An overview of child sexual abuse research conducted in low- and middle-income countries between 2011-2021

MAY 2022
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Acknowledgements

This report is part of a project on strengthening and clarifying SVRI’s work on violence against children and child sexual abuse that has been made possible by the generous support of the Oak Foundation.

Thank you to Ayesha Mago for her inputs into this review.

Authors
Nicole Gonzalez, Anik Gevers, and Elizabeth Dartnall.

Citation

Abbreviations

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<th>Abbreviation</th>
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<tr>
<td>CSA</td>
<td>Child Sexual Abuse</td>
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<td>LMIC</td>
<td>Low and Middle Income Country</td>
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<td>SVRI</td>
<td>Sexual Violence Research Initiative</td>
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<td>VAC</td>
<td>Violence Against Children</td>
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<td>VAW</td>
<td>Violence Against Women</td>
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Executive Summary

To strengthen our understanding of what kinds of child sexual abuse research is coming from low and middle income countries we conducted a brief scoping review of studies published over the past 10 years.

One hundred and ninety four studies were included in this review based on a search of the MEDLINE (PubMed) database. The majority of articles were epidemiological studies (n=146) and the remaining articles included intervention studies, methodology and ethics work, and theory and frameworks articles. Most publications were based on research conducted in the Sub-Saharan Africa region (n=98) and the fewest publications were from the East Asia and Pacific region.

The review revealed that there is no cohesive body of evidence and that there seems little connection between, for example, epidemiological research and intervention research. Further, very little of the epidemiological research focused on identifying the risk and protective factors for child sexual abuse including the drivers of perpetration and more analysis of the norms, systems, and social structures that impact and influence child sexual abuse. The review found several methodological gaps in the evidence base as studies utilized different definitions of child sexual abuse, a variety of measurements for child sexual abuse, and at times grounding in ethics was not clear. Few studies were intersectional (n=25).

More priority-driven child sexual abuse research is needed from low and middle income countries with clear links to policy and practice. A clear, shared research agenda is needed to guide the field toward building a cohesive evidence base as well as capacity strengthening to address methodological and ethics issues of this research. This research should be intersectional in order to build a nuanced understanding of child sexual abuse across diverse and particularly marginalised or vulnerabilised groups. There is evidence on the mental health impact of child sexual abuse but few studies evaluated interventions that addressed these outcomes among survivors. Research that will improve our understanding of the drivers, risk factors, and protective factors for different forms of child sexual abuse – including perpetration of this violence – is needed to inform prevention intervention strategies.
I. Background

The child sexual abuse (CSA) evidence base is dominated by research from high income countries (HICs) [1]. One of SVRI’s priorities is to strengthen research in low- and middle-income countries (LMICs). Therefore, to strengthen our understanding of what kinds of CSA research is coming from LMICs we conducted a scoping review of literature published over the past 10 years.

II. Methodology

Search strategy and study selection

The search terms included keywords for child sexual abuse, LMIC names, and language parameters (abstracts in English, Spanish, French, or Arabic were included). Keywords were combined into a phrase including Boolean (AND, OR) terms as illustrated in Appendix I.

Criteria for inclusion and exclusion

The following inclusion and exclusion criteria were used to screen search results and select studies for the review.

Inclusion criteria:

- Articles published in English, French, Spanish, Arabic
- Articles published between January 2011- January 2021 (in the last 10 years)
- Studies that included children: ages 0-18 years old (all person’s age 0 to 18 years (including infants, toddlers, young children, children, adolescents, teenagers) of all gender and sexuality identities (girls, boys, non-binary, intersex, LGBTQI+, etc.) and from any population group within a (or several) LMIC(s)
- Studies about child sexual abuse: all types of sexual abuse, sexual violence, sexual exploitation, sexual harassment, grooming
- Research conducted in LMIC(s) - utilizing World Bank Group’s criteria of LMIC(s)

Exclusion criteria:

- Articles published in languages other than English, French, Spanish, or Arabic.
- Articles published before January 2011
- Studies that do not include any form of CSA
- Studies where CSA was not disaggregated in reporting from other forms of violence
- Studies conducted in HIC(s)
- Studies where data from children were grouped together with adults who experienced sexual violence during adulthood without disaggregating the data by age (such as VAWG)
**Figure 1. Abstract Review**

Search Yielded 635 Results

**Title Screening:**
Excluded 386, Included 249

- Excluded:
  - 221 focused on populations in HIC (57%)
  - 165 were not about CSA (43%)

**Abstract Screening:**
Excluded 55, Included 194

- Excluded:
  - 33 did not disaggregate data between adults and children who experienced sexual violence (60%)
  - 18 did not disaggregate data between type of violence experienced (33%)
  - 2 included both HIC and LMICs without disaggregating data (3.5%)
  - 2 were not a study (3.5%)

**194 Articles** Included in Review
Limitations
An optimal systematic review would include a search of multiple databases including Embase, MEDLINE, Web of Science Core Collection, and Google Scholar[2]. This study was not designed to be a systematic review of the state of evidence of CSA but rather a scoping review to enable the extraction of some key trends in published CSA research from LMICs. Given the time and resources available to conduct this scoping review, only MEDLINE (PubMed) was searched for this review. The results of the review should be read with these limitations in mind.

III. Overview of Studies

194 articles were included in the scoping review. Overall, most studies (~76%) were epidemiological, focusing on understanding the nature, extent, risks or impact of CSA. Within the interventions theme, there were a similar number of response intervention studies (22) and prevention intervention studies (14). There were some methodological/ethics studies (10), and two theory/framework studies. Studies included in the methodology and ethics theme focused on improving or testing methodology regarding CSA research while studies characterized under theory/framework theme utilized new theories to study cases of CSA and/or analyzed current frameworks to prevent or respond to CSA. Table 1 summarises the number of papers according to the type of study and its region.

<table>
<thead>
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<th>Table 1: Number of Articles per Region and Theme</th>
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<td>Epidemiology</td>
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<tr>
<td>Sub-Saharan Africa</td>
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<td>Multi-regional</td>
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<td>N (%) Total</td>
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IV. Research Key Findings

A. Epidemiology Studies

Research in this theme focused on understanding the extent, nature and consequences of CSA (impact, risk and protective factors, prevalence, and incidence studies). As mentioned earlier, epidemiology focused studies were by far the largest theme. Studies in this theme were further subcategorized into the following groups:

- impact/consequences
- risk and protective factors
- prevalence and incidence.

The majority of the studies were based on impact of CSA on study participants (n=73) followed by risk and protective factor studies (n=48) which focused on participant characteristics that increased or decreased the risk of experiencing CSA.

Studies focusing on Impact and Consequence: Impact studies largely focused on consequences or impacts of CSA on study participants who experienced CSA. The majority of these studies looked at the associations between mental health and CSA, with exposure to CSA linked with higher rates of PTSD, depression and anxiety [3-30]. The relationship between CSA and risky or maladaptive behaviors among children and adults who experienced CSA was the focus of the next largest group of studies [31-49], including studies on the risk of contracting HIV in childhood or adulthood [35, 39, 40, 48, 50], developing an eating disorder [36, 38], and engaging in substance use after experiencing CSA [42-45]. Studies on the physiological impacts of CSA exposure was the third largest group [51-61]. Four of these studies looked at cortisol levels in individuals who experienced CSA [51, 55, 60, 61]. A select number of studies researched the impact on community and support systems [62-68], coping strategies [69], and pregnancy outcomes of women who experienced CSA [59]. Lastly, a few studies described specific cases, their characteristics, and their outcomes [70-75]. Two articles included involved incest as a form of CSA [43, 73].

Risk and Protective Factors Studies: Studies on risk and protective factors for CSA victimization formed the second largest sub-theme within the epidemiology theme. This subtheme referred to studies that looked at factors that increased children’s risk of experiencing CSA or at factors that protected children from experiencing CSA. Overall, more studies that focused on the risk factors rather than protective factors for CSA. Common topics found within this sub-theme included: familial and gender factors, school environments, common risk and protective factors associated with CSA victimisation, and social norms that deter reporting. Most of these studies investigated familial, gendered factors including [76-85]: lack of adequate parental care, community patriarchal attitudes, biological parental separation and remarriage, and alcohol abuse within the family. Studies on child sexual exploitation including online sexual abuse were also part of this group [86-91] as were studies which discussed the associations between the
family’s socio-economic status and CSA [88, 89, 92, 93]. A multi-country study found no association between socio-economic status and CSA; they reported that adolescents experienced CSA regardless of socio-economic status [93].

Additionally, two studies looked at lifetime prevalence of CSA [94, 95]. While both studies found that girls were more likely to experience violence throughout their lifetime, one study found that younger girls are at greater risk of experiencing sexual violence compared to older girls / young women [95]. Another study found that boys who had previously experienced CSA had a higher likelihood of experiencing CSA again [91]. In a cross-sectional study, many adolescent girls and young women reported that their first sexual experience was forced sex and that this experience was often associated with emotional violence [96]. Another study looked at children’s own feelings of self-efficacy and how this impacts their risk of experiencing CSA, the study found that children with lower feelings of self-efficacy were more at risk of experiencing CSA compared to those with higher self-efficacy [97]. Lastly, two studies looked at the potential of specific styles of caregiving as protective factors [98, 99]. In these studies, one found that positive, supervisory caregiving and food security served as protective factors [98] while the other found that there was in increase in communication about sex by youth to mothers who previously experienced CSA that could also serve as a protective factor [99]. Three studies looked at associations between CSA and early forced marriages [100-102]. One study applied environmental criminology to CSA by studying the location of victims, crime scenes, and distances among them to predict possible future offences of CSA [103]. Other studies looking at characteristics of CSA also found that the majority of cases were perpetrated by an adult male [104, 105]. Similarly, a nationally representative study looked at the characteristics of pedophiles in Turkey and found that 97.4% of perpetrators were male [106].

The second largest sub-theme within the epidemiological studies were studies investigating the risks of CSA among high risk or marginalized groups (e.g. orphaned children living in residential facilities and/or street-living children). Studies found that girl children were more likely to be orphaned [107-109] and orphaned children were at higher risk of experiencing CSA [107-111]. However, a systematic review found no statistically significant risk of experiencing CSA between children who had been orphaned compared to non-orphaned counterparts in sub-Saharan Africa. The authors note that due to inconsistent data reporting and quality, these findings should be interpreted with caution [112]. One of these studies on orphaned children included the experiences of feminised men in Pakistan [111]. The majority of these interviews described experiencing sexual abuse as a child and moving into sex work to find financial and extra-familial support [111]. Three studies focused on children with disabilities and their risk of experiencing CSA and found that children with intellectual disabilities were more at risk of experiencing penetrative abuse and more frequent abuse than children without intellectual disabilities [113-115].

Factors influencing disclosure of CSA were explored by three studies. These studies found that half of the children delayed disclosing their abuse due to fear of their caregiver’s reaction [116-118].
Only one study looked at the risk of CSA in schools [119]. This study found that the majority of CSA experienced in schools was perpetrated by an adult [119]. As for research on protective factors, studies investigated schools as a protective factor especially for girls, and found that girls who had previously experienced CSA and were not in school were most at risk of experiencing CSA [120].

Three studies investigated adolescent boys’ and girls’ knowledge, attitudes and risk behaviour related to CSA. One study found that adolescent girls reported higher levels of forced sex than adolescent boys and that related risk behaviours were also high; the authors suggested that interventions within the school system should be strengthened to address these issue [121]. Another study found that adolescent boys reported more positive views about forced sex than girls associating it with a variety of constructs including signs of love, a way to satisfy sexual desires, an expectation if a female partner is financially dependent on a male partner, and as a way to punish a female partner [122]. These boys also had less knowledge on the consequences of forced sex. One study looked at sex trafficking knowledge and attitudes among adolescent girls and found that while most were aware of sex trafficking from media sources (e.g.: radio, television), not all understood the various risk factors associated with sex trafficking [123].

**Prevalence and incidence of CSA:** The third largest subtheme of epidemiology studies focused on prevalence of CSA (n=26). The largest topic of interest within these studies included a comparison of the prevalence of CSA between the sexes [124-128]. Some of these studies reported that girls experienced more sexual victimization than boys [129], whereas other studies reported that boy children experienced more forced touch or were forced to touch or look at an abuser’s private parts more than girl children [128, 130]. The next largest topic among prevalence studies were multi-country studies comparing the prevalence of CSA [131-135]. While all of these studies (n=4) utilized questionnaires to measure lifetime prevalence, the definitions of CSA and tools used varied. Two of these studies use a broad definition of CSA including both contact abuse (i.e. physical contact between the child and the abuser) and exposure abuse (e.g. exposure to pornography) [131, 133]. The other two studies defined CSA solely as unwanted intercourse during childhood [134, 135] with one making a distinction between unwanted intercourse from a partner and non-partner [135]. Lastly, one of the studies defined CSA as any unwanted contact abuse [133]. One study investigated experiences of CSA across socio-economic status and found no significant association and concluded that CSA occurred across wealth groups, education status, and area of settlement (urban vs rural) [134].

There were three nationally representative studies from South Africa, Zimbabwe, and Vietnam [136-138]. All three studies used a household questionnaire for data collection and the studies in South Africa and Vietnam defined CSA as both contact abuse and exposure abuse [136, 138] while the study in Zimbabwe defined CSA as only contact abuse [137]. The studies in South Africa and Zimbabwe both asked about lifetime experience of CSA and past year CSA while the Vietnam study compared the experience of CSA over 10 years by comparing data from 2004 and 2014. The South Africa study surveyed 5,631 households and found that 9,99% of boys and
14.61% of girls reported some lifetime sexual victimization [136]. The Zimbabwe study surveyed 7,797 households and included 567 women and 589 men: 32.5% and 8.9% respectively reported experiencing CSA [137]. Lastly, the study in Vietnam concluded an increase in CSA prevalence from the year 2004 to 2014 among older adolescents [138].

Two studies looked at cases in smaller populations and recommended further studies to calculate the prevalence of CSA in their countries [139, 140]. There was one study that compared the differences in past year incidence of CSA in five countries (Cambodia, Haiti, Kenya, Malawi, and Tanzania) based on age and gender [141]. The study found that female adolescents experienced CSA at higher rates than male adolescents in every country. Risk of sexual violence increased with age for males in Kenya (OR=1.332, p<0.01) and Tanzania (OR=1.81, p<0.05). In Haiti, the odds of experiencing sexual violence increased with age similarly for males and females [141].

There were two studies that looked at incestuous cases of CSA [142, 143]. One of these studies focused on high school students and found that more than half of the incidents occurred in the home, involved penetration, and children knew their abuser [143].

The other articles within this sub-theme studied the prevalence of reporting for children who experienced CSA [144] as well as the services available to CSA victims [145]. Others studied the prevalence of CSA during armed conflict [146], compared experiences of sexual violence during trafficking (children vs older women) [147], measured the prevalence of physical and or sexual abuse among street-living children [148].

B. Intervention Studies

Intervention studies were the second largest theme accounting for approximately 18% (n=36) of studies in this review. There were slightly more response intervention studies than there were prevention intervention studies.

- **Response Interventions**

  The majority of response intervention studies analyzed the effectiveness of current or recent CSA response services and many evaluations indicated that current CSA services were inadequate. Various types of response services were the subject of research, including:

  - Mental health services [149-151]
  - Justice sector responses: law enforcement [152, 153] and legal systems [154-157]
• Health sector responses: physician education [158-160] and attitudes of medical professionals [161]
• Integration of and access to CSA services [162-166]
• Response interventions: guidelines [167, 168], recommendations [169], and methods to increase disclosure [170]

Mental health services: Studies on current mental health services found that mental health services do not satisfactorily support children’s recovery and care after CSA [149-151]. One study looked at mental health services provided to children after reporting CSA in South Africa and found that the current services are not sufficient for adequate recovery [151]. Other studies in Turkey and South Africa evaluated receiving immediate psychiatric help after report of CSA as well as therapy before trial respectively. Both found that immediate psychiatric health and pre-trial therapy were necessary for an adequate recovery after report of CSA [149, 150].

Justice sector responses: Two studies that assessed law enforcement responses to CSA reports found that they did not meet families’ needs [152, 153]. Other studies explored current laws and screening processes to identify cases of non-violent CSA (cases that are thought of as consensual but involve a child and a perpetrator over the age of 18 years) [155], protective and supportive legal injunctions for children exposed to CSA [154], and the legal criteria used to decide punishment for perpetrators of CSA [156]. Another study analyzed current government frameworks in Zimbabwe, specifically the Victim Friendly Courts, to understand the management of intrafamilial CSA cases [157].

Health sector responses: Two studies noted the need for physicians to receive additional training to adequately identify CSA [158, 159]. One of these studies, however, found that only one third of physicians were interested in receiving more training [159]. A study on medical and non-medical students’ attitudes towards survivors of sexual violence found that many (about two thirds) had negative attitudes about survivors (would not want them to supervise or marry their [students’] child or be friends with a survivor) [161]. Lastly, a study from Pakistan provided examples for practitioners to create strong doctor-patient relationships as well as tactics to encourage the CSA survivor (child) and non-offending accompanying adult caregiver to continue treatment, specifically for cases where the father is the perpetrator and the mother is financially dependent on the father. Such tactics included encouraging the inclusion of another trusted family member to bring the child to treatment when the mother is not able to or discussing the addition of a lock to the child’s bedroom door [160].

Integration of and access to CSA services: There were two interventions that integrated support for CSA survivors, preventing HIV, and connecting participants to sexual and reproductive health services [162, 163]. Additional studies categorized in this sub-theme included a comparison of care requirements for children who were raped vs children who consented to sex [164], an expression through art intervention for adolescent girls who experienced CSA where intervention value was measured [165], and a third study conducted
an analysis of families’ utilization of coping mechanisms (both internal and external) in dealing with their child’s experience of CSA [166].

**Intervention guidelines and recommendations:** Two studies provided a set of guidelines [167, 168]. The first provided suggestions for other aspects to consider when expert medical examination does not confirm CSA [168]. These examples are meant to reduce the discomfort of medical witnesses and improve quality of expert medical testimony [168]. The second provided guidelines for stakeholders working with mothers of sexually abused children [167]. Guidelines included: a social-ecological model (SEM) detailing factors that affect mothers of children who experience CSA as well as details in each level explaining the factors and what is recommended to help mothers [167]. Intervention recommendations based on a previous CSA case perpetrated by a religious leader included providing intervention after CSA as soon as possible and a longer follow-up period as psychological consequences can carry on into adulthood [169].

**CSA disclosure interventions:** Among studies that reviewed methods to increase reporting, one study tested two methods of disclosure among primary school children: the face-to-face-interview (FTFI) method and the sealed-envelope method (SEM). The study found that the SEM method was superior to FTFTIs in identifying cases of forced sex, particularly for boys [170].

- **Prevention Interventions**


**Family-based interventions:** Three family-based interventions were included in this review. These interventions focused on parents, caregivers, and mothers in preventing and responding to CSA [170-172]. One of these interventions focused on training caregivers to teach children about CSA prevention and found that children who received CSA prevention education from their parents demonstrated improved knowledge about private parts and what to do if they suspect they have experienced sexual abuse [172]. In another study, after finding out that mothers have inaccurate information about preventing CSA, a short-term training was provided to mothers which improved their knowledge and they then supported disseminating CSA prevention trainings in preschools [170].

**School-based interventions:** Five school-based interventions were included in this review. Three of these interventions worked with adolescents [175-177]. In one intervention, adolescent boys learned about healthy gender norms and adolescent girls learned empowerment, gender relations, and self-defense [175]. The intervention resulted in an increase in self-efficacy and a reduction in the rate of sexual assault among girls [175]. In another intervention primary and secondary school-aged girls were the target group and the study found effective results in reduction in sexual violence victimization [176]. An intervention
called Let Us Protect Our Future Intervention (an HIV/STD risk reduction intervention) sought to prevent perpetration and experience of forced sex among adolescents [177]. Of the other two interventions that worked with younger children, one focused on providing information to children about their body and developing self-protection skills [178]. The other focused on preventing CSA among children with mild intellectual disabilities through increasing their awareness of sexual abuse [174].

**Community-based interventions:** There is one community-based interventions included in this review. This intervention employed empowerment and self-defence to prevent sexual assault among adolescent girls. This intervention found a reduction in sexual assault rates among adolescent girls and an increase in disclosure of assaults and care seeking [179].

**Social determinants:** Four studies looked at policies to address social determinants associated with CSA such as laws and a regulatory framework, social services, improving access to schools, and securing basic needs [180, 181, 184]. One of these studies, based in Zimbabwe, found that while the country has well-established legal and regulatory frameworks to protect children from CSA, implementation of these policies is weak [180]. The study stated that the lack of financial, human, and material resources explain the lack of CSA prevention interventions and recommended implementing existing legislation, targeting school children, and getting the community involved [180]. The study also mentioned the impact of a dedicated budget but argued that benefits can still be achieved without such a budget [180]. Another study looked at anti-child trafficking strategies put in place by South and Southeast Asian governments and non-governmental organizations and whether they target all 21 social determinants of child trafficking [181]. The study found that government and NGO anti-child-trafficking strategies addressed 15 and 12 social determinants respectively and failed to address organizational level determinants [181]. The two other studies focused on low-income settings and noted the need to address underlying social and economic determinants to prevent transactional CSA including reduction of gender inequalities, accessing school, and securing basic needs [184].

The last subgroup included studies that focused on sharing implications for future prevention interventions. A South African study found that youth’s pursuits were most directed by safety issues rather than by what should be fun and healthy for this developmental period. The authors recommended that any health promotion activity first had to provide safe spaces for youth and also opportunities to critically question patriarchal norms that drove much of the violence they face [183]. The study also delved into multi-layered issues including poverty, prevalence of crime, dysfunctional education systems, and limited or absent leisure facilitators that all negatively impacted on youth’s wellbeing and risks for experiencing violence, including CSA [183]. A literature review provided guidelines for preventing CSA in the family including: defining CSA, describing types of CSA, discussing actions to take when a child experiences CSA, describing risk factors for CSA, discussing rights of children especially care and protection, describing the impact of CSA, discussing the importance of communication within the family system, discussing the importance of providing care and protection to children, and making group members aware of social work interventions in relation to CSA [182].
C. Methodology and Ethics Studies

Studies in the methodology theme included work on improving or testing various tools and approaches to measure CSA including specific questionnaires and technology to understand and predict the impact of CSA [185, 186]; testing validity and reliability of specific CSA instruments [187-189]; comparing methods to increase reporting and identify CSA [190]; and guidelines for methods to improve diagnosis of CSA among medical and legal professionals [191-193]. One study was included in as an ethical study [194].

Two studies tested tools and technology to better understand and predict the impact of CSA [185, 186]. The first study tested the reliability and validity of the “Shame Questionnaire” [185]. This study compared scores among girls who had experienced sexual abuse to scores among girls who had never experienced sexual abuse. Results were consistent with theoretical hypotheses: girls who experienced more traumatic events had higher scores. However, there was no significant difference in mean scores among girls who had experienced sexual abuse compared to girls who had not experienced sexual abuse [185]. The second study investigated machine learning to predict the development of depression and PTSD in children who had experienced CSA. Survivors’ records were examined and predictions were compared to psychiatric evaluations and concluded that predictions were accurate [186].

Three studies in this theme studied the validity and reliability of specific instruments [187, 188]. One study tested the validity and reliability of the Turkish version of the “Child Sexual Abuse Knowledge/Attitude Scale” for parents (CSAKAS) and found the scale to be a valid and reliable tool that could be used to evaluate the knowledge and attitudes of parents about CSA [188]. Another study tested the reliability and validity of the “What If Situations Test” (WIST) for Turkish culture, a test used to assess pre-schooler’s skills regarding self-protection against CSA. It was found that the Test’s adaptation to Turkish culture was reliable and valid [187]. The last study tested the adaptability, reliability, and validity of the ISPCAN child abuse screening tool-retrospective version in Sri Lanka [189]. The study found the screening tool to have adequate validity for the assessment of physical, sexual and emotional abuse during childhood among Sri Lankan young adults [189].

One study compared measuring CSA through individual computer-assisted self-administered surveys (ACASI) to participatory social mapping activities [190]. The study found that group-based narratives of violence focused on events perpetrated by strangers or members of the community [190] whereas ACASI interviews revealed violence perpetrated by family members and intimate partners [190].

Three case study reports emphasized the use of a specific methodology to improve medico-legal services responses to reports of CSA [191-193]. One report emphasized the importance of prompt collection and submission of biological evidence in cases of suspected CSA [191]. This conclusion was based on a case of adolescent injury which seemed like an accident but was CSA
Another study recommended the Polymerase Chain Reaction (PCR) test to detect STDs in cases suspected of CSA [192]. The study provided a series of cases where this test was used and was able to identify the perpetrator and gonorrhea [192]. Similarly, another report showed how some medical conditions can be misinterpreted as physical CSA indicators by using one case as an example [193].

Lastly, only one study focused on ethics of CSA research [194]. This study with CSA survivors investigated the impact of being a research participant and found that victims of abuse were more likely than non-victims to report benefits (71.9% vs 67.1%; p=.02) and harms (31% vs 20.9%; p<.01), and were less likely to report experiencing regret from involvement (13.1% vs 16.7%; p=.02) [195].

D. Theory and Framework Studies

There were only two studies included in the theory and framework theme [195, 196]. One study analyzed current frameworks for developing CSA prevention and response interventions. The study argued that medical and legal measures should focus on reducing current threats for CSA by identifying and treating individuals with paraphilia, specifically pedophilia [195]. The other study looked into the intersections of violence against women and violence against children. This study investigated adding prevention of HIV and CSA among children within existing HIV and violence prevention programs directed at adults [196]. The study found that sexual and physical violence in childhood were linked to negative health outcomes such as increased sexual risk taking, and experiencing IPV during adolescence [196]. It suggested that interventions seeking to prevent HIV should increase knowledge among children and caregivers by addressing attitudes and practices around violence and dating relationships [196]. Programs should also build awareness of services available for children who experience violence [196].
V. Commentary

Geographical Representation in CSA Research
Similar to the overall trends, in all regions, except for East Europe and Central Asia, studies focused on understanding CSA across populations were more numerous (75%) with less attention to intervention research (19%) and all other thematic areas (6%). Almost half (49.5%) of the research studies included were from the Sub-Saharan Africa region and 61.1% of all intervention research studies were also from this region. About half of the existing evidence base was spread thinly across the rest of the 5 regions and a small group of multi-country, multi-region studies.

Figure 2. Number of articles per geographical region

Further analysis revealed country-level disparities within some regions. For example, in Sub-Saharan Africa, the majority of studies (n=38 out of 96; about 40%) came from South Africa and in the Middle East and North Africa region, the majority of studies (n=49 out of 55; about 88%) came from Turkey. In the Latin America and the Caribbean region, the largest concentration of studies came from Mexico (n=7 out of 13; about 54%). In all Asian regions, the largest concentration of studies from a single country came from Malaysia (n=4). Lastly, in Eastern Europe, the largest concentration of studies came from Serbia (n=3). Overall, there is very little CSA research coming from LMICs which makes it difficult to build a nuanced contextual understanding of CSA and CSA interventions for a large proportion of the global population.
Methodological Gaps: Defining and Measuring CSA
Most studies discussed CSA in general and did not specify particular types of CSA. A few studies focused on intrafamilial/incest and online sexual exploitation, but it was uncommon for this level of specificity to be the focus of the study. Understanding different forms of CSA is important in order for us to understand the problem and build adequate service responses and prevention interventions that address multiple forms of CSA.

The majority of studies used self-report methods to measure CSA including a variety of questionnaires and interviewing methods. A few studies relied on scales and indexes to measure CSA including: the Traumatic Experiences Checklist [5], Child Abuse Scale [128], Children’s Impact of Traumatic Events Scale [63], and the Childhood Sexual Abuse Measurement [68]. Other studies utilized evaluations by a child and adolescent psychologist [33, 186]. Lastly, a few studies utilized a mixture of questionnaires and interviews to measure a child’s experience of sexual violence [80, 115, 127, 133].

Intersectional Research
An intersectional approach is more inclusive and appreciates diversity in order to ensure that we build understanding and interventions for children in all their diversity – not only for a small but dominant group. That is, intersectional research would dive into experiences, perspectives, and needs of vulnerablised or marginalised groups (e.g., LGBTQ populations, individuals with HIV, orphaned children, children with disabilities, marginalized groups etc.) as well as the norms, systems, and social structures that create and perpetuate this marginalisation, inequity, and vulnerability. Across all thematic areas, 25 studies (12.7%) were conducted with an intersectional perspective [32, 33, 40, 44, 45, 47, 48, 72, 79, 89, 105, 107-115, 148, 162, 174, 190, 196]. Seven of these studies focused on individuals living with HIV or on individuals at risk of contracting HIV. Five studies worked with orphaned or street-living children and three studies worked with orphaned children at risk of contracting HIV. Five studies focused on children with disabilities and three studies worked with refugee populations or individuals in conflict areas. Lastly, one study worked with individuals utilizing substances and one study looked at sexual violence against boys. In this review, there was a lack of LGBTQ focused studies.

Feminist Perspective
The review found only one study that indicated that they applied a feminist perspective [76]. This study investigated the experiences of girls’ and boys’ of sexual abuse by adults in a post-conflict region in Northern Uganda and reviewed interventions (both prevention and response) that worked on improving the current state of children at risk of CSA. The study found that there was a need for separate, specialized units for reporting and handling cases of CSA. Training of personnel and a new filing system within child protection agencies was also identified as a need. Lastly, the study found that there was a need for family programs for both fathers and mothers on child protection strategies for prevention and mitigation of CSA. A feminist approach to CSA research could contribute to the field by promoting a an analysis of norms, systems and structures which create vulnerabilities or protection against CSA as well as a power analysis to understand another perspective of CSA.
Gaps

Most CSA research in LMICs was epidemiological rather than evaluating or improving current systems and programmes of prevention and response to CSA. In studies that were categorised as epidemiological research, many focused on CSA’s impact on a child’s mental health and bodily functioning. Despite the focus on the mental health impact of CSA, there were only a few response interventions that focused on mental health. Many studies focused on the potential increased risk of CSA for orphaned and street children, however there are not additional prevention and response interventions that focus on serving these groups of children. A greater variety of epidemiological research is necessary, specifically to identify the risk and drivers of different types of CSA in different environments (e.g., in schools, online, by adults or by peers). In particular, more research is needed to better understand the drivers of different types of CSA perpetration. This understanding can inform the design of primary prevention interventions to effectively prevent and end perpetration of CSA.

There is also a need for strengthening ethics guidelines that should drive all aspects of CSA research including methodologies, tools, dissemination, and funding research for impact that can improve the survivors’ lives and keep children safe from all forms of sexual abuse. Ethics review committees may also prefer to assess proposals using clearly defined, shared ethical guidelines.

The field would also benefit greatly from priority driven research to systematically build the evidence base in ways that will address strategic gaps in understanding and practice. The focus and relevance of research questions and ensuring that they are equitable and non-discriminatory can be strengthened by a shared research agenda.

There is a clear gap in research on the intersections between CSA and violence against women (VAW) both to better understand where these two types of violence intersect and the pathways between them, as well as to guide effective and ethical actions to address both CSA and VAW at the intersections.
VI. Concluding Remarks

This review was helpful to show the vast range of existing research on CSA in LMICs. The findings of the review show that there is not a cohesive body of knowledge on CSA from LMICs – the research does not appear to be driven by strategic priorities. Much of the research studies do not have a clear policy or practice imperative and the tools, methods, and ethics guiding the research vary a lot. There are very few intervention studies. The current body of evidence from CSA research from LMICs does not provide clear knowledge to guide policy and practice. The field would benefit from more research and this research needs to:

- be driven by a clear research agenda,
- use validated and reliable methods, tools, and measures for ethical research,
- focus on hard to reach and vulnerable populations,
- build a better understanding of CSA perpetration to drive prevention strategies, and
- investigate multi-component intervention models and frameworks.
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Appendix I

Keywords for CSA were established by testing different combinations of keywords in the PubMed MeSH terms database and identifying keywords most used within the criteria and parameters outlined below. Low- and middle-income country names were included as search terms, and searches were applied within title and abstract fields as well as within MeSH terms in articles on PubMed. The search strategy is illustrated in the table below.

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AND

(LMIC OR "developing country" OR "under-developed country" OR "third-world country" OR "third-world nations" OR "under-developed nation" OR "less-developed country" OR "least developed country" OR Afghanistan OR Albania OR Algeria OR "America Samoa" OR Angola OR Argentina OR Armenia OR Azerbaijan OR Bangladesh OR Belarus OR Belize OR Benin OR Bhutan OR Bolivia OR "Bosnia and Herzegovina" OR Botswana OR Brazil OR "Burkina Faso" OR Burundi OR "Cabo Verde" OR Cambodia OR Cameroon OR "Central African Republic" OR Chad OR China OR Colombia OR Comoros OR "Democratic Republic of the Congo" OR DRC OR "Republic of the Congo" OR "Costa Rica" OR "Cote D'Ivoire" OR Cuba OR Djibouti OR Dominica OR "Dominican Republic" OR Ecuador OR Egypt OR "El Salvador" OR "Equatorial Guinea" OR Eritrea OR Eswatini OR Ethiopia OR Fiji OR Gabon OR Gambia OR Georgia OR Ghana OR Grenada OR Guatemala OR Guinea OR Guinea-Bissau OR Guyana OR Haiti OR Honduras OR India OR Indonesia OR Iran OR Iraq OR Jamaica OR Jordan OR Kazakhstan OR Kenya OR Kiribati OR Korea OR "Democratic People's Republic of Korea" OR Kosovo OR "Kyrgyz Republic" OR Laos OR Lebanon OR Lesotho OR Liberia OR Libya OR Madagascar OR Malawi OR Malaysia OR Maldives OR Mali OR "Marshall Islands" OR Mauritania OR Mexico OR "Federated States of Micronesia" OR Micronesia OR Moldova OR Mongolia OR Montenegro OR Morocco OR...
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