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Caregiver parenting and gender attitudes: Associations with violence against adolescent girls in South Kivu, Democratic Republic of Congo

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ABSTRACT

Violence against adolescent girls occurs at alarmingly high rates in conflict-affected settings, in part due to their increased vulnerability from their age and gender. However, humanitarian programming efforts have historically focused either on child abuse prevention or intimate partner violence prevention and have not fully addressed the specific needs of adolescent girls, including engagement of caregivers to reduce risk of violence against adolescent girls. Thus, the objectives of this analysis are to examine the whether gendered and parental attitudes of caregivers in South Kivu, Democratic Republic of Congo (DRC) were associated with their adolescent girls' experiences of violence and girls' attitudes towards IPV. Cross-sectional data from 869 girls (10–14 years) and their caregivers (n = 764) were drawn from a baseline assessment of a violence prevention evaluation conducted in 2015. Findings suggest that female caregiver's gender equitable attitudes for adults may be associated with reduced odds of sexual abuse and less acceptance of IPV for adolescent girl children. Parenting attitudes and beliefs and gender equity for girl children were not associated with violence risk for girls, while increased accepting attitudes of negative discipline were only associated with lowered odds of sexual abuse. Understanding of caregivers' attitudes may provide potential insight into how to more effectively engage and develop programming for caregivers to promote the safety and well-being of adolescent girls.

1. Introduction

Adolescent girls, typically defined as girls aged 10–19 years, represent a unique population whose needs and vulnerabilities towards violence are compounded by their age and gender. These vulnerabilities straddle child abuse and violence against women as girls move from childhood to adulthood (Guedes, Bott, Garcia-Moreno, & Colombini, 2016; UNICEF, 2014). Violence against adolescent girls encompasses sexual violence, intimate partner violence (IPV), forced marriage, and corporal punishment, among other forms, and is the second leading global cause of death among adolescent girls (UNICEF, 2014). Perpetrators of such violence are

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most often those closest to girls, such as their caregivers or intimate partners (Stark et al., in press; UNICEF, 2014). Violence against adolescent girls may result in many similar negative outcomes found in IPV research among adult women, including increased risk of poor sexual and reproductive health, mental health, or physical health outcomes (Campbell, 2002; World Health Organization, London School of Hygiene and Tropical Medicine, & South African Medical Research Council, 2013).

Within conflict-affected communities (i.e. communities where at least two armed groups have fought), recent analyses have found that over 60% of adolescent girls have reported experiencing physical, sexual, or emotional violence and approximately 20% of girls are married (Starket al., in press). Girls in these environments may face vulnerabilities above and beyond those experienced in stable settings due to displacement, family separation, disruptions of education, and weakened protection systems (van der Gaag, 2013). Further, humanitarian crises, such as disasters, civil war, and forced displacement, occur in the context of pre-existing gender beliefs and norms and instability, fractured social support networks, etc. may increase risk of violence against women and girls (Annan & Brier, 2010) In fact, research suggests that nations characterized by high levels of gender equality employ less state-level violence during crises and that increasing gender equality can mitigate a tendency towards violence (Caprioli & Boyer, 2001). On an individual level, women are more at risk of experiencing violence in societies which characterize males as dominant and restrict females to limited roles (Heise & Garcia-Moreno, 2002). Adolescent girls, particularly younger adolescent girls, are uniquely at risk in these societies due to their position as being both in a vulnerable stage in life and female.

Further amplifying risk of violence in conflict-affected settings is that adolescent girls' unique needs, such as equal access to education as well as targeted sexual and reproductive health services, have been largely neglected in the humanitarian community (van der Gaag, 2013). Typical programming has centered on child protection strategies such as safe spaces without tailored gender components (Ager, Metzler, Vojta, & Savage, 2013) or parenting programs for young children (e.g., 3–7 years) to reduce child abuse and harsh discipline (Sim, Annan, Puffer, Salhi, & Betancourt, 2014; Sim, Puffer et al., 2014). On the other hand, IPV prevention efforts in protracted emergencies have focused more so on the needs of adult women (Gupta et al., 2013; Hossain et al., 2014). Historically, programming for adolescent girls has not been specialized and thus has failed to recognize that girls may concurrently experience abuse by both caregivers and intimate partners. In addition, only recently has there been increased attention for service providers to meet the sexual and reproductive health needs of adolescent girls as they transition to adulthood (Robles, Katz, & Rastogi, 2014; United Nations Population Fund and Save the Children, 2009).

In support of the points highlighted above, a recent systematic review found no rigorously evaluated studies of programs focused on reducing violence against adolescent girls in humanitarian contexts (Noble, Ward, French, & Falb, 2017). Despite this weak evidence base, there is growing interest in programming to protect and empower adolescent girls such as life skills trainings or engagement of caregivers. Caregivers are key actors in adolescent girls' social networks and may influence girls' propensity for experiencing violence through multiple mechanisms, such as the provision, or lack thereof, of instrumental, emotional, or informational social support or by limiting or promoting girls' mobility and social engagement (Berkman, Glass, Brissette, & Seeman, 2000). The gendered attitudes of caregivers may also frame girls' attitudes and norms around their own value and acceptability of violence as a form of social influence (Berkman et al., 2000). Additionally, experiences of harsh discipline in childhood have been linked to the acceptance of violence in adult intimate relationships suggesting that negative parenting practices may increase future vulnerability (Ponce, Williams, & Allen, 2004). Thus, a burgeoning strategy within programmatic work is to engage caregivers to better support and meet the needs of their adolescent girls by addressing both parenting behaviors as well as promote equitable gender norms among caregivers (Noble et al., 2017).

In conflict-affected settings where gendered hierarchies keep females in disenfranchised positions, adolescent girls are even more at risk of experiencing violence. Social network theory, which proposes that an individual is influenced by their relationships, can be employed to underscore an implicit hypothesis that caregivers' systematic devaluation of girl children may increase girls' vulnerability to violence inside and outside of the home. However, this association of caregivers' gender attitudes and parenting attitudes has not been well explored in relation to violence outcomes for girls in a conflict-affected setting.

Thus, the objectives of this analysis are to examine the association of gendered and parental attitudes of caregivers in South Kivu, Democratic Republic of Congo (DRC) with their early adolescent girls' (aged 10–14 years) experiences of violence and girls' attitudes towards IPV. Specific hypotheses that were tested were the following:

H1. Positive parenting attitudes, operationalized as acceptance of their children and rejection of negative discipline, would be associated with less vulnerability to violence inside and outside of the home.

H2. Caregivers' inequitable gender norms would be associated with more girls' vulnerability to violence inside and outside of the home.

Findings may inform what types of caregiving programming components may have the highest potential to reduce violence against younger adolescent girls in eastern DRC and the broader humanitarian community.

2. Methods

2.1. Study setting

In eastern DRC, specifically South Kivu province, populations have been affected by vacillating levels of armed conflict and displacement for nearly two decades. Communities consist of a variety of ethnic groups, though most individuals are either Catholic or Protestant. This research was conducted in both rural and peri-urban settings where the population largely consists of internally

displaced persons. Previous studies estimate staggering levels of violence against women in DRC, (Peterman, Palermo, & Bredenkamp, 2011) with approximately 40% of women reporting sexual violence (Johnson et al., 2010). While there are strong networks of community-based organizations and numerous international organizations working to address violence against women and children in this setting, specific programming and specialized services for adolescent girls has been lacking. Fourteen communities across South Kivu in eastern DRC are included in the study.

2.2. Study design

This secondary analysis uses data drawn from a baseline assessment of an ongoing cluster randomized controlled trial, "Creating Opportunities through Mentorship, Parental involvement, And Safe Spaces (COMPASS)" that was conducted in 2015. The overall objective of the trial in DRC is to understand the incremental effectiveness of adding a caregiver component to the overall COMPASS programming, which includes life skills and safe spaces activities for girls, as well as general community mobilization and service provider trainings. The evaluation is led by Columbia University in partnership with the implementing organization, the International Rescue Committee (IRC). The full study protocol and further details are found elsewhere (Falb et al., 2016).

IRC program staff introduced the program to the communities and interested girls age 10–14 and their caregivers were encouraged to register. A total of 869 girls and 764 caregivers (96.97% response rate) participated in the baseline survey. Caregivers with more than one girl participating in the program were requested to consider their eldest daughter as they answered survey questions. Computer-assisted personal interviews were administered by trained female enumerators for caregivers and for the non-sensitive portion of the girls' surveys in Mashi or Swahili.

All caregivers provided written informed consent for their participation as well as for their girl children's participation, while girls provided informed assent. Ethical approval was provided by the Columbia University School of Public Health and the Ministry of Health, Gender, Family and Humanitarian Affairs for South Kivu Province.

2.3. Measures

2.3.1. Outcomes

Outcomes of the present analysis include past-year sexual violence, physical violence, emotional violence, and girls' attitudes towards IPV, which were obtained through adolescent participants' self-report. Past-year sexual violence for girls includes unwanted sexual touching and/or sexual coercion in the last 12 months. Items were adapted from the CDC Violence Against Children Survey (Center for Disease Control, 2014). Physical violence was defined as being hit or beaten in the last 12 months. Emotional violence was operationalized as being screamed at loudly or aggressively in the last 12 months; both violence measures were derived from the ISPCAN Child Abuse Screening Tools (Zolotor et al., 2009). Attitudes towards IPV was a composite of questions adapted from the UNICEF Multiple Cluster Indicator Survey, and coded as accepting of violence if adolescents agreed to all 5 statements about acceptability of wife-beating in scenarios such as burning food, refusing sex, not caring for children in a 'proper' way, and leaving without telling the husband.

2.3.2. Independent variables

Parents' feelings towards their children were assessed through the 24-item Parental Acceptance-Rejection Questionnaire (PARQ), which calculates continuous scores using a 4-point Likert scale (Rohner & Khaleque, 2005). The range for this scale is 24–96, where higher scores indicate higher rejection of children. Example statements include, "I say nice things about my child" and "I see my child as a big nuisance". Cronbach's alpha for the total PARQ scale was 0.70, suggesting it performed reasonably well in this context.

Caregivers' attitudes towards gender norms were assessed through two piloted subscales for a total of ten items assessing gender norms. The first subscale uses 8 items out of 10 items from the Gender Norms Attitudes (GNA) Scale's Rights and Privileges of Men (Cronbach's alpha of 0.82, indicating high reliability) and the second uses 2 items out of 4 items from the Equity for Girls subscales (Cronbach's alpha of 0.53, indicating moderate reliability) (Nanda, 2011). Example statements include, "It is important that sons have more education than daughters" and "A good woman never questions her husband's opinions, even if she is not sure she agrees with them." The possible minimum range for the score is 1, which indicates gender inequitable attitudes, and maximum is 2, which indicates gender equitable attitudes. Scores for the subscales were averaged yielding a final range between 1 and 2.

Eleven binary (yes/no) questions assessed caregiver's attitudes towards acceptance of negative discipline techniques, such as "They [caregivers] are right to beat them [children] if the child is disobedient. Affirmative responses were coded as '1' and were summed for a total range of 0–11 whereas higher scores indicate more accepting attitudes of negative discipline (Ruis-Caseres, 2011).

Demographics included continuous measures of girls' age and highest grade completed and caregiver age.

2.4. Analysis

Using simple logistic regression and mixed-effects logistic regression models, we assessed relationships between girls' socio-demographic characteristics and their caregiver's attitudes and odds of reporting violence outcomes and girls' attitudes towards IPV. To account for non-independence of siblings included in the study, family unit was included as a second-level factor, and both simple and adjusted mixed-effects regression analyses allowed for variability in reports of outcomes that were related to inclusion of siblings with the same caregiver. Simple logistic regression identified variables that may have associations with the outcomes. Relationships with significance for at least one outcome at $\alpha = 0.05$ were placed into an adjusted model, which was run for each outcome of

Table 1
Overall frequencies of outcomes by girl and caregiver characteristics.

	Overall	Any Past-Year Physical Violence	Any Past-Year Emotional Violence	Any Past-Year Sexual Abuse past 12 months	Girls' Attitudes Towards IPV
	% (n)	% (n)	% (n)	% (n)	% (n)
Overall	100% (869)	42.3% (340/804)	43.8% (346/790)	22.2% (166/747)	14.6% (127/869)
Girl Variables	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Age	12.03 (1.50)	11.89 (1.42)	11.86 (1.50)	11.66 (1.47)	12.26 (1.47)
Highest Grade Completed	3.40 (2.06)	3.10 (1.88)	3.11 (1.90)	2.88 (1.82)	3.05 (1.98)
Caregiver Variables	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)
Age	38.12 (10.15)	38.35 (11.00)	38.00 (10.74)	37.02 (10.02)	38.96 (10.99)
Gender Attitudes:					
Men's Rights Scale	1.39 (0.32)	1.35 (0.31)	1.38 (0.31)	1.34 (0.30)	1.33 (0.30)
Equity for Girls	1.94 (0.20)	1.94 (0.20)	1.94 (0.19)	1.93 (0.20)	1.93 (0.21)
Parental Acceptance of Children	45.50 (8.12)	46.08 (7.89)	45.78 (7.96)	45.47 (7.66)	46.70 (7.58)
Attitudes on Acceptance of Negative Discipline Techniques	8.07 (2.80)	8.13 (2.89)	8.06 (2.88)	7.81 (3.24)	8.43 (2.75)

interest. Adjusted models enabled us to examine the relative strength of hypothesized associations and outcomes when all other variables of interest were included. However, caregiver age was excluded from analyses given lack of association with outcomes. Missing data were excluded using listwise deletion in adjusted models. 92.02% of the baseline sample of caregivers who participated in the survey were females. Given that the relationship differences between fathers and girls versus mothers and girls would need further investigation to understand and that there was not enough statistical power to do a stratified analysis, the analysis was restricted to women to aid in interpretation of results. All analyses were completed using STATA 13.1.

3. Results

3.1. Demographics and frequency of outcomes

On average, girls were 12.03 years old (sd 1.50) and had completed 3.40 years of school (sd 2.06) (Table 1). Average caregiver age was 38.12 years (sd 10.15).

Approximately 60% of girls reported exposure to at least one form of past-year physical, sexual, or emotional violence. Overall, 42.3%, 43.8%, and 22.2% of girls aged reported any physical violence, emotional violence, or sexual abuse, respectively. All forms of violence were most commonly perpetrated by partners or caregivers. Approximately 15% of girls agreed that IPV was acceptable in all circumstances.

Caregiver beliefs in gender norms attitudes were mixed: they both generally believed in the rights of men over women, but also believed in more equity for girls. On average, caregivers agreed that it was acceptable to beat children for 73% of the examples presented (mean = 8.07 out of 11 items). The overall parental acceptance of children was 45.50 (sd 8.12), indicating relatively higher acceptance than rejection of children.

3.2. Unadjusted models

In unadjusted models, age and educational attainment for girls were significantly associated with experiencing most violence outcomes such that younger girls and girls with fewer years of schooling demonstrated increased odds of reporting violence (Table 2). These demographics were not significantly related to early marriage or girls' attitudes towards IPV in unadjusted models.

Caregivers' who held more gender equitable attitudes regarding men's rights over women tended to have girls who were 53% less likely to report experiencing of any form of sexual abuse (95%CI: 0.26–0.86; p = 0.01) and have girls who themselves were less likely to accept IPV (OR: 0.46; 95%CI: 0.23-0.91; p = 0.03). Caregivers' agreement with equity for girls, acceptance of children, and attitudes towards discipline were not significantly related to any violence or girls' attitudes outcomes.

3.3. Adjusted models

Adjusted models (Table 3) include adjustment for girls' age, educational attainment, as well as all four caregiver variables to determine their differential associations with each girl outcome.

When adjusting for these covariates, caregiver's gender equitable attitudes were associated with 72% fewer reports of sexual abuse among girls (95%CI: 0.13–0.64; p = 0.002) and 65% less likelihood in girls' accepting all instances of IPV (95%CI: 0.16–0.90; p = 0.03). Greater acceptance of negative discipline techniques among caregivers was also associated with a reduction in reported sexual abuse (aOR: 0.90; 95%CI: 0.83–0.99; p = 0.03). Caregivers' agreement with equity for girls and PARQ scores were not statistically associated with any of the girls' outcomes. Girls' educational attainment was associated with lowered odds of emotional

Table 2
Unadjusted associations of demographics and caregiver characteristics with girls' outcomes.

	Any Physical Violence OR (95% CI)	Any Emotional Violence OR (95% CI)	Any Sexual Abuse for Girls OR (95% CI)	Girls' Attitudes Towards IPV OR (95% CI)
Age	0.88 (0.80–0.97)**	0.87 (0.79–0.95)**	0.77 (0.69–0.87)***	1.13 (0.99–1.28)
Highest Grade Completed	0.88 (0.81–0.97)**	0.88 (0.82–0.96)**	0.81 (0.72–0.90)***	0.90 (0.80–1.01)
Caregiver				
Gender Norms: Men's Rights	0.68 (0.43–1.10)	0.96 (0.60–1.55)	0.47 (0.26–0.86)**	0.46 (0.23–0.91)*
Gender Norms: Equity for Girls	0.96 (0.44–2.08)	1.24 (0.55–2.74)	1.09 (0.43–2.77)	0.82 (0.30–2.25)
Parental Acceptance of Children	1.01 (0.99–1.03)	1.01 (0.99–1.03)	1.00 (0.98–1.03)	1.02 (0.99–1.05)
Attitudes on Acceptance of Negative Discipline Techniques	1.00 (0.95–1.05)	0.98 (0.93–1.03)	0.95 (0.90–1.02)	1.06 (0.98–1.14)

Exponentiated coefficients; Standard errors in parentheses.
* $p < 0.0$.
** $p < 0.01$.
*** $p < 0.001$.

abuse among girls. Conversely, girls' age was no longer associated with violence outcomes once the additional covariates were included in the model.

4. Discussion

This analyses sought to determine whether positive parenting attitudes and caregivers' inequitable gender norms would be associated with more or less vulnerability to violence for early adolescent girls inside and outside the home. Findings suggest that caregiver's gender equitable attitudes for adults emerged as one of the only factors associated with less risk of violence for adolescent girls, above and beyond attitudes and beliefs surrounding parenting. This was particularly true for girls' experiences of sexual violence and attitudes towards IPV, but not for physical or emotional violence. Although causality cannot be inferred given the cross-sectional nature of the data, as only females were included in the analysis, multiple insights emerge from this finding. First, adult women's experiences of IPV may be correlated with their own gender inequitable attitudes (Khawaja, Linos, & El-Roueiheb, 2008). As violence against women and violence against children are likely to co-occur in a home (Guedes et al., 2016; Guedes & Mikton, 2013), these attitudes may serve as a risk marker for violence against adolescent girls. Further, caregiver gender inequitable attitudes may also serve as a risk factor for such violence as previous research has found that accepting attitudes towards wife beating and corporal punishment among mothers was also associated with increased risk of abuse of children (Lansford, Deater-Deckard, Bornstein, Putnick, & Bradley, 2014).

Second, programs that seek to reduce IPV and improve gender equitable attitudes among adults may have trickle down effects that may also improve the equitable attitudes among adolescent girls and promote girls' safety as well. Recent efforts have

Table 3
Adjusted associations of demographics and caregiver characteristics with girls' outcomes.

	Any Physical Violence aOR (95% CI)	Any Emotional Violence aOR (95% CI)	Any Sexual Abuse for Girls age 10–14[b] aOR (95% CI)	Girls' Attitudes Towards IPV aOR (95% CI)
Age	0.95 (0.81–1.10)	0.91 (0.77–1.07)	0.90 (0.76–1.06)	1.21 (0.98–1.50)
Highest Grade Completed	0.90 (0.79–1.01)	0.86* (0.74–0.99)	0.87 (0.76–1.00)	0.88 (0.75–1.05)
Caregiver				
Gender Norms: Men's Rights	0.73 (0.36–1.46)	1.13 (0.54–2.34)	0.28** (0.13–0.63)	0.35* (0.12–0.98)
Gender Norms: Equity for Girls	1.05 (0.29–3.77)	1.01 (0.26–3.92)	0.71 (0.18–2.72)	0.47 (0.09–2.35)
Parental Acceptance of Children	1.02 (0.99–1.05)	1.01 (0.98–1.04)	1.00 (0.97–1.03)	1.02 (0.98–1.06)
Attitudes on Acceptance of Negative Discipline Techniques	0.96 (0.89–1.04)	0.93 (0.85–1.02)	0.90* (0.83–0.98)	0.98 (0.88–1.09)

Exponentiated coefficients; Standard errors in parentheses; Adjusted for all variables in the column.
* $p < 0.05$.
** $p < 0.01$.

demonstrated promising bidirectional generational impacts of violence prevention programming, such that parenting programs may have secondary impacts on improving spousal relationships, or conversely, IPV prevention programs among parents may reduce children's exposure to violence (Bacchus et al., 2017; Kyegombe et al., 2015; Sim, Annan et al., 2014; Sim, Puffer et al., 2014). Indeed, measuring both outcomes is important as we are unable to determine any causality in this cross-sectional dataset. Continued investments and measurement of the impacts of child abuse prevention or parenting skills programming on IPV and IPV prevention programming on child well-being are needed to understand the full impacts of these efforts on reducing family violence. As such, evaluations of IPV programming should assess secondary impacts on preventing violence against adolescent girls in the home.

Perhaps surprisingly, caregiver acceptance of children, as measured via the PARQ, and attitudes toward discipline and girls' equity, was not robustly associated with outcomes for girls. Given the anticipated importance of caregivers in adolescent girls' social networks for girls' wellbeing, findings suggest a need to re-examine these relationships and potential pathways of influence. For example, female caregivers may not be the primary decision-maker in households for social engagement of girl children. It may be that, because of this, female caregivers do not exert enough influence on girls' school attendance or interactions with other peer groups in their communities, which would otherwise serve as potential protective factors against violence. Consistent with other studies, qualitative evidence from this study also suggests a lack of communication about violence, relationships, or sexual health topics between caregivers and girls (Bastien, Kajula, & Muhwezi, 2011; Sommer et al., in press); thus, caregivers may also not be equipped to offer different forms of educational and social support for adolescent girls, particularly around these crucial topics. Finally, perpetrators of violence against adolescent girls are likely to be intimate partners or caregivers (Stark et al., in press). It may be that the latter category of perpetrators is comprised of male caregivers; thus, female caregivers' parenting beliefs and attitudes are less likely to impact girls' experiences of violence. Interestingly, in the adjusted models, increased acceptance of harsh discipline was associated with reduced risk of sexual abuse. There is a need for further specificity of the pathways between caregiver attitudes to each unique form of violence that girls may experience. Additionally, further research is needed in conflict-affected communities to understand more fully the relationships between caregivers and adolescent girls, which may be particularly complex for families that may have become separated or experienced unstable housing due to displacement.

Findings must also be interpreted with limitations in mind. Given the sensitive nature of the study, outcomes may be underreported. In addition, our measures of physical and emotional violence were single items which may not represent the full range of experiences of these forms of violence. Other factors that may provide additional insight were not included in the survey, including any potential separation between adolescent girls and their caregivers, which may be a particularly salient concern in a conflict-affected setting. Measurement of female caregivers' experiences of IPV would also help add to contextual findings in future studies. Finally, causality cannot be determined given the cross-sectional nature of the survey.

Despite these limitations, this analysis represents a step towards increased understanding of caregivers' attitudes and provides potential insights into how to more effectively engage and develop programming for caregivers and their adolescent girls at the family level. For instance, targeted engagement of male caregivers may be needed within programming, as well as additional research to understand how these associations may change when examining associations between violence against adolescent girls and male caregiver parenting and gender attitudes (Panter-Brick et al., 2014). Additional work is needed to improve the status and leverage the roles of adult females in influencing the lives of adolescent girls in their care, given the somewhat weak associations found in the current analysis. Further research must also be undertaken to understand how community and structural factors increase or decrease the safety of adolescent girls in humanitarian settings. These factors may be more robust predictors of violence above and beyond the family level and may continue to interact with adolescents' development during this critical period (Patton et al., 2016). Such factors related to the humanitarian context include forced displacement or broader experiences of violence among the family members (Murphy, Rodrigues, Costigan, & Annan, 2017). Investments to promote the health and wellbeing of adolescents are urgently needed as experiences during this time period may continue to shape trajectories of wellbeing throughout adulthood and for future generations in humanitarian settings (Noble et al., 2017).

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