotho (17.99% vs. 10.35%) and Malawi (78.82% vs. 60.89%), suggesting that childhood exposure to DVA may contribute to broader patterns of aggressive or violent behaviour beyond intimate partnerships. These findings support social learning theory (Bandura, 1973) and theories of intergenerational transmission of violence, which suggest that early exposure to family violence may shape attitudes, normalise aggression, and impair the development of pro-social conflict resolution strategies (Widom, 1989; Ireland & Smith, 2009).

Taken together, these findings build on existing evidence by demonstrating that the mental health impacts of childhood exposure to DVA are not limited to HIC or Western contexts. This study makes a novel and policy-relevant contribution by being the first to provide standardised, cross-national estimates of the mental health burden associated with childhood DVA exposure in LMICs, thereby extending the global evidence base and offering urgently needed data to inform global child protection and development strategies. The findings from Paper Three (Chapter 6) build on those of Paper Two (Chapter 5), which showed the widespread prevalence and co-occurrence of DVA with other forms of violence, underscoring the need for holistic, trauma-informed responses. They also reinforce arguments from Paper One (Chapter 4) about the importance of improved measurement to enable international comparisons and policy planning.

By evidencing consistent mental health associations across culturally and economically diverse settings, this study underscores the global relevance of early trauma for adolescent wellbeing and reinforces the urgency of prioritising DVA prevention and mental health support in child protection systems and development agendas. Future research should extend the range of mental health outcomes explored and examine protective and mediating factors that support resilience and mental wellbeing in LMIC settings.

Key Finding 9: There are differences in mental health outcomes by biological sex, with females more likely to experience internalising symptoms

Prior research in high-income settings has consistently shown that females exposed to DVA are more likely to experience internalising symptoms such as anxiety, depression, and suicidal thoughts; while males may be more prone to exhibiting externalising symptoms, including aggression and antisocial behaviour (Evans et al., 2008; Fergusson & Horwood, 1998; Wolfe et al., 2003; Baldry, 2007; Sternberg et al., 2006). Paper Three (Chapter 6) contributes new evidence from LMICs, using harmonised VACS data to estimate predicted probabilities of mental health outcomes disaggregated by biological sex. This provides the first standardised, multi-country estimates of sex-based mental health outcomes associated with DVA exposure across ten LMICs, advancing the field beyond previous single-country studies and odds-based metrics. These findings are also consistent with earlier VACS-based analyses in Cambodia, Malawi, and Nigeria (Kieselbach et al., 2021), although this study contributes to the evidence base considerably, expanding analysis to include more countries, outcomes, and incorporates adjusted predicted probabilities across multiple outcomes. To the researcher's knowledge, this is the first study to estimate sex-disaggregated, cross-national predicted probabilities for these outcomes in diverse LMIC contexts.

The results show a consistent gendered pattern in mental health outcomes across ten LMICs, across both internalising and externalising symptoms. For internalising symptoms, in all countries with significant results, females exposed to DVA had a higher predicted probability of psychological distress than their male peers. For example, in Namibia, the predicted probability of psychological distress was 38.32% among females compared to 20.64% among males; in Colombia, the figures were 34.11% and 20.56%, respectively; and in Moldova, 34.69% vs. 23.83%. Similar patterns were observed in Cambodia (32.12% vs. 21.95%), Honduras (39.04% vs. 31.13%), and Côte d'Ivoire (19.13% vs. 15.08%). Suicidal thoughts also showed consistent sex-based disparities. In Zambia, the predicted probability of suicidal thoughts among exposed females was 13.01%, compared to 8.05% for males; in Namibia, Colombia, and Honduras, the gaps were similarly wide (6.90% vs. 1.87%; 4.27% vs. 0.87%; and 7.79% vs. 2.00%, respectively). These patterns support existing psychological theories suggesting that females may internalise trauma more than males due to gendered norms around emotional expression (Baldry, 2007; Sternberg et al., 2006), and highlight the heightened emotional and psychological burden experienced by females exposed to DVA.

For externalising symptoms, biological sex also demonstrates a consistent association, but the reverse pattern emerged. In every country with significant results, males exposed to DVA had higher predicted probabilities of engaging in risky behaviours than females. In Nigeria, for instance, 25.91% of exposed males were predicted to engage in risky behaviours, compared to 7.82% of females. In Lesotho, the gap was even wider, with 28.21% of males compared to 5.15% of females; and in Namibia, 33.22% vs. 16.75%. Males were also more likely to perpetrate non-partnered physical violence. In Malawi, 60.89% of exposed males were predicted to perpetrate such violence, compared to 41.39% of females. This supports social learning theory (Bandura, 1973) and research on intergenerational transmission of violence (Widom, 1989; Ehrensaft et al., 2003), which suggest that males exposed to violence may be more likely to model and reproduce violent behaviours – although country-level variation in DVA perpetration by sex suggests that local gender norms and structural conditions also play a role (Key Finding 10).

Notably, some outcomes (such as perpetration of physical DVA) showed more mixed patterns. In Zambia, the predicted probability of perpetration was higher among exposed males (5.79%) than females (2.64%), as was the case in Nigeria (14.93% vs. 6.44%) and Lesotho (1.71% vs. 0.52%). However, in Colombia, Honduras, and Cambodia, exposed females were more likely than males to report perpetrating DVA – for example, in Cambodia, 8.37% of exposed females were predicted to perpetrate physical DVA compared to 4.13% of males. These findings may reflect differences in how DVA is conceptualised, experienced, and reported by gender across contexts (Hamby, 2014), consistent with critiques raised in Paper One (Chapter 4) about variation and limitations in existing DVA measures.

These cross-national findings confirm that biological sex is a key moderator in the mental health impacts of childhood exposure to DVA, especially for internalising symptoms, and extend what was previously known from HICs to a wider range of LMIC contexts. When viewed alongside Paper Two (Chapter 5), which demonstrated that females were also more likely to be exposed to DVA, this suggests a disproportionate burden of psychological harm for girls and young women in many LMIC settings. Together, these results support the case for gender-sensitive mental health services that address the specific needs of children exposed to violence, as well as upstream policy reforms that tackle gendered norms and improve mental health support systems (Baldry, 2007; Sternberg et al., 2006). This study contributes novel, policy-relevant evidence that helps clarify how DVA exposure shapes mental health outcomes differently by sex across diverse global contexts. Future research should explore mediating factors such as

gender norms, emotional regulation, and access to support services, to further understand these disparities and support effective interventions.

Key Finding 10: Variables in the ecological domains of community and society also impact mental health outcomes

Paper Three (Chapter 6) builds on the ecological risk factors examined in Paper Two (Chapter 5) by investigating whether these same variables help explain variation in mental health outcomes among children exposed to DVA. While ecological models of violence (Bronfenbrenner, 1979; Shaw & McKay, 1942) have long highlighted the importance of broader environmental contexts, few studies have quantified these effects on mental health following DVA exposure in LMICs. This study contributes new evidence on the significance of community and societal-level variables (specifically exposure to community violence and societal acceptance of DVA) as consistent predictors of both internalising and externalising symptoms. These findings extend existing research by estimating sex-disaggregated, adjusted predicted probabilities for six mental health outcomes across ten LMICs, offering the first cross-national evidence of the broader environmental risks surrounding DVA exposure in these settings.

Exposure to community violence was one of the most consistent and significant correlates of mental health symptoms. For internalising outcomes, individuals exposed to community violence had a substantially higher predicted probability of experiencing psychological distress in several countries, including Honduras (46.51% vs. 31.13%), Moldova (38.64% vs. 23.83%), Namibia (33.78% vs. 20.64%), and Cambodia (32.89% vs. 21.95%). Intentional self-harm was also more likely among those exposed to community violence, particularly in Colombia (18.70% vs. 8.29%), Malawi (7.35% vs. 2.03%), and Honduras (10.35% vs. 5.55%). Suicidal thoughts followed a similar pattern: in Honduras, the predicted probability among those exposed to community violence was 3.86%, compared to 2.00% among those not exposed. Other notable differences were seen in Namibia (3.55% vs. 1.87%), Moldova (1.85% vs. 0.96%), and Cambodia (1.34% vs. 0.66%).

Externalising symptoms showed similarly strong associations. In Colombia, adolescents and young adults exposed to community violence had a predicted probability of 38.62% of engaging in recent risky behaviours, compared to 21.93% among their non-exposed peers. Differences were also pronounced in Namibia (43.12% vs. 33.22%) and Moldova (28.39% vs. 15.20%). Predicted probabilities for perpetration of physical DVA were also significantly higher among those exposed to community violence in six countries, most notably Nigeria (30.06% vs.

14.93%), Cambodia (8.20% vs. 4.13%), and Lesotho (3.48% vs. 1.71%). An inverse association was observed in Moldova, where those exposed to community violence had lower predicted probabilities than their non-exposed peers (0.08% vs. 0.70%), highlighting the need to consider differing contextual dynamics and the possibility of protective factors or reporting differences in specific settings. For perpetration of physical non-partnered violence, exposure to community violence was associated with markedly elevated probabilities in Namibia (15.59% vs. 4.88%), Nigeria (10.65% vs. 5.66%), and Lesotho (14.97% vs. 10.35%). These findings suggest that exposure to violence within the broader community environment not only contributes to internal distress but may also normalise or reinforce aggressive or high-risk behaviours.

Together, these findings make an important contribution by demonstrating that the mental health burden associated with childhood exposure to DVA is not solely an individual or family-level phenomenon, but it is embedded in broader community and societal environments. They extend the findings of Paper Two (Chapter 5), which identified similar patterns in risk factors for DVA exposure, and link directly to Paper Four (Chapter 7), where professionals in Nepal described how entrenched community norms and limited support infrastructure created barriers to effective child-centred responses.

This study is the first to quantify these associations using predicted probabilities across ten LMICs, advancing the literature beyond HIC-centric studies or isolated country examples. The findings underscore the need for trauma-informed, multi-level interventions that address both the direct impacts of violence and the contextual conditions that enable it. Addressing community violence and shifting societal norms around DVA should therefore be central priorities for both mental health policy and violence prevention efforts in LMICs.

Taken together, the findings of Paper Three make three key contributions to the global evidence base on the mental health impacts of childhood exposure to DVA in LMICs. First, the paper presents the first standardised, cross-national estimates of predicted probabilities for internalising and externalising symptoms associated with exposure to DVA across ten LMICs, demonstrating consistent and significant mental health impacts in adolescence and early adulthood (Key Finding 8). These findings extend what is known from high-income contexts and provide robust evidence of the need to prioritise mental health support for children exposed to DVA in LMIC settings. Second, the study offers the first cross-national analysis of sex-disaggregated predicted probabilities for these outcomes, revealing systematic gendered patterns whereby females exposed to DVA are more likely to experience internalising symptoms, and males more likely to display externalising behaviours (Key Finding 9). This

highlights the importance of gender-sensitive approaches to trauma-informed care and violence prevention. Third, the paper demonstrates that community and societal-level variables (specifically, exposure to community violence and societal acceptance of DVA) exert a strong and consistent influence on mental health outcomes, further embedding childhood DVA exposure within a wider ecology of risk (Key Finding 10, also linking to Key Finding 7). These findings provide new empirical support for multi-level, trauma-informed interventions that address both the direct and contextual effects of violence. Collectively, the contributions of this paper reinforce the need for integrated child protection and mental health responses in LMICs, and lay critical groundwork for future research and policy focused on resilience, prevention, and recovery.

Paper Four: Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal

Key Finding 11: There is misunderstanding and confusion around childhood exposure to DVA in Nepal, impacting children's recognition within policy and programmes

Despite Nepal's status as a signatory to the UN Convention on the Rights of the Child (UNCRC; 1989), which obligates states to uphold children's rights to protection from all forms of violence, findings from this study highlight a pervasive lack of recognition for children who are exposed to DVA. General Comment No. 13 (2011) explicitly urges states to integrate the experiences of "children who experience and witness violence in the home and in communities" into national coordinating frameworks across legislative, administrative, social, and educational measures, spanning all stages from prevention to recovery and intervention. However, in Nepal, this obligation has not yet translated into consistent recognition or targeted action for childhood exposure to DVA.

This study provides new empirical evidence of the cultural invisibility of childhood exposure to DVA in Nepal, where such experiences are often subsumed within broader narratives of family dysfunction or direct child abuse. While prior research has acknowledged the marginalisation of women's experiences of DVA in the South Asian region (Thiara & Gill, 2012; Park et al., 2024), the specific needs and harms faced by children remain underexamined. This study provides rare empirical insight into how such invisibility plays out within contemporary policy, service delivery, and frontline professional understanding. Interviews with professionals and policymakers revealed not only a lack of awareness, but significant conceptual confusion

around the notion of childhood exposure to DVA. Many respondents conflated childhood exposure to DVA with other forms of child abuse (such as direct physical abuse or neglect), even when definitions were provided. Most did not consider it a distinct form of harm warranting independent recognition or policy response.

This confusion appears to be partly shaped by the legal framing of childhood harm. Nepal's Domestic Violence (Crime and Punishment) Act (2009/2066) and the Act Relating to Children (2018/2075), contain provisions for child protection and for addressing DVA, but allow for broad interpretations of domestic relationships and forms of violence⁹¹. Neither acts explicitly recognises the indirect harms associated with exposure to DVA. As a result, children may be categorised solely as direct victims of DVA or direct child abuse, rather than as individuals whose developmental and emotional wellbeing is directly impacted through exposure to DVA. These findings extend prior global literature on the invisibility of children exposed to DVA within policy and frameworks (Callaghan et al., 2017) and offer new evidence on how legal ambiguity reinforces conceptual neglect. This has important implications for how services are structured, as children's specific needs (which are distinct from those of directly abused children) may be overlooked.

Participants also described how this conceptual confusion is mirrored in practice. Policy frameworks were described as fragmented, inconsistently implemented, and poorly understood, particularly at the local government level. These challenges were compounded by a lack of cross-sectoral training and coordination, with professionals across health, education, social work, and justice sectors working in silos. While similar policy gaps have been identified for both other issues and in other LMICs (Lundy et al., 2017; Khadka et al., 2024), this study provides a more granular understanding of how these gaps are maintained through institutional logics, unclear mandates, and normative assumptions within the Nepali context.

Crucially, legal and institutional limitations are embedded within wider sociocultural norms that normalise DVA as a private family matter or as a women's issue (Subtheme 1.3), with little space to consider its impact on children. Children themselves were often not framed as rights-holders but instead as dependents or property, echoing broader cultural attitudes and contributing to their exclusion from policy and support systems. These dynamics reflect and

⁹¹ This confusion within policy can also be observed when examining the definition provided of DVA in the Domestic Violence (Crime and Punishment) Act (2009/2066) (Appendix I.3), where children would be included as a victim or perpetrator of DVA, with the same action or crime also present in the Act Relating to Children (2018/2075), potentially making the protection of children harder to implement.

reinforce the normalisation of violence described in international frameworks such as the World Health Organization (2016), and are particularly salient in South Asian contexts where gender and age hierarchies shape understanding of harm and influence who is recognised as entitled to protection, voice, and support (United Nations Population Fund, 2017; UNICEF Regional Office for South Asia, 2023).

This paper makes an original contribution by illustrating how legal definitions, professional perceptions, and cultural norms intersect to produce systemic ambiguity and neglect. While earlier chapters (Papers Two and Three) quantified the prevalence and mental health consequences of childhood exposure to DVA, this chapter offers a vital complementary perspective – highlighting how conceptual and institutional blind spots limit policy and practice responses, even in the face of compelling evidence. Together, these findings demonstrate a clear disjuncture between international obligations, national legal frameworks, and frontline practice.

Addressing this gap requires a shift towards greater conceptual clarity and recognition of children's exposure to DVA as a specific safeguarding concern. National policy and legislation must explicitly reflect children's right to protection from indirect as well as direct violence. Equally, cross-sector training, public awareness, and investment in coordinated systems of care are essential. Without these foundations, children exposed to DVA will remain structurally unsupported and socially invisible, despite the clear and growing evidence of harm (Key Finding 8).

Key Finding 12: The current support structures for children facing violence is fragmented, insufficient, and poorly coordinated

This study builds on existing global literature that has consistently identified fragmented, siloed, and adult-oriented responses to domestic violence and child protection (Callaghan et al., 2017). While such critiques are well documented in high-income contexts, this study extends them to the Nepali setting, showing how institutional fragmentation and resource constraints intersect with cultural and legal ambiguities to create a system that is largely unresponsive to the needs of children exposed to DVA.

Interviews with professionals and policymakers revealed that Nepal's child protection infrastructure is fragmented, inconsistently implemented, poorly coordinated, and insufficiently resourced. These challenges are not limited to childhood exposure to DVA; they also apply to more widely recognised forms of violence, such as physical child abuse or neglect, which are

explicitly addressed in national laws. The fact that even these forms of harm are not met with robust, functioning support structures suggests that children exposed to DVA, whose experiences are not yet formally recognised in law or policy (Key Finding 11), are particularly unlikely to receive protection or services. The findings reinforce the urgency of formally recognising childhood exposure to DVA as a distinct form of harm, without which meaningful policy and service reform is unlikely to occur.

The findings identify several systemic barriers. First, there is a lack of clarity and coordination across government departments and levels of administration. Respondents described overlapping laws, inconsistent implementation, and a general lack of understanding of institutional responsibilities. These findings align with recent analyses of child protection governance in Nepal (Khadka et al., 2024), and point to a need for much stronger vertical and horizontal coordination. Second, the lack of sustained government investment has left most services reliant on short-term NGO funding, creating competition among providers and discouraging collaboration. Similar patterns have been noted in other LMICs, where donor-driven models struggle to support comprehensive, long-term support systems (Baniya & Aryal, 2022; Regmi et al., 2023).

Respondents frequently reported that even where services exist, they are primarily structured around women's needs and safety, with limited consideration of children's developmental, psychological, or social needs. Children were often described as passive or peripheral within service provision, echoing international critiques of adult-centric DVA frameworks (Callaghan et al., 2017). This adult focus not only marginalises children's experiences but also limits the scope and effectiveness of interventions, reinforcing the invisibility of children's experiences within policy and practice responses. This lack of recognition continues to render children's experiences invisible within national safeguarding structures, a theme echoed throughout this thesis (Key Finding 11).

The insufficiency of the current system also constrains the implementation of effective, multilevel interventions. While respondents expressed a clear appetite for integrated responses (such as awareness campaigns, school-based initiatives, and family-centred support) these proposals remain largely aspirational in the absence of a coordinated, well-resourced infrastructure. Participants consistently stressed that effective intervention would require collaboration between government agencies, NGOs, schools, and community actors, as well as improved training, funding, and political prioritisation.

This study makes a novel contribution by showing that service gaps are not merely logistical but reflect deeper conceptual absences. Without formal recognition of childhood exposure to DVA as a distinct safeguarding concern, the issue remains structurally unsupported. Earlier chapters demonstrated both the prevalence (Chapter 5) and mental health impacts (Chapter 6) of childhood exposure to DVA. This chapter shows how service systems are currently unequipped to respond to these harms, highlighting a critical gap between evidence, legal recognition, and frontline response. By drawing directly on the insights of professionals navigating these systems, this study offers a grounded, practice-informed account that extends beyond policy critique to illuminate the real-world constraints on safeguarding responses in Nepal – a contribution that, to the researcher's knowledge, has not previously been documented in the Nepalese context. Bridging this gap requires clear policy mandates, sustainable investment, and a commitment to building child-centred frameworks that recognise and respond to the full ecology of harm.

Key Finding 13: Further research is required to understand the country-specific context of childhood exposure to DVA within Nepal to initiate a national conversation and work towards the inclusion of childhood exposure to DVA in national policies, provision, and support

The final key finding relates back to the research process presented in Figure 1.1 and highlights a crucial gap: the need for foundational, context-sensitive research to support meaningful public health and policy responses to childhood exposure to DVA in Nepal (and, likely to other LMICs). To date, there has been no nationally representative data on the scale or nature of this issue. The only published insight comes from the International Men and Gender Equality Survey (IMAGES), which included two limited questions – whether male respondents witnessed violence against their mother in childhood and whether any children were present when they themselves perpetrated DVA as an adult (Equimundo, 2012; Gupta et al., 2021). Whilst this offered an initial insight that childhood exposure to DVA occurs in Nepal, it did not explore the context, impact, or service needs of affected children, and has not, to date, led to future research or policy development.

This thesis directly addresses this significant gap in the literature by following a multi-stage research process (Figure 1.1), designed to build understanding on childhood exposure to DVA through a cumulative approach: defining the concept (Stage 1), assessing how it can be measured and its prevalence (Stages 2-3), exploring associated outcomes (Stage 4), and identifying existing or potential interventions (Stage 5). The qualitative study presented in Paper

Four (Chapter 7) was initially designed to focus on Stage 5 by exploring barriers and facilitators to implementing public health interventions for children exposed to DVA in Nepal. However, it quickly became apparent during early interviews that the earlier stages of the research process were not yet established in the Nepali context. Professionals and policymakers were largely unfamiliar with the concept of childhood exposure to DVA (Stage 1), and there was little recognition of its prevalence, impacts, or implications for support and protection (Stages 2-4). As a result, the interviews became a more interactive and reflexive process, with the researcher informally guiding participants through the earlier stages – helping to define the concept, explore potential effects on children, and reflect on appropriate responses. Rather than simply documenting existing interventions, the interviews themselves became a form of capacity building, fostering reflection and prompting new insights and, in some cases, personal shifts in perspective. One participant reflected:

“It’s a very new subject for me as well – and listen, your research has triggered myself to think, OK, I haven’t thought that before, but I must. Thank you very much.”

(IDI 14, Independent)

This is a unique contribution of the study: not only in producing new empirical knowledge, but in demonstrating that, in some contexts, research itself becomes an intervention, raising awareness and prompting engagement with an under-recognised safeguarding issue. To the researcher’s knowledge, no previous study has examined the conceptual, structural, and service-level barriers to addressing childhood exposure to DVA in Nepal, using a rights-informed, multi-sector perspective. Before this thesis, the field lacked any comprehensive understanding of childhood exposure to DVA in Nepal and limited cross-national evidence across LMICs more broadly. Through its three empirical papers, this research fills critical gaps in the global evidence base, offering novel insights into prevalence, consequences, and systemic response.

This key finding weaves together the contributions of the thesis’s empirical chapters. Paper Two (Chapter 5) provided the first standardised, cross-national estimates of childhood exposure to DVA across ten LMICs, establishing it as a widespread yet under-acknowledged issue. Paper Three (Chapter 6) demonstrated its strong association with adverse mental health outcomes in adolescence and early adulthood. Paper Four (Chapter 7) then explored how, in the absence of legal recognition, policy frameworks and coordinated service provision, professionals in Nepal are unable to respond effectively. Taken together, the findings show that while evidence of harm

exists, it is not yet currently met with appropriate evidence-based policy or programming, highlighting an urgent need for context-specific, applied research that can inform sustainable solutions.

While the qualitative study focused on Nepal, its implications are relevant to other LMICs, particularly those where childhood exposure to DVA remains unrecognised within national safeguarding policies or frameworks (see Appendix I.2 for examples of countries where childhood exposure to DVA is acknowledged). This research challenges the assumption that systems designed for adult survivors or for general child protection can adequately address the lived experiences of children who have been exposed to DVA, supporting research by Callaghan et al. (2017). They also call into question the direct applicability of evidence from high-income countries, underscoring the importance of local knowledge, co-produced solutions, and critical reflexivity in research design and implementation. These insights are discussed further in Section 8.5.

In sum, further research is not only necessary, but foundational. Without conceptual clarity, local data, and collaborative engagement, childhood exposure to DVA will remain invisible within both national and global responses to violence against children.

Taken together, the findings of Paper Four make three key contributions to understanding childhood exposure to DVA in Nepal and addressing broader gaps in LMIC contexts. First, the study provides novel empirical evidence of the widespread misunderstanding, cultural invisibility, and conceptual confusion surrounding childhood exposure to DVA within the Nepali legal, policy, and service landscape (Key Finding 11). It shows how children's experiences are often subsumed within narratives of direct abuse or family dysfunction, and how institutional and sociocultural dynamics intersect to obscure recognition of their specific needs and harms. Second, the study demonstrates that existing child protection and DVA support structures in Nepal are fragmented, insufficient, and poorly coordinated, offering little meaningful support to children exposed to DVA (Key Finding 12). These systemic gaps are not merely logistical but rooted in a lack of legal recognition and conceptual clarity, highlighting the disconnect between evidence, policy, and practice. Third, the research identifies the urgent need for foundational, context-specific research to initiate a national conversation, build conceptual understanding, and develop appropriate, sustainable responses (Key Finding 13). By following a cumulative research process and showing that research itself can function as a form of intervention, this study (and the thesis as a whole) makes a unique methodological and applied contribution. Collectively, the findings extend global knowledge by providing the first multi-sectoral, rights-

informed account of how childhood exposure to DVA is (mis)understood and (under)addressed in Nepal – a context where the issue has received little prior attention, and offer critical insights for advancing child-centred policy and practice in similar LMIC settings.

Overarching Contributions of the Thesis

Across all four papers, this thesis reveals a consistent pattern of invisibility, neglect, and systemic failure in how childhood exposure to DVA is understood and addressed LMICs. What emerges is not just a set of disconnected empirical findings, but a cohesive narrative of marginalisation – one that spans measurement, prevalence, consequences, and response.

At the heart of this marginalisation is the absence of child-centred frameworks. Children's exposure to DVA perpetrated within their homes is often subsumed within adult-focused definitions, with measurement tools, policy structures, and services failing to reflect the specific ways in which children are affected. This marginalisation begins at the conceptual level, where no clear or consistent definition exists, and extends to a global lack of standardised data. Without this foundation, the issue remains largely invisible in international development and child protection agendas.

The scale and complexity of the problem compound this invisibility: over 19 million children across the ten study countries are estimated to have been exposed to DVA perpetrated between caregivers, often alongside other forms of adult-perpetrated violence such as child abuse and community violence. Yet these patterns of co-occurrence are rarely acknowledged in policy, leading to siloed responses that do not reflect the lived realities of children experiencing multiple, overlapping harms. The thesis also demonstrates that exposure to DVA is gendered, and that the mental health impacts are significant and persist into adolescence and early adulthood. These impacts are shaped not only by individual experiences, but also by broader social and structural factors, particularly exposure to community violence and societal acceptance of DVA, which compound trauma and undermine resilience.

This thesis also highlights the near-total absence of infrastructure to address childhood exposure to DVA in Nepal (examined as an example of an LMIC), where the concept is not widely recognised or prioritised, and professionals and policymakers lack the tools, resources, or institutional mandate to respond. This is not just a gap in service delivery, but a deeper structural issue: a lack of conceptual, political, and institutional commitment to children's

rights, and a failure to recognise that children exposed to DVA are rights-holders in need of protection and support.

Taken together, the findings reveal that the marginalisation of childhood exposure to DVA in LMICs is sustained by a lack of appropriate measurement tools, an underestimation of both prevalence and harm, gendered and structural barriers to recognition and response, and a failure to translate emerging evidence into policy and practice. Addressing these gaps is essential not only for advancing academic understanding but also for informing effective public health, education, and development policy. Without further research and sustained action, intergenerational cycles of violence are likely to persist, with lasting consequences for child wellbeing and societal progress.

In summary, this thesis makes a clear and urgent case: without dedicated research, local engagement, and cross-sector action, childhood exposure to DVA will remain an unacknowledged form of harm in many LMICs. The findings call for a fundamental shift – from treating exposure as a peripheral concern, to recognising it as central to both violence prevention and child development. Only through this shift can sustainable, equitable, and rights-based responses begin to take shape.

8.3 Strengths and Limitations of the Current Research

This thesis contributes to the understanding of children's exposure to DVA perpetrated within their home in LMICs – an emerging but essential area of research. Taking a systematic approach and looking at each stage of the research process (Figure 1.1) provides a comprehensive overview of where current knowledge is lacking and where future research is required to better protect children from DVA exposure in LMICs. Section 8.2 details the Key Findings from the research, including the novel contributions that this thesis has made, such as providing evidence that the current global estimates of childhood exposure to DVA are outdated and underestimated – whilst reiterating the need for updated statistics to be obtained and monitored. It also provides an oversight into what factors are associated with an increased risk of a child being exposed to caregiver-perpetrated DVA within LMICs, allowing for children most at-risk to be identified so interventions can be targeted. Examining mental health outcomes revealed that those who were exposed to DVA as children were more likely to experience a wealth of adverse outcomes across both internalising and externalising symptoms in adolescence and early adulthood – some of which could have a wider impact outside of the

individual ecological domain. Finally, it looks at the current understanding of children's exposure to DVA within an LMIC (Nepal), by talking to those who design policies or provide support to children and victims of DVA – and what they think is required to better protect and support children.

This thesis provides the first comprehensive piece of work looking at the topic of exposure to DVA in LMICs at all stages of the research process (Figure 1.1), and there are strengths at each stage of the research. In particular, the way in which the definition of exposure to DVA (whilst narrow given the data constraints) has been rigorously applied to these datasets to make them as comparable as much as possible (see Table 3.5) provides a valuable insight, which strengthens both the methodology and the findings of this work. This is particularly relevant and situates this work apart from others when looking at the prevalence estimates of childhood exposure to DVA in LMICs (Paper Two, Chapter 5). Previous attempts at gaining estimates, such as UNICEF (2006), and Kieselbach et al. (2022) utilised existing data to address the paucity of research in this area, but did not use a standardised measure. In their work, Kieselbach et al. (2022) also discuss how in most of the studies used within their systematic review, measures were used without an appropriate cross-cultural validation and adaption, linking to the findings and importance of Paper One (Chapter 4) and its findings.

The VACS are continually being implemented in new countries, and a strength of this research is that due to the rigorous and empirically-based way in which the variables were recoded, the methodology and analysis used within this thesis could be applied to new country datasets, continuing to build up the global picture of exposure to DVA in LMICs as data becomes available. In addition, the utilisation of the VACS as the core data upon which the two quantitative papers are based (Paper Two and Paper Three) demonstrates the wider utility of gathering data on childhood experiences of violence perpetrated between adults in their home, and how this moves toward achieving the SDGs (United Nations, 2015). This thesis builds the argument for why data should be collected on exposure within these wider surveys, and argues for a consistent, standardised measure which is simple to implement in survey instruments, as it demonstrates that if the data is collected, then interesting insights can be obtained which can be used to develop research, to ultimately better protect children.

To the researcher's knowledge, the research within this thesis provides the first attempt at a large-scale multi-country comparative analysis on the topic of childhood exposure to DVA in LMICs. The fact that this thesis takes an approach which offers both breadth (through performing a multi-county comparative analysis of ten LMICs), and depth (through both the

focused level of analysis for each country within the quantitative papers, and the focus on one LMIC for the final paper), is another strength. Whilst it is acknowledged that LMICs are heterogenous, this thesis does not claim to speak for all LMICs, but instead highlights a paucity of literature in this area to illustrate this, highlighting patterns and demonstrating that there is a need for further research and action in this area to ensure that children are protected. However, some findings within the papers, particularly that of Paper Four (Chapter 7), may have some generalisable aspects. While there are certain contextual factors unique to Nepal, many of the challenges identified in the research, such as the lack of understanding around childhood exposure to DVA, resource constraints, insufficient support systems, and barriers to accessing services, are likely shared by other LMICs (as revealed when exploring policies for childhood exposure to DVA in Appendix I). Therefore, the findings from this research, including the ideas for improvement and interventions suggested by respondents, provide a valuable resource.

The very nature of speaking to policymakers and professionals working in the field of child protection and DVA support could be argued to have started the research process for this topic – as it has raised awareness of an issue that many of the respondents had not considered before. Some respondents voiced this during the interview: *“It’s a very new subject for me as well – and listen, your research has triggered myself to think, OK, I haven’t thought that before, but I must. Thank you very much”* (IDI 14, Independent). Therefore, even through the act of researching childhood exposure to DVA has raised its profile, and it is hoped that by sharing the research findings with those who consented, the research process can be continued independently amongst the experts interviewed in Nepal.

While the body of research presented in this thesis has greatly advanced our understanding of the complex topic of children’s exposure to DVA in LMICs, our knowledge remains somewhat incomplete due to some general limitations.

Perhaps one of the primary limitations of this study was the data available for secondary data analysis. The CDC Violence Against Children Surveys (VACS) were the only data available which could provide a comparative analysis of exposure to DVA in more than one LMIC. As this thesis wanted to gain a holistic view of exposure within LMICs⁹², the VACS was the only option for a multi-country analysis. There are four main limitations associated with the VACS data used in this thesis: limited measurement of exposure to DVA, the cross-sectional design and resulting

⁹² Whilst acknowledging that no two countries are the same, and whilst similarities and differences can be observed, the findings from this thesis cannot be generalised to all LMICs.

issues with temporality, the fact that data were collected prior to the COVID-19 pandemic, and limitations related to sampling and respondent eligibility.

First, the question asked within these surveys allows for a very limited definition of exposure to DVA to be measured – limiting exposure to seeing and hearing the DVA (only two categories of Holden’s 2003 taxonomy of exposure) and limiting the violence to physical (hit, punched, kicked, or beaten). If other types of violence encompassed under the definition of DVA (for example, physical, sexual, or psychological, as well as involving violence such as economic coercion⁹³) and all ten types of exposure (Holden, 2003) were considered, then the estimates of children’s exposure to DVA would likely be a lot higher than in this paper. This links back to Key Finding 2 and Key Finding 3 – a global consensus on a standardised tool for measuring exposure to DVA is an urgent research priority, and this tool needs to reflect the current understanding of both exposure and DVA. In addition, there were differences in phrasing regarding exposure across the country questionnaires, primarily in how the victim and perpetrator of the violence were specified (Table 3.5). This highlights the need for the measurement of exposure to be consistent, and generally, argues for a need for guidance and consistency across surveys, ensuring that questions are comparable and conform to definitions, even within iterations of the same survey. Whilst access to additional VACS datasets was granted, in some datasets, bad skip patterns meant that the question about exposure to DVA was not asked to all respondents, meaning that they were not included in the analysis within this thesis.

As previously discussed, assessing the relationship between childhood exposure to DVA, and both risk factors for exposure and adolescent and adult mental health within the VACS can be difficult due to the cross-sectional nature of the VACS. Because temporality cannot be assessed, there is, therefore, no way of knowing if some of the associated outcomes (e.g., not attending school or suicidal thoughts) happened before, during, and/or after exposure to DVA. This limitation is in addition to the broader limitation that correlational data cannot reveal causal relationships. These are issues acknowledged by other papers using the VACS (e.g., Annor et al., 2022; Kafuko et al., 2022). Therefore, only associational relationships can be implied from the VACS data. However, these associations still provide valuable insights into

⁹³ Examples of physical aggression include slapping, hitting, shaking, kicking, burning, or threatening someone with a dangerous object, such as a knife; sexual abuse includes coerced sex through threats or intimidation or through physical force, forcing unwanted sexual acts, forcing sex in front of others, and forcing sex with others (UNICEF, 2006). Finally, psychological violence involves acts such as humiliation, intimidation, excessive jealousy, control of a victim’s activities, verbal aggression, constant belittling and humiliation, and behaviours such as stalking or isolating a victim from friends or family (Evans, Davies, & DiLillo, 2008).

factors associated with children's exposure to DVA in LMICs, again emphasising the need for improved data using standardised tools.

As mentioned previously, the data for the VACS used within this thesis was all collected prior to 2020, which is not a limitation of the dataset itself, but means that the figures provided within this thesis are likely not accurate if trying to gain an accurate picture of the state of childhood exposure to DVA today. If the surveys were to be conducted over the last few years, there would likely be a higher amount of exposure reported due to the 'shadow pandemic' of COVID-19. Whilst not a necessary a limitation of the current analysis, this again highlights an urgent need for regular data to be collected, and to observe and monitor these figures to ensure that the issue of childhood exposure to DVA is addressed.

When examining participation rates at the household, individual, and overall levels (Table 3.4), it was noted that within the countries of Colombia and Moldova, there was a much lower completion rate of the household questionnaire compared to the other countries⁹⁴. For variables derived from the Household questionnaire, this missing data has been considered in analysis by creating an additional category, "no household questionnaire", to not skew the data and distort analysis through the removal of individuals without this information. However, it is essential to consider that where there is violence in a household, a family may be less willing to participate in the VACS due to fear of judgment or punishment. This means that the statistics gained from these surveys may not be accurate, and there is the potential for those most at risk to have been missed and their data not captured. In addition, a limitation of the VACS is the exclusion of certain groups of people. Whilst the VACS are nationally representative surveys, there are groups of people who are deemed ineligible for the survey (as is standard practice with nationally representative surveys). However, there are certain groups who were not included in the sampling, which could have distorted the results, for example, children living in institutions. Whilst Nguyen et al. (2019) argue that this group is a small percentage of the population and would not significantly affect the national estimates because institutions were not on the sampling frames to draw households, when considering the topic of childhood exposure to

⁹⁴ The researcher contacted Together for Girls to query why this was, to which they said: "In VACS, the head of household questionnaire does not need to be completed in order for the respondent questionnaire to be completed. For example, there are instances where the Head of Household gave consent for the eligible to participate in the survey but did not agree to complete the head of household questionnaire. So, you will see a completed respondent questionnaire but no matching head of household questionnaire. Another thing is that eligible respondents who are minors need the consent of the head of household (or acting head of household) to participate in the survey. However, if they are emancipated minors (e.g., in some countries 16 years, married, and head of their own household), they also do not need consent from the Head of Household to complete the survey because they are considered head of their own household."

DVA, those in institutions could be a high-risk category for having previously been exposed to DVA. For example, in the UK, if a child is found by authorities to be living in a home with violence, then they may be in this category (through the involvement of social services). However, not including this group is similar to other surveys in HICs, for example, the Crime Survey for England and Wales, which does not include non-household populations such as care home residents (Office for National Statistics, 2023). Therefore, it is crucial to consider that not everyone who has been exposed to DVA as a child may be included in the surveys, or had the opportunity to partake. These exclusions reflect not only methodological constraints but also broader ethical and institutional decisions about whose experiences are counted in global monitoring efforts.

In addition, there are a few limitations within the analysis of this thesis. Because the focus of the VACS is violence against children, the survey is about different forms of violence, and so it would be impossible to control for everything that could cause adverse mental health when looking at mental health outcomes in Paper Three (Chapter 6). Notably, direct child abuse (or abuse at the hands of a parent/caregiver) was not controlled for, nor were the respondent's own experiences of DVA. This again links back to the points of Key Finding 2 and Key Finding 3 – that a global consensus on a standardised tool for measuring exposure to DVA is an urgent research priority, and this tool needs to reflect the current understanding of both exposure, and of DVA.

Finally, as discussed in Section 1.1, the operationalisation of exposure to DVA in this thesis was shaped by the available data, but its interpretation was also influenced by broader conceptual and ethical considerations. While the VACS surveys primarily capture exposure through seeing or hearing physical violence, the implications of this framing extend beyond measurement to the kinds of harm and resilience the thesis could examine. The mixed-methods approach helped mitigate some of these constraints, particularly through the contextual insights offered in Paper Four (Chapter 7). However, the thesis is also shaped by the researcher's disciplinary and geographical standpoint, as outlined in Chapter 3. This included a psychological framing of outcomes and an outsider perspective on LMIC contexts. A reflexive stance was maintained throughout to engage critically with these influences and to foreground the voices and knowledge of those working locally in child protection. These reflections highlight the importance of continued efforts to broaden both the conceptual and methodological tools available to study childhood exposure to DVA globally.

8.4 Recommendations for Future Research

The limitations highlighted in Section 8.3 directly inform the recommendations for future research. If actioned, these could help build on the foundation of knowledge presented in this thesis and contribute to more effective measurement, monitoring, and interventions for childhood exposure to DVA in LMICs. These recommendations are informed by the five-stage research process outlined in Figure 1.1, offering concrete next steps to advance evidence-informed responses to childhood exposure to DVA in LMICs.

Many of the limitations stem from the data used in Papers Two (Chapter 5) and Three (Chapter 6), which relied on secondary data analysis of Violence Against Children Surveys (VACS; Chiang et al., 2016). Whilst the VACS have been a valuable resource for advancing global understanding of violence against children, several improvements are needed. For example, standardising phrasing across country iterations would enhance comparability, allowing for trends to be observed and monitored. More broadly, this thesis reinforces growing calls in the literature for improvements in the global surveillance infrastructure for violence against children (Hillis et al., 2016; WHO, 2020), including investment in inclusive, reliable, and culturally valid measurement tools.

The first set of recommendations relate to measurement. A central finding of this thesis is the lack of definitional consensus and standardised approaches to measuring childhood exposure to DVA, particularly in LMICs (Key Findings 1-3). This remains a critical barrier to global monitoring and meaningful comparison across settings (Hamby, 2016; Fulu et al., 2017). Findings from Paper One (Chapter 4) suggest that the Child Exposure to Domestic Violence Scale (CEDV; Edleson, Shin & Armendariz, 2008) provides a useful foundation for a core measure, given its alignment with the COSMIN PROMs criteria and its conceptual consistency with Holden's (2003) taxonomy of exposure. Future measurement tools should draw from both high-income and LMIC contexts and be co-developed with experts and local stakeholders, including children, to ensure contextual relevance and cultural validity. This aligns with views of respondents in Paper Four (Chapter 7) and wider scholarship advocating for child-centred and participatory approaches in violence research (Lundy & McEvoy, 2011; Byrne & Lundy, 2015; Bovarnick et al., 2018).

Future tools should also extend beyond the current focus on seeing or overhearing physical violence, as in the VACS, to encompass a wider range of DVA forms (e.g., emotional abuse, coercive control, economic abuse) and exposure types (e.g., observing the initial effects or

experiencing the aftermath). This would better reflect current conceptual understandings of exposure (Holden, 2003; Katz, 2016; Callaghan et al., 2018) and strengthen cross-national comparability. The questions should also encompass violence between any adults in the home, acknowledging that children may be exposed to harm beyond heterosexual, male-perpetrated IPV, including abuse between extended family members, same-sex partners, or female caregivers (World Health Organization & Pan American Health Organization, 2012).

In addition, children in residential or alternate care settings, or those with involvement in social services (or equivalent in their country), should be included in national surveys. These children are often at an elevated risk of prior exposure to violence (Petrowski et al., 2017) but remain largely excluded from many large-scale surveys. Not including this population in instruments such as the VACS and CSEW risks overlooking a particularly vulnerable group, potentially preventing them from being counted, heard, or supported.

The next recommendation relates to data design. The cross-sectional nature of the VACS limits causal interpretation (linking to Key Findings 5-9). There is an urgent need for longitudinal data collection to understand trajectories, mediators, and the long-term consequences of childhood exposure to DVA. Such data would allow researchers to move beyond simple associations and examine outcomes over time, including those beyond the scope of this thesis, such as impacts on educational or employment outcomes. Longitudinal studies would also support evaluation of the effectiveness of interventions and policy changes.

Qualitative and mixed-methods research should also continue to be prioritised to explore how childhood exposure is experienced and conceptualised in specific socio-cultural contexts (Key Findings 10-12). Paper Four (Chapter 7) highlights how limited professional awareness and fragmented services were shaped by normative, institutional, and structural barriers in Nepal, underscoring the importance of understanding how childhood exposure is conceptualised locally, and how this influences practice. Expanding this body of work across diverse LMIC settings would help ground context-sensitive research in lived experiences and avoid the imposition of Western frameworks that may not reflect local understandings or service environments. Ethnographic, participatory, or longitudinal qualitative approaches could be especially valuable in identifying protective factors, understanding resilience, and co-developing appropriate interventions with children and families.

Further recommendations arise relate to policy and systems change. Paper Four (Chapter 7) revealed that childhood exposure to DVA was not recognised as a specific form of harm in its

own right, and therefore was excluded from national policies and frameworks (Key Finding 10). Governments should consider its explicit inclusion in national child protection strategies and gender-based violence policies. Doing so would support more tailored prevention and intervention efforts and avoid subsuming children's needs under adult-focused systems. The need to improve service coordination, accountability, and infrastructure was also highlighted by participants (Key Findings 11-12). This reflects broader challenges in operationalising multi-sectoral child protection systems in LMICs, where service fragmentation and limited inter-agency collaboration have been widely documented (Wessells, 2015). Cross-sectoral partnerships, capacity-building, and bottom-up policy design involving children and local communities should be prioritised in future implementation research. Participatory approaches that engage children and families in shaping services have been shown to increase relevance, ownership, and uptake, particularly in complex social and cultural settings (Morris et al., 2020; Angelöw & Psouni, 2025).

Finally, this thesis recommends the integration of childhood exposure to DVA into major international surveys and development indicators. Instruments such as the Demographic and Health Surveys (DHS) and UNICEF's MICS programme should include validated questions on childhood exposure to DVA. Doing so would facilitate the systematic collection of high-quality, representative data and support monitoring of trends, disparities and progress (Key Finding 3, 4, 6 and 9), including the ability to assess the impact of policies or interventions. This aligns with Stage 3 (identifying groups at risk), Stage 4 (understanding consequences), and Stage 5 (evaluating interventions) of the research framework proposed in this thesis (Figure 1.1). However, this will require investment in the development and validation of robust, culturally-appropriate questions, linking back to the first recommendation of this thesis. In addition, such inclusion would also require sustained investment – not only in question development and validation, but in analytical and institutional capacity to act on the findings. Therefore, there would need to be a commitment to the inclusion of childhood exposure to DVA in both national and international agendas and that it would be an area included, monitored, and reported on.

This thesis has highlighted a series of research and knowledge gaps related to childhood exposure to DVA in LMICs. Addressing these gaps will require conceptual clarity, methodological innovation and rigour, and ethical commitment – not only to improving measurement and data infrastructure, but to centring children's voices, rights, and needs throughout. Doing so is essential not only for advancing the research agenda, but for achieving global commitments such as SDG 5.2 (Eliminate all forms of violence against all women and

girls) and 16.2 (End abuse, exploitation, trafficking and all forms of violence against children; United Nations, 2015) and improving the wellbeing of children globally.

8.5 Concluding Remarks

This thesis presents the first comprehensive investigation into childhood exposure to domestic violence and abuse (DVA) in low- and middle-income countries (LMICs), examining the issue across all stages of the research process (Figure 1.1). By establishing the need for a standardised measurement, identifying prevalence and risk factors across ten LMICs, examining mental health outcomes, and exploring professional and policy responses in Nepal, this body of work offers an essential, multi-dimensional view of a critically under-researched area.

The findings across these four studies reveal an urgent need for global, validated measures of childhood exposure to DVA, particularly in LMIC contexts where current tools are rarely validated. Paper One demonstrated that without a reliable and universal measure, true estimates of exposure to DVA remain unknown, likely leading to underestimation and missed opportunities for prevention and intervention. A consistent, standardised measure that is simple to implement in large-scale surveys would enable more accurate global comparisons, facilitate monitoring, and support the design of contextually relevant, targeted interventions. Paper Two reinforced this necessity, showing that the existing estimates from UNICEF (2006) likely significantly underestimate the number of children exposed to DVA across LMICs. While risk factors varied across countries, shared patterns at community and societal levels underscore the need for multilevel prevention strategies that extend beyond the individual or family.

Paper Three extends the analysis by investigating the mental health outcomes of children exposed to DVA, drawing on data from ten LMICs. Findings confirmed significant associations with both internalising and externalising symptoms, offering strong evidence that childhood exposure to DVA within the home contributes to adverse outcomes in adolescence and early adulthood. These results reinforce the global relevance of this issue, while also highlighting the need for longitudinal, context-sensitive research to better understand causal pathways, resilience, and long-term impacts, particularly in LMIC settings where resources for mental health support often remain underdeveloped.

Paper Four shifted focus to qualitatively explore the specific context of Nepal, examining how professionals and policymakers understood and respond to childhood exposure to DVA. The findings exposed significant gaps in awareness, fragmented systems of support, and the absence of child-focused provision for children exposed to DVA perpetrated between adults within their home. Barriers spanned structural, normative, and institutional domains, and pointed to the need for multi-sectoral responses that centre children's voices and rights in both policy and practice. Respondents advocated for school-based interventions, participatory approaches, and coordinated cross-agency work, but also identified entrenched challenges to realising this vision.

Taken together, these four studies underscore a critical insight: childhood exposure to DVA is both deeply complex, and inadequately addressed in LMICs. By examining this issue at all stages of the research process – measurement, prevalence, mental health outcomes, and what is currently being done – this thesis offers a unique and holistic approach that lays the groundwork for impactful, evidence-based responses. Each paper contributes a vital piece to the overall understanding, and when read as a coherent whole, the thesis demonstrates that addressing childhood exposure to DVA requires interconnected strategies across research, policy, and practice. The findings indicate that without a standardised approach to measurement, a true grasp of prevalence, and insight into both the consequences and existing systemic responses to DVA perpetrated within the home, efforts to mitigate exposure and improve outcomes for children will remain fragmented.

As a unified body of work, this thesis highlights that advancing knowledge on childhood exposure to DVA in LMICs can drive progress towards a more coordinated, multi-level interventions. This progress is essential for creating supportive environments where children are protected from exposure and have access to effective, context-specific support when needed. The insights generated by this thesis have the potential to reshape global public health and child protection efforts, offering a pathway for more effective policies and interventions that could profoundly improve the lives of children exposed to DVA in LMICs. This research advocates for a renewed and sustained focus on childhood exposure to DVA in LMICs in the global conversation on DVA – placing their rights, needs, and voices at the centre of efforts to create safer, more supportive environments in which all children can thrive.

Appendix A Summary of Measures Exploring Childhood Exposure to Domestic Violence and Abuse

Note: some of these measures also explore direct victimization, or violence in another domain (e.g., peer-to-peer violence, exposure to community violence). For the purpose of this table, only information related to exposure to DVA has been included. The language used in this table reflects that used within the respective measure.

Measure	Year of Publication	Country of Origin (COI)	Population group the measure was designed for	Victim-Perpetrator Relationship Assessed (DVA)	Violence Domain	Exposure Timeframe	Type of DVA Measured (physical, sexual, psychological/emotional, coercive control, economic abuse, harassment and stalking, online/digital abuse)	Type of Exposure to DVA Measured (Using Holden's 2003 taxonomy)	Countries Implemented In (Other than COI)
Caregiver-report Modified version of the Severity of Violence Against Women Scales (DeJonghe et al., 2011)	2011 Adaptation of Marshall (1992).	United States	Mothers with a child 1-3 years old	Mother-partner	Intimate Partner Violence	Lifetime	Physical, sexual, psychological	Victimized, eyewitness, overhears, observes the initial effects, experiences the aftermath, ostensibly unaware.	None
Child Exposure to Domestic Violence Scale (Edleson et al., 2008)	2008	United States	Children 10-16 years old	Female caregiver-partner	Exposure to domestic violence at home and in the community, the child's exposure and involvement in the situation, presence	Lifetime	Physical, psychological, coercive control	Eyewitness, overhears, observes the initial effects, hears about it, intervenes	Brazil (Pinto Junior et al., 2017) India (Anitha & Venus, 2016) Iran (Sajadi et al., 2014)

Appendix A

					of risk factors and exposure to other types of victimization Specifically asks about school and community, on television or in a movie, video games, and other adults in their family that they do not live with. This includes questions on exposure and experiencing different types of violence and victimization.				Iraqi-Kurdistan (Jumma & Çerkez, 2017) Pakistan (Khatoon et al., 2014) South Africa (Idemudia & Makhubela, 2011) Spain (Díez et al., 2018) Sweden (Cater et al., 2015; Grip et al., 2013, 2014)
Childhood Experiences of Violence Questionnaire (Walsh et al., 2008)	2008	Canada	Children 12-18 years old	Caregiver-partner	Peer-to peer violence, exposure to domestic violence, physical violence and sexual violence	Lifetime; respondent provides information on the timeframe of exposure	Physical, sexual, psychological, emotional	Eyewitness, overhears	None found
Children's Perception of Interparental Conflict Scale (Grych et al., 1992)	1992	United States	Children 9-12 years old	Parent-parent Exposure to interparental conflict and the relationship to child adjustment.	Exposure to IPV	Not specified	Physical, psychological/emotional	Eyewitness, overhears, intervenes	China (Chi & Xin, 2002; He et al., 2021; Wang et al., 2021) Pakistan (Bukhari & Masood, 2020)

Appendix A

									Portugal (Moura et al., 2010) Spain (Iraurgi et al., 2008)
Computer Assisted Child Maltreatment Inventory (DiLillo et al., 2010)	2010	United States	Adults over the age of 18	Parent-parent	Exposure to IPV	Lifetime	Physical, verbal, psychological/emotional	Eyewitness, overhears, hears about it, observes the initial effects	None found
Family Aggression Screening Tool (Cecil et al., 2016)	2016	England, United Kingdom	Children and young adults 16-24 years old	Parent (or adult)-opposite sex partner	Family violence and IPV exposure	Lifetime	Physical, Emotional/psychological, verbal	Not specified, children are asked "if you remember this kind of aggression happening in your house when you were growing up"	None found
Juvenile Victimization Questionnaire (Finkelhor et al., 2005)	2005	United States	Children 8-17 years old, caregiver of 2-9 year old child. The questionnaire is usable in interview format with children as young as age 8 and as old as age 17. It can be used in a self-administered format for	Parent-opposite sex partner	Conventional crime, child maltreatment, peer and sibling victimization, sexual victimization, and witnessing/exposure to indirect victimization	Lifetime	Physical, sexual, psychological/emotional	Witnessing and indirect victimization	Australia (Mathews et al., 2023) China (Chan et al., 2011) Israel (Lev-Wiesel et al., 2018) Pakistan (Bashir & Dasti, 2015) Portugal (Almeida et al., 2020)

Appendix A

			juveniles 12 and older. There is also a “Caregiver version”, by which a caregiver could be interviewed as a proxy for a child, especially a child under age 8. Additionally, it can be adapted for retrospective reporting of childhood events by adult respondents.						South Africa (Ward et al., 2018) Spain (Pereda et al., 2018) UK (Radford et al., 2013)
Things I Have Seen and Heard (TISH) (Richters & Martinez, 1990)	1990	United States	Children 6-14 years old	“Grownups in my home”	Exposure to violence at home and in the community	Lifetime	Physical and psychological	Witnesses and overhears	None found
Timeline Followback Interview – Children’s Exposure to Partner Violence (Lam et al., 2009)	2009	United States	Couples with a child 6-16 years old (interviewed separately)	Caregiver-partner	Exposure to IPV	Past 90 days	Physical	Eyewitness, overhears, ostensibly unaware	None found
Violence Exposure	1995	United States	Children aged 4-10	“At home”	Exposure to violence at home, school,	Not specified	Physical	Eyewitness	Israel (Raviv et al., 2001)

Appendix A

Scale for Children (Fox & Leavitt, 1995)					and/or the neighbourhood				The measure is also available in Spanish (Stover & Berkowitz, 2005), although no studies using this measure could be found.

Appendix B Recoding of Variables for Paper Two Analysis

To allow for analysis of associated factors, some of the variables within the VACS needed to be recoded, to allow for cross-country comparisons to be made. For illustrative purposes, the country of Côte d'Ivoire has been used throughout this appendix as an example for how all variables were recoded for analysis within this paper. In some cases, there were some individual country differences in either the phrasing of the question or response options, which have been noted. All variables were recoded and analysed in Stata SE 17.

This appendix starts by explaining the most common response options for questions used for analysis (B.1), then details how responses were recoded when the analysis has come directly from a question within the VACS (B.2), and then explains some more complex variables which were created for analysis (B.3).

B.1 Response Options to Question Types

Within the analysis for risk factors associated with exposure to domestic violence and abuse (DVA), two main types of question types were used across the datasets. The below table illustrates the slight phrasing differences that exist within these commonly used question types:

Question Type	Applicable Variables	Response Options	Countries
Frequency	Exposure to DVA Exposure to Child Abuse Exposure to Community Violence	Never, once, more than once, don't know, declined	Colombia, Côte d'Ivoire, Lesotho, Namibia (varies between more than once/more than one time)
		Never, once, more than one time, don't know, declined	Honduras, Moldova, Namibia (varies between more than once/more than one time)
		Never, once, few, many, don't know/declined	Cambodia, Malawi, Nigeria, Zambia
Simple Response	Ever attended school Death of biological mother	Yes, no, don't know, declined	Colombia, Côte d'Ivoire, Honduras, Lesotho, Moldova, Namibia

Appendix B

	Death of biological father	Yes, no, don't know/declined	Cambodia, Malawi, Nigeria, Zambia

Not included in the above is the response options for the variable “completed primary school”, as responses reflected local schooling systems. Wealth is also detailed separately.

Don't know and declined were both treated as a non-response, and so were coded as 99 (missing). Variables which were created for the analysis from existing questions are detailed below.

B.2 Recoding of Existing Questions/Variables within the VACS

Several factors were explored based off of existing questions from within the VACS, and minimal recoding was required. These are detailed below, using Côte d'Ivoire as an example. The final column of the table notes any differences across the ten countries explored.

Associated Factor	Question	Survey Response Options	Recoded to	Notes
Exposure to DVA	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than once (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)	As this is the central variable in Papers 2 and 3, a full breakdown of the questions asked and response options for each country for this variable is available in Table 3.5. In all datasets (other than Cambodia and Zambia), the following text precedes this question: “13-17 years old: at any time in your life 18-24 years old: before the age of 18” Cambodia and Zambia does not specify before the age of 18, which is a limitation of this dataset.
Exposure to Child Abuse	How many times did you see or hear a parent punch, kick, or beat your brothers or sisters?	Never (1) Once (2) More than one time (3)	No (2) Yes (1) Yes (1) No (2) Missing (99) Missing (99)	The phrasing of this question was consistent across country questionnaires, but was not asked in Cambodia. In all datasets (other than Zambia), the following text precedes this question: “13-17 years old: at any time in your life

Appendix B

		I have no brothers or sisters (4) ⁹⁵ Don't now (98) Declined (99)		<i>18-24 years old: before the age of 18"</i> Therefore, this is exposure to child abuse before the age of 18 in eight of the nine countries where this variable was explored.
Exposure to Community Violence	Outside of your home and family environment, how many times did you see anyone get attacked?	Never (1) Once (2) More than one time (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)	Within the Cambodia questionnaire, this question was "Have you ever seen anyone physically hurt or scare someone else in your community?". This question also did not specify before the age of 18, although asks the respondent how old they were the first time that this happened, the most recent time that this has happened, and if this has happened in the last 12 months. In all datasets (other than Zambia), the following text precedes this question: <i>"13-17 years old: at any time in your life 18-24 years old: before the age of 18"</i> Therefore, this is exposure to child abuse before the age of 18 in eight of the ten countries.
Ever Attended School	Have you ever attended school?	Yes (1) No (2) Don't know (98) Declined (99)	Yes (1) No (2) Missing (99) Missing (99)	All surveys asked, "Have you ever attended school?", with the only variation being in the Colombia survey, which asked "Have you ever attended school/educational center/university?". Response options were the same across all datasets (yes, no, or don't know/declined), and so no recoding was necessary for analysis. This was cross tabulated with the next question of the survey, "Are you currently attending school?", to ensure that everyone had been captured.

⁹⁵ For the question related to child abuse, the answer, "I have no brothers and sisters" was recoded as "no", rather than missing, because the new variable was designed to determine the number of children exposed to child abuse within the country, regardless of whether they had siblings.

Appendix B

Completed Primary School	What is the highest level of schooling you have completed?	Less than primary (1) Primary (2) Secondary (3) Higher than secondary (4) Don't know (98) Declined (99)	No – Not completed primary (2) Yes – Completed Primary (1) Yes – Completed Primary (1) Yes – Completed Primary (1) Missing (99) Missing (99)	If participants indicated that they were currently attending school, they were asked, “what is your current level of schooling?”. If they were not currently attending school, they were instead asked, “what is the highest level of schooling you have completed?”. Response options varied across countries to reflect local education systems. Therefore, to assess whether someone had completed primary school, these two variables were used to create the variable “primarycompleted”, to indicate whether someone had completed primary school, hadn't completed primary school, or was currently completing primary school.
	What is your current level of schooling?	Less than primary (1) Primary (2) Secondary (3) Higher than secondary (4) Don't know (98) Declined (99)	No – Not completed primary (2) Currently completing primary (3) Yes – Completed Primary (1) Yes – Completed Primary (1) Missing (99) Missing (99)	
Death of Biological Mother	Is your biological mother still alive?	Yes (1) No (2) Don't know (98) Declined (99)	Alive (1) Dead (2) Missing (99) Missing (99)	Whilst there is a question within the survey “is your biological mother still alive”, this variable was also explored in other questions, and sometimes not all respondents were captured through this question alone. Therefore, for some datasets this variable was created through multiple questions, which was recoded to the variable “motherdeath”. The variable of death of motherdeath was cross tabulated for each country with the question “how old were you when she died?” to check that everyone whose biological mother had died had been captured. <u>Other questions which were checked to ensure that everyone was captured:</u> Is your biological mother living with you? What was the main reason you stopped living with her?
Death of Biological Father	Is your biological father still alive?	Yes (1) No (2) Don't know (98) Declined (99)	Alive (1) Dead (2) Missing (99) Missing (99)	Whilst there is a question within the survey “is your biological father still alive”, this variable was also explored in other questions, and sometimes not all respondents were captured through this question alone. Therefore, for some datasets this variable was

Appendix B

				created through multiple questions, which was recoded to the variable “fatherdeath”. The variable of death of fatherdeath was cross tabulated for each country with the question “how old were you when he died?” to check that everyone whose biological father had died had been captured. <u>Other questions which were checked to ensure that everyone was captured:</u> Is your biological father living with you? What was the main reason you stopped living with him?
Living with Biological Mother	<i>13-17 years old:</i> has your biological mother ever lived away from you for 6 months or more? <i>18-24 years old:</i> has your biological mother ever lived away from you for 6 months or more before you were 18 years old?	Yes (1) No (2) Don’t know (98) Declined (99)	No (2) Yes (1) Missing (99) Missing (99)	All surveys asked the question, “has your biological mother ever lived away from you for 6 months or more” (if the respondent was aged 13-17), or “has your biological mother ever lived away from you for 6 months or more before you were 18 years old?” (if the respondent was aged 18-24). As the variable is phrased to indicate whether someone lives with their biological mother, (1) is yes – living/lived with mother and (2) is no – not living/lived with mother. Within the country questionnaires of Côte d’Ivoire, Lesotho and Moldova, respondents were not asked this question if their mother had died. In the countries of Cambodia, Malawi, Nigeria, and Zambia, the question was instead “is your biological mother living with you?”, not specifying whether this was the case before the age of 18. This question was recoded to the variable “livingwithmother”.
Living with Biological Father	<i>13-17 years old:</i> has your biological father ever lived away from you for 6 months or more?	Yes (1) No (2) Don’t know (98) Declined (99)	No (2) Yes (1) Missing (99) Missing (99)	All surveys asked the question, “has your biological father ever lived away from you for 6 months or more” (if the respondent was aged 13-17), or “has your biological father ever lived away from you for 6 months or more

	18-24 years old: has your biological father ever lived away from you for 6 months or more before you were 18 years old?			before you were 18 years old?” (if the respondent was aged 18-24). As the variable is phrased to indicate whether someone lives with their biological father, (1) is yes – living/lived with father and (2) is no – not living/lived with father. Within the country questionnaires of Côte d’Ivoire, Lesotho and Moldova, respondents were not asked this question if their father had died. In the countries of Cambodia, Malawi, Nigeria, and Zambia, the question was instead “is your biological mother living with you?”, not specifying whether this was the case before the age of 18. This question was recoded to the variable “livingwithfather”.

B.3 Creation of New Variables for Analysis for Risk Factors Associated with Exposure to DVA

B.3.1 Family Economic Conditions (‘Wealth’)

For this, a PCA was used to create a variable which represented the latent concept of ‘wealth’. This was done using the head of household (HOH) questionnaire for each country. In line with the DHS Wealth Index measurement approach (Filmer & Pritchett, 1998; Rutstein & Staveteig, 2014), three tertiles were created – “richer”, “middle”, “poorer”. Whilst the HOH questionnaire had a core set of questions in common, there was also some country-specific questions. Anything which could indicate wealth was included in the creation of each country PCA, as ‘wealth’ is not something which should be comparable across countries. A binary category was created for each of the response options for the below variables included within the PCA, following the standard methodology as highlighted by Rutstein and Staveteig (2014).

In line with the rest of this appendix, detailed below is the questions used and categories included for the country of Côte d’Ivoire.

Appendix B

Questions Used	Categories included in the PCA
What is the main source of drinking water for members of your household?	Piped water; tube well; protected dug well; water from spring; rainwater; tanker water; cart with small tank; surface water (river/dam/lake/pond/stream/irrigation canal); bottled water; bagged water
What kind of toilet facility do members of your household mostly use?	Flush toilet; pit latrine ventilated; pit latrine with slab; pit latrine without slab/open pit; composting toilet; bucket toilet; hanging toilet/hanging latrine; no facility/bush/field; other
What type of fuel does your household mainly use for cooking?	Electricity; liquefied petroleum gas (LPG); biogas; kerosene; coal, lignite; charcoal; wood; straw/shrubs/grass; animal dung; no food cooked in household; other
Record the main material of the dwelling floor.	Earth/sand; dung; wood planks; palm/bamboo; broken bricks; parquet/polished wood; vinyl/asphalt strips; ceramic tiles; cement; carpet; other
Record the main material of the roof.	No roof; thatch/palm leaf; rustic mat; palm/bamboo/grass; wood planks; cardboard; iron sheets; wood; calamine/cement fiber; ceramic tiles; cement; roofing shingles; other
Record the main material of the walls.	No walls; cane/palm/trunks; plastered dirt; unplastered dirt; bamboo/tree trunks with mud; stone with mud; plywood; cardboard/tarp/tin/plastics/construction waste; reused wood; cement; stone with lime cement; burnt bricks; unburnt bricks; cement blocks; wood planks; other
Does any member of your household own a watch?	Yes; no
Does this household own any livestock, herds, other farm animals or poultry?	Yes; no
Does any member of this household have a bank account, including a Mobile Money account?	Yes; no

Stata Code Used to Generate Variable – Wealth (tertiles)
creating a wealth PCA tab H4, gen (drinkingwatersourcebinary) tab H5, gen (toiletbinary) tab H8, gen (fuelcookingbinary) tab H9, gen (floormaterialbinary) tab H10, gen (roofmaterialbinary) tab H11, gen (wallmaterialbinary) tab H14A, gen (watchbinary) tab H17, gen (bankaccountbinary)

```
pca drinkingwatersourcebinary* toiletbinary* fuelcookingbinary* floormaterialbinary* roofmaterialbinary* wallmaterialbinary* watchbinary* ownlivestockbinary*
bankaccountbinary*
predict wealth2 //this predicts a new continuous variable from the factor loadings for each individual – a continuous wealth score
xtile wealth3cat=wealth2, nq(3) //this puts the continuous wealth score into three equal groups
label define wealth3cat 1 "Poorer" 2 "Middle" 3 "Richer" 99 "Missing" //defines the label for wealth3cat
label values wealth3cat wealth3cat //labelling the variable
gen wealthcat3=0
recode wealthcat3 (0=1) if wealth3cat==1
recode wealthcat3 (0=2) if wealth3cat==2
recode wealthcat3 (0=3) if wealth3cat==3
recode wealthcat3 (0=99)
label define wealthcat3 1 "Poorer" 2 "Middle" 3 "Richer" 99 "Missing"
label values wealthcat3 wealthcat3
```

B.3.2 Death of a Biological Parent

This factor was derived based on death data for mothers and fathers (“motherdeath” and “fatherdeath”) to determine whether a biological parent had died for each respondent. The variables of death of father and death of mother were cross tabulated for each country to check that everyone who had a biological parent who had died had been captured.

Stata Code Used to Generate Variable – Death of a Biological Parent

```
gen deathofbioparent=0 //have one or more of your biological parents died?
recode deathofbioparent (0=1) if fatherdeath==2 & motherdeath==2 //yes - father died and mother died
recode deathofbioparent (0=1) if fatherdeath==2 //yes - father died
recode deathofbioparent (0=1) if motherdeath==2 //yes - mother died
recode deathofbioparent (0=2) if fatherdeath & motherdeath==1 //no - both parents alive
recode deathofbioparent (0=99) if motherdeath==99
recode deathofbioparent (0=99) if fatherdeath==99
recode deathofbioparent (0=2)
label define yesnodkd 1 "yes" 2 "no" 99 "don't know/declined"
label values deathofbioparent yesnodkd
```

B.3.3 Living with Both Biological Parents

This factor was derived based on the data for whether a respondent lived with their biological mother, and whether they lived with their biological father (“livingwithmother” and “livingwithfather”) to determine whether a respondent lived with both biological parents. The variables of living with biological father and living with biological mother were cross tabulated for each country to check that everyone who lived with both biological parents had been captured.

Stata Code Used to Generate Variable – Living with Both Biological Parents

```
gen livingbothparents=0
recode livingbothparents (0=1) if livingwithmother==1 & livingwithfather==1
recode livingbothparents (0=2) if livingwithfather==2
recode livingbothparents (0=2) if livingwithmother==2
recode livingbothparents (0=99) if livingwithmother==99
recode livingbothparents (0=99) if livingwithfather==99
recode livingbothparents (0=99)
label define yesnodkd 1 "yes" 2 "no" 99 "don't know/declined"
label values livingbothparents yesnodkd
```

B.3.4 Societal Acceptance of DVA

This binary variable indicates whether the respondent thinks that it is ever okay for a husband to hit or beat his wife. Five questions were asked about different situations and whether in these situations it was felt whether it was “right” for a man to hit or beat his wife. If any of these were answered positively then the overall violence variable was coded as 1, indicating that violence is believed to be justified. The five scenarios are listed below.

Do you believe, it is right for a man to hit or beat his wife if:

Scenario	Phrasing Differences	Country with Phrasing Difference
1) If she goes out without telling him	N/A	N/A
2) If she ignores/neglects the children	If she ignores the children	Cambodia

Appendix B

	If she does not take care of the children If she neglects the children	Colombia, Honduras, Malawi, Nigeria, Zambia Côte d'Ivoire, Lesotho, Moldova, Namibia
3) If she argues with him	N/A	N/A
4) If she refuses to have sex with him	N/A	N/A
5) If she makes bad food	If she makes bad food If she burns the food	Cambodia Colombia, Côte d'Ivoire, Honduras, Lesotho, Malawi, Moldova, Namibia, Nigeria, Zambia

Stata Code Used to Generate Binary Variable – Societal Acceptance of Domestic Violence and Abuse

*first, 5 beat categories were created for each of the scenarios (demonstrated bellow for scenario 1)

```
gen beat1=0
recode beat1 (0=1) if Q43A==1
recode beat1 (0=2) if Q43A==2
recode beat1 (0=99) if Q43A==98
recode beat1 (0=99) if Q43A==99
recode beat1 (0=99)
label define yesnodkd 1 "yes" 2 "no" 99 "don't know/declined"
label values beat1 yesnodkd
```

*(repeated for all five scenarios, not shown in this code)

*making these variables binary

```
gen hitwife1=.
gen hitwife2=.
gen hitwife3=.
gen hitwife4=.
gen hitwife5=.
recode hitwife1 (.=1) if beat1==1
recode hitwife2 (.=1) if beat2==1
recode hitwife3 (.=1) if beat3==1
recode hitwife4 (.=1) if beat4==1
recode hitwife5 (.=1) if beat5==1
```

```

recode hitwife1 (.=0) if beat1==2
recode hitwife2 (.=0) if beat2==2
recode hitwife3 (.=0) if beat3==2
recode hitwife4 (.=0) if beat4==2
recode hitwife5 (.=0) if beat5==2

gen hitwifebinary=.
recode hitwifebinary (.=1) if beat1==1|beat2==1|beat3==1|beat4==1|beat5==1
recode hitwifebinary (.=0) if beat1==2&beat2==2&beat3==2&beat4==2&beat5==2
recode hitwifebinary (.=98) if beat1==99|beat2==99|beat3==99|beat4==99|beat5==99 //recoding as 98 rather than 99 will mean that I do not need to change anything in my
regression code when I make all 99=. - also, this means that it's clearer when I come back to look at this, as all of my variables have missing and "not complete" will help me
remember that this is different
tab hitwifebinary, nol
label define hitwifeyesnotcomplete 0 "no" 1 "yes" 98 "not complete"
label values hitwifebinary hitwifeyesnotcomplete

```

Appendix C Childhood Exposure to Types of Violence in the VACS

This appendix shows the distribution (variation) of answers for each variable explored within the VACS, along with how the outcome prevalence varies amongst these.

The first table demonstrates the weighted percentage estimate and variation for exposure to different types of violence (as presented in Table 5.1). The second table shows the percentage of children exposed to child abuse if they were exposed to DVA (the cross-tabulation between the exposure to child abuse with the exposure to domestic violence and abuse variable). Both tables also include 95% confidence intervals to indicate the degree of confidence in the accuracy of point estimates, within a specified margin of error.

Statistics are reported for overall country (O), males (M) and females (M) to demonstrate the distribution of exposure both between, and within each country for each variable.

As each table contains ten countries (grouped by MDG region), they have been split in two:

- The first contains the results for the countries: Côte d'Ivoire, Lesotho, Malawi, Namibia, and Nigeria
- The second contains the results for the countries: Zambia, Colombia, Honduras, Cambodia, and Moldova

This is to make the tables easier to read and interpret.

C.1 Exposure to Domestic Violence and Abuse

Distribution (Variation) in Answers

Exposure to DVA	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa														
	Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	17.69 (15.48-20.15)	17.77 (15.06-20.84)	17.62 (14.27-21.55)	29.12 (26.83-31.52)	26.23 (22.27-30.61)	32.02 (30.31-34.10)	30.68 (27.43-34.14)	31.12 (27.13-35.41)	30.29 (25.28-35.81)	15.45 (13.64-17.46)	15.05 (12.41-18.13)	15.95 (13.60-18.62)	29.60 (27.19-32.13)	25.99 (23.09-29.12)	33.10 (29.34-37.09)
No	81.74 (79.22-84.02)	81.73 (78.63-84.48)	81.75 (77.65-85.25)	70.50 (68.05-72.84)	73.36 (68.90-77.39)	67.64 (65.53-69.69)	68.66 (65.25-71.89)	68.61 (64.33-72.61)	68.71 (63.28-73.67)	81.15 (78.91-83.20)	81.16 (77.89-84.05)	81.13 (77.91-83.99)	67.49 (64.69-70.17)	71.63 (67.82-75.15)	63.48 (59.29-67.48)
Missing	0.56 (0.28-1.14)	0.50 (0.22-1.15)	0.63 (0.22-1.80)	0.38 (0.23-0.60)	0.42 (0.19-0.90)	0.34 (0.21-0.53)	0.65 (0.36-1.18)	0.27 (0.10-0.72)	1.01 (0.51-1.99)	3.40 (2.41-4.78)	3.79 (2.31-6.17)	2.92 (1.86-4.54)	2.91 (2.13-3.95)	2.38 (1.40-4.02)	3.42 (2.35-4.96)

C.1 Exposure to DVA Distribution (Variation) in Answers Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Exposure to DVA	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	30.31 (27.97-32.76)	27.27 (24.44-30.30)	33.25 (30.27-36.36)	19.68 (16.21-23.68)	16.12 (12.50-20.54)	23.39 (17.73-30.21)	11.80 (10.77-12.91)	8.95 (7.70-10.39)	14.54 (13.03-16.18)	20.41 (18.32-22.68)	21.24 (18.50-24.28)	19.57 (16.47-23.09)	17.36 (14.70-20.39)	12.82 (9.78-16.62)	21.92 (18.03-26.37)
No	67.91 (65.32-70.39)	71.23 (68.27-74.02)	64.69 (61.20-68.03)	78.52 (74.48-82.07)	82.67 (78.23-86.37)	74.17 (67.38-79.98)	87.81 (86.67-88.86)	90.79 (89.34-92.07)	84.94 (83.24-86.49)	79.44 (77.18-81.53)	78.46 (75.44-81.21)	80.43 (76.91-83.53)	77.28 (73.65-80.54)	82.93 (78.76-86.42)	71.62 (66.25-76.45)

Outcome prevalence is not reported as exposure to DVA is the outcome for this paper.

Appendix C

Exposure to DVA	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Missing	1.78 (1.14-2.77)	1.49 (0.84-2.65)	2.06 (1.11-3.81)	1.81 (0.80-4.01)	1.20 (0.41-3.51)	2.43 (0.81-7.07)	0.39 (0.24-0.63)	0.25 (0.11-0.56)	0.53 (0.29-0.96)	0.15 (0.05-0.41)	0.29 (0.11-0.81)	-	5.35 (3.98-7.16)	4.25 (2.92-6.15)	6.46 (4.31-9.58)

C.2 Exposure to Child Abuse

Distribution (Variation) in Answers

Exposure to Child Abuse	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa														
	Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	42.02 (38.37-45.76)	42.85 (37.52-48.36)	41.18 (36.40-46.12)	24.15 (21.80-26.68)	24.15 (19.44-29.59)	24.16 (22.30-26.11)	41.72 (38.47-45.04)	46.96 (42.66-51.31)	37.00 (33.07-41.10)	26.00 (22.98-29.26)	24.90 (20.60-29.76)	27.34 (23.28-31.82)	56.59 (54.07-59.07)	52.65 (49.44-55.83)	60.40 (56.62-64.07)
No	57.27 (53.55-60.91)	56.31 (50.83-61.65)	58.24 (53.36-62.97)	75.34 (72.82-77.70)	75.42 (70.01-80.13)	75.26 (73.23-77.19)	57.94 (54.61-61.2)	52.98 (48.63-57.28)	62.41 (58.24-66.41)	70.78 (67.49-73.86)	71.28 (66.28-75.82)	70.16 (65.79-74.19)	41.34 (38.83-54.89)	46.59 (43.34-49.88)	36.24 (32.60-40.05)
Missing	0.71 (0.35-1.45)	0.84 (0.34-2.04)	0.58 (0.18-1.84)	0.50 (0.30-0.84)	0.43 (0.16-1.10)	0.58 (0.32-1.06)	0.34 (0.15-0.76)	0.06 (0.01-0.44)	0.59 (0.24-1.42)	3.22 (2.31-4.49)	3.82 (2.46-5.88)	2.50 (1.49-4.17)	2.08 (1.50-2.87)	0.76 (0.47-1.22)	3.35 (2.31-4.83)

Appendix C

C.2 Exposure to Child Abuse Distribution (Variation) in Answers Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Exposure to Child Abuse	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	40.70 (37.85-43.62)	41.81 (38.28-45.43)	39.63 (3.06-43.39)	23.96 (20.03-28.38)	23.60 (18.05-30.22)	24.33 (19.10-30.45)	11.53 (10.37-12.81)	9.61 (8.15-11.30)	13.38 (11.65-15.32)	Not assessed in questionnaire			16.69 (14.07-19.70)	13.42 (10.58-16.88)	19.97 (15.97-24.68)
No	57.77 (54.75-60.72)	56.89 (53.30-60.40)	58.61 (54.70-62.42)	74.53 (70.11-78.50)	74.89 (68.26-80.52)	74.17 (68.14-79.40)	88.17 (86.86-89.36)	90.26 (88.57-91.72)	86.16 (84.16-87.95)				80.48 (77.16-83.41)	83.75 (79.78-87.07)	77.20 (72.07-81.62)
Missing	1.53 (0.98-2.38)	1.30 (0.75-2.24)	1.75 (0.97-3.14)	1.51 (0.62-3.61)	1.52 (0.57-3.94)	1.50 (0.32-6.73)	0.30 (0.17-0.52)	0.13 (0.06-0.32)	0.46 (0.24-0.90)				2.83 (1.91-4.17)	2.83 (1.71-4.64)	2.83 (1.54-5.15)

Outcome Prevalence

Exposure to Child Abuse	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa														
	Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	28.44 (24.74-32.44)	26.62 (21.71-32.18)	30.35 (24.76-36.60)	46.89 (42.53-51.30)	43.63 (35.28-52.37)	50.15 (46.76-53.54)	48.83 (42.90-54.79)	46.19 (39.97-52.53)	51.85 (41.57-61.98)	27.93 (24.23-31.96)	24.30 (19.89-29.33)	31.96 (26.02-38.55)	45.59 (42.17-49.06)	41.94 (37.80-46.19)	48.68 (43.51-53.88)
No	10.00 (7.90-12.57)	11.23 (8.59-14.56)	8.79 (6.00-12.69)	23.40 (21.29-25.64)	20.69 (17.10-24.81)	26.11 (24.18-28.15)	17.69 (15.01-20.73)	17.80 (13.50-23.09)	17.61 (14.34-21.42)	11.42 (9.56-13.59)	12.42 (9.42-16.22)	10.17 (8.41-12.26)	8.46 (7.03-10.15)	8.03 (6.24-10.29)	9.00 (6.84-11.74)
Missing	2.58 (0.32-18.13)	4.36 (0.49-29.79)	-	33.08 (17.07-54.28)	19.59 (2.40-70.74)	42.96 (27.81-59.55)	17.98 (2.43-65.86)	-	19.65 (2.54-69.66)	3.40 (1.31-8.58)	3.67 (1.00-12.54)	2.91 (0.82-9.76)	14.68 (6.62-29.48)	22.52 (8.84-46.57)	12.96 (4.51-31.96)

Appendix C

C.2 Exposure to Child Abuse Outcome Prevalence Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Exposure to Child Abuse	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	52.78 (48.38- 57.13)	47.56 (41.73- 53.45)	58.10 (52.88- 63.15)	42.89 (34.24- 52.00)	36.33 (27.55- 46.13)	49.53 (34.95- 64.19)	39.98 (35.43- 44.71)	35.13 (28.47- 42.43)	43.34 (37.35- 49.52)	Not assessed in questionnaire			47.73 (39.14- 54.45)	36.96 (25.29- 50.38)	54.97 (43.90- 65.57)
No	14.71 (12.63- 17.07)	12.73 (10.12- 15.89)	16.57 (13.67- 19.95)	12.56 (9.57- 16.33)	9.99 (6.34- 15.39)	15.28 (10.84- 21.12)	8.15 (7.28- 9.12)	6.18 (5.10- 7.47)	10.14 (8.85- 11.60)				11.17 (9.17- 13.55)	8.84 (6.44- 12.03)	13.70 (10.73- 17.34)
Missing	21.45 (10.95- 37.74)	11.29 (2.24- 25.94)	28.74 (12.46- 53.33)	2.70 (0.39- 16.56)	4.62 (0.52- 31.01)	0.68 (0.06- 7.72)	-	-	-				14.31 (6.35- 29.14)	15.92 (5.48- 38.21)	12.70 (3.34- 37.95)

C.3 Exposure to Community Violence

Distribution (Variation) in Answers

Exposure to Community Violence	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa														
	Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	32.44 (28.88-36.22)	38.88 (33.57-44.47)	25.92 (21.46-30.95)	29.49 (26.25-32.96)	37.96 (32.19-44.09)	21.01 (19.20-22.95)	33.52 (30.59-36.59)	37.09 (32.83-41.57)	30.31 (26.63-34.25)	49.07 (44.17-53.98)	52.82 (44.39-61.08)	44.49 (40.11-48.97)	41.42 (38.80-44.09)	39.51 (36.52-42.58)	43.27 (39.03-47.61)
No	67.11 (63.26-70.75)	60.81 (55.16-66.19)	73.49 (68.19-78.19)	70.36 (66.89-73.61)	61.95 (55.81-67.73)	78.78 (76.81-80.62)	66.33 (63.27-69.26)	62.64 (58.21-66.88)	69.65 (65.70-73.33)	48.12 (43.20-53.08)	44.29 (36.16-52.75)	52.79 (48.09-57.45)	54.73 (52.18-57.25)	57.88 (54.79-60.92)	51.67 (47.64-55.68)
Missing	0.45 (0.21-0.94)	0.31 (0.10-0.94)	0.59 (0.22-1.55)	0.15 (0.06-0.35)	0.09 (0.02-0.36)	0.21 (0.07-0.61)	0.15 (0.03-0.66)	0.26 (0.05-1.47)	0.04 (0.01-0.31)	2.81 (1.91-4.12)	2.89 (1.62-5.10)	2.71 (1.64-4.46)	3.85 (2.98-4.96)	2.61 (1.77-3.81)	5.06 (3.67-6.93)

Appendix C

C.3 Exposure to Community Violence Distribution (Variation) in Answers Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Exposure to Community Violence	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	36.46 (33.64-39.38)	33.7 (30.28-37.31)	39.13 (35.90-42.46)	52.47 (48.04-56.85)	54.12 (47.84-60.28)	50.73 (44.52-56.92)	32.99 (30.95-35.10)	34.22 (31.38-37.17)	31.82 (28.90-34.88)	58.49 (55.64-61.28)	59.53 (55.31-63.60)	57.43 (53.49-61.28)	56.67 (52.24-60.99)	62.67 (56.65-68.31)	50.66 (44.51-56.80)
No	62.04 (58.93-65.05)	64.87 (60.96-68.59)	59.31 (55.74-62.79)	46.50 (42.10-50.95)	44.82 (38.71-51.08)	48.25 (41.97-54.58)	66.85 (64.74-68.90)	65.65 (62.69-68.49)	68.01 (64.95-70.93)	41.39 (38.60-44.23)	40.36 (36.29-44.57)	42.43 (38.59-46.36)	37.88 (33.41-42.56)	33.57 (27.82-39.85)	42.19 (35.37-49.33)
Missing	1.50 (0.95-2.35)	1.43 (0.80-2.54)	1.56 (0.83-2.93)	1.04 (0.50-2.13)	1.06 (0.34-3.27)	1.02 (0.42-2.45)	0.15 (0.08-0.30)	0.13 (0.04-0.40)	0.17 (0.08-0.39)	0.13 (0.04-0.40)	0.11 (0.02-0.81)	0.14 (0.03-0.57)	5.45 (3.68-8.00)	3.76 (2.42-5.81)	7.15 (4.14-12.07)

Outcome Prevalence

Exposure to Community Violence	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa														
	Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	24.33 (19.26-30.24)	22.14 (17.07-28.21)	27.66 (18.17-39.71)	41.77 (37.72-45.94)	37.91 (32.06-44.12)	48.76 (45.18-52.35)	38.05 (33.78-42.51)	36.01 (30.79-41.59)	40.29 (33.42-47.57)	21.32 (18.68-24.22)	19.59 (16.19-23.50)	23.83 (19.83-28.36)	46.56 (42.69-50.47)	44.74 (39.92-49.66)	48.17 (42.48-53.91)
No	14.56 (12.52-16.87)	15.06 (11.74-19.11)	14.14 (11.75-16.91)	23.86 (21.85-25.98)	19.11 (15.99-22.67)	27.59 (25.57-29.71)	27.03 (22.80-31.71)	28.35 (23.17-34.18)	25.95 (19.70-33.36)	10.30 (8.14-12.96)	10.62 (7.11-15.57)	9.98 (7.71-12.82)	17.46 (15.34-19.81)	13.04 (10.77-15.71)	22.25 (18.78-26.16)
Missing	6.16 (0.76-35.87)	-	9.42 (1.03-51.00)	11.72 (1.99-46.55)	-	16.88 (2.51-61.61)	-	-	-	1.27 (0.34-4.56)	-	2.91 (0.77-10.36)	19.78 (13.55-27.96)	29.42 (16.71-46.41)	14.97 (8.63-24.70)

Appendix C

C.3 Exposure to Community Violence Outcome Prevalence Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Exposure to Community Violence	Distribution (variation) in Answers by VACS Country (weighted %, 95% CI)														
	Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
	Zambia			Colombia			Honduras			Cambodia			Moldova		
	O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Yes	47.07 (42.18-52.02)	43.80 (38.12-49.65)	49.80 (43.68-55.92)	22.11 (17.64-27.34)	18.38 (13.98-23.79)	26.26 (18.65-35.65)	17.29 (15.35-19.42)	14.29 (11.90-17.07)	20.39 (17.42-23.73)	27.18 (24.08-30.53)	27.40 (23.36-31.85)	26.96 (22.27-32.21)	21.75 (18.09-25.90)	16.73 (12.97-21.32)	27.96 (21.95-34.87)
No	20.72 (18.23-23.46)	18.91 (15.88-22.35)	22.64 (18.94-26.83)	17.06 (12.41-22.99)	13.61 (7.90-22.43)	20.40 (13.70-29.24)	9.12 (7.99-10.39)	6.19 (4.79-7.97)	11.84 (10.27-13.60)	10.83 (8.92-13.09)	12.22 (9.30-15.90)	9.48 (7.20-12.39)	10.52 (7.89-13.90)	4.02 (2.15-7.40)	15.69 (11.72-20.69)
Missing	19.35 (9.06-36.63)	17.23 (2.54-32.82)	21.23 (7.25-48.15)	14.26 (3.99-39.96)	6.91 (1.17-31.69)	22.23 (4.58-62.99)	-	-	-	25.65 (2.93-79.81)	-	46.50 (4.92-93.59)	19.40 (11.43-30.98)	26.12 (12.39-46.92)	15.86 (7.70-29.88)

Appendix D Risk Factors Associated with Exposure to Domestic Violence and Abuse: Results

D.1 Individual Level Risk Factors

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Overall Percentage of Exposure to Domestic Violence and Abuse		17.69 (15.48-20.15)	17.77 (15.06-20.84)	17.62 (14.27-21.55)	29.12 (26.83-31.52)	26.23 (22.27-30.61)	32.02 (30.31-34.10)	30.68 (27.43-34.14)	31.12 (27.13-35.41)	30.29 (25.28-35.81)	15.45 (13.64-17.46)	15.05 (12.41-18.13)	15.95 (13.60-18.62)	29.60 (27.19-32.13)	25.99 (23.09-29.12)	33.10 (29.34-37.09)
Ever Attended School	Yes	18.26 (15.83-20.98)	18.82 (15.86-22.20)	17.64 (13.86-22.18)	29.10 (26.77-31.54)	26.15 (22.06-30.69)	32.01 (30.00-34.08)	31.04 (21.71-34.57)	31.08 (26.89-35.61)	30.99 (25.91-36.59)	15.57 (13.73-17.62)	15.17 (12.48-18.32)	16.06 (13.67-18.78)	28.77 (26.32-27.14)	25.28 (22.51-28.27)	32.56 (28.58-36.81)
	No	14.39 (10.72-19.26)	9.014 (4.88-16.07)	17.51 (12.44-24.07)	30.13 (19.43-43.54)	28.72 (14.22-49.49)	33.58 (21.76-47.89)	22.35 (14.22-33.33)	32.27 (17.23-52.16)	16.50 (9.086-28.09)	11.82 (5.445-23.78)	10.09 (2.375-34.12)	14.39 (7.292-26.43)	33.53 (31.35-40.58)	30.76 (20.04-44.05)	35.08 (27.18-43.90)
Education Level	Completed Primary	18.22 (15.72-21.02)	19.43 (16.18-23.14)	16.88 (13.29-21.19)	30.17 (27.65-32.82)	27.39 (22.74-32.60)	32.76 (30.63-34.97)	32.22 (27.83-36.95)	32.73 (27.43-38.52)	31.83 (25.26-39.21)	16.36 (14.38-18.55)	16.51 (13.49-20.06)	16.18 (13.74-18.97)	28.65 (26.06-31.38)	24.99 (22.17-28.03)	32.67 (28.38-37.27)
	Not Completed Primary	14.39 (10.72-19.06)	9.01 (4.88-16.07)	17.51 (12.44-24.07)	27.92 (18.62-39.61)	26.92 (13.89-45.69)	30.00 (20.20-42.04)	23.20 (14.94-34.19)	32.27 (17.23-52.16)	18.02 (10.08-30.13)	10.23 (4.75-20.65)	7.22 (1.59-27.31)	16.05 (8.28-28.82)	32.77 (26.96-39.16)	28.86 (19.94-39.79)	35.13 (27.38-43.76)
	Currently Completing Primary	18.73 (12.22-27.63)	12.41 (6.35-22.84)	25.82 (14.71-41.27)	23.18 (19.31-27.56)	20.30 (14.30-27.99)	27.09 (23.61-30.88)	28.97 (23.71-34.87)	28.92 (24.03-34.36)	29.03 (19.24-41.25)	12.41 (9.14-16.63)	10.80 (6.76-16.82)	15.26 (10.49-21.67)	29.68 (23.80-36.33)	29.39 (21.40-38.90)	29.97 (21.74-39.73)

Appendix D

D.1 Individual Level Risk Factors Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) O = Overall, M = Male, F = Female														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Overall Percentage of Exposure to Domestic Violence and Abuse		30.31 (27.97-32.76)	27.27 (24.44-30.30)	33.25 (30.27-36.36)	19.68 (16.21-23.68)	16.12 (12.50-20.54)	23.39 (17.73-30.21)	11.80 (10.77-12.91)	8.95 (7.70-10.39)	14.54 (13.03-16.18)	20.41 (18.32-22.68)	21.24 (18.50-24.28)	19.57 (16.47-23.09)	17.36 (14.70-20.39)	12.82 (9.78-16.62)	21.92 (18.03-26.37)
Ever Attended School	Yes	30.58 (28.21-33.05)	27.37 (24.64-30.29)	33.63 (30.50-36.91)	19.71 (16.22-23.73)	16.18 (12.53-20.65)	22.43 (17.72-30.30)	11.80 (10.76-12.92)	8.82 (7.59-10.24)	14.65 (13.12-16.33)	20.66 (18.51-22.99)	21.21 (18.42-24.30)	20.09 (16.86-23.77)	17.23 (14.56-20.29)	12.85 (9.81-16.66)	21.66 (17.75-26.17)
	No	24.68 (14.98-37.86)	25.44 (12.28-45.40)	23.70 (14.92-35.49)	18.10 (3.81-55.20)	10.21 (1.41-47.54)	21.83 (3.30-69.57)	12.01 (5.70-23.58)	17.14 (7.39-34.90)	6.55 (1.43-25.28)	13.48 (6.77-25.05)	22.50 (8.76-46.75)	7.59 (3.14-17.20)	42.72 (13.99-77.39)	-	53.36 (21.79-82.45)
Education Level	Completed Primary	30.83 (28.10-33.70)	27.58 (24.27-31.16)	33.84 (30.16-37.73)	19.82 (16.26-23.95)	16.18 (12.41-20.83)	23.66 (17.86-30.65)	11.65 (10.53-12.87)	8.86 (7.53-10.40)	14.34 (12.68-16.18)	19.05 (16.25-22.20)	21.16 (16.87-26.19)	17.51 (14.00-21.68)	17.18 (14.50-20.24)	12.82 (9.77-16.64)	21.60 (17.67-26.12)
	Not Completed Primary	24.78 (16.85-34.88)	23.41 (12.55-39.43)	26.21 (19.38-34.43)	15.80 (3.32-50.62)	8.68 (1.22-42.32)	19.30 (2.92-65.56)	15.46 (11.93-19.80)	11.63 (7.05-18.59)	18.35 (13.53-24.40)	23.71 (19.97-27.90)	22.64 (17.70-28.49)	24.84 (19.43-31.17)	42.72 (13.99-77.39)	-	53.36 (21.79-82.45)
	Currently Completing Primary	30.27 (25.21-35.86)	27.51 (21.44-34.54)	33.22 (27.31-39.71)	15.79 (5.36-38.28)	17.75 (3.33-57.46)	13.29 (4.55-33.02)	9.90 (7.80-12.49)	7.83 (5.27-11.48)	12.23 (9.09-16.27)	19.94 (16.48-23.91)	20.47 (16.70-24.84)	19.09 (12.86-27.38)	-	-	-

D.2 Family Level Risk Factors

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Family Economic Conditions 'Wealth'	Poorer	15.38 (12.16-19.26)	15.16 (12.00-18.98)	15.56 (10.53-22.38)	24.79 (21.89-27.94)	19.95 (15.51-25.27)	29.40 (26.31-32.70)	31.46 (26.79-36.55)	31.74 (24.24-40.31)	31.23 (25.52-37.56)	17.02 (14.05-20.47)	17.44 (13.25-22.61)	16.65 (12.63-21.63)	25.33 (21.80-29.20)	23.02 (19.30-27.21)	27.30 (21.66-33.78)
	Middle	16.41 (13.44-19.89)	15.92 (11.83-21.08)	16.90 (12.82-21.95)	30.53 (27.05-34.24)	29.34 (23.67-35.74)	31.75 (28.82-34.83)	34.43 (27.91-41.59)	33.53 (27.72-39.88)	35.33 (24.05-48.51)	16.25 (13.64-19.25)	14.25 (11.15-18.03)	19.42 (15.51-24.04)	30.93 (27.13-35.01)	25.92 (21.56-30.81)	35.39 (29.62-41.63)
	Richer	21.83 (17.85-26.41)	21.67 (16.30-28.21)	22.05 (16.44-28.91)	31.27 (27.35-35.49)	28.27 (21.42-36.28)	34.41 (31.33-37.62)	25.02 (21.03-29.49)	26.93 (20.36-34.69)	23.40 (18.76-28.78)	13.39 (10.15-17.48)	14.25 (9.02-21.79)	12.32 (9.89-15.25)	32.32 (28.17-36.78)	28.24 (22.69-34.54)	36.84 (30.50-43.66)
	No Household Questionnaire	-	-	-	-	-	-	-	-	-	-	-	-	-	-	-
Death of a Biological Parent	Yes (a parent has died)	16.83 (12.67-22.02)	20.43 (13.26-30.15)	13.97 (9.64-19.82)	27.56 (24.80-30.50)	23.91 (19.20-29.37)	31.35 (28.97-33.84)	26.78 (22.42-31.65)	29.48 (23.15-36.71)	24.64 (18.99-31.31)	14.64 (11.47-18.50)	17.07 (12.02-23.67)	11.99 (8.78-16.18)	24.85 (21.64-28.37)	25.97 (21.59-30.88)	23.93 (19.43-29.09)
	No (both parents are alive)	18.04 (15.67-20.69)	16.99 (14.44-19.88)	19.21 (15.18-24.01)	30.54 (27.80-33.42)	28.41 (23.33-34.09)	32.60 (30.19-35.11)	32.17 (28.03-36.62)	31.69 (26.97-36.82)	32.63 (25.99-40.05)	15.84 (13.72-18.23)	14.38 (11.39-17.99)	17.72 (14.97-20.86)	30.78 (28.14-33.54)	25.90 (22.70-29.39)	35.68 (31.63-39.94)
Death of Biological Mother	Yes (mother has died)	16.81 (10.13-26.60)	19.52 (7.83-40.92)	14.67 (8.94-23.14)	28.80 (25.62-32.19)	24.91 (19.44-31.33)	32.63 (29.31-36.12)	27.75 (21.83-34.57)	33.20 (24.12-43.72)	23.60 (16.76-32.14)	13.52 (9.45-18.97)	15.98 (9.30-26.08)	11.10 (7.26-16.62)	26.73 (21.73-32.41)	30.64 (24.25-37.87)	23.20 (16.33-31.85)
	No (mother is alive)	17.85 (15.63-20.31)	17.59 (15.19-20.27)	18.13 (14.48-22.47)	29.23 (26.71-31.89)	26.63 (22.10-31.72)	31.85 (29.75-34.02)	31.12 (27.56-34.92)	30.87 (26.73-35.35)	31.35 (25.72-37.59)	15.74 (13.77-17.93)	15.00 (12.14-18.39)	16.67 (14.19-19.48)	29.84 (27.34-32.46)	25.53 (22.48-28.85)	34.02 (30.22-38.05)

Appendix D

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Death of Biological Father	Yes (father has died)	16.00 (12.25-20.62)	20.22 (14.07-28.17)	12.62 (9.05-17.33)	26.73 (23.74-29.95)	23.15 (17.71-29.65)	30.36 (27.89-32.94)	27.39 (22.28-33.18)	29.53 (22.33-37.92)	25.75 (18.94-33.98)	15.01 (11.13-19.94)	17.90 (11.67-26.46)	11.91 (8.09-17.19)	24.02 (20.39-28.07)	21.96 (17.05-27.82)	25.64 (20.58-31.46)
	No (father is alive)	18.10 (15.66-20.83)	17.33 (14.33-20.80)	18.94 (15.13-23.44)	31.08 (28.42-33.88)	28.78 (23.98-34.11)	33.44 (31.12-35.84)	31.17 (27.45-35.16)	31.25 (27.01-35.84)	31.10 (25.09-37.82)	15.36 (13.38-17.58)	14.30 (11.64-17.45)	16.72 (13.91-19.98)	30.57 (28.02-33.25)	26.63 (23.52-29.99)	34.52 (30.53-38.74)
Living with both Biological Parents	Yes	18.03 (15.17-21.30)	17.14 (14.25-20.47)	19.20 (14.05-25.66)	28.13 (25.21-31.25)	26.10 (21.21-31.66)	30.32 (27.61-33.19)	30.57 (26.33-35.17)	29.00 (24.10-34.44)	32.94 (25.47-41.39)	13.67 (11.02-16.84)	12.01 (8.33-17.01)	15.54 (12.13-19.68)	30.23 (27.26-33.37)	26.05 (22.58-29.83)	36.10 (31.20-41.30)
	No	17.35 (14.57-20.53)	18.60 (13.95-24.35)	16.37 (13.30-19.98)	29.55 (26.93-32.31)	26.23 (21.49-31.60)	32.76 (30.62-34.97)	30.74 (27.05-34.70)	32.87 (27.73-38.47)	29.30 (24.27-34.90)	16.37 (14.15-18.87)	16.49 (13.31-20.25)	16.23 (13.26-19.70)	28.65 (25.64-31.86)	25.62 (22.13-29.46)	30.43 (26.09-35.15)
Living with Biological Mother	Yes	17.90 (15.30-20.82)	17.67 (15.00-20.70)	18.15 (13.75-23.59)	28.46 (25.84-31.24)	26.56 (21.94-31.77)	30.45 (28.18-32.83)	30.71 (26.92-34.78)	30.01 (25.80-34.59)	31.60 (24.97-39.08)	16.79 (14.34-19.57)	16.14 (12.24-21.00)	17.55 (15.06-20.34)	29.57 (26.80-32.51)	25.67 (22.44-29.20)	34.75 (30.26-39.53)
	No	17.38 (14.20-21.09)	18.00 (12.45-25.29)	16.88 (13.67-20.67)	30.05 (27.34-32.92)	25.68 (21.24-30.69)	34.15 (31.55-36.84)	30.65 (26.77-34.83)	33.00 (27.24-39.33)	29.25 (24.23-34.83)	13.12 (10.80-15.84)	13.30 (10.25-17.09)	12.86 (9.47-17.24)	29.50 (25.94-33.32)	26.80 (22.79-31.22)	30.79 (25.85-36.21)
Living with Biological Father	Yes	17.54 (15.02-20.38)	15.89 (13.37-18.78)	19.63 (15.12-25.09)	28.88 (25.93-32.03)	26.55 (21.53-32.25)	31.44 (28.89-34.12)	30.42 (26.54-34.60)	29.41 (24.73-34.55)	31.84 (25.30-39.17)	13.69 (11.44-16.29)	12.09 (9.14-15.82)	15.68 (12.50-19.49)	30.34 (27.57-33.26)	27.04 (23.72-30.63)	34.79 (30.26-39.62)
	No	17.97 (14.60-21.90)	21.68 (15.87-28.89)	15.31 (11.94-19.43)	29.32 (26.52-32.28)	26.06 (20.85-32.05)	32.37 (30.21-34.61)	30.55 (26.86-34.50)	31.98 (26.93-37.49)	29.59 (24.47-35.27)	16.88 (14.42-19.66)	17.30 (13.70-21.61)	16.36 (13.19-20.12)	28.3 (24.97-31.88)	22.86 (18.98-27.34)	31.15 (26.52-36.18)
Multiple Children in Household	Yes	17.85 (15.61-20.33)	17.90 (15.19-20.97)	17.79 (14.38-21.81)	28.45 (26.20-30.83)	25.65 (21.68-30.06)	31.20 (29.18-33.29)	30.96 (27.56-34.58)	31.13 (27.14-35.43)	30.80 (25.42-36.75)	15.98 (14.07-18.08)	15.70 (12.94-18.92)	16.31 (13.81-19.16)	30.00 (27.55-32.57)	25.91 (22.96-29.09)	34.08 (30.22-38.17)

Appendix D

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
	No	12.21 (4.24-30.39)	14.51 (3.25-46.16)	11.01 (2.57-36.71)	39.69 (31.66-48.31)	34.31 (22.01-49.15)	48.15 (40.59-55.79)	10.53 (3.44-27.99)	32.75 (8.25-72.53)	7.54 (1.81-26.47)	7.66 (2.31-22.52)	-	14.68 (5.11-35.47)	24.73 (15.80-36.53)	34.64 (21.43-50.74)	17.20 (7.41-35.06)

Appendix D

D.2 Family Level Risk Factors Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) O = Overall, M = Male, F = Female														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Family Economic Conditions 'Wealth'	Poorer	29.50 (25.39-33.97)	27.31 (22.67-32.51)	31.58 (27.21-36.31)	16.97 (12.34-22.88)	12.17 (7.39-19.38)	21.93 (14.53-31.70)	12.86 (11.00-14.98)	8.79 (6.78-11.31)	15.86 (13.11-19.07)	21.61 (18.59-24.98)	23.14 (18.63-28.37)	20.18 (16.34-24.65)	17.63 (12.77-23.82)	9.61 (5.94-15.18)	25.03 (14.83-33.02)
	Middle	31.28 (27.42-35.42)	29.77 (24.51-35.63)	32.85 (27.97-38.13)	21.16 (14.56-29.72)	20.48 (13.48-29.86)	21.79 (11.75-36.83)	12.74 (11.15-14.53)	9.67 (7.68-12.11)	15.74 (13.40-18.40)	23.49 (19.67-27.79)	23.89 (19.52-28.89)	22.98 (16.62-30.87)	12.46 (9.42-16.31)	9.88 (5.97-15.90)	15.14 (10.70-21.00)
	Richer	30.21 (26.06-34.71)	24.81 (20.38-29.86)	35.10 (28.88-41.86)	23.66 (17.42-31.29)	18.92 (11.89-28.75)	29.04 (19.04-41.59)	9.86 (8.25-11.74)	7.58 (5.64-10.11)	12.34 (10.02-15.12)	16.34 (13.67-19.41)	16.59 (12.66-21.45)	16.12 (12.62-20.37)	19.63 (15.65-24.33)	17.70 (12.16-25.03)	21.66 (16.22-28.31)
	No Household Questionnaire	-	-	-	15.97 (9.65-25.26)	11.46 (5.13-23.68)	21.46 (11.25-37.07)	-	-	-	-	-	-	22.94 (14.49-34.34)	16.86 (7.77-32.81)	29.24 (16.77-45.86)
Death of a Biological Parent	Yes (a parent has died)	28.15 (24.47-32.15)	23.68 (19.36-28.63)	31.64 (26.80-36.92)	14.58 (8.56-23.73)	9.23 (3.91-20.28)	19.88 (10.36-34.76)	11.97 (9.55-14.90)	10.42 (6.91-15.40)	13.31 (10.24-17.12)	24.96 (19.88-30.83)	24.64 (17.67-33.24)	25.23 (18.23-33.80)	27.14 (20.14-35.49)	18.91 (10.73-31.14)	32.03 (22.47-43.38)
	No (both parents are alive)	31.25 (28.34-34.31)	28.64 (25.14-32.41)	34.04 (30.53-37.73)	20.28 (16.69-24.42)	16.85 (12.95-21.64)	23.87 (18.07-30.83)	11.78 (10.66-13.01)	8.76 (7.43-10.29)	14.74 (13.06-16.60)	19.69 (17.45-22.14)	20.77 (17.90-23.97)	18.56 (15.18-22.49)	15.98 (13.15-19.30)	12.21 (9.19-16.05)	20.04 (15.49-25.54)
Death of Biological Mother	Yes (mother has died)	25.59 (20.38-31.61)	22.60 (16.23-30.56)	27.82 (21.00-35.85)	10.07 (2.98-29.00)	16.49 (2.69-58.51)	5.46 (1.87-14.88)	8.61 (5.31-13.67)	4.78 (1.98-11.10)	11.70 (6.60-19.91)	37.89 (28.53-48.24)	32.06 (20.25-46.72)	43.86 (30.69-57.94)	25.45 (13.79-42.14)	6.25 (1.83-19.30)	33.96 (17.94-54.74)
	No (mother is alive)	30.96 (28.39-33.65)	27.88 (24.79-31.19)	34.08 (30.85-37.46)	19.92 (16.37-24.02)	15.97 (12.37-20.36)	24.09 (18.18-31.21)	11.90 (10.84-13.04)	9.06 (7.77-10.53)	14.65 (13.09-16.35)	19.63 (17.49-21.97)	20.77 (17.92-23.94)	18.48 (15.35-22.07)	17.04 (14.31-20.17)	13.01 (9.94-16.84)	21.21 (17.05-26.06)

Appendix D

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Death of Biological Father	Yes (father has died)	28.06 (23.95-32.58)	22.39 (17.75-27.84)	32.51 (27.05-38.48)	14.67 (8.19-24.89)	6.62 (2.76-15.04)	22.68 (11.31-40.27)	12.63 (9.75-16.22)	11.90 (7.69-17.95)	13.28 (9.65-18.00)	19.49 (14.27-26.02)	19.59 (12.40-29.55)	19.40 (12.47-28.91)	28.19 (20.77-37.01)	22.40 (12.80-36.17)	32.03 (22.05-43.98)
	No (father is alive)	30.69 (27.92-33.59)	28.21 (24.92-31.75)	33.28 (29.82-36.94)	20.03 (16.43-24.20)	16.91 (12.96-21.78)	23.31 (17.51-30.31)	11.69 (10.57-12.90)	8.64 (7.32-10.16)	14.67 (13.01-16.50)	20.53 (18.30-22.95)	21.41 (18.58-24.54)	19.60 (16.21-23.49)	16.29 (13.41-19.65)	11.98 (8.90-15.93)	20.87 (16.33-26.29)
Living with both Biological Parents	Yes	28.99 (25.43-32.81)	26.51 (22.40-31.07)	32.34 (27.62-37.46)	18.73 (14.03-24.55)	16.27 (10.88-23.62)	21.25 (14.01-30.90)	8.30 (7.06-9.73)	6.21 (4.82-7.98)	10.76 (8.75-13.17)	18.94 (16.53-21.60)	20.40 (17.27-23.94)	17.27 (13.69-21.54)	14.54 (11.29-18.52)	11.67 (7.80-17.10)	17.63 (12.72-23.93)
	No	31.34 (28.30-34.54)	28.22 (24.68-32.04)	33.67 (29.95-37.60)	20.92 (15.84-27.11)	15.12 (9.99-22.22)	27.41 (19.24-37.44)	15.12 (13.63-16.74)	12.23 (10.11-14.73)	17.43 (15.47-19.57)	24.38 (20.84-28.30)	24.03 (18.68-30.35)	24.64 (20.04-29.89)	21.95 (18.36-26.03)	15.56 (11.07-21.43)	27.39 (22.80-32.52)
Living with Biological Mother	Yes	29.92 (26.93-33.10)	26.65 (23.29-30.32)	34.01 (29.83-38.45)	19.66 (15.83-24.15)	16.48 (12.39-21.60)	23.32 (16.96-31.16)	10.74 (9.62-11.97)	8.30 (6.96-9.87)	13.39 (11.67-15.32)	19.50 (17.23-21.98)	20.66 (17.68-23.99)	18.26 (14.90-22.17)	16.45 (13.67-19.67)	13.56 (10.01-18.12)	19.39 (15.43-24.07)
	No	30.92 (27.41-34.68)	28.71 (24.09-33.83)	32.34 (28.09-36.91)	19.52 (11.55-31.06)	11.68 (5.70-22.46)	24.41 (12.92-41.29)	15.46 (13.50-17.65)	12.04 (9.31-15.43)	17.61 (15.03-20.53)	26.13 (21.51-31.35)	25.59 (19.09-33.40)	26.54 (20.25-33.96)	21.54 (15.93-28.46)	9.55 (5.28-16.68)	32.89 (24.19-42.96)
Living with Biological Father	Yes	30.18 (26.82-33.77)	27.32 (23.27-31.79)	33.72 (29.39-38.34)	19.21 (14.57-24.91)	16.05 (10.93-22.94)	22.46 (15.15-31.97)	8.66 (7.48-10.02)	6.58 (5.24-8.23)	11.09 (9.17-13.36)	19.68 (17.32-22.27)	20.90 (17.77-24.43)	18.28 (14.84-22.31)	15.36 (12.09-19.32)	11.10 (7.67-15.81)	19.97 (14.68-26.59)
	No	30.28 (27.08-33.67)	27.37 (23.73-31.34)	32.51 (28.47-36.83)	20.10 (15.11-26.24)	15.34 (9.83-23.14)	25.87 (17.99-35.70)	15.59 (13.97-17.35)	12.54 (10.21-15.31)	17.98 (15.89-20.28)	22.83 (19.11-27.04)	22.70 (17.15-29.40)	22.93 (18.08-28.62)	21.80 (18.14-25.96)	18.20 (13.07-24.77)	24.65 (20.00-29.98)
Multiple Children in Household	Yes	30.35 (27.96-32.86)	27.24 (24.36-30.33)	33.36 (30.30-36.57)	20.18 (16.61-24.30)	16.40 (12.73-20.88)	24.17 (18.28-31.24)	11.86 (10.81-13.00)	8.97 (7.69-10.43)	14.65 (13.12-16.33)	Not assessed in questionnaire			17.50 (14.52-20.93)	12.00 (8.91-15.96)	23.08 (18.55-28.33)

Appendix D

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
	No	40.48 (23.86-59.61)	49.57 (24.53-74.82)	28.65 (10.82-57.08)	13.20 (6.22-25.85)	12.65 (3.59-36.04)	13.59 (5.05-31.75)	9.87 (4.85-19.06)	8.82 (3.36-21.25)	10.88 (3.85-27.14)				17.06 (10.71-26.09)	19.49 (10.16-34.13)	14.89 (7.68-26.91)

D.3 Community and Societal Level Risk Factors

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) <i>O = Overall, M = Male, F = Female</i>														
		Sub-Saharan Africa														
		Côte d'Ivoire			Lesotho			Malawi			Namibia			Nigeria		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Exposure to Violence in the Community	Yes	24.33 (19.26-30.24)	22.14 (17.07-28.21)	27.66 (18.17-39.71)	41.77 (37.72-45.94)	37.91 (32.06-44.12)	48.76 (45.18-52.35)	38.05 (33.78-42.51)	36.01 (30.79-41.59)	40.29 (33.42-47.57)	21.32 (18.68-24.22)	19.59 (16.19-23.50)	23.83 (19.83-28.36)	46.56 (42.69-50.47)	44.74 (39.92-49.66)	48.17 (42.48-53.91)
	No	14.56 (12.52-16.87)	15.06 (11.74-19.11)	14.14 (11.75-16.91)	23.86 (21.85-25.98)	19.11 (15.99-22.67)	27.59 (25.57-29.71)	27.03 (22.80-31.71)	28.35 (23.17-34.18)	25.95 (19.70-33.36)	10.30 (8.14-12.96)	10.62 (7.11-15.57)	9.98 (7.71-12.82)	17.46 (15.34-19.81)	13.04 (10.77-15.71)	22.25 (18.78-26.16)
Societal Acceptance of Domestic Violence and Abuse †††	Yes (Violence is Acceptable)	22.14 (18.38-26.42)	21.53 (16.40-27.74)	22.86 (17.78-28.88)	33.83 (30.25-37.61)	31.29 (25.04-38.30)	35.98 (32.83-39.26)	38.89 (31.59-46.72)	38.04 (29.56-47.31)	39.46 (28.84-51.19)	22.72 (19.19-26.69)	27.51 (21.77-34.11)	17.87 (14.72-21.52)	35.79 (31.76-40.04)	33.91 (28.24-40.08)	37.12 (31.67-42.91)
	No (Violence is not Acceptable)	14.50 (11.79-17.71)	14.66 (10.48-20.14)	14.36 (10.93-18.66)	27.58 (25.13-30.17)	24.71 (20.47-29.50)	30.65 (28.48-32.91)	26.54 (23.35-30.00)	28.48 (24.41-32.93)	24.46 (19.88-29.70)	13.16 (11.07-15.58)	15.55 (8.738-15.12)	15.28 (12.47-18.60)	26.89 (24.27-29.69)	22.76 (19.97-25.81)	31.38 (26.95-36.19)
	Incomplete Answer	3.06 (1.34-6.87)	3.03 (0.84-10.33)	3.10 (1.00-9.16)	25.00 (16.48-36.03)	23.75 (8.90-49.84)	25.85 (18.25-35.25)	11.40 (5.93-20.83)	14.46 (6.28-29.89)	8.97 (2.91-24.47)	10.56 (5.57-19.11)	7.32 (1.69-26.63)	14.28 (8.37-23.30)	23.09 (17.05-30.49)	24.90 (17.36-34.37)	19.78 (11.59-31.70)

Appendix D

D.3 Community and Societal Level Risk Factors Cont. – Zambia, Colombia, Honduras, Cambodia, and Moldova

Associated Factor		Children exposed to domestic violence and abuse by associated factor and country by MDG Region (weighted %, 95% CI) O = Overall, M = Male, F = Female														
		Sub-Saharan Africa			Latin America and the Caribbean						South-Eastern Asia			Eastern Europe		
		Zambia			Colombia			Honduras			Cambodia			Moldova		
		O	M	F	O	M	F	O	M	F	O	M	F	O	M	F
Exposure to Violence in the Community	Yes	47.07 (42.18-52.02)	43.80 (38.12-49.65)	49.80 (43.68-55.92)	22.11 (17.64-27.34)	18.38 (13.98-23.79)	26.26 (18.65-35.65)	17.29 (15.35-19.42)	14.29 (11.90-17.07)	20.39 (17.42-23.73)	27.18 (24.08-30.53)	27.40 (23.36-31.85)	26.96 (22.27-32.21)	21.75 (18.09-25.90)	16.73 (12.97-21.32)	27.96 (21.95-34.87)
	No	20.72 (18.23-23.46)	18.91 (15.88-22.35)	22.64 (18.94-26.83)	17.06 (12.41-22.99)	13.61 (7.90-22.43)	20.40 (13.70-29.24)	9.12 (7.99-10.39)	6.19 (4.79-7.97)	11.84 (10.27-13.60)	10.83 (8.92-13.09)	12.22 (9.30-15.90)	9.48 (7.20-12.39)	10.52 (7.89-13.90)	4.02 (2.15-7.40)	15.69 (11.72-20.69)
Societal Acceptance of Domestic Violence and Abuse †††	Yes (Violence is Acceptable)	35.18 (31.32-39.24)	30.17 (25.70-35.06)	39.31 (34.48-44.36)	32.79 (14.92-57.58)	36.54 (13.98-67.10)	25.11 (5.83-64.50)	14.01 (11.12-17.50)	9.05 (6.06-13.31)	18.87 (14.40-24.33)	20.64 (17.33-24.40)	22.44 (17.88-27.78)	18.70 (14.15-24.28)	32.60 (24.92-41.33)	27.18 (17.32-39.93)	38.89 (28.27-50.68)
	No (Violence is not Acceptable)	26.92 (23.96-30.09)	25.71 (22.01-29.79)	28.23 (24.53-32.26)	18.89 (15.28-23.13)	14.61 (11.08-19.03)	23.17 (17.29-30.32)	11.55 (10.45-12.75)	9.11 (7.74-10.70)	13.95 (12.33-15.75)	19.93 (17.33-22.80)	19.29 (16.11-22.92)	20.52 (16.56-25.14)	15.33 (12.28-18.96)	10.93 (8.29-14.29)	19.76 (14.84-25.82)
	Incomplete Answer	25.23 (16.36-36.78)	22.62 (7.28-37.56)	27.85 (14.69-46.38)	24.27 (12.58-41.64)	21.30 (11.30-36.51)	28.71 (8.30-64.18)	10.33 (6.84-15.32)	4.06 (1.57-10.11)	13.85 (8.89-20.96)	23.22 (17.01-30.85)	28.15 (19.87-38.25)	14.71 (7.35-27.28)	16.61 (11.23-23.87)	10.99 (5.22-21.69)	21.44 (13.47-32.35)

††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance, then they were coded as “incomplete answer”.

Appendix E Recoding of Variables for Paper Three Analysis

To allow for analysis of mental health outcomes associated with DVA, some of the variables within the VACS needed to be recoded, to allow for cross-country comparisons to be made. For illustrative purposes, the country of Côte d'Ivoire has been used throughout this appendix as an example for how all variables were recoded for analysis within this paper. In some cases, there were some individual country differences in either the phrasing of the question or response options, which have been noted. All variables were recoded and analysed in Stata SE 17.

Appendix B details how the exposure to DVA, and associated risk factors were recoded. These were used as potential explanatory factors in the Paper Three regression models.

This appendix starts by explaining the most common response options for questions used for analysis (E.1), then details how responses were recoded when the analysis has come directly from a question within the VACS (E.2), and then explains some more complex variables which were created for analysis (E.3).

E.1 Response Options to Question Types

Within the analysis for risk factors associated with exposure to domestic violence and abuse (DVA), two main types of question types were used across the datasets. The below table illustrates the slight phrasing differences that exist within these commonly used question types:

Question Type	Applicable Variables	Response Options	Countries
Frequency	Exposure to DVA	Never, once, more than once, don't know, declined	Colombia, Côte d'Ivoire, Lesotho, Namibia (varies between more than once/more than one time)
		Never, once, more than one time, don't know, declined	Honduras, Moldova, Namibia (varies between more than once/more than one time)

Appendix E

		Never, once, few, many, don't know/declined	Cambodia, Malawi, Nigeria, Zambia
Simple Response	Intentional Self-Harm Suicidal Thoughts Suicide Attempt Using Drugs Perpetration of [Physical] DVA (each scenario)* Perpetration of [Physical] Non-Partnered Violence (each scenario)*	Yes, no, don't know, declined	Colombia, Côte d'Ivoire, Honduras, Lesotho, Moldova, Namibia
		Yes, no, don't know/declined	Cambodia, Malawi, Nigeria, Zambia

*Further information on the scenarios for perpetration of [physical] DVA and perpetration of [physical] non-partnered violence is detailed in F.3.3 and F.3.4.

Don't know and declined were both treated as a non-response, and so were coded as 99 (missing). Variables which were created for the analysis from existing questions are detailed below.

E.2 Recoding of Existing Questions/Variables within the VACS

Several factors were explored based off of existing questions from within the VACS, and minimal recoding was required. These are detailed below, using Côte d'Ivoire as an example. The final column of the table notes any differences across the ten countries explored.

Associated Factor	Question	Survey Response Options	Recoded to	Notes
Exposure to DVA	How many times did you see or hear your mother or step-mother being hit, punched, kicked or beaten by your father or step-father?	Never (1) Once (2) More than once (3) Don't know (98) Declined (99)	No (2) Yes (1) Yes (1) Missing (99) Missing (99)	As this is the central variable in Papers 2 and 3, a full breakdown of the questions asked and response options for each country for this variable is available in Table 3.5. In all datasets (other than Cambodia and Zambia), the following text precedes this question: "13-17 years old: at any time in your life 18-24 years old: before the age of 18"

Appendix E

				Cambodia and Zambia does not specify before the age of 18, which is a limitation of this dataset.
Intentional Self-Harm	Have you ever intentionally hurt yourself in any way?	Yes (1) No (2) Don't know (98) Declined (99)	Yes (1) No (2) Missing (99) Missing (99)	The phrasing of this question was consistent across country questionnaire, except Lesotho, which asked, "Have you ever hurt yourself on purpose in any way?"
Suicidal Thoughts	Have you ever thought about killing yourself?	Yes (1) No (2) Don't know (98) Declined (99)	Yes (1) No (2) Missing (99) Missing (99)	The phrasing of this question was consistent across country questionnaire, except Moldova, which asked, "Have you ever seriously considered ending your life?"
Suicide Attempt	Have you ever tried to kill yourself?	Yes (1) No (2) Don't know (98) Declined (99)	Yes (1) No (2) Missing (99) Missing (99)	The phrasing of this question was consistent across country questionnaire, except Moldova, which asked, "Have you ever tried ending your life?"
Smoking Tobacco	Do you currently smoke tobacco on a daily basis, less than daily, or not at all?	Daily (1) Less than daily (2) Not at all (3) Don't know (98) Declined (99)	Yes (1) Yes (1) No (2) Missing (99) Missing (99)	This phrasing was consistent in the questionnaires for Colombia, Honduras, Lesotho, Moldova, and Namibia. In Cambodia, Malawi, Nigeria, and Zambia, cigarettes were instead specified, "During the past 30 days, did you smoke cigarettes daily, occasionally, or not at all?"
Binge Drinking	In the past 30 days, on how many days did you have 4 or more drinks of alcohol in a row?	Number of days: 0 Number of days: >1 Don't know (98) Declined (99)	No (2) Yes (1) Missing (99) Missing (99)	This phrasing was consistent in the questionnaires for Colombia, Honduras, Lesotho, Moldova, and Namibia. In Cambodia, Malawi, Nigeria and Zambia, respondents were instead asked, "In the past 30 days, on how many days did you drink alcohol to the point that you became drunk?". Again, if someone indicated no days, then they were coded as no, they have not engaged in binge drinking. If they indicated any number of days, they were coded as yes.
Using Drugs	In the past 30 days, have you used drugs such as marijuana, pills, ecstasy, or	Yes (1) No (2) Don't know (98) Declined (99)	Yes (1) No (2) Missing (99) Missing (99)	The phrasing of this question was consistent across questionnaires. However, in some countries, different drugs were given as examples:

	sniffed any chemical such as petrol or glue?			• In Cambodia: “marijuana, pills, ecstasy, yama or sniffed any chemical such as petrol or glue” • In Lesotho: “dagga, prescription pills, injection drugs, ecstasy, or sniffed any chemical such as petrol or glue” • In Namibia: “mandrax, marijuana/dagga, cocaine, tik, or sniffed any chemical such as paint thinner” • Nigeria and Zambia: “marijuana, pills, codeine, cocaine, or sniffed any chemical such as petrol or glue”

E.3 Creation of New Variables for Analysis for Risk Factors Associated with Exposure to DVA

E.3.1 Psychological distress

Psychological distress was assessed using the Kessler 6 (K6) scale (Kessler et al., 2003), which consists of six questions exploring feelings of hopelessness, restlessness, worthlessness, depression, effort, and sadness by the respondent during the previous 30 days. The K6 is an instrument that measures psychological distress and includes items that assess anxiety and depression, and it has demonstrated excellent internal consistency and reliability across different cultures and ethnic groups, including in many LMICs (Easton, Safadi, Wang, & Hasson, 2017; Krieger, Kosheleva, Waterman, Chen, & Koenen, 2011; Van der Auwera, Debacker & Hubloue, 2012; Vissoci et al., 2018). Each item uses a scale response format from 1 to 5, where 1 corresponds to experiencing a mental health symptom “all the time” and 5 corresponds to “never”. The reference time frame is the past 30 days.

The scores of the individual items were reversed and added up to form a unidimensional summary score of psychological distress to create an index ranging from 0 to 24, following the approach used in previous studies (e.g., Furukawa, Kessler, Slade & Andres, 2003; Swartz & Lurigio, 2006). Respondents scoring 0 to 4 were defined as having no psychological distress, scores of 5 to 12 indicated mild to moderate psychological distress, and scores of 13 or higher indicated severe psychological distress (Prochaska, Sung, Max, Shi, & Ong, 2012). Respondents were classed as having a missing K6 score if they failed to provide a response to any of the six questions asked. This ensured that the results were not distorted at all.

Appendix E

The six questions used to create the psychological distress variable are detailed below:

Question	Sub-Question	Survey Response Options	Notes
During the past 30 days, how often did you feel the following ways:	Nervous	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire.
	Hopeless	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire, except in Colombia, where this is instead "hopeless/anxious"
	Restless	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire.
	So sad that nothing could cheer you up	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire, except in Cambodia, where this is instead "so depressed that nothing could cheer you up"
	That everything was an effort	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire.

Appendix E

	Worthless	All the time (1) Most of the time (2) Some of the time (3) A little of the time (4) None of the time (5) Don't know (98) Declined (99)	The phrasing of this question was consistent across country questionnaire.

Using the methodology detailed above and in 6.2.3, a variable was then created to group respondents into four categories: “no psychological distress”, “mild/moderate psychological distress”, “severe psychological distress”, and “missing K6 score”.

Stata Code Used to Generate Variable – Psychological distress
<pre> *first, the 6 feelings were created from their related questions recode Q1405A (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(nervous_k6) recode Q1405B (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(hopeless_k6) recode Q1405C (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(restless_k6) recode Q1405D (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(depressed_k6) recode Q1405E (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(everythingeffort_k6) recode Q1405F (1=4) (2=3) (3=2) (4=1) (5=0) (98=.) (99=.), generate(worthless_k6) label define k6responsereversed 0 "none of the time" 1 "a little of the time" 2 "some of the time" 3 "most of the time" 4 "all of the time" label values nervous_k6 hopeless_k6 restless_k6 depressed_k6 everythingeffort_k6 worthless_k6 k6responsereversed //allows me to analyse at each feeling if needed in future analysis. egen k6_total_new=rowtotal(nervous_k6 hopeless_k6 restless_k6 depressed_k6 everythingeffort_k6 worthless_k6), m egen anymiss=rowmiss(nervous_k6 hopeless_k6 restless_k6 depressed_k6 everythingeffort_k6 worthless_k6) //counts up how many missing amongst individual 6 variables. recode k6_total_new (0/max=.) if anymiss>0 //recoding original variable. missing if anything is missing. gen k6_total_new_cat = . replace k6_total_new_cat = 1 if k6_total_new >= 0 & k6_total_new <= 4 replace k6_total_new_cat = 2 if k6_total_new >= 5 & k6_total_new <= 12 replace k6_total_new_cat = 3 if k6_total_new > 12 & k6_total_new <=24 replace k6_total_new_cat = 99 if k6_total_new_cat == . label define k6_total_cat_label 1 "No psychological distress" 2 "Mild to moderate distress" 3 "Severe distress" 99 "Missing" label values k6_total_new_cat k6_total_cat_label </pre>

Further analysis required this variable to be binary, with 0 indicating “no psychological distress”, and 1 indicating “any psychological distress”. This was done using the following code:

Stata Code Used to Generate Binary Variable – Any Psychological distress

```
gen k6_total_bin = .
replace k6_total_bin = 0 if k6_total_new_cat==1 //no distress
replace k6_total_bin = 1 if k6_total_new_cat==2 //mild to moderate distress
replace k6_total_bin = 1 if k6_total_new_cat==3 //severe distress
replace k6_total_bin = 99 if k6_total_new_cat==99 // missing

label define kesslerbin 0 "No psychological distress" 1 "Any psychological distress" 99 "Missing"
label values k6_total_bin kesslerbin
```

E.3.2 Engaging in Behaviours Harmful to Health (‘Risky Behaviours’)

This factor was derived from three existing variables: binge drinking, smoking tobacco, and drug use. These were combined to indicate whether a respondent had partaken in any risky behaviours in the past 30 days. Similarly to some other outcome variables explored, whilst the questions asked about frequency of the behaviour, for the purpose of analysis these were dichotomised. Even though when done in moderation some of these behaviours may not indicate poor mental health, for the purpose of this variable, anyone doing anything which could be harmful for their health has been considered. Therefore, if someone drinks, smokes, or takes drugs at all, then they have been coded as having engaged with the behaviour, no matter what the frequency was. From this, an overall ‘risky behaviours’ variable was created, where if anyone had indicated that they engage with any of the three behaviours, they were coded as yes, whereas respondents were coded as no if they answered no to the three behaviours. The three individual variables were cross tabulated with the new “riskybehaviours” variable for each country to check that everyone had been captured.

Stata Code Used to Generate Variable – Risky Behaviours

```
gen riskybehaviours=.
recode riskybehaviours (.=1) if currentlysmoke==1|bingedrinking==1|druguse==1
```

```

recode riskybehaviours (.=0) if currentlsmoke==2&bingedrink==2&druguse==2
recode riskybehaviours (.=99) if currentlsmoke==99|bingedrink==99|druguse==99
tab riskybehaviours, nol
label define yesnomissingbin 0 "no" 1 "yes" 99 "missing"
label values riskybehaviours yesnomissingbin

**creating a risky behaviours variable with an incomplete category
gen riskybehavioursincomplete=.
recode riskybehavioursincomplete (.=1) if currentlsmoke==1|bingedrink==1|druguse==1
recode riskybehavioursincomplete (.=0) if currentlsmoke==2&bingedrink==2&druguse==2
recode riskybehavioursincomplete (.=98) if currentlsmoke==99|bingedrink==99|druguse==99
recode riskybehavioursincomplete (.=99)
tab riskybehavioursincomplete, nol
label define yesnonotcompletemissingbin 0 "no" 1 "yes" 98 "not complete" 99 "missing"
label values riskybehavioursincomplete yesnonotcompletemissingbin

```

E.3.3 Perpetration of [Physical] DVA

For those who indicated that they had ever had a relationship, respondents were asked a range of questions about types of violence that they have perpetrated towards a current or former husband, wife, partner, girlfriend, or boyfriend. In some countries, these included questions about perpetration of sexual violence or economic or coercive control, however, these were not consistent across all ten countries. Therefore, only those behaviours which were consistently asked across all ten countries were asked, which all relate to perpetration of physical violence:

Have you ever done any of the following to a current or previous boyfriend, romantic partner or husband?

1. Punching, kicking, whipping, or beating a current or previous partner with an object.
2. Choking, smothering, trying to drown, or intentionally burning or scalding a current or previous partner.
3. Using or threatening to use a knife or other weapon against a current or previous partner.

Appendix E

The table below details the phrasing and response options within each country:

Question	Sub-Question	Survey Response Options	Notes
Have you ever done any of the following to a current or previous boyfriend, girlfriend, romantic/intimate partner, husband or wife:	Punched, kicked, whipped, or beat them with an object?	Yes (1) No (2) Don't know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d'Ivoire, Honduras, Lesotho, and Namibia. This phrasing was the same in the Cambodian questionnaire, but this had different response options (detailed below). In the countries of Malawi, Nigeria, and Zambia, the question was instead “punched, kicked, whipped, or beat them”. In Moldova, an additional action was specified, meaning that the question was “punched, kicked, hit, whipped, or beat them with an object”.
		Never (1) Once (2) Few (3) Many (4) Don't know/declined (99)	In the country questionnaire for Cambodia, this question had the same phrasing, but instead asked about the frequency of the event occurring. Any indication that this had ever happened was recoded as yes (in the same way that the exposure to DVA variable was recoded).
	Choked, smothered, tried to drown them, or burned them intentionally?	Yes (1) No (2) Don't know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d'Ivoire, Honduras, Lesotho, and Malawi. In the countries of Nigeria and Zambia, the question was instead “choked, suffocated, tried to drown, or intentionally burn them”. In Moldova, the question was instead “choked, smothered, tried to drown them, or burned/scald them intentionally”. This phrasing was the same in the Cambodian questionnaire, but this had different response options (detailed below).

Appendix E

			Finally, in Namibia, this phrasing for this question was, “strangled, smothered, tried to drown them, or burned them intentionally”.
		Never (1) Once (2) Few (3) Many (4) Don’t know/declined (99)	In the country questionnaire for Cambodia, this question had the same phrasing as in Moldova, but instead asked about the frequency of the event occurring. Any indication that this had ever happened was recoded as yes (in the same way that the exposure to DVA variable was recoded).
	Used or threatened them with a knife, gun or other weapon?	Yes (1) No (2) Don’t know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d’Ivoire, Honduras, and Moldova. In the countries of Malawi, Nigeria and Zambia, the questionnaire instead asked whether a respondent had “used or threatened to use a knife, gun or other weapon against them”. This phrasing was the same in the Cambodian questionnaire, but this had different response options (detailed below). In the country questionnaire for Lesotho, an additional weapon was specified “used or threatened them with a stick, knife, gun or other weapon?”. Similarly in Namibia, an additional weapon was specified “used or threatened them with a knife, panga, gun or other weapon”.
		Never (1) Once (2) Few (3) Many (4) Don’t know/declined (99)	In the country questionnaire for Cambodia, this question had the same phrasing as in Malawi, Nigeria, and Zambia, but instead asked about the frequency of the event occurring. Any indication that this had ever happened was recoded as yes (in the same way that the exposure to DVA variable was recoded).

These questions were then used to create a binary variable:

Stata Code Used to Generate Variable – Perpetration of [Physical] DVA

*To be able to examine perpetration of DVA, I need to make a group of people who have ever been in a relationship or been married
 tab Q36 //have you ever been married or lived with someone as if you were married?
 tab Q41 //have you ever had a boyfriend/girlfriend or romantic partner?

```

gen everrelationship=.
recode everrelationship (.=1) if Q36==1|Q36==2|Q41==1
recode everrelationship (.=2) if Q36==3&Q41==2
recode everrelationship (.=99) if Q36==99|Q41==99|Q36==98|Q41==98
label values everrelationship yesnodkd

* IPV Violence Perpetration
recode Q200B (1=1) (2=0) (98/99=.), gen (PerpIPVB) //punched/kicked/whipped/beat with object
recode Q200C (1=1) (2=0) (98/99=.), gen (PerpIPVC) //choked/smothered/tried to drown/burned
recode Q200D (1=1) (2=0) (98/99=.), gen (PerpIPVD) //used or threatened with weapon

gen PerpPhysicalIPVBinary=.
recode PerpPhysicalIPVBinary (.=1) if PerpIPVB==1|PerpIPVC==1|PerpIPVD==1
recode PerpPhysicalIPVBinary (.=0) if PerpIPVB==0 & PerpIPVC==0 & PerpIPVD==0
recode PerpPhysicalIPVBinary (.=99) if everrelationship==1

label values PerpPhysicalIPVBinary yesnomissingbin

tab PerpPhysicalIPVBinary if everrelationship==1, m

*the everrelationship variable can now be used in analysis to examine bivariate analyses with exposure to DVA, e.g.:
svy: tab exposeddva PerpPhysicalIPVBinary if everrelationship==1, perc row ci //overall country population
svy: tab exposeddva PerpPhysicalIPVBinary if everrelationship==1 & respondentsex==1, perc row ci //males
svy: tab exposeddva PerpPhysicalIPVBinary if everrelationship==1 & respondentsex==2, perc row ci //females

```

E.3.4 Perpetration of [Physical] Non-Partnered Violence

This question was not possible to assess in Cambodia, as the questionnaire did not contain the questions.

Respondents were also asked whether had perpetrated any of the violent acts to someone who was not a current or previous partner. Again, within some country questionnaires a variety of violent acts were explored, but only three were consistent across all ten datasets (the same three explored within the Physical DVA Perpetration variable), and so these were what were explored for this variable. Again, each violent act was recoded to form a binary variable, and

then if statements were used to form two groups – those who had ever perpetrated any of the three types of physical violence explored, and those who had never perpetrated those violent acts towards others.

The table below details the phrasing and response options within each country:

Question	Sub-Question	Survey Response Options	Notes
Have you ever done any of the following to someone who is not a current or previous boyfriend, girlfriend, romantic/intimate partner, husband or wife:	Punched, kicked, whipped, or beat them with an object?	Yes (1) No (2) Don't know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d'Ivoire, Honduras, Lesotho, Moldova, and Namibia. In the countries of Malawi, Nigeria, and Zambia, the question was instead “punched, kicked, whipped, or beat them”.
	Choked, smothered, tried to drown them, or burned them intentionally?	Yes (1) No (2) Don't know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d'Ivoire, Honduras, Lesotho, and Malawi. In the countries of Nigeria and Zambia, the question was instead “choked, suffocated, tried to drown, or intentionally burn them”. In Moldova, the question was instead “choked, smothered, tried to drown them, or burned/scald them intentionally”. Finally, in Namibia, this phrasing for this question was, “strangled, smothered, tried to drown them, or burned them intentionally”.
	Used or threatened them with a knife, gun or other weapon?	Yes (1) No (2) Don't know (98) Declined (99)	The phrasing of this question was consistent across the country questionnaires of Colombia, Côte d'Ivoire, Honduras, and Moldova. In the countries of Malawi, Nigeria and Zambia, the questionnaire instead asked whether a respondent had “used or threatened to use a knife, gun or other weapon against them”.

Appendix E

			In the country questionnaire for Lesotho, an additional weapon was specified “used or threatened them with a stick, knife, gun or other weapon?”. Similarly in Namibia, an additional weapon was specified “used or threatened them with a knife, panga, gun or other weapon”.

These questions were then used to create a binary variable:

Stata Code Used to Generate Variable – Perpetration of Non-Partnered [Physical] Violence
<pre> recode Q201B (1=1) (2=0) (98/99=.), gen (PerpNonIPVB) //punched/kicked/whipped/beat with object recode Q201C (1=1) (2=0) (98/99=.), gen (PerpNonIPVC) //choked/smothered/tried to drown/burned recode Q201D (1=1) (2=0) (98/99=.), gen (PerpNonIPVD) //used or threatened with weapon gen PerpNonIPVViolenceBinary=. recode PerpNonIPVViolenceBinary (.=1) if PerpNonIPVB==1 PerpNonIPVC==1 PerpNonIPVD==1 recode PerpNonIPVViolenceBinary (.=0) if PerpNonIPVB==0 & PerpNonIPVC==0 & PerpNonIPVD==0 recode PerpNonIPVViolenceBinary (.=99) label values PerpNonIPVViolenceBinary yesnomissingbin </pre>

Appendix F Associated Mental Health Outcomes for Children Exposed to Domestic Violence and Abuse: Bivariate Correlates with Confidence Intervals

F.1 Internalising Symptoms

F.1.1 Psychological distress (last 30 days)

MDG Region	Country (Survey Year)	Kessler K6 Level of Psychological distress (last 30 days) % (95% CI)							
		No Psychological distress (0-4)		Mild/Moderate Psychological distress (5-12)		Severe Psychological distress (13+)		Missing K6 Score	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	37.03 (30.65-43.9)	46.79 (43.03-50.6)	50.29 (44.06-56.51)	42.23 (38.83-45.71)	10.71 (6.50-17.17)	7.89 (6.13-10.10)	1.96 (0.60-6.22)	3.09 (2.28-4.18)
	Male	39.82 (29.42-51.23)	49.92 (45.27-54.56)	48.83 (39.37-58.37)	41.45 (37.03-46.01)	9.97 (3.94-22.99)	5.09 (3.58-7.19)	1.39 (0.47-4.02)	3.55 (2.47-5.08)
	Female	34.18 (26.64-42.63)	43.63 (38.16-49.25)	51.78 (43.9-59.58)	43.03 (38.24-47.94)	11.48 (7.03-18.2)	10.73 (7.87-14.45)	2.56 (0.44-13.44)	2.62 (1.60-4.26)
	Lesotho (2018)	63.75 (59.67-67.63)	75.65 (72.49-78.56)	32.22 (28.27-36.44)	21.60 (18.73-24.79)	3.59 (2.76-4.64)	2.23 (1.76-2.81)	0.45 (0.24-0.82)	0.51 (0.31-0.85)
	Male	63.11 (54.88-70.64)	74.37 (68.42-79.54)	35.92 (28.24-44.41)	24.10 (18.94-30.15)	0.98 (0.37-2.53)	1.37 (0.80-2.33)	0.00 (0.00-0.00)	0.16 (0.02-1.21)
	Female	64.27 (61.47-66.98)	77.05 (74.60-79.33)	29.18 (26.84-31.65)	18.89 (16.89-21.07)	5.73 (4.62-7.09)	3.16 (2.55-3.92)	0.81 (0.45-1.45)	0.90 (0.58-1.39)
	Malawi (2013)	53.54 (47.03-59.94)	70.18 (66.55-73.57)	36.22 (29.56-43.46)	23.73 (21.10-26.57)	8.48 (5.75-12.33)	5.04 (3.62-6.99)	1.76 (0.89-3.42)	1.05 (0.57-1.93)
	Male	56.85 (49.65-63.77)	68.57 (63.36-73.35)	34.34 (28.08-41.20)	24.29 (20.56-28.46)	6.793 (4.03-11.24)	5.77 (3.86-8.56)	2.02 (0.74-5.35)	1.36 (0.58-3.15)

Appendix F

MDG Region	Country (Survey Year)	Kessler K6 Level of Psychological distress (last 30 days) % (95% CI)							
		No Psychological distress (0-4)		Mild/Moderate Psychological distress (5-12)		Severe Psychological distress (13+)		Missing K6 Score	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	50.48 (40.63-60.30)	71.63 (66.68-76.1)	37.96 (27.16-50.11)	23.22 (19.74-27.11)	10.04 (5.70-17.08)	4.39 (2.52-7.53)	1.52 (0.63-3.58)	0.76 (0.34-1.68)
	Namibia (2019)	58.20 (51.49-64.63)	70.49 (65.72-74.84)	33.45 (27.91-39.48)	25.16 (21.36-29.38)	4.99 (3.05-8.05)	2.53 (1.76-3.60)	3.36 (2.01-5.58)	1.83 (1.29-2.59)
	Male	66.71 (56.89-75.27)	78.64 (72.17-83.93)	25.79 (18.75-34.34)	19.00 (14.15-25.02)	4.34 (2.05-8.97)	0.94 (0.48-1.83)	3.16 (1.56-6.27)	1.43 (0.74-2.72)
	Female	48.41 (39.94-56.98)	60.55 (54.71-66.10)	42.26 (34.74-50.15)	32.68 (27.86-37.89)	5.73 (2.94-10.88)	4.46 (3.05-6.47)	3.60 (1.65-7.65)	2.32 (1.59-3.36)
	Nigeria (2014)	61.42 (57.08-65.58)	68.23 (65.60-70.75)	27.27 (23.67-31.19)	24.19 (21.75-26.79)	5.89 (4.23-8.15)	3.00 (2.27-3.96)	5.42 (4.05-7.21)	4.58 (3.49-5.99)
	Male	53.75 (47.53-59.85)	71.12 (67.86-74.18)	34.45 (28.83-40.54)	22.08 (19.41-25.01)	4.12 (2.47-6.78)	1.69 (1.09-2.63)	7.69 (5.37-10.88)	5.10 (3.66-7.07)
	Female	67.26 (61.62-72.44)	65.07 (60.83-69.08)	21.80 (17.39-26.96)	26.50 (22.53-30.89)	7.25 (4.82-10.77)	4.43 (3.14-6.22)	3.69 (2.39-5.67)	4.00 (2.62-6.06)
	Zambia (2014)	51.20 (46.70-55.68)	60.10 (56.62-63.48)	33.10 (29.04-37.42)	27.98 (25.00-31.16)	12.06 (9.21-15.65)	6.70 (5.17-8.64)	3.64 (2.13-6.15)	5.23 (4.05-6.72)
	Male	52.52 (45.66-59.29)	59.84 (55.51-64.02)	32.59 (27.22-38.47)	28.08 (24.30-32.20)	10.28 (6.69-15.47)	6.68 (4.78-9.28)	4.61 (2.22-9.33)	5.40 (3.67-7.87)
	Female	50.15 (44.91-55.39)	60.38 (55.73-64.84)	33.49 (28.73-38.61)	27.87 (23.85-32.28)	13.48 (10.14-17.70)	6.71 (4.95-9.05)	2.88 (1.29-6.29)	5.04 (3.77-6.72)
Latin America and the Caribbean	Colombia (2018)	34.72 (26.89-43.48)	60.01 (54.86-64.94)	51.18 (40.68-61.58)	34.81 (29.98-39.98)	11.87 (5.93-22.36)	3.04 (2.04-4.51)	2.23 (0.85-5.68)	2.14 (1.01-4.47)
	Male	37.77 (25.39-51.98)	67.85 (61.04-73.99)	52.21 (36.36-67.63)	28.86 (22.5-36.19)	6.47 (2.61-15.16)	1.64 (0.83-3.22)	3.55 (1.00-11.82)	1.64 (0.43-6.10)
	Female	32.54 (22.93-43.85)	50.88 (44.23-57.5)	50.44 (36.8-64.01)	41.73 (35.43-48.31)	15.76 (6.65-32.96)	4.67 (2.88-7.48)	1.27 (0.35-4.51)	2.72 (1.12-6.43)
	Honduras (2017)	33.72	49.61	51.62	42.53	14.04	7.10	0.62	0.76

Appendix F

MDG Region	Country (Survey Year)	Kessler K6 Level of Psychological distress (last 30 days) % (95% CI)							
		No Psychological distress (0-4)		Mild/Moderate Psychological distress (5-12)		Severe Psychological distress (13+)		Missing K6 Score	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Male	(29.49-38.24)	(47.68-51.54)	(47.25-55.96)	(40.81-44.27)	(11.33-17.28)	(6.20-8.13)	(0.22-1.73)	(0.52-1.11)
		42.86 (35.49-50.55)	53.49 (50.81-56.15)	45.2 (37.94-52.67)	41.48 (39.18-43.81)	11.94 (8.24-17.01)	4.57 (3.55-5.88)	0.00 (0.00-0.00)	0.46 (0.22-0.97)
	Female	28.31 (23.38-33.83)	45.61 (42.91-48.33)	55.42 (50.02-60.69)	43.61 (41.03-46.22)	15.29 (11.73-19.67)	9.71 (8.34-11.28)	0.98 (0.35-2.76)	1.07 (0.69-1.65)
	Cambodia (2013)	46.34 (40.61-52.17)	67.38 (64.72-69.93)	41.32 (35.86-47)	29.13 (26.73-31.66)	10.27 (7.01-14.80)	2.76 (2.01-3.79)	2.08 (0.93-4.55)	0.72 (0.30-1.74)
South-Eastern Asia	Male	55.21 (47.07-63.08)	72.43 (47.07-75.7)	36.71 (30.01-43.96)	24.18 (30.01-27.51)	4.81 (2.01-11.08)	2.00 (2.01-3.57)	3.27 (1.31-7.92)	1.40 (1.31-3.41)
	Female	36.54 (29.41-44.31)	62.37 (58.61-65.99)	46.41 (37.85-55.19)	34.05 (30.71-37.56)	16.29 (10.91-23.63)	3.52 (2.45-5.05)	0.75 (0.19-2.99)	0.06 (0.01-0.41)
	Moldova (2019)	33.03 (26.16-40.72)	58.53 (53.97-62.95)	48.64 (41.23-56.10)	33.79 (29.93-37.89)	10.20 (6.75-15.13)	2.87 (1.78-4.60)	8.13 (5.11-12.69)	4.80 (3.08-7.43)
Eastern Europe	Male	42.85 (30.23-56.47)	63.31 (57.8-68.50)	43.00 (31.32-55.51)	31.89 (26.74-37.51)	4.02 (1.62-9.64)	1.57 (0.62-3.91)	10.13 (4.69-20.54)	3.23 (1.89-5.46)
	Female	27.29 (19.81-36.31)	52.98 (46.05-59.81)	51.94 (42.67-61.08)	36.01 (30.73-41.64)	13.82 (8.83-20.97)	4.38 (2.58-7.34)	6.96 (3.97-11.90)	6.63 (3.49-12.23)

F.1.2 Intentional Self-Harm (ever)

MDG Region	Country (Survey Year)	Intentional Self-Harm (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	15.97 (10.55-23.46)	13.78 (10.42-18.00)	83.82 (76.33-89.27)	85.96 (81.76-89.31)	0.20 (0.03-1.46)	0.27 (0.11-0.67)
	Male	13.18	9.12	86.82	90.81	-	0.07

Appendix F

MDG Region	Country (Survey Year)	Intentional Self-Harm (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	(6.53-24.79)	(6.57-12.51)	(75.21-93.47)	(87.42-93.35)		(0.01-0.54)
		18.83	18.50	80.76	81.04	0.41	0.46
		(11.11-30.11)	(12.72-26.11)	(69.47-88.56)	(73.52-86.80)	(0.06-3.03)	(0.17-1.29)
	Lesotho (2018)	3.08	1.99	96.80	97.97	0.12	0.04
		(1.89-4.99)	(1.48-2.68)	(94.85-98.03)	(97.29-98.49)	(0.02-0.87)	(0.01-0.09)
		3.72	1.91	96.01	98.09	0.27	-
	Male	(1.54-8.72)	(1.05-3.46)	(90.93-98.30)	(96.54-98.95)	(0.03-2.10)	-
	Female	2.56	2.07	97.44	97.85	-	0.07
		(1.94-3.37)	(1.60-2.68)	(96.63-98.06)	(97.24-98.33)	-	(0.03-0.18)
	Malawi (2013)	6.30	3.87	93.71	96.13	-	-
		(3.68-10.55)	(2.63-5.68)	(89.45-96.32)	(94.32-97.38)	-	-
		5.75	5.76	94.25	94.24	-	-
	Male	(3.44-9.44)	(3.67-8.92)	(90.53-96.56)	(91.08-96.33)	-	-
	Female	6.80	2.18	93.20	97.82	-	-
		(2.84-15.40)	(1.07-4.39)	(84.60-97.16)	(95.61-98.93)	-	-
	Namibia (2019)	13.46	8.65	86.54	91.27	-	0.08
		(10.23-17.51)	(6.63-11.21)	(82.49-89.77)	(88.68-93.32)	-	(0.02-0.31)
		11.14	8.16	88.86	91.75	-	0.10
	Male	(6.96-17.38)	(5.18-12.61)	(82.62-93.04)	(87.21-94.77)	-	(0.01-0.72)
	Female	16.13	9.25	83.87	90.69	-	0.05
		(11.53-22.11)	(7.00-12.14)	(77.89-88.47)	(87.81-92.95)	-	(0.02-0.15)
	Nigeria (2014)	7.32	5.82	92.01	93.49	0.67	0.69
		(5.67-9.41)	(4.85-6.98)	(89.88-93.72)	(92.11-94.64)	(0.22-2.08)	(0.29-1.64)
		8.75	6.48	89.70	92.25	1.56	1.27
	Male	(6.43-11.78)	(5.21-8.03)	(86.70-92.08)	(90.16-93.93)	(0.53-4.52)	(0.52-3.06)
	Female	6.24	5.11	93.76	94.84	-	0.05
		(4.11-9.35)	(3.72-6.97)	(90.65-95.89)	(92.97-96.23)	-	(0.01-0.36)
	Zambia (2014)	10.39	10.42	89.61	89.44	-	0.14

Appendix F

MDG Region	Country (Survey Year)	Intentional Self-Harm (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Male	(7.62-14.01)	(8.67-12.47)	(85.99-92.38)	(87.38-91.19)		(0.03-0.60)
		10.39 (6.30-16.68)	10.36 (7.88-13.50)	89.61 (83.32-93.70)	89.47 (86.39-91.92)	-	0.17 (0.02-1.26)
	Female	10.38 (7.06-15.02)	10.48 (8.29-13.17)	89.62 (84.98-92.94)	89.41 (86.67-91.64)	-	0.11 (0.02-0.82)
Latin America and the Caribbean	Colombia (2018)	14.52 (10.40-19.92)	10.62 (7.75-14.39)	85.48 (80.08-89.60)	89.36 (85.60-92.23)	-	0.02 (0.00-0.12)
		12.60 (6.95-21.76)	8.72 (4.89-15.08)	87.40 (78.24-93.05)	91.28 (84.92-95.11)	-	-
	Female	15.91 (10.55-23.29)	12.83 (9.10-17.79)	84.09 (76.71-89.45)	87.13 (82.17-90.86)	-	0.04 (0.01-0.26)
	Honduras (2017)	17.02 (14.05-20.47)	10.41 (9.23-11.73)	82.98 (79.53-85.95)	89.51 (88.19-90.69)	-	0.08 (0.03-0.20)
		14.15 (9.65-20.27)	8.53 (7.04-10.31)	85.85 (79.73-90.35)	91.39 (89.61-92.89)	-	0.08 (0.02-0.31)
	Female	18.72 (15-23.11)	12.35 (10.58-14.36)	81.28 (76.89-85.00)	87.57 (85.55-89.34)	-	0.08 (0.03-0.27)
South-Eastern Asia	Cambodia (2013)	11.09 (8.16-14.92)	4.56 (3.52-5.89)	88.91 (85.08-91.85)	95.36 (94.00-96.42)	-	0.09 (0.02-0.35)
		7.41 (4.47-12.04)	4.14 (2.87-5.94)	92.60 (87.96-95.54)	95.69 (93.79-97.02)	-	0.17 (0.04-0.70)
	Female	15.17 (10.47-21.48)	4.97 (3.50-7.03)	84.83 (78.52-89.53)	95.03 (92.98-96.51)	-	-
Eastern Europe	Moldova (2019)	10.79 (7.08-16.11)	7.15 (5.43-9.36)	87.08 (81.54-91.15)	92.43 (90.21-94.17)	2.13 (1.00-4.48)	0.43 (0.19-0.95)
		8.65 (3.63-19.23)	6.76 (4.59-9.85)	88.53 (78.72-94.16)	92.88 (89.81-95.08)	2.82 (0.95-8.06)	0.36 (0.12-1.12)
	Female	12.04	7.60	86.24	91.90	1.72	0.51

Appendix F

MDG Region	Country (Survey Year)	Intentional Self-Harm (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
		(7.48-18.83)	(5.17-11.03)	(78.94-91.28)	(88.49-94.36)	(0.57-5.06)	(0.16-1.55)

F.1.3 Suicidal Thoughts (ever)

MDG Region	Country (Survey Year)	Suicidal Thoughts (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	7.63 (4.63-12.32)	4.43 (3.33-5.86)	92.17 (87.45-95.21)	95.37 (93.95-96.47)	0.20 (0.03-1.46)	0.20 (0.07-0.57)
	Male	2.40 (0.77-7.26)	1.88 (1.03-3.41)	97.60 (92.74-99.23)	97.95 (96.46-98.82)	-	0.17 (0.04-0.71)
	Female	12.97 (8.17-19.99)	7.01 (5.13-9.51)	86.61 (79.54-91.50)	92.75 (90.27-94.64)	0.41 (0.06-3.03)	0.24 (0.05-1.05)
	Lesotho (2018)	9.04 (7.43-10.92)	4.09 (3.32-5.01)	90.98 (89.08-92.57)	95.88 (94.95-96.64)	-	0.04 (0.01-0.20)
	Male	4.32 (2.267-8.08)	2.38 (1.38-4.05)	95.65 (91.92-97.73)	97.56 (95.91-98.56)	-	0.06 (0.01-0.47)
	Female	12.88 (11.22-14.76)	5.94 (5.08-6.94)	87.12 (85.24-88.78)	94.05 (93.05-94.91)	-	0.01 (0.00-0.08)
	Malawi (2013)	6.28 (4.03-9.65)	3.69 (2.55-5.30)	93.72 (90.35-95.97)	96.31 (94.70-97.45)	-	-
	Male	3.99 (1.97-7.90)	2.87 (1.70-4.79)	96.01 (92.10-98.03)	97.13 (95.21-98.30)	-	-
	Female	8.39 (4.70-14.56)	4.42 (2.70-7.18)	91.61 (85.44-95.30)	95.58 (92.82-97.30)	-	-
	Namibia (2019)	12.13 (8.74-16.58)	6.02 (4.59-7.86)	87.87 (83.42-91.26)	93.90 (92.04-95.35)	-	0.08 (0.02-0.31)
	Male	5.22 (2.24-11.72)	2.87 (1.45-5.61)	94.78 (88.28-97.76)	97.03 (94.21-98.50)	-	0.10 (0.01-0.72)
	Female	20.07 (14.85-26.55)	9.87 (7.75-12.49)	79.93 (73.45-85.15)	90.08 (87.46-92.20)	-	0.05 (0.02-0.14)
	Nigeria (2014)	4.90 (3.53-6.76)	4.81 (3.79-6.10)	94.96 (93.08-96.35)	94.70 (93.33-95.80)	0.14 (0.02-1.00)	0.49 (0.20-1.21)
	Male	2.61 (1.58-4.30)	3.41 (2.37-4.88)	97.06 (95.22-98.21)	95.78 (94.00-97.05)	0.33 (0.05-2.29)	0.82 (0.29-2.25)
	Female	6.64 (4.53-9.63)	6.35 (4.67-8.59)	93.36 (90.37-95.47)	93.51 (91.28-95.21)	-	0.13 (0.03-0.57)
	Zambia (2014)	13.71 (10.42-17.83)	8.24 (6.78-9.98)	86.29 (82.17-89.58)	91.19 (89.37-92.72)	-	0.57 (0.19-1.73)

Appendix F

MDG Region	Country (Survey Year)	Suicidal Thoughts (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Male	12.24 (7.90-18.48)	5.51 (3.78-7.98)	87.76 (81.52-92.10)	94.05 (91.52-95.86)	-	0.44 (0.13-1.42)
	Female	14.88 (10.54-20.59)	11.15 (9.11-13.57)	85.12 (79.41-89.46)	88.14 (85.64-90.25)	-	0.71 (0.13-3.86)
Latin America and the Caribbean	Colombia (2018)	19.25 (13.34-26.95)	10.00 (7.31-13.54)	80.75 (73.05-86.66)	89.79 (86.26-92.49)	-	0.21 (0.07-0.66)
	Male	10.25 (5.08-19.59)	3.64 (2.20-5.98)	89.75 (80.41-94.92)	96.36 (94.02-97.80)	-	-
	Female	25.72 (17.28-36.47)	17.40 (12.53-23.65)	74.28 (63.53-82.72)	82.15 (75.96-87.05)	0.00 (0.00-0.00)	0.45 (0.14-1.42)
	Honduras (2017)	20.60 (17.14-24.54)	7.90 (6.86-9.08)	79.40 (75.46-82.86)	92.04 (90.86-93.09)	-	0.06 (0.02-0.19)
	Male	7.65 (4.68-12.26)	3.45 (2.71-4.36)	92.35 (87.74-95.32)	96.56 (95.64-97.29)	-	-
	Female	28.27 (23.53-33.53)	12.48 (10.75-14.43)	71.73 (66.47-76.47)	87.40 (85.44-89.13)	-	0.12 (0.04-0.39)
South-Eastern Asia	Cambodia (2013)	10.66 (7.45-15.03)	3.24 (2.26-4.63)	89.34 (84.97-92.55)	96.76 (95.38-97.74)	-	-
	Male	3.69 (1.49-8.81)	1.23 (0.61-2.46)	96.31 (91.19-98.51)	98.77 (97.54-99.39)	-	-
	Female	18.37 (12.91-25.47)	5.24 (3.52-7.73)	81.63 (74.53-87.09)	94.76 (92.27-96.48)	-	-
Eastern Europe	Moldova (2019)	13.37 (9.31-18.82)	4.52 (3.43-5.95)	84.39 (78.6-88.83)	94.62 (93.17-95.77)	2.25 (1.05-4.76)	0.86 (0.43-1.70)
	Male	6.02 (2.49-13.84)	2.63 (1.55-4.41)	92.22 (84.33-96.31)	96.41 (94.42-97.71)	1.76 (0.47-6.36)	0.96 (0.38-2.44)
	Female	17.67 (12.06-25.14)	6.72 (5.13-8.77)	79.80 (71.92-85.91)	92.54 (90.52-94.16)	2.53 (0.99-6.33)	0.74 (0.27-2.02)

F.1.4 Suicide Attempt (ever)

MDG Region	Country (Survey Year)	Attempted Suicide (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	2.88 (1.55-5.28)	2.14 (1.35-3.36)	96.92 (94.35-98.34)	97.66 (96.45-98.46)	0.20 (0.03-1.46)	0.20 (0.07-0.57)
	Male	0.30 (0.04-2.19)	1.03 (0.36-2.86)	99.70 (97.81-99.96)	98.80 (97.10-99.51)	0.00 (0.00-0.00)	0.17 (0.04-0.71)
	Female	5.52 (2.95-10.08)	3.26 (2.00-5.29)	94.07 (89.10-96.86)	96.50 (94.53-97.77)	0.41 (0.06-3.03)	0.24 (0.05-1.05)
	Lesotho (2018)	2.15 (1.61-2.85)	1.21 (0.89-1.65)	97.85 (97.15-98.39)	98.75 (98.32-99.07)	-	0.04 (0.01-0.20)
	Male	0.58 (0.21-1.63)	0.81 (0.42-1.58)	99.42 (98.37-99.79)	99.13 (98.38-99.53)	-	0.06 (0.01-0.47)
	Female	3.43 (2.66-4.41)	1.65 (1.23-2.21)	96.57 (95.59-97.34)	98.34 (97.78-98.76)	-	0.01 (0.00-0.08)
	Malawi (2013)	1.56 (0.51-4.64)	0.30 (0.11-0.80)	98.44 (95.36-99.49)	99.70 (99.20-99.89)	-	-
	Male	0.65 (0.17-2.45)	0.62 (0.23-1.68)	99.35 (97.55-99.83)	99.38 (98.32-99.77)	-	-
	Female	2.39 (0.60-9.00)	-	97.61 (91.00-99.40)	100.00	-	-
	Namibia (2019)	4.68 (3.18-6.84)	1.74 (1.19-2.55)	95.32 (93.16-96.82)	98.18 (97.37-98.74)	-	0.08 (0.02-0.31)
	Male	1.30 (0.39-4.22)	0.49 (0.16-1.53)	98.70 (95.78-99.61)	99.41 (98.41-99.79)	-	0.10 (0.01-0.72)
	Female	8.57 (5.93-12.23)	3.28 (2.29-4.67)	91.43 (87.77-94.07)	96.67 (95.27-97.67)	-	0.05 (0.02-0.14)
	Nigeria (2014)	3.10 (1.94-4.89)	1.48 (1.01-2.16)	96.76 (94.95-97.94)	98.03 (97.18-98.63)	0.14 (0.02-1.00)	0.49 (0.20-1.22)
	Male	1.05 (0.45-2.43)	0.74 (0.35-1.54)	98.62 (96.98-99.38)	98.45 (97.10-99.17)	0.33 (0.05-2.29)	0.82 (0.29-2.25)
	Female	4.65 (2.77-7.69)	2.29 (1.47-3.54)	95.35 (92.31-97.23)	97.58 (96.32-98.42)	-	0.13 (0.03-0.57)
Latin America and the Caribbean	Zambia (2014)	3.69 (2.35-5.76)	2.55 (1.68-3.85)	95.90 (93.71-97.35)	96.88 (95.37-97.91)	0.40 (0.06-2.82)	0.57 (0.19-1.73)
	Male	1.97 (0.75-5.06)	1.28 (0.48-3.41)	98.03 (94.94-99.25)	98.28 (96.23-99.22)	-	0.44 (0.13-1.42)
	Female	5.06 (3.15-8.04)	3.89 (2.49-6.02)	94.22 (91.04-96.32)	95.40 (92.83-97.08)	0.72 (0.10-5.12)	0.71 (0.13-3.86)
	Colombia (2018)	12.89 (8.45-19.18)	5.58 (3.57-8.62)	87.10 (80.80-91.54)	94.04 (91.03-96.08)	0.01 (0.00-0.08)	0.39 (0.15-1.01)
	Male	6.97 (2.79-16.38)	2.25 (1.09-4.60)	93.03 (83.62-97.21)	97.75 (95.40-98.91)	-	-
	Female	17.15 (10.84-26.06)	9.44 (5.72-15.18)	82.83 (73.92-89.14)	89.72 (84.15-93.49)	0.02 (0.00-0.14)	0.84 (0.32-2.19)
	Honduras (2017)	12.25 (9.70-15.36)	4.54 (3.80-5.42)	87.75 (84.64-90.30)	95.38 (94.49-96.14)	-	0.08 (0.03-0.22)
	Male	2.44 (1.10-5.32)	1.65 (1.18-2.30)	97.56 (94.68-98.90)	98.35 (97.70-98.82)	-	-

Appendix F

MDG Region	Country (Survey Year)	Attempted Suicide (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	18.07 (14.38-22.44)	7.51 (6.22-9.04)	81.93 (77.56-85.62)	92.33 (90.78-93.64)	-	0.16 (0.06-0.45)
South-Eastern Asia	Cambodia (2013)	4.75 (2.79-7.96)	1.34 (0.82-2.20)	95.25 (92.04-97.21)	98.66 (97.80-99.18)	-	-
	Male	1.30 (0.41-4.05)	0.40 (0.11-1.44)	98.70 (95.95-99.59)	99.60 (98.56-99.89)	-	100.00
	Female	8.56 (4.84-14.70)	2.28 (1.35-3.82)	91.44 (85.30-95.16)	97.72 (96.18-98.65)	-	-
Eastern Europe	Moldova (2019)	6.43 (3.84-10.56)	2.11 (1.29-3.44)	93.21 (89.04-95.86)	97.57 (96.26-98.43)	0.37 (0.08-1.67)	0.32 (0.12-0.81)
	Male	2.31 (0.67-7.67)	1.18 (0.53-2.61)	96.70 (91.25-98.80)	98.63 (97.32-99.31)	0.99 (0.20-4.69)	0.19 (0.05-0.69)
	Female	8.84 (5.03-15.09)	3.19 (1.77-5.70)	91.16 (84.91-94.97)	96.34 (93.92-97.82)	-	0.46 (0.13-1.62)

F.2 Externalising Symptoms

F.2.1 Engaging in Behaviours Harmful to Health ('Risky Behaviours') (last 30 days)

This variable is a combination of whether someone had engaged in three behaviours over the last 30 days: binge drinking, smoking tobacco, and drug use. The results from the individual behaviours can be found in F.2.2-F.2.4.

MDG Region	Country (Survey Year)	Engaged in Risky Behaviours (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	24.42 (18.74-31.16)	19.65 (16.74-22.92)	68.81 (62.22-74.71)	72.53 (69.26-75.58)	6.78 (3.97-11.35)	7.82 (6.02-10.10)
	Male	26.71 (18.03-37.65)	28.15 (24.06-32.63)	63.36 (52.76-72.80)	63.83 (59.49-67.95)	9.94 (5.36-17.69)	8.03 (5.72-11.17)
	Female	22.07 (14.79-31.61)	11.04 (8.322-14.50)	74.38 (65.58-81.56)	81.35 (77.16-84.93)	3.55 (1.51-8.11)	7.61 (5.13-11.15)
	Lesotho (2018)	22.27 (18.04-27.15)	17.08 (14.61-19.87)	75.73 (71.06-79.86)	80.39 (77.65-82.86)	2.01 (1.25-3.20)	2.54 (1.85-3.47)
	Male	38.38 (31.02-46.32)	27.60 (24.09-31.41)	59.88 (52.16-67.13)	69.94 (66.23-73.41)	1.74 (0.57-5.20)	2.46 (1.38-4.34)
	Female	9.05 (7.343-11.10)	5.66 (4.76-6.71)	88.73 (86.60-90.56)	91.73 (90.42-92.88)	2.23 (1.57-3.15)	2.62 (1.91-3.57)
	Malawi (2013)	19.61 (15.57-24.4)	15.69 (12.48-19.55)	75.26 (69.73-80.07)	79.92 (75.73-83.54)	5.13 (2.83-9.11)	4.39 (2.78-6.87)
	Male	26.53 (21.29-32.51)	21.70 (17.70-26.32)	63.52 (56.16-70.31)	70.33 (65.04-75.13)	9.95 (5.50-17.34)	7.96 (4.93-12.63)
	Female	13.21 (7.63-21.89)	10.29 (6.04-16.98)	86.13 (77.50-91.80)	88.54 (82.11-92.86)	0.66 (0.17-2.53)	1.17 (0.42-3.20)
	Namibia (2019)	26.33 (21.23-32.15)	17.34 (14.74-20.30)	72.10 (66.38-77.19)	80.80 (77.66-83.58)	1.57 (0.68-3.56)	1.86 (1.27-2.72)
	Male	35.48 (27.52-44.34)	21.83 (17.50-26.87)	62.92 (54.38-70.73)	76.45 (71.08-81.09)	1.60 (0.38-6.52)	1.73 (0.89-3.31)
	Female	15.80 (11.59-21.18)	11.88 (9.81-14.31)	82.66 (77.16-87.06)	86.10 (83.44-88.39)	1.54 (0.75-3.12)	2.03 (1.35-3.02)
	Nigeria (2014)	22.30 (18.77-26.28)	14.10 (12.28-16.13)	62.66 (57.49-67.56)	79.74 (77.18-82.08)	15.04 (11.55-19.36)	6.16 (4.86-7.79)
	Male	35.76 (29.99-41.97)	19.93 (17.27-22.89)	41.37 (35.41-47.59)	72.60 (69.16-75.79)	22.87 (17.00-30.04)	7.47 (5.66-9.80)
	Female	12.05 (8.69-16.48)	7.71 (5.948-9.944)	78.87 (72.94-83.79)	87.55 (84.46-90.10)	9.08 (5.73-14.09)	4.74 (3.12-7.14)
	Zambia (2014)	24.61 (20.35-29.43)	22.05 (18.97-25.48)	69.66 (64.76-74.15)	74.92 (71.32-78.22)	5.74 (3.60-9.03)	3.02 (2.01-4.52)
	Male	34.43 (28.35-41.08)	32.21 (28.15-36.55)	59.77 (53.32-65.89)	63.14 (58.97-67.13)	5.80 (4.14-8.07)	4.65 (3.01-7.12)

Appendix F

MDG Region	Country (Survey Year)	Engaged in Risky Behaviours (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	16.81 (12.18-22.76)	11.25 (8.75-14.34)	77.50 (71.69-82.41)	87.46 (84.00-90.26)	5.68 (3.16-10.00)	1.29 (0.61-2.71)
Latin America and the Caribbean	Colombia (2018)	35.99 (27.00-46.08)	37.95 (32.83-43.35)	58.92 (49.09-68.08)	49.48 (44.43-54.55)	5.10 (2.62-9.70)	12.57 (9.20-16.94)
	Male	47.92 (32.31-63.94)	48.73 (41.07-56.45)	51.03 (35.06-66.80)	42.82 (36.11-49.81)	1.05 (0.32-3.35)	8.45 (5.11-13.66)
	Female	27.40 (18.40-38.73)	25.40 (19.66-32.15)	64.59 (52.91-75.75)	57.24 (49.86-64.30)	8.01 (4.01-15.38)	17.36 (11.91-24.61)
	Honduras (2017)	20.86 (17.33-24.91)	15.35 (13.79-17.05)	78.57 (74.54-82.11)	83.38 (81.66-84.97)	0.57 (0.23-1.40)	1.27 (0.96-1.66)
	Male	31.54 (24.93-38.98)	21.88 (19.67-24.30)	68.03 (60.57-74.66)	76.96 (74.50-79.26)	0.44 (0.06-3.09)	1.16 (0.77-1.73)
	Female	14.54 (11.00-18.98)	8.64 (7.24-10.28)	84.81 (80.40-88.37)	89.99 (88.32-91.44)	0.65 (0.24-1.74)	1.38 (0.95-1.99)
South-Eastern Asia	Cambodia (2013)	55.74 (50.09-61.25)	54.00 (50.55-57.41)	40.79 (35.35-46.47)	40.74 (37.26-44.32)	3.47 (1.83-6.48)	5.26 (3.78-7.29)
	Male	64.59 (57.22-71.32)	57.43 (52.97-61.78)	33.44 (26.98-40.59)	37.64 (33.29-42.19)	1.97 (0.65-5.80)	4.93 (2.86-8.37)
	Female	45.97 (38.39-53.73)	50.58 (45.50-55.66)	48.91 (40.94-56.94)	43.83 (38.68-49.11)	5.12 (2.29-11.05)	5.59 (3.73-8.29)
Eastern Europe	Moldova (2019)	35.01 (28.76-41.82)	25.16 (21.65-29.03)	61.95 (55.06-68.38)	72.70 (68.8-76.29)	3.05 (1.57-5.84)	2.13 (1.36-3.33)
	Male	45.87 (34.13-58.09)	35.26 (30.26-40.60)	52.32 (40.00-64.36)	62.01 (56.80-66.96)	1.81 (0.54-5.84)	2.73 (1.54-4.80)
	Female	28.64 (21.89-36.51)	13.45 (10.36-17.29)	67.58 (59.45-74.78)	85.10 (81.07-88.40)	3.78 (1.81-7.72)	1.44 (0.68-3.06)

F.2.2 Smoking Tobacco (last 30 days)

MDG Region	Country (Survey Year)	Smoked Tobacco (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	4.57 (2.38-8.61)	4.74 (3.35-6.66)	95.43 (91.39-97.62)	95.17 (93.26-96.56)	-	0.09 (0.02-0.38)
	Male	9.05 (4.64-16.90)	9.14 (6.78-12.20)	90.95 (83.10-95.36)	90.68 (87.64-93.04)	-	0.18 (0.04-0.77)
	Female	-	0.28 (0.10-0.80)	100.00	99.72 (99.20-99.90)	-	-
	Lesotho (2018)	15.74 (11.63-20.95)	12.47 (10.23-15.12)	83.82 (78.66-87.93)	87.27 (84.66-89.49)	0.44 (0.13-1.50)	0.26 (0.11-0.59)
	Male	31.53 (24.11-40.03)	22.30 (19.29-25.63)	67.88 (59.25-75.44)	77.70 (74.37-80.71)	0.59 (0.07-4.68)	-

Appendix F

MDG Region	Country (Survey Year)	Smoked Tobacco (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	2.79 (1.75-4.40)	1.81 (1.29-2.53)	96.90 (95.32-97.96)	97.65 (96.78-98.29)	0.32 (0.15-0.65)	0.54 (0.24-1.20)
	Malawi (2013)	8.59 (5.93-12.30)	7.73 (5.22-11.30)	90.73 (86.89-93.53)	91.77 (88.24-94.31)	0.68 (0.18-2.49)	0.51 (0.26-1.00)
	Male	11.73 (7.87-17.14)	10.36 (7.87-13.54)	86.86 (81.18-91.01)	88.58 (85.45-91.13)	1.41 (0.38-5.10)	1.06 (0.54-2.06)
	Female	5.68 (2.81-11.16)	5.35 (2.06-13.21)	94.32 (88.84-97.19)	94.64 (86.79-97.93)	-	0.01 (0.00-0.08)
	Namibia (2019)	7.29 (4.96-10.59)	4.35 (2.89-6.49)	92.18 (88.75-94.62)	95.47 (93.30-96.96)	0.53 (0.08-3.31)	0.19 (0.08-0.41)
	Male	11.08 (7.00-17.09)	6.88 (4.27-10.93)	87.99 (81.74-92.30)	92.86 (88.78-95.53)	0.93 (0.12-6.72)	0.26 (0.09-0.72)
	Female	2.94 (1.51-5.62)	1.25 (0.67-2.32)	96.99 (94.33-98.43)	98.65 (97.58-99.25)	0.07 (0.02-0.29)	0.10 (0.05-0.21)
	Nigeria (2014)	12.29 (9.70-15.44)	7.93 (6.58-9.53)	85.49 (82.18-88.27)	91.29 (89.56-92.75)	2.23 (1.36-3.63)	0.78 (0.46-1.32)
	Male	20.71 (16.60-25.54)	11.79 (9.73-14.23)	75.34 (70.60-79.53)	87.11 (84.49-89.34)	3.95 (2.41-6.43)	1.10 (0.58-2.08)
	Female	5.87 (3.38-9.98)	3.71 (2.47-5.54)	93.22 (89.06-95.87)	95.86 (93.96-97.18)	0.91 (0.28-2.90)	0.43 (0.18-1.00)
	Zambia (2014)	13.39 (10.35-17.15)	12.62 (10.24-15.45)	86.53 (82.76-89.57)	87.08 (84.21-89.49)	0.08 (0.01-0.60)	0.31 (0.10-0.96)
	Male	20.86 (16.33-26.26)	18.56 (15.17-22.51)	79.14 (73.74-83.67)	80.85 (76.91-84.25)	-	0.59 (0.31-1.12)
	Female	7.47 (4.75-11.54)	6.29 (4.26-9.20)	92.39 (88.32-95.12)	93.71 (90.80-95.74)	0.15 (0.02-1.12)	-
Latin America and the Caribbean	Colombia (2018)	11.86 (7.57-18.12)	10.84 (8.01-14.53)	88.14 (81.88-92.43)	89.14 (85.45-91.98)	-	0.02 (0.00-0.11)
	Male	19.31 (11.10-31.44)	15.26 (10.70-21.30)	80.69 (68.56-88.90)	84.73 (78.69-89.29)	-	0.01 (0.00-0.06)
	Female	6.51 (3.05-13.34)	5.70 (3.15-10.09)	93.49 (86.66-96.95)	94.27 (89.88-96.82)	-	0.04 (0.01-0.28)
	Honduras (2017)	11.28 (8.82-14.32)	9.64 (8.38-11.07)	88.72 (85.68-91.18)	90.28 (88.86-91.54)	-	0.08 (0.03-0.22)
	Male	17.26 (12.26-23.74)	14.89 (12.96-17.06)	82.74 (76.26-87.74)	85.11 (82.94-87.04)	-	-
	Female	7.74 (5.51-10.77)	4.25 (3.29-5.48)	92.26 (89.23-94.49)	95.60 (94.37-96.57)	-	0.15 (0.05-0.46)
South-Eastern Asia	Cambodia (2013)	14.65 (11.52-18.45)	15.21 (12.78-18.00)	85.35 (81.55-88.48)	84.76 (81.97-87.19)	-	0.02 (0.00-0.18)
	Male	22.08 (17.05-28.09)	20.56 (17.04-24.61)	77.92 (71.91-82.95)	79.44 (75.39-82.96)	-	-
	Female	6.44 (3.98-10.24)	9.89 (7.01-13.79)	93.56 (89.76-96.02)	90.06 (86.14-92.96)	-	0.05 (0.01-0.36)
Eastern Europe	Moldova (2019)	19.76 (14.55-26.27)	16.02 (12.95-19.66)	79.48 (72.94-84.76)	83.47 (79.81-86.58)	0.76 (0.24-2.41)	0.51 (0.27-0.96)
	Male	30.20 (19.93-42.92)	26.08 (22.02-30.60)	68.34 (55.67-78.77)	73.17 (68.65-77.25)	1.46 (0.36-5.69)	0.75 (0.35-1.61)
	Female	13.65 (8.74-20.69)	4.36 (2.56-7.32)	86.00 (78.89-90.99)	95.41 (92.47-97.24)	0.35 (0.05-2.51)	0.23 (0.08-0.69)

F.2.3 Binge Drinking (last 30 days)

MDG Region	Country (Survey Year)	Engaged in Binge Drinking (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	21.77 (16.5-28.16)	16.46 (13.87-19.42)	70.85 (64.27-76.66)	75.25 (72.18-78.08)	7.38 (4.35-12.25)	8.30 (6.47-10.57)
	Male	21.48 (14.32-30.93)	21.99 (18.01-26.57)	66.93 (56.42-75.99)	68.85 (64.43-72.96)	11.59 (6.53-19.68)	9.16 (6.69-12.41)
	Female	22.07 (14.79-31.61)	10.85 (8.16-14.28)	74.86 (66.07-81.99)	81.73 (77.61-85.23)	3.07 (1.21-7.60)	7.43 (4.99-10.90)
	Lesotho (2018)	13.22 (10.29-16.82)	8.87 (7.23-10.83)	84.28 (80.38-87.53)	88.57 (86.52-90.35)	2.50 (1.50-4.14)	2.56 (1.84-3.54)
	Male	21.60 (16.00-28.49)	13.41 (10.47-17.01)	75.18 (67.63-81.45)	83.37 (80.02-86.26)	3.23 (1.32-7.69)	3.22 (1.98-5.20)
	Female	6.34 (4.96-8.07)	3.94 (3.20-4.86)	91.75 (89.82-93.34)	94.22 (93.08-95.19)	1.91 (1.28-2.83)	1.83 (1.26-2.67)
	Malawi (2013)	16.22 (12.28-21.14)	13.82 (10.64-17.77)	78.19 (72.60-82.90)	81.78 (77.55-85.37)	5.59 (3.11-9.84)	4.40 (2.81-6.83)
	Male	21.60 (16.52-27.74)	18.95 (15.04-23.60)	67.48 (59.9-74.25)	73.06 (67.72-77.81)	10.91 (6.10-18.76)	7.99 (5.00-12.53)
	Female	11.24 (5.837-20.56)	9.20 (4.96-16.43)	88.10 (78.86-93.62)	89.63 (82.72-93.97)	0.66 (0.17-2.53)	1.17 (0.42-3.20)
	Namibia (2019)	22.02 (17.08-27.91)	14.78 (12.48-17.42)	76.97 (71.16-81.91)	83.99 (81.24-86.40)	1.01 (0.43-2.34)	1.23 (0.77-1.96)
	Male	29.45 (21.66-38.67)	17.57 (13.83-22.07)	69.88 (60.84-77.61)	81.56 (76.86-85.49)	0.66 (0.09-4.80)	0.87 (0.32-2.34)
	Female	13.47 (9.57-18.65)	11.37 (9.36-13.75)	85.12 (79.82-89.21)	86.94 (84.41-89.12)	1.41 (0.65-3.01)	1.68 (1.08-2.61)
	Nigeria (2014)	17.75 (14.66-21.33)	10.85 (9.32-12.59)	66.57 (61.57-71.22)	83.48 (81.19-85.54)	15.68 (12.01-20.21)	5.67 (4.45-7.20)
	Male	26.19 (21.21-31.86)	14.33 (12.10-16.89)	48.44 (42.08-54.84)	78.88 (75.83-81.65)	25.37 (19.05-32.94)	6.78 (5.18-8.85)
	Female	11.33 (8.04-15.73)	7.04 (5.38-9.18)	80.37 (74.60-85.10)	88.50 (85.40-91.02)	8.30 (5.08-13.27)	4.45 (2.85-6.89)
	Zambia (2014)	23.03 (18.90-27.76)	19.38 (16.48-22.66)	71.57 (66.6-76.06)	77.76 (74.28-80.89)	5.40 (3.27-8.78)	2.86 (1.86-4.37)
	Male	31.52 (25.51-38.21)	27.89 (23.95-32.21)	62.21 (55.51-68.47)	67.78 (63.56-71.74)	6.28 (4.50-8.70)	4.33 (2.76-6.71)
	Female	16.31 (11.78-22.14)	10.32 (7.96-13.28)	79.00 (72.99-83.96)	88.38 (85.04-91.06)	4.70 (2.236-9.61)	1.29 (0.61-2.71)
Latin America and the Caribbean	Colombia (2018)	28.52 (21.00-37.47)	33.31 (28.34-38.68)	66.13 (57.10-74.12)	53.94 (48.66-59.13)	5.35 (2.82-9.90)	12.75 (9.38-17.09)
	Male	34.71 (21.91-50.18)	41.52 (33.95-49.52)	63.90 (48.44-76.93)	49.20 (41.80-56.63)	1.39 (0.49-3.86)	9.28 (5.87-14.38)
	Female	24.08 (15.92-34.69)	23.75 (18.13-30.48)	67.73 (56.47-77.26)	59.46 (52.15-66.37)	8.19 (4.15-15.52)	16.79 (11.39-24.05)
	Honduras (2017)	13.65 (10.52-17.52)	8.39 (7.38-9.54)	85.63 (81.79-88.77)	90.23 (89.02-91.32)	0.72 (0.32-1.62)	1.38 (1.06-1.78)
	Male	21.91 (15.87-29.43)	11.91 (10.35-13.68)	77.65 (70.11-83.73)	86.48 (84.61-88.16)	0.44 (0.06-3.09)	1.61 (1.14-2.25)
	Female	8.75 (5.71-13.20)	4.78 (3.85-5.91)	90.36 (86.00-93.46)	94.08 (92.86-95.11)	0.89 (0.37-2.14)	1.14 (0.77-1.70)

Appendix F

MDG Region	Country (Survey Year)	Engaged in Binge Drinking (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
South-Eastern Asia	Cambodia (2013)	54.56 (48.81-60.20)	52.77 (49.34-56.17)	41.97 (36.38-47.77)	42.14 (38.66-45.70)	3.47 (1.83-6.48)	5.09 (3.61-7.14)
	Male	62.91 (55.19-70.01)	55.76 (51.43-60.00)	35.12 (28.25-42.67)	39.43 (35.13-43.89)	1.97 (0.65-5.80)	4.81 (2.72-8.38)
	Female	45.33 (37.72-53.18)	49.79 (44.63-54.96)	49.55 (41.48-57.64)	44.84 (38.65-50.14)	5.12 (2.29-11.05)	5.37 (3.56-8.02)
Eastern Europe	Moldova (2019)	27.49 (21.83-33.98)	17.25 (13.94-21.15)	68.56 (61.73-74.67)	80.52 (76.56-83.96)	3.95 (2.01-7.62)	2.23 (1.31-3.76)
	Male	34.45 (25.77-44.30)	23.34 (18.26-29.32)	62.49 (51.64-72.22)	73.62 (67.74-78.77)	3.06 (0.72-12.06)	3.04 (1.55-5.89)
	Female	23.42 (16.42-32.25)	10.19 (7.011-14.59)	72.11 (63.09-79.64)	88.52 (83.84-91.98)	4.47 (2.10-9.26)	1.29 (0.56-2.93)

F.2.4 Using Drugs (last 30 days)

MDG Region	Country (Survey Year)	Used Drugs (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	0.41 (0.09-1.80)	0.66 (0.32-1.36)	99.35 (97.92-99.80)	99.07 (98.32-99.49)	0.24 (0.03-1.69)	0.27 (0.08-0.84)
	Male	0.81 (0.18-3.58)	1.15 (0.53-2.50)	99.19 (96.42-99.82)	98.62 (97.20-99.33)	-	0.23 (0.03-1.63)
	Female	-	0.16 (0.02-1.20)	99.52 (96.52-99.94)	99.53 (98.61-99.84)	0.48 (0.06-3.48)	0.31 (0.08-1.21)
	Lesotho (2018)	6.70 (4.61-9.64)	3.71 (2.80-4.90)	93.12 (90.18-95.23)	96.11 (94.93-97.02)	0.18 (0.04-0.72)	0.19 (0.10-0.36)
	Male	13.36 (9.45-18.54)	6.18 (4.54-8.35)	86.37 (81.16-90.31)	93.82 (91.65-95.46)	0.27 (0.03-2.10)	-
	Female	1.25 (0.77-2.01)	1.02 (0.68-1.54)	98.66 (97.90-99.14)	98.59 (98.01-99.00)	0.10 (0.03-0.32)	0.39 (0.20-0.74)
	Malawi (2013)	1.61 (0.86-2.99)	0.70 (0.33-1.51)	97.70 (95.85-98.74)	98.80 (97.94-99.30)	0.69 (0.19-2.48)	0.50 (0.25-0.99)
	Male	3.34 (1.88-5.87)	1.49 (0.70-3.11)	95.22 (91.74-97.27)	97.47 (95.76-98.50)	1.44 (0.38-5.08)	1.05 (0.53-2.06)
	Female	-	-	-	-	-	-
	Namibia (2019)	1.59 (0.79-3.16)	0.13 (0.04-0.37)	92.83 (89.76-95.04)	96.12 (94.08-97.47)	5.58 (3.71-8.31)	3.76 (2.43-5.78)

Appendix F

MDG Region	Country (Survey Year)	Used Drugs (last 30 days) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Male	2.49 (1.10-5.57)	0.17 (0.04-0.73)	89.07 (83.55-92.89)	93.92 (90.04-96.35)	8.44 (5.24-13.33)	5.91 (3.52-9.76)
	Female	0.55 (0.20-1.47)	0.07 (0.03-0.16)	97.17 (94.50-98.56)	98.80 (97.84-99.33)	2.29 (1.02-5.05)	1.13 (0.61-2.10)
	Nigeria (2014)	2.46 (1.57-3.82)	1.00 (0.66-1.51)	95.39 (93.61-96.69)	97.64 (96.67-98.33)	2.16 (1.31-3.52)	1.36 (0.81-2.27)
	Male	5.20 (3.27-8.18)	1.72 (1.11-2.64)	90.87 (87.51-93.39)	96.43 (94.84-97.54)	3.93 (2.36-6.48)	1.85 (1.02-3.36)
	Female	0.37 (0.12-1.13)	0.21 (0.07-0.65)	98.83 (97.30-99.50)	98.97 (97.73-99.53)	0.80 (0.26-2.46)	0.82 (0.33-2.05)
	Zambia (2014)	1.29 (0.58-2.85)	1.35 (0.86-2.11)	98.24 (96.66-99.08)	98.31 (97.40-98.90)	0.47 (0.15-1.46)	0.34 (0.12-0.95)
	Male	2.92 (1.83-4.60)	2.62 (1.72-3.95)	97.09 (95.4-98.17)	96.72 (95.12-97.80)	-	0.67 (0.26-1.74)
	Female	-	-	99.16 (97.43-99.73)	100.00	0.84 (0.27-2.57)	-
Latin America and the Caribbean	Colombia (2018)	10.76 (5.82-19.07)	4.35 (2.52-7.40)	89.19 (80.89-94.14)	95.32 (92.23-97.22)	0.05 (0.01-0.20)	0.34 (0.06-2.00)
	Male	22.99 (12.40-38.64)	6.95 (3.75-12.52)	76.95 (61.31-87.55)	93.04 (87.47-96.23)	0.06 (0.01-0.42)	0.02 (0.00-0.08)
	Female	1.97 (0.55-6.80)	1.32 (0.57-3.02)	97.99 (93.26-99.42)	97.98 (95.40-99.12)	0.04 (0.01-0.32)	0.70 (0.11-4.36)
	Honduras (2017)	3.75 (2.43-5.74)	1.87 (1.46-2.39)	96.25 (94.26-97.57)	98.04 (97.49-98.47)	-	0.09 (0.03-0.33)
	Male	6.63 (3.83-11.24)	2.65 (2.00-3.52)	93.37 (88.76-96.17)	97.26 (96.35-97.95)	-	0.09 (0.02-0.39)
South-Eastern Asia	Female	2.04 (1.03-3.99)	1.06 (0.66-1.68)	97.96 (96.01-98.97)	98.84 (98.18-99.26)	-	0.10 (0.01-0.74)
	Cambodia (2013)	3.29 (1.83-5.84)	0.98 (0.56-1.69)	96.72 (94.16-98.17)	98.67 (97.84-99.17)	-	0.35 (0.12-1.04)
	Male	6.26 (3.50-10.95)	1.32 (0.65-2.65)	93.74 (89.05-96.50)	98.46 (97.09-99.19)	-	0.22 (0.05-1.08)
	Female	-	0.64 (0.27-1.49)	100.00	98.88 (97.61-99.48)	-	0.48 (0.11-1.97)
Eastern Europe	Moldova (2019)	1.77 (0.74-4.19)	0.27 (0.09-0.79)	97.68 (94.88-98.96)	99.44 (98.89-99.72)	0.55 (0.08-3.89)	0.29 (0.12-0.71)
	Male	2.21 (0.53-8.71)	0.40 (0.11-1.45)	97.79 (91.29-99.47)	99.14 (98.10-99.61)	-	0.46 (0.16-1.29)
	Female	1.52 (0.44-5.14)	0.12 (0.03-0.49)	97.61 (93.37-99.16)	99.78 (99.45-99.91)	0.87 (0.12-6.29)	0.10 (0.03-0.35)

F.2.5 Perpetration of Domestic Violence and Abuse (ever)

MDG Region	Country (Survey Year)	Perpetrated Domestic Violence and Abuse (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	11.03 (6.67-17.71)	6.87 (5.09-9.22)	88.33 (81.72-92.77)	92.19 (89.68-94.12)	0.63 (0.15-2.56)	0.94 (0.47-1.88)
	Male	11.92 (5.73-23.15)	7.45 (4.79-11.40)	87.47 (76.37-93.78)	91.76 (87.56-94.63)	0.60 (0.08-4.30)	0.79 (0.21-3.00)
	Female	10.30 (5.08-19.77)	6.45 (4.18-9.84)	89.05 (79.76-94.37)	92.50 (88.92-94.98)	0.66 (0.09-4.67)	1.05 (0.47-2.34)
	Lesotho (2018)	4.76 (2.81-7.96)	2.48 (1.65-3.69)	95.24 (92.04-97.19)	97.46 (96.25-98.29)	-	0.07 (0.02-0.24)
	Male	8.22 (4.34-15.01)	3.73 (2.21-6.23)	91.78 (84.99-95.66)	96.27 (93.77-97.79)	-	-
	Female	1.89 (1.21-2.92)	1.22 (0.81-1.83)	98.11 (97.08-98.79)	98.65 (98.03-99.08)	-	0.13 (0.04-0.48)
	Malawi (2013)	11.12 (7.65-15.91)	5.60 (3.59-8.63)	88.69 (83.93-92.17)	94.39 (91.36-96.40)	0.19 (0.03-1.37)	0.01 (0.00-0.09)
	Male	10.10 (6.64-15.08)	6.04 (4.07-8.87)	89.48 (84.46-93.01)	93.93 (91.10-95.90)	0.42 (0.06-3.02)	0.03 (0.00-0.21)
	Female	11.97 (6.82-20.16)	5.25 (2.41-11.06)	88.03 (79.84-93.18)	94.75 (88.94-97.59)	-	-
	Namibia (2019)	6.87 (3.83-12.03)	1.58 (1.01-2.47)	91.92 (86.86-95.14)	95.93 (94.40-97.06)	1.21 (0.41-3.50)	2.48 (1.66-3.70)
	Male	7.10 (2.79-16.90)	1.08 (0.42-2.77)	92.51 (82.99-96.91)	97.79 (95.75-98.86)	0.39 (0.05-2.84)	1.13 (0.47-2.66)
	Female	6.59 (3.41-12.38)	2.14 (1.36-3.35)	91.20 (85.28-94.88)	93.88 (91.54-95.60)	2.21 (0.65-7.27)	3.99 (2.64-5.99)
	Nigeria (2014)	12.54 (9.72-16.03)	7.41 (5.94-9.20)	86.55 (82.79-89.58)	92.24 (90.41-93.75)	0.92 (0.26-3.21)	0.35 (0.13-0.96)
	Male	21.92 (16.86-27.97)	9.50 (7.39-12.14)	76.24 (69.77-81.69)	89.94 (87.20-92.15)	1.84 (0.37-8.57)	0.56 (0.15-2.05)
	Female	6.98 (4.27-11.21)	5.72 (3.95-8.23)	92.65 (88.39-95.43)	94.10 (91.60-95.89)	0.37 (0.09-1.54)	0.18 (0.04-0.73)
Latin America and the Caribbean	Zambia (2014)	15.64 (11.83-20.40)	7.20 (5.44-9.48)	84.00 (79.27-87.82)	92.11 (89.75-93.96)	0.36 (0.09-1.49)	0.70 (0.27-1.79)
	Male	19.62 (13.25-28.07)	10.66 (7.69-14.59)	79.50 (71.22-85.86)	88.12 (83.84-91.38)	0.88 (0.20-3.75)	1.23 (0.38-3.85)
	Female	12.93 (8.50-19.20)	4.54 (2.90-7.04)	87.07 (80.80-91.50)	95.17 (92.67-96.85)	-	0.29 (0.07-1.20)
	Colombia (2018)	8.60 (4.91-14.64)	3.63 (2.12-6.13)	90.71 (84.69-94.51)	92.38 (88.87-94.85)	0.69 (0.29-1.68)	3.99 (2.21-7.10)
	Male	6.19 (2.06-17.18)	1.94 (0.90-4.11)	92.85 (82.19-97.33)	91.93 (86.42-95.33)	0.96 (0.25-3.63)	6.13 (3.09-11.77)
	Female	10.27 (5.32-18.92)	5.73 (2.90-11.00)	89.22 (80.67-94.26)	92.94 (87.89-95.98)	0.51 (0.18-1.40)	1.34 (0.72-2.49)
	Honduras (2017)	5.50 (3.89-7.72)	2.56 (1.97-3.31)	94.50 (92.28-96.11)	97.35 (96.58-97.95)	-	0.09 (0.02-0.42)
	Male	1.67 (0.61-4.45)	1.24 (0.72-2.13)	98.33 (95.55-99.39)	98.63 (97.69-99.19)	-	0.13 (0.02-0.94)

Appendix F

MDG Region	Country (Survey Year)	Perpetrated Domestic Violence and Abuse (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Female	7.64 (5.29-10.90)	3.88 (2.89-5.17)	92.36 (89.10-94.71)	96.08 (94.77-97.07)	-	0.05 (0.01-0.35)
South-Eastern Asia	Cambodia (2013)	16.17 (10.62-23.84)	12.56 (9.79-15.97)	83.83 (76.16-89.38)	87.44 (84.03-90.21)	-	-
	Male	11.70 (5.79-22.23)	9.38 (5.89-14.61)	88.30 (77.77-94.21)	90.62 (85.39-94.12)	-	-
	Female	20.01 (11.90-31.68)	14.69 (11.00-19.34)	79.99 (68.32-88.10)	85.31 (80.66-89.00)	-	-
Eastern Europe	Moldova (2019)	2.22 (0.64-7.35)	0.63 (0.24-1.61)	97.65 (92.70-99.27)	98.86 (97.40-99.51)	0.14 (0.02-1.00)	0.51 (0.12-2.18)
	Male	0.00	0.33 (0.08-1.31)	100.00	99.33 (97.74-99.80)	-	0.34 (0.05-2.45)
	Female	3.24 (0.93-10.67)	0.95 (0.29-3.08)	96.56 (89.43-98.94)	98.36 (95.22-99.45)	0.20 (0.03-1.49)	0.70 (0.09-4.94)

Note: For this variable, only those who had indicated that they were ever in a relationship were included.

F.2.6 Perpetration of [Physical] Non-Partnered Violence (ever)

MDG Region	Country (Survey Year)	Perpetrated [Physical] Non-Partnered Violence (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
Sub-Saharan Africa	Côte d'Ivoire (2018)	23.61 (17.23-31.46)	14.62 (11.74-18.05)	76.16 (68.30-82.52)	84.26 (80.81-87.19)	0.25 (0.06-1.04)	1.12 (0.49-2.53)
	Male	28.46 (19.08-40.17)	18.22 (13.71-23.8)	71.31 (59.61-80.72)	81.39 (75.71-85.99)	0.23 (0.03-1.66)	0.39 (0.11-1.31)
	Female	18.66 (10.09-31.91)	10.97 (8.00-14.86)	81.06 (67.91-89.64)	87.17 (83.09-90.39)	0.28 (0.04-2.07)	1.86 (0.72-4.74)
	Lesotho (2018)	12.70 (8.64-18.28)	7.17 (5.59-9.16)	87.14 (81.59-91.2)	92.42 (90.38-94.05)	0.16 (0.05-0.52)	0.41 (0.22-0.76)
	Male	21.52 (13.24-33.01)	11.37 (8.49-15.08)	78.48 (66.99-86.76)	88.31 (84.47-91.30)	-	0.32 (0.09-1.08)
	Female	5.46 (4.25-7.00)	2.61 (2.02-3.37)	94.24 (92.64-95.51)	96.88 (96.02-97.56)	0.30 (0.09-0.93)	0.51 (0.27-0.94)
	Malawi (2013)	28.80 (24.60-33.40)	14.76 (11.85-18.22)	71.20 (66.60-75.40)	85.20 (81.72-88.10)	-	0.05 (0.01-0.20)

Appendix F

MDG Region	Country (Survey Year)	Perpetrated [Physical] Non-Partnered Violence (ever) % (95% CI)					
		Yes		No		Missing	
		Exposed	Not Exposed	Exposed	Not Exposed	Exposed	Not Exposed
	Male	36.11 (30.08-42.62)	20.30 (16.24-25.06)	63.89 (57.38-69.92)	79.60 (74.83-83.67)	-	0.10 (0.02-0.43)
	Female	22.04 (17.25-27.71)	9.77 (6.71-14.02)	77.96 (72.29-82.75)	90.23 (85.98-93.29)	-	-
	Namibia (2019)	9.79 (7.13-13.29)	5.79 (4.22-7.90)	88.26 (84.32-91.31)	91.74 (89.44-93.58)	1.96 (0.95-3.98)	2.47 (1.77-3.45)
	Male	13.12 (8.86-19.00)	7.92 (5.21-11.86)	86.01 (79.38-90.75)	90.30 (85.79-93.49)	0.87 (0.20-3.77)	1.78 (0.84-3.71)
	Female	5.95 (3.61-9.64)	3.19 (2.31-4.38)	90.85 (86.36-93.96)	93.49 (92.49-94.37)	3.20 (1.39-7.22)	3.32 (2.61-4.22)
	Nigeria (2014)	11.78 (9.55-14.45)	8.63 (7.18-10.33)	86.72 (83.74-89.22)	90.37 (88.55-91.92)	1.50 (0.82-2.73)	1.01 (0.57-1.77)
	Male	14.81 (11.61-18.71)	7.62 (6.00-9.62)	82.55 (78.44-86.01)	91.05 (88.81-92.88)	2.64 (1.38-5.00)	1.33 (0.64-2.74)
	Female	9.47 (6.67-13.28)	9.73 (7.40-12.69)	89.89 (85.67-92.98)	89.62 (86.57-92.04)	0.63 (0.19-2.10)	0.65 (0.30-1.41)
	Zambia (2014)	11.36 (8.82-14.54)	6.04 (4.68-7.75)	88.55 (85.41-91.08)	91.83 (89.73-93.54)	0.10 (0.01-0.69)	2.13 (1.18-3.81)
	Male	15.24 (11.08-20.59)	8.06 (6.00-10.76)	84.55 (79.23-88.69)	88.84 (85.75-91.32)	0.22 (0.03-1.58)	3.10 (1.75-5.42)
Latin America and the Caribbean	Female	8.28 (5.481-12.32)	3.88 (2.49-5.99)	91.72 (87.68-94.52)	95.02 (92.62-96.67)	-	1.10 (0.38-3.13)
	Colombia (2018)	19.44 (11.79-30.36)	10.60 (7.75-14.34)	79.63 (69.26-87.16)	86.52 (82.42-89.78)	0.92 (0.21-3.97)	2.88 (1.34-6.08)
	Male	36.64 (21.55-54.90)	16.14 (11.64-21.94)	63.17 (44.96-78.27)	79.68 (73.53-84.70)	0.19 (0.03-1.20)	4.19 (1.64-10.27)
	Female	7.07 (3.56-13.58)	4.16 (2.01-8.42)	91.48 (85.86-95.00)	94.47 (90.28-96.92)	1.45 (0.31-6.57)	1.36 (0.52-3.55)
	Honduras (2017)	6.00 (4.34-8.24)	2.95 (2.35-3.71)	94.00 (91.76-95.66)	97.02 (96.26-97.63)	-	0.02 (0.01-0.10)
South-Eastern Asia	Male	4.31 (2.08-8.71)	2.82 (1.99-3.98)	95.69 (91.29-97.92)	97.18 (96.02-98.01)	-	-
	Female	7.00 (4.92-9.87)	3.10 (2.28-4.19)	93.00 (90.13-95.08)	96.85 (95.76-97.67)	-	0.05 (0.01-0.20)
	Cambodia (2013)	Not assessed in questionnaire					
Eastern Europe	Male						
	Female						
	Moldova (2019)	2.55 (1.25-5.16)	1.56 (0.90-2.69)	95.88 (92.41-97.80)	97.48 (96.26-98.30)	1.57 (0.55-4.42)	0.96 (0.52-1.79)
	Male	5.12 (2.10-11.95)	2.70 (1.53-4.73)	92.45 (84.34-96.53)	96.75 (94.76-98.00)	2.43 (0.65-8.75)	0.56 (0.21-1.44)
	Female	1.05 (0.32-3.45)	0.24 (0.08-0.71)	97.89 (94.26-99.24)	98.33 (96.64-99.17)	1.06 (0.19-5.65)	1.43 (0.64-3.19)

Appendix G Associated Mental Health Outcomes for Children Exposed to Domestic Violence and Abuse: Regression Models

This appendix presents the full regression models for Paper Three (Chapter 6). Models are presented in the form of predicted probabilities by ecological domain, grouped by MDG region (UN Stats, 2015; United Nations, 2015). Three levels of significance were assessed – $p < 0.1$ (weakly significant), $p < 0.05$ (moderately significant), and $p < 0.01$ (strongly significant).

G.1 Psychological Distress (last 30 days)

A regression model for those who have experienced any psychological distress in the past 30 days, derived from the K6 scale (Kessler et al., 2003), presented as predicted probabilities.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Yes	0.206***	0.228***	0.295***	0.267**	0.349**	0.464**	0.404***	0.421***	0.377***	0.413***
	Respondent sex										
	Male (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Female	0.191*	0.149	0.177	0.383***	0.284	0.371	0.341***	0.390***	0.321***	0.347***
Individual	Education level										
	Completed primary (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Not completed primary	0.166	0.166	0.163	0.246	0.309	0.431	0.266	0.342	0.251	0.445**
	Currently in primary †	0.064***	0.105***	0.135*	0.129***	0.242	0.305**	0.171	0.281	0.117***	-
Family	Wealth										
	Richer (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Middle	0.148	0.153	0.195	0.201	0.297	0.367	0.193	0.354**	0.229	0.186*
	Poorer	0.175	0.138	0.161	0.381***	0.304	0.350	0.155	0.334	0.173**	0.287
	No household questionnaire†††	-	-	-	-	-	-	0.160	-	-	0.281
	Death of a biological parent										
	No, both parents are alive (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Yes, a parent has died	0.198*	0.166	0.198	0.242	0.301	0.459**	0.166	0.366**	0.247	0.278
	Living with both biological parents										
	Yes (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	No	0.232***	0.171	0.190	0.240	0.356**	0.361	0.267	0.327	0.249	0.273
	Multiple children in household ††										
	No (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	-	0.238
	Yes	0.322**	0.216**	0.279	0.242*	0.238	0.330	0.270	0.366	-	0.238
Community and Societal	Exposed to community violence										
	No (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Yes	0.230***	0.260***	0.243***	0.338***	0.315	0.411	0.279**	0.465***	0.329***	0.386***
	Societal acceptance of DVA ††††										
	No, DVA is not acceptable (ref)	0.151	0.158	0.177	0.206	0.291	0.381	0.206	0.311	0.219	0.238
	Yes, DVA is acceptable	0.197***	0.192**	0.164	0.266**	0.330	0.508***	0.355	0.361**	0.278***	0.245
	Incomplete answer	0.107	0.115	0.164	0.221	0.254	0.367	0.357*	0.500	0.185	0.174**

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Number of Obs	<i>n</i>	2271	8293	2094	4807	3666	1669	2531	4972	2331	1669
	% of total population	94%	97%	97%	93%	87%	92%	94%	96%	98%	85%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

G.2 Intentional Self Harm (lifetime)

A regression model for those who have ever intentionally self-harmed, presented as predicted probabilities.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Yes	0.109	0.009	0.028	0.055	0.038	0.094	0.104	0.077***	0.076***	0.035
	Respondent sex										
	Male (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Female	0.203***	0.008	0.013	0.050	0.020**	0.097	0.131*	0.080***	0.043	0.034
	Education level										
	Completed primary (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
Family	Not completed primary	0.122	0.021*	0.015	0.016*	0.017	0.111	0.048	0.058	0.043	0.151***
	Currently in primary †	0.163	0.004	0.024	0.031	0.021	0.067**	0.050	0.070*	0.023	-
	Wealth										
	Richer (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Middle	0.115	0.003*	0.014	0.055	0.035	0.112	0.052	0.064	0.021*	0.025
	Poorer	0.115	0.002***	0.008***	0.087**	0.042*	0.118	0.074	0.054	0.019*	0.016
	No household questionnaire†††	-	-	-	-	-	-	0.089	-	-	0.015
	Death of a biological parent										
	No, both parents are alive (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Yes, a parent has died	0.095	0.010	0.027	0.039	0.031	0.124	0.140	0.050	0.031	0.028
	Living with both biological parents										

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Yes (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	No	0.083	0.008	0.020	0.057	0.034	0.091	0.068	0.074***	0.037	0.034
	Multiple children in household ††										
	No (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	-	0.026
	Yes	0.079	0.011	0.027	0.037	0.053	0.077	0.058	0.053	-	0.068
Community and Societal	Exposed to community violence										
	No (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Yes	0.114	0.020***	0.073***	0.067**	0.031	0.104	0.187***	0.103***	0.050*	0.037
	Societal acceptance of DVA †††										
	No, DVA is not acceptable (ref)	0.101	0.007	0.020	0.043	0.029	0.098	0.083	0.056	0.032	0.026
	Yes, DVA is acceptable	0.119	0.012	0.034	0.061	0.039**	0.153***	0.191	0.086***	0.057***	0.035
	Incomplete answer	0.024**	0.008	0.076	0.053	0.015*	0.058	0.019**	0.500	0.012*	0.011**
Number of Obs	<i>n</i>	2327	8340	2121	4927	3833	1742	2554	5006	2354	1765
	<i>% of total population</i>	97%	97%	98%	95%	91%	96%	94%	96%	99%	88%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

G.3 Suicidal Thoughts (lifetime)

A regression model for those who have ever had suicidal thoughts, presented as predicted probabilities.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Yes	0.027**	0.027***	0.005*	0.031**	0.020	0.130***	0.016**	0.045***	0.022***	0.021***
	Respondent sex										
	Male (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Female	0.053***	0.039***	0.005*	0.069***	0.041***	0.130***	0.043***	0.078***	0.031***	0.027***
	Education level										
	Completed primary (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	-
Family	Not completed primary	0.015	0.019	0.003	0.015	0.009**	0.159**	0.006	0.022	0.014**	-
	Currently in primary †	0.004	0.004***	0.001***	0.008**	0.013	0.049	0.005	0.023	0.004*	-
	Wealth										
	Richer (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Middle	0.027**	0.009***	0.001**	0.035	0.028	0.062	0.010	0.029**	0.004*	0.008
	Poorer	0.026***	0.006***	0.002	0.064***	0.033	0.043***	0.010	0.033***	0.003***	0.016
	No household questionnaire†††	-	-	-	-	-	-	0.007	-	-	0.009
	Death of a biological parent										
	No, both parents are alive (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Yes, a parent has died	0.015	0.015	0.007**	0.016	0.025	0.117*	0.013	0.023	0.008	0.024***
	Living with both biological parents										

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Yes (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	No	0.036***	0.019*	0.003	0.026*	0.028	0.077	0.012	0.032***	0.007	0.017**
	Multiple children in household ††										
	No (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	-	0.010
	Yes	0.005**	0.024**	0.028**	0.008	0.019	0.061	0.020	0.013	-	0.011
Community and Societal	Exposed to community violence										
	No (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Yes	0.016	0.019**	0.005**	0.036***	0.032**	0.088	0.018***	0.039***	0.013**	0.018**
	Societal acceptance of DVA †††										
	No, DVA is not acceptable (ref)	0.014	0.014	0.003	0.019	0.021	0.080	0.009	0.020	0.007	0.010
	Yes, DVA is acceptable	0.018	0.017	0.003	0.026	0.024	0.111*	0.020	0.029**	0.015***	0.011
	Incomplete answer	0.028	0.009	0.001	0.014	0.014	0.061	0.006	0.500	0.012	0.007
Number of Obs	<i>n</i>	2329	8344	2121	4926	3840	1740	2551	5008	2356	1766
	<i>% of total population</i>	97%	97%	98%	95%	91%	96%	94%	96%	99%	88%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova. Education level was removed from this model for Moldova as there was no variation.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

G.4 Risky Behaviours (last 30 days)

A regression model for those who have partaken in risky behaviours in the past 30 days (derived from questions on smoking, binge drinking and drug use), presented as predicted probabilities.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Yes	0.149	0.377***	0.139	0.444***	0.454***	0.113	0.188	0.075***	0.666	0.234***
	Respondent sex										
	Male (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Female	0.057***	0.051***	0.043***	0.167***	0.078***	0.028***	0.106***	0.017***	0.539***	0.047***
	Education level										
Family	Completed primary (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Not completed primary	0.095**	0.352	0.152	0.303	0.255	0.141**	0.187	0.060	0.617	0.144
	Currently in primary †	0.064**	0.021***	0.091	0.083***	0.275	0.068**	0.010***	0.015***	0.418***	-
	Wealth										
	Richer (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Middle	0.122	0.232*	0.132	0.292	0.254	0.098	0.192	0.062	0.702	0.212*
	Poorer	0.149	0.238	0.073**	0.386	0.264	0.089	0.288	0.074***	0.704	0.277***
Family	No household questionnaire†††	-	-	-	-	-	-	0.502***	-	-	0.192
	Death of a biological parent										
	No, both parents are alive (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
Family	Yes, a parent has died	0.121	0.382***	0.090	0.435**	0.266	0.106	0.325	0.070**	0.661	0.272***

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Living with both biological parents										
	Yes (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	No	0.152	0.321	0.131	0.290	0.270	0.105	0.255	0.064*	0.704	0.167
	Multiple children in household ††										
	No (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	-	0.152
	Yes	0.239	0.257	0.278	0.226	0.207	0.308*	0.329	0.164**	-	0.173
Community and Societal	Exposed to community violence										
	No (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Yes	0.179**	0.328	0.103	0.431***	0.301	0.126*	0.386***	0.089***	0.683	0.284***
	Societal acceptance of DVA †††										
	No, DVA is not acceptable (ref)	0.132	0.282	0.113	0.332	0.259	0.097	0.219	0.053	0.672	0.152
	Yes, DVA is acceptable	0.174**	0.348**	0.110	0.333	0.273	0.104	0.416*	0.058	0.729**	0.178
	Incomplete answer	0.061	0.056*	0.048	0.294	0.250	0.088	0.191	0.500	0.666	0.114
Number of Obs	<i>n</i>	2184	8159	1992	4804	3488	1672	2228	4950	2243	1734
	<i>% of total population</i>	91%	95%	92%	93%	83%	92%	82%	95%	94%	87%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

G.5 Perpetration of Physical DVA (lifetime)

A regression model for those who have ever perpetrated physical DVA, presented as predicted probabilities.

For this outcome, the population was different, as instead of involving all those who took the survey, this variable has been controlled so that only those who have ever been in a relationship have been included.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Yes	0.098	0.031***	0.043***	0.004***	0.199	0.121***	0.002	0.005**	0.051	0.023
	Respondent sex										
	Male (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Female	0.060	0.005***	0.017	0.001	0.064***	0.026***	0.003**	0.013***	0.084***	0.023
	Education level										
	Completed primary (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	-
Family	Not completed primary	0.111	0.014	0.015	0.002	0.086**	0.029*	0.001	0.004	0.047	-
	Currently in primary †	0.013	0.009	0.012 *	0.001	0.133	0.076	0.001	0.002	0.114***	-
	Wealth										
	Richer (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Middle	0.065	0.015	0.019	0.001	0.114	0.051	0.001	0.007**	0.059	0.016
	Poorer	0.061	0.011	0.022	0.002*	0.110	0.032**	0.001	0.007***	0.070*	0.008
	No household questionnaire†††	-	-	-	-	-	-	0.001	-	-	-
	Death of a biological parent										
	No, both parents are alive (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Yes, a parent has died	0.062	0.044**	0.009**	0.001	0.108	0.060	0.001	0.005	0.054	0.011

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Living with both biological parents										
	Yes (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	No	0.074	0.019	0.047**	0.001	0.195	0.087	0.003**	0.004	0.026	0.007
	Multiple children in household ††										
	No (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	-	0.007
	Yes	0.061	0.013	0.051	0.005*	0.080	0.064	0.007**	0.003	-	0.004
Community and Societal	Exposed to community violence										
	No (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Yes	0.106	0.035**	0.022	0.002**	0.301***	0.076	0.003**	0.008***	0.082***	0.001**
	Societal acceptance of DVA ††††										
	No, DVA is not acceptable (ref)	0.068	0.017	0.022	0.001	0.149	0.058	0.001	0.003	0.041	0.007
	Yes, DVA is acceptable	0.070	0.043***	0.023	0.002**	0.230***	0.113***	0.001	0.006*	0.037	0.041**
	Incomplete answer	-	-	0.016	0.006**	0.314	0.078	0.002	0.500	0.015	-
Number of Obs	<i>n</i>	1375	5161	1339	2910	2122	1092	1925	2523	759	697
	<i>% of total population who have ever been in a relationship</i>	94%	96%	96%	93%	92%	96%	92%	96%	99%	72%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$. For this variable, only those who had indicated that they were ever in a relationship were included. This is the number of obs reported.

† No respondents reported currently attending primary school in Moldova. Education level was removed from this model for Moldova as there was no variation.

†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived. For Moldova, this category was removed for this model, as there was no variation.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”. For this model, this category was removed for the countries of Côte d'Ivoire, Lesotho, and Moldova, as there was no variation.

G.6 Perpetration of [Physical] Non-Partnered Violence (lifetime)

A regression model for those who have ever perpetrated [physical] non-partnered violence, presented as predicted probabilities.

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
Individual	Exposed to DVA										
	No (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Yes	0.075*	0.180***	0.788***	0.060	0.063	0.094***	0.058**	0.010***	-	0.032
	Respondent sex										
	Male (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Female	0.036*	0.025***	0.414***	0.019***	0.052	0.022***	0.003***	0.006	-	0.003***
	Education level										
	Completed primary (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
Family	Not completed primary	0.036	0.059	0.491	0.049	0.044	0.013	0.038	0.005	-	0.059
	Currently in primary †	0.083**	0.113	0.679*	0.035	0.048	0.048	0.033	0.006	-	-
	Wealth										
	Richer (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Middle	0.051	0.098	0.529*	0.027	0.060	0.026***	0.024	0.014***	-	0.032
	Poorer	0.032*	0.109	0.433***	0.054	0.066	0.020***	0.041*	0.023***	-	0.022
	No household questionnaire†††	-	-	-	-	-	-	0.027	-	-	0.030
	Death of a biological parent										
	No, both parents are alive (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Yes, a parent has died	0.035*	0.102	0.604	0.060	0.070	0.063	0.021	0.004	-	0.028
	Living with both biological parents										

Appendix G

Explanatory Factor		MDG Region									
		Sub-Saharan Africa						Latin America and the Caribbean		South-Eastern Asia	Eastern Europe
Ecological Domain	Country	Côte d'Ivoire	Lesotho	Malawi	Namibia	Nigeria	Zambia	Colombia	Honduras	Cambodia	Moldova
	Yes (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	No	0.059	0.120	0.605	0.061	0.054	0.062	0.016	0.008	-	0.017
	Multiple children in household ††										
	No (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Yes	0.144	0.070	0.204	0.031	0.064	0.090	0.060	0.006	-	0.013
Community and Societal	Exposed to community violence										
	No (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Yes	0.095***	0.150**	0.687**	0.156***	0.106***	0.083**	0.063***	0.017***	-	0.037
	Societal acceptance of DVA †††										
	No, DVA is not acceptable (ref)	0.052	0.103	0.609	0.049	0.057	0.052	0.020	0.006	-	0.019
	Yes, DVA is acceptable	0.083**	0.200***	0.661	0.096***	0.073*	0.069	0.006	0.004	-	0.017
	Incomplete answer	0.038	0.121	0.535	0.052	0.024**	0.077	0.064**	0.500	-	0.005
Number of Obs	<i>n</i>	2315	8314	2120	4768	3818	1729	2507	5009	-	1758
	<i>% of total population</i>	96%	97%	98%	92%	91%	95%	93%	96%	-	88%

Note: * $p < .10$, ** $p < .05$, *** $p < .01$.

† No respondents reported currently attending primary school in Moldova.

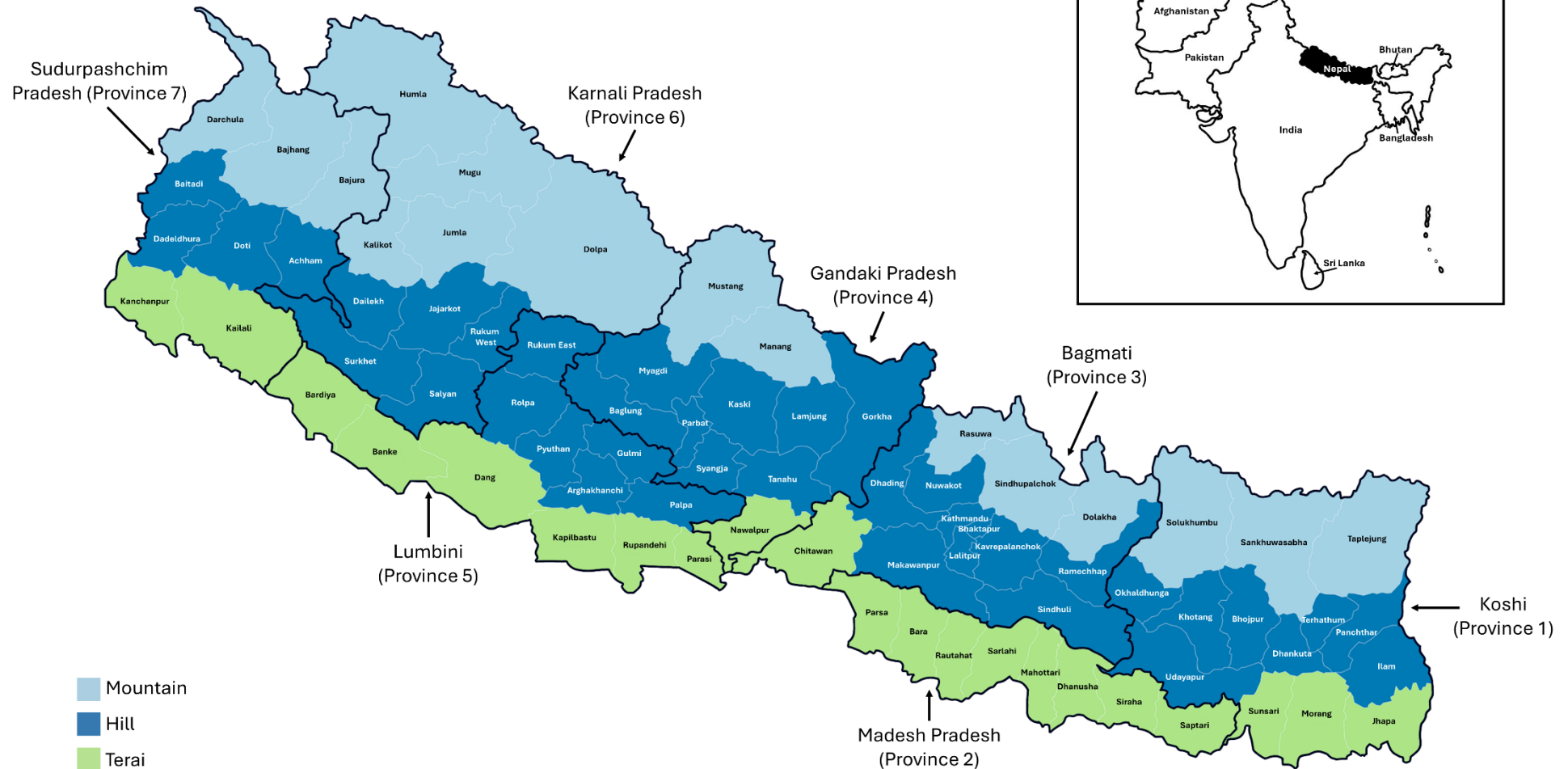
†† The question from which the “multiple children in household” question was derived was not asked in Cambodia, and so this could not be assessed.

††† For the countries of Colombia and Moldova, an extra category was created for those who did not complete the head of household survey from which the wealth variable is derived.

†††† This variable was constructed using one question within the VACS: “do you believe it is right for a man to hit or beat his wife if ...”, which was followed by a series of five scenarios. A binary variable was created, where if someone answered “yes” to any situation, they were coded as “yes”, they believed that DVA was acceptable. If someone failed to provide an answer to a scenario and had not indicated that they believed DVA was acceptable in any circumstance (or unacceptable in all circumstances), then they were coded as “incomplete answer”.

Appendix H A Map of Nepal

This Appendix allows for Figure 7.2 to be examined in more detail, also noting the 77 districts of Nepal.



A map of Nepal showing the subdivision of the country into Mountain, Hill and Terai districts. Inset is a thumbnail map showing the location of Nepal within South Asia.

Appendix I Policies and Legislation related to Childhood Exposure to DVA

This appendix provides examples of policies and legislation related to childhood exposure to DVA. It does this by firstly looking at international rights, treaties and conventions, then looking at examples of country level policies from around the world. Finally, it focuses on specific policies within Nepal, the country of focus for Paper Four (Chapter 7).

I.1 International Rights, Treaties and Conventions on Childhood Exposure to DVA

Childhood exposure to DVA is either implicitly, or explicitly mentioned in a few international rights, treaties and conventions, which many countries have agreed or ratified. In country level policies (Appendix I.2), these are often cited.

International treaties and conventions	Number/Article	Detail/Quote	Agreed/ratified by
Convention on the Rights of the Child (1989) ⁹⁶	Article 19: Protection from violence, abuse and neglect	1. States Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has the care of the child. 2. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have the care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow-up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.	State Party 196 Signatory 1 (USA) No action 0
Convention on the Rights of the Child General comment No. 13 (2011): The	VI. National coordinating	72. Elements to be mainstreamed into national coordinating frameworks. The following elements need to be mainstreamed across the measures (legislative, administrative,	

⁹⁶ Nepal's signature and ratification/accession was in 1990

Appendix I

International treaties and conventions	Number/Article	Detail/Quote	Agreed/ratified by
right of the child to freedom from all forms of violence	framework on violence against children	social and educational) and stages of intervention (from prevention through to recovery and reintegration): (g) <i>Children in potentially vulnerable situations</i> . Groups of children which are likely to be exposed to violence include, but are not limited to, children ⁹⁷ : [...] who experience and witness violence in the home and in communities.	
Istanbul Convention: Council of Europe Convention on preventing and combating violence against women and domestic violence (2011)	Preamble	Recognising that children are victims of domestic violence, including as witnesses of violence in the family.	As of January 2024, the Convention has been signed by all EU Member States, and ratified by 22 (Austria, Belgium, Croatia, Cyprus, Denmark, Estonia, Finland, France, Germany, Greece, Ireland, Italy, Latvia, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovenia, Spain and Sweden).
	Article 26: Protection and support for child witnesses	- Parties shall take the necessary legislative or other measures to ensure that in the provision of protection and support services to victims, due account is taken of the rights and needs of child witnesses of all forms of violence covered by the scope of this Convention. - Measures taken pursuant to this article shall include age-appropriate psychosocial counselling for child witnesses of all forms of violence covered by the scope of this Convention and shall give due regard to the best interests of the child.	
	Article 56: Measures of protection	- Parties shall take the necessary legislative or other measures to protect the rights and interests of victims, including their special needs as witnesses, at all stages of investigations and judicial proceedings, in particular by: - providing for their protection, as well as that of their families and witnesses, from intimidation, retaliation and repeat victimisation - A child victim and child witness of violence against women and domestic violence shall be afforded, where appropriate, special protection measures taking into account the best interests of the child.	
Sustainable Development Goals (2017)	Goal 5: Achieve gender equality and empower all women and girls	5.1 End all forms of discrimination against women and girls everywhere	Agreed and adopted by 193 countries

⁹⁷ Within this clause, it also lists children in potentially vulnerable situations as children not living with their biological parents, in low socio-economic urban environments – two of the risk factors explored within Paper Two (Chapter 5).

Appendix I

International treaties and conventions	Number/Article	Detail/Quote	Agreed/ratified by
		5.2 Eliminate all forms of violence against all women and girls in the public and private spheres, including trafficking and sexual and other types of exploitation	(including Nepal) in 2015.
	Goal 16: Promote peaceful and inclusive societies for sustainable development, provide access to justice for all and build effective, accountable and inclusive institutions at all levels	16.1 Significantly reduce all forms of violence and related death rates everywhere 16.2 End abuse, exploitation, trafficking and all forms of violence against children	

I.2 Examples of Policies on Childhood Exposure to DVA in Other Countries

This appendix explores examples where childhood exposure to DVA is explicitly mentioned within a country's policy. Whilst children are often mentioned in DVA laws in the context of protection orders for the victim (usually the mother), which extend to the child, or custody arrangements following DVA, very few explicitly mention the *harm* or *impact* of childhood exposure to DVA. Therefore, only those which explicitly do are mentioned below.

Country	Legislation (Year)	Detail
Australia	The Family Law Act 1975 (Commonwealth)	Creates a mandatory reporting duty for personnel from the Family Court of Australia, the Federal Circuit Court of Australia, the Family Court of Western Australia and other designated practitioners. Under section 4, 'abuse' is effectively defined as including: (a) assault, including a sexual assault; (b) sexual abuse; (c) serious psychological harm, including but not limited to harm caused by the child being subjected to, or exposed to, family violence; or (d) serious neglect. (Australian Institute of Family Studies, 2023)
Denmark	The Danish Act on Parental Responsibility 2017	Part 1: Introductory provisions 4. Decisions made pursuant to the Act shall be based on the child's best interests. The Agency of Family Law and the Family Court shall focus on measures to ensure that decisions contribute to safeguarding the wellbeing of the child and to protecting the child from acts of violence or other treatment that exposes the child to harm or danger, including witnessing violence.
Kenya	Children Act (2001)	PART X – CHILDREN IN NEED OF CARE AND PROTECTION 119. When a child is in need of care and protection. (1) For the purposes of this Act, a child is in need of care and protection – (j) who is exposed to domestic violence
	Protection Against Domestic Violence Act (2015; revised in 2022)	(3) A person psychologically abuses a child if that person: a) causes or allows a child to see or hear the physical, sexual or psychological abuse of a person with whom the child has a domestic relationship; or b) puts the child or allows the child to be put at risk of seeing or hearing the physical, sexual, or psychological abuse of a person with whom the child has a domestic relationship, but the person who suffers the abuse shall not be regarded as having caused or allowed the child to see or hear the abuse or as having put the child, or allowed the child to be put, at risk of seeing or hearing the abuse.

Appendix I

Country	Legislation (Year)	Detail
New Zealand	Family Violence Act 2018	11 Meaning of psychological abuse 2. A person psychologically abuses a child if that person – a. causes or allows the child to see or hear the physical, sexual, or psychological abuse of a person with whom the child has a family relationship; or b. puts the child, or allows the child to be put, at real risk of seeing or hearing that abuse occurring. 3. However, the person who suffers the abuse in subsection (2)(a) and (b) is not regarded, under subsection (2), as having (as the case may be) – a. caused or allowed the child to see or hear that abuse; or b. put the child, or allowed the child to be put, at risk of seeing or hearing that abuse.
Philippines	Anti-Violence Against Women and Their Children Act (2004)	SECTION 3. Definition of Terms – As used in this Act: (a) “Violence against women and their children” refers to any act or a series of acts committed by any person against a woman who is his wife, former wife, or against a woman with whom the person has or had a sexual or dating relationship, or with whom he has a common child, or against her child whether legitimate or illegitimate, within or without the family abode, which result in or is likely to result in physical, sexual, psychological harm or suffering, or economic abuse including threats of such acts, battery, assault, coercion, harassment or arbitrary deprivation of liberty. It includes, but is not limited to, the following acts: C. “Psychological violence” refers to acts or omissions causing or likely to cause mental or emotional suffering of the victim such as but not limited to intimidation, harassment, stalking, damage to property, public ridicule or humiliation, repeated verbal abuse and marital infidelity. It includes causing or allowing the victim to witness the physical, sexual or psychological abuse of a member of the family to which the victim belongs, or to witness pornography in any form or to witness abusive injury to pets or to unlawful or unwanted deprivation of the right to custody and/or visitation of common children. (h) “Children” refers to those below eighteen (18) years of age or older but are incapable of taking care of themselves as defined under Republic Act No. 7610. As used in this Act, it includes the biological children of the victim and other children under her care.
South Africa	Domestic Violence Act (1998)	Definitions 1. In this Act, unless the context indicates otherwise -- (ii) “complainant” means any person who is or has been in a domestic relationship with a respondent and who is or has been subjected or allegedly subjected to an act of domestic violence, including any child in the care of the complainant; (xv)

Appendix I

Country	Legislation (Year)	Detail
	The Children's Act (2005)	CHAPTER 2 GENERAL PRINCIPLES Best interests of child standard 7. (1) Whenever a provision of this Act requires the best interests of the child standard 25 to be applied, the following factors must be taken into consideration where relevant, namely- (b) the need for a child to be brought up within a stable family environment and, where this is not possible, in an environment resembling as closely as possible a caring family environment; (c) the need to protect the child from any physical or psychological harm that may be caused by – (i) subjecting the child to maltreatment, abuse, neglect, exploitation or degradation or exposing the child to violence or exploitation or other harmful behaviour; or (ii) exposing the child to maltreatment, abuse, degradation, ill-treatment, violence or harmful behaviour towards another person; (d) any family violence involving the child or a family member of the child; and (e) which action or decision would avoid or minimise further legal or administrative proceedings in relation to the child
Sweden	Socialtjänstlag (2001) <i>Translates to: The Social Services Act (2001)</i>	The Social Welfare Board should also pay particular attention to a child witnessing violence or other abuse of or against related are the victims of crimes and be responsible for ensuring that the child receives the support and the help your child needs.
	<i>Barnfridsbrott (2021)</i> <i>The Violation of a Child's Integrity Act</i>	<i>The exact translation for this law cannot be found, but it is explained in a publication by the Swedish Public Prosecutor's Office (Swedish Prosecution Authority, 2022):</i> • Since July 1, 2021, it is a criminal offense to allow children to witness, for example, violence, threats or sexual abuse between relatives, because according to research, this means an increased risk of suffering from both mental and physical ill health. • That it is now a criminal offense to allow a child to witness crimes such as violence, threats and sexual abuse between two people who can both be considered close to the child. The child becomes the plaintiff himself and has the right to plaintiff counsel. • The legislator has expressed that the relationship must be so close that it involves an existing or former caregiver of the child, or someone with whom the child has or had a strong emotional connection in everyday life. It is clearly stated that the assessment must be made from the child's perspective • "Witness" in this context means that the child must have seen or heard the essential parts of the basic offence. The child must therefore have seen or heard precisely what is criminal, such as threats or an assault, where the sound of blows may suffice.

Appendix I

Country	Legislation (Year)	Detail
		On the website, “<i>informationsverige: guiden till det svenska samhället</i>” (the guide to Swedish society), this is also described (Informationsverige, 2023): Exposing children to crime (barnfridsbrott): It is illegal to expose a child to seeing or hearing certain crimes in an intimate relationship. Children must not have to see or hear assault, threats or sexual abuse between parents, siblings or relatives. This means that violence between parents is also violence against children. The crime is called exposing children to crime, or "barnfridsbrott" in Swedish.
England and Wales (United Kingdom)	Domestic Abuse Act (2021)	Section 3 Children as victims of domestic abuse 1. This section applies where behaviour of a person (“A”) towards another person (“B”) is domestic abuse. 2. Any reference in this Act to a victim of domestic abuse includes a reference to a child who – (a) sees or hears, or experiences the effects of, the abuse, and (b) is related to A or B. 3. A child is related to a person for the purposes of subsection (2) if – (a) the person is a parent of, or has parental responsibility for, the child, or (b) the child and the person are relatives. 4. In this section – “child” means a person under the age of 18 years; “parental responsibility” has the same meaning as in the Children Act 1989 (see section 3 of that Act); “relative” has the meaning given by section 63(1) of the Family Law Act 1996.

In addition, the following countries have policies or laws which are specific to certain areas of the country, rather than applying at a national, country-level. Due to the complexity and the fact that this is not the focus of this thesis, these have been grouped to illustrate where childhood exposure to DVA sits within policy:

Country	Detail
Australia	• For The Family Law Act 1975 (Commonwealth) described above, there are some differences in the types of abuse and neglect that must be reported across the states and territories. In New South Wales, the Northern Territory and Tasmania it is mandatory to report all 5 recognised types of abuse and neglect: physical abuse, sexual abuse, emotional abuse, neglect, and exposure to family violence. In South Australia it is mandatory to report physical abuse, sexual abuse, emotional abuse, and neglect. In the Australian Capital Territory and Victoria only physical and sexual abuse must be reported (Australian Institute of Family Studies, 2023). • Whilst from 2011, Richards (2011) provides an overview of where legislation which includes provisions for childhood exposure to DVA are located across Australian states and territories, including: New South Wales Crimes (Domestic and Personal Violence) Act 2007; Australian Capital Territory

Appendix I

Country	Detail
	Children and Young People Act 2008, Victoria Family Violence Protection Act 2008; Queensland Domestic and Family Violence Protection Act 2012; Western Australia Restraining Orders Act 1997; South Australia Intervention Orders (Prevention of Abuse) Act 2009; Tasmania Children, Young Persons and their Families Act 1997 and Family Violence Act 2004; Northern Territory Care and Protection of Children Act 2007 and Domestic and Family Violence Act 2007. • Child Protection Laws: Each Australian state and territory has child protection laws that include provisions for intervening when children are exposed to domestic violence. For example, New South Wales includes exposure to DVA under its definition of child abuse (New South Wales Government, 2024). • Recognition in DVA Laws: Similarly to Child Protection laws, each Australian state and territory has its own DVA laws, with varying levels of protection for childhood exposure to DVA. An example is Queensland's Domestic and Family Violence Protection Act (2012), which contains a section which defines childhood exposure to DVA, which contains a comprehensive definition of exposure which addresses many of Holden's (2003) taxonomy.⁹⁸
Canada	• On the Government of Canada's website, it states (Department of Justice Canada, 2024): ○ Children who witness family violence are at risk for both short and long-term harm. Even if they don't see or hear the violence, they can be affected by hearing or seeing the results of the violence. They can have emotional, behavioural and developmental problems. These problems can last a long time. They are also at risk of developing post-traumatic stress disorder. ○ Exposing a child to family violence can be grounds for child protection intervention under provincial and territorial child protection laws. • In Canada, suspecting childhood exposure to DVA meets the threshold to report to child welfare authorities as its own type of maltreatment or as a form of child abuse or neglect. However, the reporting process depends on age-related thresholds for each province/territory (Canadian Paediatric Society, 2023). • Exposure to DVA is also considered across all provinces/territories when determining the best interests of the child in family law proceedings, particularly regarding custody and access to parents.
United States	• Child Welfare Information Gateway (2021) published an overview of childhood exposure to DVA within each States' laws. Alongside definitions of childhood exposure to DVA (including whether a child has to be physically present, can see or hear the violence, within 30 feet or within the same residential unit, or if the child is related to a member of the household or a noncustodial child of the perpetrator), it discusses the legal consequences across States. In many States, a conviction for DVA that was committed in the presence of a child may result in harsher penalties than a conviction for domestic violence without a child present. In nine states, if DVA was committed in the presence of a child then this is considered an "aggravating circumstance" when sentencing, an additional seven require harsher penalties (whilst not using the term "aggravating

⁹⁸ Within Queensland's Domestic and Family Violence Protection Act 2012, "a child is *exposed* to domestic violence if the child sees or hears domestic violence or otherwise experiences the effects of domestic violence. *Examples of being exposed to domestic violence*: overhearing threats of physical abuse; overhearing repeated derogatory taunts, including racial taunts; experiencing financial stress arising from economic abuse; seeing or hearing an assault; comforting or providing assistance to a person who has been physically abused; observing bruising or other injuries of a person who has been physically abused; cleaning up a site after property has been damaged being present at a domestic violence incident that is attended by police officers". Exposure to DVA is also considered under "condition for protection of unborn child".

Appendix I

Country	Detail
	circumstance”), and in five States, committing DVA in the presence of a child is a separate crime that may be charged separately or in addition to the act of violence⁹⁹. In addition, mandatory reporting procedures across various states require professionals to report suspected cases of child abuse, which in some states includes exposure to DVA. An example of this is California (https://capc-coco.org/wp-content/uploads/2020/05/Mandated-Reporter-FAQs-2020.pdf), as exposure to DVA is mentioned in Penal Code 1170.76.

⁹⁹These States are Delaware, Georgia, North Carolina, Oklahoma, and Utah.

I.3 National Acts, Laws and Policies on Childhood Exposure to DVA in Nepal

This appendix focuses on one LMIC, Nepal (the focus for Paper Four, Chapter 7), and explores existing national legislation which could relate to childhood exposure to DVA within Nepal.

Name	Year (Gregorian/Bikram Sambat Calendar)	Relevant Clauses	Is Childhood Exposure to DVA Acknowledged?
Act Relating to Children	2018 / 2075	CHAPTER 2: CHILD RIGHTS <u>7. Right to protection</u> (5) Every child shall have the right to protection from all forms of physical or mental violence and torture, neglect, inhuman behaviour, gender based or untouchability related abuse, sexual abuse and exploitation by his/her father, mother, other family member or guardian, teacher and other persons. CHAPTER 5: SPECIAL PROTECTION AND REHABILITATION OF CHILDREN <u>48. Children in need of special protection:</u> (g) Children who have been separated from their families for their best interest due to abuse, violence or neglect by their fathers, mothers or guardians. <u>57. Child protection standards:</u> (1) Every school, public body, private sector and social organisation that directly works with children shall formulate and enforce child protection standards at institutional level in order to prevent violence against children or child sexual abuse, ensure protection of children and to immediately act on complaints. (2) It shall be the duty of the chief of every school, public body, private sector and social organisation to enforce the child protection standards formulated pursuant to Subsection (1) CHAPTER 8: OFFENCES AGAINST CHILDREN <u>66. Offences against children:</u>	• This legislation operationalises constitutional provisions on child protection. It outlines protections from physical, mental, sexual, and emotional abuse, along with exploitation and neglect. • The Act reinforces child rights and specifies punitive measures for those engaging in acts of violence against children. • However, exposure to DVA is not explicitly defined as a form of abuse or violence against children. The Act mainly focuses on direct abuse towards children, rather than considering the psychological harm experienced by children exposed to DVA within their homes.

		(1) If a person engages in any act of violence pursuant to subsection (2) [...] it shall be deemed an offence against children under this Act. (2) If any person commits any of these acts, stated below, against children, it shall be deemed an act of violence against children: (d) Inflict physical or mental punishment or behave in an undignified manner, whether at home, school or any other place, (e) Inflict physical injuries or harm, terrorise or intimidate, humiliate, neglect, discriminate, exclude or hate, isolate or cause mental torture <u>68. To be reported:</u> (1) If the father, mother, guardian and those who directly provide services to children such as caregivers, teachers, health-workers or any other person come to know about an incident of violence against children or child sexual abuse that has taken place, that is taking place or that is going to take place, she/he shall inform the nearest police station immediately. (2) The police station concerned shall provide information pursuant to subsection (1) to the child welfare authority and seek necessary support <u>70. Rescue, protection and health check-up to be done</u> (1) If police personnel receive an information, complaint or report about an incident of violence against children or child sexual abuse, she/he shall write, or cause to write, necessary details and register it, and if the child needs to be rescued, immediately rescue her/him and refer her/him to a temporary protection service. (2) If it is found that the child victim is in physical or mental pain, the police personnel shall send her/him to a nearby hospital or health centre and get her/his health checked up and treated (3) While recording the statement of the child victim, police personnel shall do so in the presence of, if possible, her/his parents, other family members or guardian, and, if it is not possible to do so in their presence or they cannot be present, in the presence of a female representative of a social organisation or a social service provider. Nevertheless, if the parents, guardian or other family members are the perpetrator of violence against children or child sexual abuse, their presence shall not be allowed during recording of statement. CHAPTER 10: MISCELLANEOUS <u>77. Children's duties</u>	

Appendix I

		It shall be the duty of every child to respect her/his father, mother, guardian, other family members, teachers and school social service providers and obey the advice, suggestion, guidance and instruction given by them by keeping in mind her/his best interest.	
Constitution of Nepal	2015 / 2072	Article 39 of the Constitution guarantees the Rights of the child: (1) Every child shall have the right to name and birth registration along with his or her identity. (2) Every child shall have the right to education, health, maintenance, proper care, sports, entertainment and overall personality development from the families and the State. (3) Every child shall have the right to elementary child development and child participation. (4) No child shall be employed to work in any factor, mine or engaged in similar other hazardous work. (5) No child shall be subjected to child marriage, transported illegally, abducted/kidnapped or taken in hostage. (6) No child shall be recruited or used in army, police or any armed group, or be subjected, in the name of cultural or religious traditions, to abuse, exclusion or physical, mental, sexual or other form of exploitation or improper use by any means or in any manner. (7) No child shall be subjected to physical, mental or any other form of torture in home, school or other place and situation whatsoever. (8) Every child shall have the right to juvenile friendly justice. (9) The child who is helpless, orphan, with disabilities, conflict victim, displaced or vulnerable shall have the right to special protection and families from the State. Any act contrary to in clauses (4), (5), (6) and (7) shall be punishable by law, and a child who is the victim of such act shall have the right to obtain compensation from the perpetrator, in accordance with law.	While this provision offers broad protection, it does not specifically recognise children as victims when exposed to DVA, even though this could be inferred under the general protection from exploitation and harm.
Domestic Violence (Crime and Punishment) Act <i>Sometimes also referred to as the Domestic Violence (Offence and Punishment) Act</i>	2009 / 2066	<u>2. Definitions:</u> In this Act unless the context otherwise requires: a) "Domestic Violence" means any form of physical, mental, sexual and economic abuse perpetrated by any person to the other person with whom he has a family relationship. The definition also covers acts of reprimand or emotional abuse. b) "Domestic relationship" means a relationship between two persons who live or have, at any point of time, lived together in a shared household and are related by consanguinity, marriage, adoption or are family members living together as a joint family; or a dependent domestic help living in the same family. c) "Physical abuse" means any act or conduct which is of such nature as to cause bodily harm or injury except the losing and breaking of limbs; holding the person captive, inflicting physical pain or any other act connected therewith and incidental thereto.	- Although it acknowledges the impact of DVA on victims, it does not directly recognise children exposed to DVA as victims in their own right, and the clause mentioned about protection orders is the only time the word "child", "children", or "minor" is mentioned in the act. - However, according to the definition of Domestic

Appendix I

		d) “Mental abuse” means any act of threatening the aggrieved person of physical torture, showing terror, reprimanding him, accusing him of false deeds, forcefully evicting him from the house or otherwise causing injury or harm to the aggrieved person emotionally and this phrase also denotes discrimination carried out on the basis of thought, religion or culture and customs and traditions. e) “Sexual abuse” means any conduct of a sexual nature that abuses, humiliates, degrades or otherwise violates the dignity of any person; or any other act that hampers safe sexual relations. f) “Economic abuse” includes deprivation of all or any property jointly or separately held by the aggrieved person to which he/she is entitled to under the law; or deprivation of or access to employment opportunities, economic resources or means. g) “Aggrieved person” means any person who is, or has been, in a domestic relationship with the defendant and who alleges to have been subjected to an act of domestic violence by the perpetrator. h) “Perpetrator” means the person having family relations with the aggrieved person who alleges to have been subjected to an act of domestic violence by the defendant and this word also indicates any person who is involved in some way in the act of domestic violence or in the abetment of the crime. <u>6. Power to grant interim protection order</u> (1) If the Court has reason to believe, on the basis of preliminary investigation of the complaint, that the aggrieved person needs to be given immediate protection, it may, till the time the final decision on the complaint is made, pass the following orders against the perpetrator: (a) To allow the aggrieved person to continue living in the shared household, to provide him/her with food, clothes, to not cause physical injury to him/her and to behave with him/her in a civilised and dignified manner. (b) To provide necessary treatment or to give money for the treatment of the aggrieved person if he/she has incurred physical or mental injury. (c) To make necessary arrangements for the separate living of the perpetrator in the event that it’s not conducive for them to live together, and in such cases, make necessary arrangements for the maintenance of the aggrieved person. (d) To not insult, threaten or behave in an uncivilised manner; or aid and abet these acts.	Violence, it is not specified that the victim or perpetrator has to be over the age of 18, which suggests that children could also be considered under this Act – although it does not account for exposure, only direct victimisation. This means that there is tension between the definition of DVA used within this thesis, and that within Nepal’s DVA act. • The law allows for the provision of interim protection orders and rehabilitation services, which can indirectly benefit children, but the psychological and developmental harm from exposure to DVA is not specifically acknowledged in the legal framework.

Appendix I

		(e) To not harass the aggrieved person by entering his/her place of separate residence; or in public roads; or entering his/her place of employment; or through the media or in any other manner. (f) To carry out or arrange for getting carried out, necessary and relevant action for the protection and welfare of the aggrieved person. On the basis of preliminary investigation upon the complaint, if the Court has reason to believe that as per sub-section (1), the minor children of the aggrieved person or any other person dependant on him, require protection, the Court shall issue, from within sub-section (1), any appropriate order.	

Appendix J Interview Guide for Paper Four: Understanding of and Support for Childhood Exposure to Domestic Violence and Abuse in Nepal: Policymaker and Professional Perspectives

Research Question: What barriers and facilitators exist when implementing public health interventions for children exposed to domestic violence in Nepal?

This question has been broken down into four areas:

1. Your role and organisation, and how this links to domestic violence services
2. The priorities of your organisation in the area of domestic violence
3. The current context, provision and support for victims of domestic violence within Nepal
4. Suggestions for improvement of policies and interventions.

Considering these questions, the following interview script for semi-structured interviews has been developed. The topics and questions below should be used to guide the interview, but can be adapted as necessary. Keep in mind when conducting the interview to respond to the answers provided by the respondent by asking additional questions to those proposed below or adapting to more appropriate questions. Suggested probes are listed below each question, but add your own probes as needed to ensure that the information provided is clear and to get more detail on topics mentioned that may be of interest to the study.

The questions below should stimulate a natural flow of conversation, and therefore, the order of the questions can be altered, although you should go through each section in turn. Use the probe questions provided if that issue has not been spontaneously mentioned by the participant.

Interview Script

- Thank the participant for their time.
- Introduce interviewer and translator and confirm informed consent form has been signed and returned. The participant should be provided the opportunity to ask any questions. Something along the lines of:

“Thank you very much for taking the time to talk to us today, I’m Rebecca and I am from the University of Southampton, and this is [name of Research Associate] from CREHPA [who will be translating for us]. We are currently undertaking a study researching children’s exposure to domestic violence. We were wondering if before we begin, if you had any questions for us, or anything you would like to clarify?”

- Explain the interview will take approximately 40 minutes and will cover four main areas: Your role and organisation, and how this links to domestic violence services; the priorities of your organisation in the area of domestic violence; the current context, provision and support for victims of domestic violence within Nepal; and suggestions for improvement of policies and interventions.
- Ensure you are in a private environment, if face-to-face ensure you cannot be overheard, if online ask if the participant is in a quiet space where they speak freely will not be disturbed.
- Start recording the interview if participant has consented to being recorded.
- Say that they can stop the interview and withdraw from the study at any time without any penalty.

Section 1 Preliminary Information (to be completed by interviewer)	
1. Name of the interviewee:	5. Name of workplace:
2. Contact information (only if they wish to be contacted again) Phone number: Email address:	6. Type of workplace (e.g., government, NGO):
3. Date of Interview: Start time: End time:	7. Position within organisation:
4. Consent Obtained: If yes continue ☐ If no, stop interview immediately ☐	8. Place of Interview:

Section 2: Interview Script			
Theme	Main questions		Probing questions
Interviewee Profile/Context	1	To know you better, could you please tell us about yourself, and your role within?	How long have you worked there? How does your organisation relate to domestic violence services? In your role, to what extent do you interact (e.g., speak to) victims and survivors of domestic violence? † Where does this take place? At their home? On the phone? How often?
	2	Which areas/roles of domestic violence do you work, or have you previously worked in?	Either the type of organisation - government role, research role, NGO etc Or type of work: Developing policies, programmes, research. Area of domestic violence?

† Not asked to respondents from INGOs

Part 2

Their understanding of domestic violence and the priorities of their workplace	3	a. Please could you describe the current context, situation and prevalence of domestic violence in Nepal? b. Within Nepal, what are the urgent priorities in terms of policies, programmes, or interventions for domestic violence?	And within the definitions of domestic violence, who is usually considered to be the perpetrator and victim? For example, helping victims directly, children?

Appendix J

		c. In your knowledge, what are the ongoing public health interventions or programmes for domestic violence within Nepal?	Do you think that enough is being done?
	4	Within your role/organisation, what specific projects, campaigns, policies, programmes, or initiatives do you engage in related to domestic violence?	Can you tell me any about particular programmes/ policies/strategies in place? Any ongoing projects, initiatives or campaigns related to domestic violence and their intended outcomes?
	5	How does the work that you do feed into or inform wider policies, programmes, or interventions within Nepal? ††	
	6	Within your role/organisation, please could you tell me about any collaborations or partnerships that you have with other organisations or government agencies that are involved with your work in addressing domestic violence?	Who/what are they?

†† not asked to those from government organisations

Children's Exposure to Domestic Violence	7	In your opinion, what is your understanding of the phrase "children's exposure to domestic violence"?	
		For the purpose of this study, we are using the following definition: <i>If a child has seen or overheard violence between adults in their home – whether it be physical, sexual or psychological.</i>	<i>Examples of behaviours are if a child has seen or heard an adult hit, punch or kick another adult in</i>

Appendix J

			<i>their home, or seen an adult's finances or daily activities be controlled by another adult.</i>
	8	a. Considering this definition, how do you believe children are affected, or harmed, by being in a home where there is domestic violence between adults? b. What about outside of your work? Do you think that children are generally perceived by society to be affected by domestic violence between adults?	How are these children identified?

Part 3

Current Context/Provision and Support	9	Within your current role, to what extent are children considered to be a priority when developing policies, programmes or interventions for domestic violence?	Or is the focus more on the direct victim, e.g., the child's mother or father?
	10	a. And for children who have been exposed to domestic violence, what types of services are currently available should they need support? b. What do you think are the major challenges and barriers faced by children exposed to domestic violence when seeking help?	

Appendix J

	11	Who do you think is responsible for providing support to children exposed to domestic violence?	
	12	a. Within your role (<i>or organisation if senior/director</i>), how do you support children exposed to domestic violence? <i>If they do not directly support children:</i> b. How does the work of your organisation (<i>or department if government</i>) contribute to ensuring that children exposed to domestic violence can access to these services?	For example, information, education or resources. What training did your organisation offer you as a staff member to deal with children exposed to domestic violence? For example, co-ordinating access to services, or referring children affected?
	13	Which other institutions or organisations are you aware of that work with children exposed to domestic violence?	Can you name the institution and describe what they do? Do they specifically provide support to children exposed to domestic violence, or do they help children generally?
	14	a. In your experience, what is the level of collaboration and communication between groups that work with children exposed to domestic violence? b. How important is collaboration with governmental agencies, NGOs, and other actors in addressing children's exposure to domestic violence?	Do you share experiences and findings with one another so that best practice can be incorporated across groups?

Appendix J

	15	a. Is there a concentration of work/services in this area in certain parts of the country? b. Are there any gaps in the current provision of support and services for victims? c. If yes, how do you think that these children can be reached so that they can also access support?	For example, do services cover both urban and rural areas? Are they centralised and concentrated around Kathmandu Valley?
	16	Based on your experience, what are the gaps or limitations in the current government policies addressing children's exposure to domestic violence?	At each level of government? Local, province or federal level?
	17	a. In your opinion, would the most effective intervention for children exposed to domestic violence be at the individual, family, community or society level? b. Based on your experiences and expertise, or using knowledge of any successful strategies or initiatives, either within Nepal or globally, can you think of any interventions/policies which could be adapted, replicated, or scaled up to better support children exposed to domestic violence within Nepal?	Examples: - Individual level: psychosocial counselling/therapy - Family: family approach - Community: community/school support groups or interventions - Society: policy or school curriculum changes Do you think it would be possible to adapt these within Nepal, and what would be needed to do this?

Part 4 – final part of the interview, suggestions for improvement

Suggestions for Improvement of Policies/ Interventions/ Recommendations	18	a. In your opinion, what could organisations like yours do better, to better support children exposed to domestic violence? b. What would you need to do this?	Any suggestions or improvements?
	19	How do you think that the government could better support children exposed to domestic violence at each level, so local, provincial and federal??	Should children's exposure to domestic violence be a priority?
	20	What about other agencies such as NGOs/INGOs/multilateral organisations? Do you have any suggestions for how they could improve their provision of services or support for children exposed to domestic violence?	
	21	What changes would you recommend to enhance the effectiveness of policies, programmes, interventions, or access to support for children exposed to domestic violence?	What one thing do you think would improve these which could help children exposed to domestic violence? Examples: legislation? Actions taken by care workers? Police?
	22	What would help facilitate these changes?	
	23	What barriers may you face which prevent this from happening within Nepal?	
	24	<i>Earlier on we spoke about the importance of collaboration amongst stakeholders in addressing children's exposure to domestic violence.</i>	How could this happen?

Appendix J

		What strategies do you believe would lead to better coordination among stakeholders for improved outcomes for children?	
Closing	25	Thank you, that is all of the set questions that I have for today. Is there anything else that you would like to mention or talk about that we haven't covered?	
Snowball	26	Is there anyone else that you think we should be talking to about this topic? Anyone you would recommend?	

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