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An analysis of child abuse cases referred to a healthcare service provider in Pietermaritzburg: An evidence-based study.

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I. ABSTRACT

Child abuse has an historical presence internationally and in South Africa, where it persists at alarming rates. Much research focuses on sexual abuse, which appears to be the most prevalent form of abuse. However, literature and the current research also recognise the presence of emotional/psychological abuse, physical abuse and neglect. Child abuse presents with harmful consequences that extend to the victim, his/her family and the larger community. This quantitative and explorative study investigated the incidence and prevalence of child abuse cases found at a private practice in Pietermaritzburg, in the Msunduzi municipality, in KwaZulu-Natal (KZN), South Africa. The research sought to discover characteristics of abuse, pathways to intervention, risk and protective factors and necessary stakeholders to assist with this public health concern. Data was obtained through case files that were selected through non-probability sampling, specifically purposive sampling. Data was collected using a questionnaire developed by the researcher for the study. Content analysis coded the data to create descriptive and inferential (Fisher's exact tests) statistics through MS Excel and SPSS. Bronfenbrenner's ecological systems theoretical framework was used to interpret the data.

The study's sample comprised of 52 case files and found that sexual abuse was most prevalent, followed by emotional abuse and then physical abuse. Most abused children fell into the 6-10 years' age group; were African; did not have a disability; were in primary school (Grades R-6); and presented with various problems at the healthcare service provider's (HSP) practice. Surprisingly, males and females were almost equally affected. The study found that a child's gender affects the type of abuse experienced. Fisher's exact test showed a relationship between a victim's father's employment status and the type of abuse experienced. Living with 1-6 people showed more risk for abuse. Perpetrators included children and the abuse type was dependent on the abuser's age and level of education. Various relationships were reported between the victim and the abuser. Many victims' abuse was discovered through an examination by the HSP. Concerningly, over $\frac{1}{3}$ of cases occurred in the school environment. Case prosecution was a major issue, with most cases having an unknown status and no files showed as completed with/without convictions. A common set of risk and protective factors did not emerge. Collaboration between stakeholders assisting victims of abuse does not seem to be occurring. Collaboration is needed between public services, like the Department of Education (DoE), the Department of Higher Education and Training (DHET), the Department of Health (DoH), Department of Justice (DoJ) and the Department of Social Development (DSD), and private services, as is enhanced education to help prevent and manage the alarming rates of abuse.

Keywords: child abuse, sexual abuse, physical abuse, emotional abuse, neglect, KwaZulu-Natal, South Africa, Bronfenbrenner's ecological systems

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I hereby declare that this is my own work. All sources and quotations used have been indicated and acknowledged by means of complete reference.

Jounelle Amy Gibson (Miss)

III. ABBREVIATIONS

Abbreviation	Full name for abbreviation
ADHD	Attention-Deficit/Hyperactivity Disorder
APA	American Psychiatric Association
ASD	Autism Spectrum Disorder
CPR	Child Protection Register
CRC	Convention on the Rights of the Child
CSA	Child sexual abuse
CSO	Civil Society Organisation
DHET	Department of Higher Education and Training
DoE	Department of Education
DoH	Department of Health
DoJ	Department of Justice
DSD	Department of Social Development
DSM	Diagnostic and Statistical Manual of Mental Disorders
DSM-5	Diagnostic and Statistical Manual of Mental Disorders 5th edition
FGM	Female genital mutilation
GBV	Gender-based violence
H_0	Null hypothesis
H_1	Alternative hypothesis
HSP	Healthcare service provider/specialist doctor (gatekeeper)
KZN	KwaZulu-Natal
NGO	Non-governmental organisation
NPA	National Prosecuting Authority
NRF	National Research Foundation
ODD	Oppositional Defiant Disorder
PTSD	Post-traumatic stress disorder
RAPCAN	Resources Aimed at the Prevention of Child Abuse and Neglect
SADC	Southern African Development Community
SAPS	South African Police Services
SOCA	Sexual Offences and Community Affairs Unit
TCC	Thuthuzela Care Centre
UK	United Kingdom
UKZN	University of KwaZulu-Natal
UNICEF	United Nations Children's Fund
USA	United States of America
WHO	World Health Organisation

When referring to abuse or emotional abuse etc., child abuse is implied as it is the focus of this study

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CHAPTER ONE: INTRODUCTION

In days gone by, and possibly even today in many instances the view has prevailed that children should 'be seen and not heard'. The time has come for our children to be seen, and to be very closely heard. The cries of our abused and exploited children must no longer fall on deaf ears or closed minds. Mandela, 1996

1.1 Background of the study

The phenomenon of childhood violence presents itself through various types of child abuse and neglect (United Nations Children's Fund, 2015; World Health Organization, 2018). Historically, children have been maltreated and subjected to heinous violent acts that can be termed emotionally, physically and sexually abusive. Children continue to remain vulnerable to violence. Despite efforts to counter abuse, it remains a global issue. Regardless of its conceptualisation, violence against children is problematic and unjust (World Health Organization, 2016).

1.1.1 Conceptualising child abuse through the DSM-5

The United Nations Children's Fund (UNICEF) (2014) includes physical, sexual, emotional/psychological abuse and neglect in the category of child abuse. The World Health Organisation (WHO) takes a broader approach by including inattentive care and exploitation (commercial or other) and acknowledges actual and potential harm to children (Panjwani, 2013). This harm can relate to their "health, survival or development or dignity" and such a broad definition is adopted by the DSD in South Africa (DSD, DWCPD, & UNICEF, 2012). Child abuse's international presence has resulted in it being defined in the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders 5th edition (DSM-5) under a section titled '*abuse and neglect*', as a possible area for inclusion in future Diagnostic and Statistical Manuals of Mental Disorders (DSM)s (American Psychiatric Association, 2013). The DSM-5 has been dubbed by many as the '*bible of psychiatry*'. However many critics argue that despite the DSM's importance, it should be seen only as a diagnostic guide and should not be over-emphasised, as other methods, including clinical interviews and informal psychological assessment procedures, are also part of diagnosing (Doorey, 2013; BBC, 2013). The debate about child abuse as a mental health issue remains, but most people agree that the act of abusing children is 'abnormal'. The DSM's suggestion of a relationship between psychological difficulties and abuse, further reiterates the seriousness and problematic

nature of these acts and the need for urgent attention. For the APA, abuse is a legal, psychological, medical and ethical concern (American Psychiatric Association, 2013).

1.1.2 Policies and legislation to curb child abuse: Adequate on paper

The protection of children against violence, abuse and neglect is a basic human right that is well documented in multiple international legislations, policies and programmes, including the Convention on the Rights of the Child (CRC) (United Nations Children's Fund, 2014) and the Optional Protocols to the CRC on Sex Trafficking (Sex Trafficking Protocol), Armed Conflict (Child Soldiers Protocol), Child prostitution and Child pornography (DSD et al., 2012). Other international ratification agreements include the African Charter on the Rights and Welfare of the Child (1990), the European Convention on the Exercise of Children's Rights (1996) and The Hague Convention on the Protection of Children in Inter-country Adoption (1993) (Library of Congress, 2015). The number of legislations and policies imply a recognition that child abuse cannot be tolerated.

The omnipresence of child violence has resulted in South Africa also adopting their own policies and legislative documents, which focus on protecting children from harm (Viviers, 2013; Badoe, 2017; UBS Optimus Foundation, 2016). The South African Constitution and Bill of Rights contain a section "that defines the rights of children to education, shelter, health and freedom from maltreatment, amongst others" (Richter & Dawes, 2008, p. 79). Another critical document, the Children's Act (38 of 2005), aims to protect the wellbeing of children against direct or indirect violence and to enforce children's rights (Republic of South Africa, 2006). The best interests of the child are paramount. The Children's Amendment Act (2006) provides further provision of care and protection; and the Prevention of Family Violence Act (1993) delineates brutality against women and children (Richter & Dawes, 2008). Further legislation like the Criminal Law (Sexual Offences and Related Matters) Amendment Act (2007) and the Domestic Violence Act of 1998, expand definitions, clarify the necessity of reporting abuse, and elucidate protection orders (DSD et al., 2012). The Schools Act 84 of 1996 made corporal punishment in schools illegal as a way of protecting children from harm (Janssen, van Dijk, Al Malki, & van As, 2013).

1.1.3 Elucidating statistics in South Africa

Violence against children is significant throughout the world (Rao & Lux, 2012), "and yet different nationalities and social groups vary considerably in the way in which they

perceive and address the issue" (Guma & Henda, 2004, p. 95). It is challenging to ascertain exact rates of abuse in South Africa owing to the multiplicity of definitions, the non-recognition of some abuse, the privacy of abuse, poor record-keeping and various research methods being used (Richter & Dawes, 2008). Moreover, when analysing literature about South Africa, it is observed that sexual abuse seems to be mostly studied and reported. Statistics suggest that 33% of children experience abuse in South Africa and Child Protection Week exists to highlight the seriousness of child violence in South Africa (1 in 3 SA children experience abuse, 2017). It is a 'national disaster' with Parliament stating that "at least 41% of all reported rape cases from the past three years involve children" (Wolfson Vorster & Magnes, 2018). Local studies, such as that by Artz, Burton, Leoschut, Ward, and Lloyd (2016) attempt to provide national data, but acknowledge problems of unreporting, under-reporting and unrecording. Their study focused mostly on sexual abuse and found that approximately 20-30 % of South African children and adolescents have experienced sexual assault at least once, and that the figures are more widespread and higher than expected (Artz et al., 2016). Moverover, 30% of their sample reported exposure to family violence and one in five "reported having been hit, beaten or kicked by an adult" (Artz et al., 2016, p. 52).

1.1.4 Access to services

Most forms of abuse require medical, psychological and judicial interventions. In South Africa, at least 76% of the population requires medical services from the public sector (77.2% in KZN), as only 16% of the population are estimated to have medical aid (Statistics South Africa, 2013). In addition, police stations may not be close by. Service accessibility is affected by people walking and/or relying on public transport to access services (40.2% and 40.4% respectively in KZN) (Statistics South Africa, 2013). The effort and financial means required make reporting abuse unworthwhile. South Africa's poor healthcare is also affected by poor monitoring and evaluation mechanisms (Passchier, 2017). Little follow up is performed and information systems "do not always provide nationally representative, good-quality information in a timely manner" (Passchier, 2017, p. 837). Time constraints make it challenging for practitioners to gather statistics regarding the number of abuse cases seen. The HSP admitted to not having gathered these statistics or looking into differences between families with and without medical aid, both of which are seen in the practice. Furthermore, inaccessibility to clinical

resources and a shortage of doctors, increase incidences of non-reporting (South Africa's healthcare, 2017).

1.1.5 Theorising about and the consequences of abuse

Knowledge relating to the aftermath of abuse informs the intervention strategies needed, the stakeholders required for intervention and who the strategies should be targeted at (Corby, 2000). The consequences of abuse are far-reaching to the child, their family, community and the larger society (Corby, 2000). A child may be affected medically, mentally, emotionally, or socially (nuisances to the community), their relationships with peers and families change, and they may require alternative care (DSD et al., 2012). Society is affected by lowered productivity and an increased burden of support. As a result of the far-reaching effects, Bronfenbrenner's ecological systems theoretical framework was used to conceptualise and understand child abuse, its risk and protective factors, and its consequences. Understanding the systemic influences on the occurrence of abuse elucidates the role they play in preventing and treating abuse. Some children, despite them experiencing horrific violence, have resilience and protective factors that assist them in dealing with the aftermath of abuse. Research suggests that protective factors in multiple contexts can mitigate the effects of abuse (Finkelhor, Ormrod, & Turner, 2007). They also provide pertinent information that should guide intervention strategies. Analysing local risk and protective factors can assist local government, Civil Society Organisations (CSO)s, and provincial and national stakeholders to co-construct mechanisms to address abuse.

1.2 Statement of the problem

The alarming statistics of South African child abuse reiterates it as a problem requiring enhanced research to create greater knowledge and to empirically inform practices (Richter & Dawes, 2008). Theoretically, the South African government has prioritised children's protection, but despite policies and procedures to mitigate the incidence and effects of abuse, statistics remain remarkably high (Richter & Dawes, 2008; Mohamed & Naidoo, 2014). Crime statistics from 2011/2012 reported 26 000 child victims accounting for 40% of sexual offences, with over 12 000 experiencing common assault and another 11 000 experiencing assault with grievous bodily harm (Mathews & Benvenuti, 2014; Viviers, 2013). The ubiquity of abuse in South Africa has normalised its occurrence, impacting on disclosure and perceptions by the victim and the abuser (Collings, Griffiths, & Kumalo, 2005). An attitude of indifference exists from families, South African Police

Services (SAPS) and other services, which exacerbates the problem. Badoe (2017) argues that there is a lack of research and data globally, but that the situation in Africa is worse. Research needs to inform, educate and assist with interventions to diminish rates of abuse. In South Africa, abuse is under-researched and ill-defined, as seen from the few existing national studies (see Artz et al., 2016). Joyner (2016) argues that abuse is commonplace and one of the country's biggest public health concerns for children, but the focus remains on other childhood problems, mostly related to the medical domain (e.g. childhood HIV/AIDS and malaria). Stakeholders like government and organisations seem aware of the problem but are at crossroads regarding what to do.

National data such as that found by Artz et al. (2016) describe how girls and boys are equally vulnerable to sexual abuse albeit in different forms. This is contrary to traditional thinking which links abuse, particularly sexual abuse, to females. This reinforces the need for further research and the importance of policies and practices recognising both genders. Much of the literature focuses on the prevalence of sexual abuse, ignoring other forms of abuse. Artz et al. (2016) reiterate the pervasiveness of other abuse types in South Africa. This observation and an analysis of numerous sources lead the current study to focus on four types of abuse: sexual, physical and emotional/psychological abuse and neglect. National, provincial and local data assist with understanding the extent of abuse and can inform preventative work and response interventions.

According to literature searches, data specific to KZN appear non-existent and/or inaccesible. Authors like Mohamed and Naidoo (2014) and Collings (2009) have performed some research. Comparative studies between provinces are limited making more tailored interventions challenging. Little data were accessible for the city of Pietermaritzburg, where the study was conducted. Some sources refrained from sharing data, possibly due to government policies and others were uninterested. Some data from the Thuthuzela Care Centre (TCC), at Edendale Hospital, were accessed and indicated, to a degree, the pervasiveness of sexual abuse. South Africa's healthcare system has considerable problems and is in a crisis (Zimmelman, 2017). Key role-players are not working collaboratively; people doubt the system and do not seek assistance. Public sector strikes, misappropriation of funds, mismanagement, expenses and lack of access to health care facilities in rural areas affect the type of help victims and their families receive, which in turn, affects reporting (World Health Organization, 2010). These

difficulties led the researcher to focus on the medical field's interventions. The excessive 'red-tape' in public institutions led the researcher to access a private specialist doctor (gatekeeper (HSP)). This was decided, despite the majority of South Africans not being able to access this type of care. It is noted that the statistics gathered from this source may not be an accurate representation of child abuse in Pietermaritzburg This small-scale project aimed to inform future, larger interventions and projects.

In conclusion, the problem concerns the number of abuse cases in South Africa, focusing on KZN, more specifically, the Msunduzi municipality, owing to the area's limited research. It is acknowledged that there are high rates of reported abuse and neglect, but these rates are likely to be even higher owing to the apparent lack of reporting and/or under-reporting. There seems to be a lack of statistics in KZN and in Pietermaritzburg. This study hopes to reduce these issues.

1.3 Purpose of the study

As a result of the challenges with abuse in South Africa, the study aimed to investigate and discover more information on the current situation of abuse and neglect in the Msunduzi municipality, so as to provide local knowledge and statistics to enhance further research. It was hoped that the study would provide statistics on the incidence and prevalence of child abuse and neglect reported at a private practice in Pietermaritzburg. Moreover, the study hoped to uncover victim and perpetrator characteristics and the nature of abuse. This information, as well as information into what pathways for intervention are taken and the risk and protective factors concerning abuse hoped to assist with informing intervention and preventative work. The findings wished to inform which stakeholders need to become involved in programmes and policy development to assist in reducing the current abuse crisis.

1.4 Objectives of the study

The exploratory study's objectives are:

1. To investigate the various forms of abuse reported at the HSP's private practice in Pietermaritzburg through the use of case files.
2. Using those case files, explore the characteristics of abuse to try profile such cases.
3. To attempt to identify the pathways of intervention for reported child abuse cases.

4. To identify risk and protective factors from the abuse cases reported at the HSP's practice.
5. To recommend the key target population/stakeholders in various fields which can effectively create preventative programmes and promote early intervention for child abuse.

1.5 Research questions for the study

With the objectives of the study in mind, the following research questions emerged:

1. What is the prevalence of abuse sampled from the HSP's private practice's database in Pietermaritzburg, in the Msunduzi local municipality?
2. What are the characteristics of the child abuse cases reported at the HSP's practice in Pietermaritzburg?
   a. Child characteristics
   b. Parents and context
   c. Perpetrator characteristics
3. What are the pathways of intervention for reported abuse cases?
4. What risk and protective factors exist from the cases reported at the private practice?
5. Who are the major stakeholders that could assist in prevention and promotion interventions for child abuse?

1.6 Significance of the study

As is already evident, the situation of abuse in South Africa requires swift intervention. This research is tentative and exploratory and hopes to add to the body of existing knowledge in the area of abuse and grow research on this topic. This research is significant in that:

1. It aims to create more data for Pietermaritzburg and the Msunduzi municipality, as there is a dearth of research and it is difficult to obtain statistics in the area.
2. It hopes to stimulate further studies, which may inform active, practical interventions that work with policies in mitigating the incidence of abuse and the effects thereof, in a proactive and preventative manner.
3. It hopes to develop profiles of abusers and victims in the Msunduzi municipality. This information could inform prevention strategies.
4. It aims to assist in educating people about child abuse.

5. It hopes to discover the pathways for intervention and information pertaining to prosecution.
6. It is hoped that the necessary stakeholders will also emerge.

1.7 Assumptions of the study

The study is assumed to be exploratory, descriptive and broad; and is quantitative because it is developing statistics. It is assumed that the HSP, a medical practitioner, receives abuse victims from various areas of the Msunduzi municipality and that the HSP sees all victims who can afford the services. It is further assumed that victims consent to sharing their data with the HSP and consequently indirectly allow the HSP to share their data for research purposes, without using identifying information. There is the assumption that all case files relating to child abuse were accessible and that the case files would be completed with the same level of detail. Furthermore, it is assumed that cases are given equal attention and that individuals visiting the specialist doctor were given the same accessibility, despite possible financial constraints.

1.8 Scope and delimitations of the study

The study's scope is limited by time, financial and academic constraints as it is for a Masters degree with coursework and research components. Data were only obtained from one site, which limits generalisability. Open access to all case files was allowed and a decision to include the case was based on the practitioner's notes. The number of case files that were accessed was limited, owing to available resources and personal constraints (e.g. time), which also affected the generalisation of the findings. Access to the HSP's services was limited to those who had access to funds to pay for consultations or to those with medical aid – i.e. the poor were not likely to have access. The study's scope relates to children who have been exposed to/suffered abuse and/or neglect and who sought services, whether directly or indirectly, from the specialist doctor. To be included in the study, individuals needed to be exposed to any of the four types of abuse (physical, sexual or psychological abuse or neglect) and be 18 years or younger at the time of seeing the HSP for consultation. Exposure to abuse may not have been known by the victim or their family, but cases where the HSP diagnosed abuse were also included. There was no limitation as to where the person resided, but he/she had to have seen the HSP through their private practice in Pietermaritzburg.

1.9 Operational definitions of terms

Definitions of the main terms used in the research are listed below.

- ***Child abuse:*** All types of harm and ill-treatment that is deliberately inflicted on a child (Republic of South Africa, 2006) including sexual, physical or emotional abuse, neglect, negligence and any exploitation, which risks creating "actual or potential harm to the child's health, survival, development or dignity in the context of a relationship of responsibility, trust or power" (World Health Organization, 2016). In this study, negligence related to all four types of abuse, particularly neglect, but was not seen as a separate category. Exploitation including labour practices was not included as it is difficult to ascertain at a medical establishment. When speaking of abuse, neglect is included and child abuse (i.e. abuse to children) is referred to.
- ***Child:*** A person under 18 years (Republic of South Africa, 2006; Viviers, 2013).
- ***Emotional/psychological abuse:*** Activities that bully the child, bring the child down and make the child feel worthless/inferior, and consequently affect the child's self-esteem and self-worth (American Psychiatric Association, 2013). It includes humiliation, threats, abandonment, confinement, scapegoating, use of force, manipulation, and rejecting and teasing the child (American Psychiatric Association, 2013; Gibb et al., 2001).
- ***Gender-based violence:*** Violence targeting individuals or groups owing to their gender, for example targeting a person because she is lesbian or murdering women on the basis of their gender, which "denies women and girls the opportunity to achieve equality and freedoms enshrined in the Constitution" (Statistics South Africa, 2018, p. 7;12).
- ***Neglect:*** Actions or inactions that fail to meet the child's physical and/or psychological needs which negatively affects a child's health and/or development, and leads to physical, intellectual or emotional damage (Corby, 2000; de Witt, 2014).
- ***Physical abuse:*** "[A]ssaulting a child or inflicting any other form of deliberate injury to a child" (Republic of South Africa, 2006, p. 16), including non-accidental injury and the use of force (Rao & Lux, 2012).
- ***Protective factors:*** Variables that act "as a buffer to prevent an adverse outcome and increase the chance of a child's positive adjustment" (Mathews & Benvenuti, 2014, p. 31).
- ***Risk factors:*** Variables like "event[s] or situation[s] that increase the possibility of a negative outcome" (Mathews & Benvenuti, 2014, p. 31).

- ***Sexual abuse:*** Sexually exploiting a child to please an adult or child (Mott, 2003) including sexual activity with contact and non-contact events that involve a child that is too young to consent (Townsend & Dawes, 2004).
- ***Violence:*** "[T]he intentional use of physical force or power, threatened or actual, against oneself, another person, or against a group or community, that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation" (World Health Organization, 2018).

1.10 Summary and overview of the study

This introduction has sought to provide a basic understanding of child abuse and neglect. Despite abuse being a global phenomenon of problematic proportions, cultural conceptualisations affect how abuse is perceived at a more local level. In multicultural South Africa, child abuse is rife, despite legislative efforts. The broad WHO definition is also adopted by the country's DSD owing to the multiplicity of events that can be included. This quantitative research focuses on discovering the prevalence and incidence of child abuse in Pietermaritzburg, in the Msunduzi municipality, at a healthcare provider's offices. Child abuse is a national disaster, but owing to the scope of the research, the focus is on the local level with the hope that this research will inform other, broader studies. The study will now turn to an exploration of some of the literature in the field of child abuse. Considerable literature exists and so every effort has been made to explore subsections that are pertinent to this study. The research will then move to discussing the study's research methodology. Findings from the study will then be presented and a discussion will follow. Lastly, concluding remarks, limitations to and reflections on the project will be drawn.

CHAPTER TWO: LITERATURE REVIEW

2.1 Introduction

Considerable literature exits on abuse and neglect and the topic is very broad. In this chapter, theoretical reviews of the literature will be presented, including the history and definitions of child abuse. Some empirical studies (international and local) will be discussed to elucidate the epidemiology of abuse as a phenomenon. Bronfenbrenner's theoretical framework will then be introduced as a way of conceptualising abuse including why children are abused, protective factors and the consequences of abuse.

2.2 Theoretical review of the literature (international and local)

2.2.1 The history of child abuse

In 1962, Dr C.H. Kempe was the first in the medical community to publish a paper concerning child abuse and neglect (The Kempe Center, 2019). The paper, *The Battered Child Syndrome*, was seen as noteworthy in terms of recognising and identifying abuse and providing an authentic account of it. It "gave doctors a way to understand and identify child abuse and neglect, along with information about how to report suspected abuse" (The Kempe Center, 2019).

Childhood and the problems that go with it are believed to be historical and social creations (Corby, 2000). Theories understanding abuse have evolved as history has evolved. Finkelhor (2002) argues that child abuse is not new and is a result of an extensive social movement and moral transformation. Individuals have become more aware of acceptable community practices (rights) and unacceptable or immoral acts (wrongs). Whilst Western influences have expanded, contextual and cultural ideologies inform many societies' ways of thinking about these rights and wrongs. Child protection gained impetus from the emergence of professionals who work with children and their families, as well women moving into professions, which led to a "moral transformation in our view of children and a social and political initiative to intervene on their behalf" (Finkelhor, 2002, p. xi). McIntyre and Silva (1992) argue that abuse and neglect have existed since the commencement of civilisation, but different interpretations of its constitution have influenced its understanding.

de Mause (1974, p. 1) states that the "further back in history one goes, …, the more massive the neglect and cruelty one finds and the more likely children are to have been killed, rejected, beaten, terrorized and sexually abused by their caretakers". There are

abusive accounts that date back to the ancient Greeks and Romans and during the Renaissance and Victorian eras (Richter & Higson-Smith, 2004). Rao and Lux (2012) argue that despite Labbé first describing abuse injuries approximately 150 years ago, they have been in existence long before. Abuse and neglect are not new phenomena but have become more prevalent possibly owing to enhanced awareness. Historically, in 1500-1800, abuse was believed to be a consequence of most caregivers having little emotional attachment to their children because mortality rates were so high (Corby, 2000). Limited psychological involvement meant caregivers experienced less torment when their children passed away from limited access to healthcare. As social classes emerged, the upper and middle classes spent more time and money on childcare, thereby becoming more in tune with their children's needs (Corby, 2000). Others argue that since the 1400s, children have been valued as an important source of help. This suggests the influence of culture and context on conceptualisations.

Historically, abuse occurred through infanticide, abandoning children, child labour, physical punishment, child prostitution, taking young girls' virginity through pubescent rites and/or holding children against their will (Corby, 2000; Richter & Higson-Smith, 2004). Infanticide was only viewed as a criminal offence after AD318 and the punishment of death emerged from AD374 (de Mause, 1974) but when considered in the context, infanticide was a method of contraception. de Mause (1974) argues that sexual abuse was common during Antiquity through girls being exploited by older men, but incest was considered taboo. Richter and Higson-Smith (2004) argue that incidences of sexual abuse were often ignored/covered up. During the 13th century, neglect existed in the form of abandoning children that could not be cared for. From the Middle Ages, the court's involvement in abuse was more evident and Corby (2000) cites a study by Pollack (1983) that found 385 cases of neglect, physical abuse and sexual abuse between 1785 and 1860 with 93% of them being found guilty. An awareness developed, with acts being recognised as morally incorrect and punishable. The temporal factor to understanding abuse is evident. Towards the end of the 19th century, stakeholders became more active in protecting children, with public knowledge focusing on physical abuse and neglect. Greater state intervention emerged in the late 19th and early 20th centuries, with abuse in the United States of America (USA) being formally rediscovered by Kempe, whose influence created public awareness and societal concern; and during the 1960s and 1970s, it gained impetus in Britain (Corby, 2000). Child abuse became more recognised

and was first responded to by social workers, followed by other role players including doctors and psychologists (Lachman, 1997).

How childrearing is understood is influenced by different social, cultural and/or religious ideologies as well as moral values (McIntyre & Silva, 1992). These differences create different practices and the varying values influence how ethnic and cultural groups view actions – either as appropriate and acceptable, or as abusive (McIntyre & Silva, 1992). The standards by which these judgements are made, are mostly dominated by Western ethnocentrism, even more so in modern society. In following the West, there has been an increased provision of rights and previous culturally accepted actions are now viewed as abusive. Anything going against Western norms and dogma is viewed as wrong (McIntyre & Silva, 1992). Western culture sees other cultural practices as backward, odd or cruel, resulting in misunderstandings and abuse violations. Abuse conceptualisations are reiterated in cultural practices like disciplining techniques, with some being influenced by religion, for example, the book of Proverbs (McIntyre & Silva, 1992). Abuse also emerges from differing perspectives concerning the use of folk medicine which is influenced by East Asian and Eastern European cultures (McIntyre & Silva, 1992). For example, cupping, which is believed to assist with blood flow can leave marks, creating the idea of physical abuse.

Child abuse remains contentious concerning its nature, causes, frequency and impact (Rao & Lux, 2012). Awareness of sexual abuse re-emerged during the 1980s following the awareness of physical abuse in the 1960s and 1970s (Poblete, 2003). During the 1950s and early 1960s in Kenya, Nigeria and Ghana, force-feeding children was routinely performed (Le Vine & Le Vine, 1981). These cultures blocked children's nostrils as a medical folk practice to prevent dehydration (Le Vine & Le Vine, 1981). This 'abusive' practice is influenced by belief systems and possible 'ignorance'. Since then, various cases have elicited public inquiries which grew stakeholders' and lobbyists' interests. State intervention in family matters and society emerged in the 1980s, with most involvement coming from social workers (Corby, 2000). African practices like ceremonial circumcisions, female circumcisions and arranged marriages for young girls have attracted considerable debate (Poblete, 2003). "Sexual molestation of girls is a known phenomenon in tropical Africa" as is the acceptance of forced sex and incest (Poblete,

2003, p. 38). Whilst acceptable in these cultures, debates about such practices remain. Western ethnocentrism continues to be at the heart of these judgments.

Research on abuse has enhanced awareness and understanding of multiple factors and an acknowledgement of the child, their family, culture and social environment (Poblete, 2003). Using research to inform practices is a delayed process but allows abuse to be acknowledged as common and affecting any individual from any social class (Poblete, 2003). Societies have enhanced awareness of what constitutes abuse, through social and economic pressures, and have learnt to acknowledge children's rights. The lack of consensus in the literature implies that a theoretical/conceptual framework is lacking, which affects professionals' conceptualisations (Lachman, 1997). Definitions are profession- and society-dependent, and risk factors are not well elucidated (Lachman, 1997). Global definitions are interpreted and enforced differently.

2.2.2 Defining child abuse

Kempe first defined child abuse as a medical condition and this biomedical approach ignored social factors and focused on 'blaming' the victim and his/her parents (Lachman, 1997). This understanding failed to recognise cultural beliefs and the psychological consequences inherent in abuse. During this time, other countries' paediatricians (including in the United Kingdom (UK)), focused on diagnosing this 'disease'. The result was a move away from abuse as an illness to abuse being multi-dimensional.

Many aspects of abuse, including how to define it, remain blurred. The common understanding that persists is that it encompasses physical, sexual and psychological/emotional abuse and neglect (Legano, McHugh, & Palusci, 2009). Other violence like gender-based violence (GBV) and exploitation have been left out of this study but are sometimes included in definitions. Abuse is "any act that negatively affects a child's physical or emotional health and development [which] can result in 'physical, cognitive and emotional impairment' which could have long-term effects" and risks affecting their survival and dignity (Mohamed & Naidoo, 2014, p. 250; Vallone, Addona, D'Elia, & Vicari, 2009). The World Health Organisation (2016) defines abuse as violence against children under 18. This is also applied in South Africa (Collings et al., 2005). Abuse relates to unequal or dependent relationships mostly between an adult and a child resulting in harm, potential harm or threats of harm to the child (Vallone et al., 2009).

Maltreatment involves deliberate or avoidable danger of abuse - “action that inflicts harm” - or neglect - “inaction that causes harm” that compromises a child’s wellbeing (Papalia, Wendkos Olds, & Duskin Feldman, 2006, p. 254). Poblete (2003) recognises that abuse is influenced by what a society/community views as socially acceptable behaviour at a particular time – i.e. abuse is culturally, contextually and temporally influenced. The level of trust, the duration of the abusive relationship, the amount of violence and aggression, and the severity of the act influence the experience’s intensity (de Witt, 2014).

Child abuse rests on a cultural continuum that is exacerbated by living in a multicultural country like South Africa. Debelle (2003) argues that there is a fine line between ethnocentricism and cultural relativism and that a middle ground must be found where cultural views are recognised, but have some limitation in order to protect children. South African laws focus on this, which is critical after the country’s history of Apartheid created a culture of violence. Child abuse may be direct or indirect and can include witnessing violence against others includng animals (Tortolani & Lanti, 2009). Legano et al. (2009) state that two other considerations for abuse are the harm standard (demonstrable harm) and the endangerment standard (in danger of experiencing harm). This reiterates that child maltreatment’s conceptualisation is context specific. Finkelhor and Korbin’s six dimensions of abuse assist in defining abuse, which states that abuse must be:

> (1) intentional; (2) socially censured in the locale in which it has occurred; (3) abusive according to international consensus; (4) perpetrated by an individual, although governmental, economic, and religious actions may also constitute child abuse; (5) harm children rather than everyone in society; and (6) be perpetrated against a child who is considered a person by that society.
>
> (Janssen et al., 2013, p. 216)

The country’s Children’s Act classifies child abuse as “bullying, exploitation, physical, sexual, emotional or psychological harm” and neglect as “a failure in the exercise of parental responsibilities to provide for the basic physical, intellectual, emotional or social needs” of a child (Mathews & Benvenuti, 2014, p. 27). Whilst physical abuse and emotional abuse are mostly directed towards a specific child, sexual abuse is said to be more opportunistic (Richter & Dawes, 2008). A breakdown of the types of abuse follow.

2.2.2.1 Physical abuse

Physical abuse includes intentional injury or beating (Hobbs, 2003) and using force against a child (Rao & Lux, 2012). It comprises of “punching, beating, kicking, biting, shaking, throwing, stabbing, choking, hitting …, burning, or any other method that is inflicted by a parent, caregiver, or another individual who has responsibility for the child” (American Psychiatric Association, 2013, p. 717). However, this ignores peers inflicting harm on each other. Physical abuse mostly occurs by a parental figure and has physical evidence like bruising, bite marks, nail scratches, fractured/broken bones, burn/scald marks, or eye and mouth injuries (Hobbs, 2003). Infants are at a high risk of experiencing head trauma, non-accidental head injury, traumatic brain injury or shaken baby syndrome as a consequence to incessant crying (Rao & Lux, 2012). The abuse risks causing injuries, permanent physical harm, death and psychological harm (Hobbs, 2003; Mohamed & Naidoo, 2014) and seldom exists on its own (Badoe, 2017). Mathews and Benvenuti (2014) argue that physical abuse mostly occurs in children aged 0–4 years old. Corporal punishment begins more at school-going age.

Laws about smacking children have emerged thereby altering how physical abuse is defined. South Africa has long since banned corporal punishment at schools; but such behaviour persists. On 19 October 2017 a ruling was made that makes corporal punishment in the home illegal (Swanepoel, 2017). This judgement aims to align with the country’s Constitution, Children’s Act and Criminal Law. The defence of **“**moderate or reasonable chastisement” is no longer accepted as it goes against the child’s best interests (Swanepoel, 2017)**.** Parents must find alternative ways to discipline their children. ‘Reasonable’ physical discipline is culturally specific, and these laws are attempting to reduce the blurred line of interpretation. The judgement aims to reduce any psychological humiliation a child may experience and wishes to minimise South Africa’s culture of violence (Swanepoel, 2017).

2.2.2.2 Sexual abuse

Sexual abuse is complicated by the age categories which are differently defined in different acts in South Africa (Mathews & Benvenuti, 2014). The Sexual Offences Act of 1957 states that consensual heterosexual relations are legal from 16 years; homosexual relations are permissible from 19 years; and a child is classified as under 21 years old if abducted (Richter & Dawes, 2008). Other, newer laws (e.g. the Criminal law) argue that a child may legally engage in sex with consent from age 12 (Republic of South Africa,

2007). However, sexual abuse occurs if a 12-year-old engages in sexual activities with a child younger than 12 or older than 16 or an adult (Republic of South Africa, 2007). A lack of consent is key, and it is argued that children under 12 cannot make informed decisions owing to their immature psychosexual development (de Witt, 2014). The DSM-5 describes sexual abuse as "any sexual act involving a child that is intended to provide sexual gratification to a parent, caregiver, or other individual who has responsibility for the child" (American Psychiatric Association, 2013, p. 718). Such a definition narrowly ignores child abusers. Sexual abuse concerns sexually exploiting a child for pleasure for an adult (Mott, 2003), another child or a third party (Republic of South Africa, 2007).

It includes any form of sexual activity (sexual contact or not, by force or not, with the victim who is unable to give consent) (Berliner & Elliott, 2002). Non-contact activities, which lack contact between the child and the abuser, include exhibitionism, exposure to pornography and prostitution; sexual grooming; creating child pornography; voyeurism and flashing (Townsend & Dawes, 2004; Republic of South Africa, 2007; de Witt, 2014; Berliner & Elliott, 2002; Mott, 2003). Sexual activities include "fondling a child's genitals, penetration, incest, rape, sodomy, and indecent exposure" as well as "forcing, tricking, enticing, threatening, or pressuring a child to participate in acts for the sexual gratification of others" (American Psychiatric Association, 2013, p. 718) and commerical sexual exploitation (Mohamed & Naidoo, 2014). Sexual abuse includes attempts and completed acts that go against accepted societal standards and norms (Townsend & Dawes, 2004). For example, having sex with a virgin and believing that it can cure HIV/AIDS is sexual abuse irrespective of the cultural beliefs (DSD et al., 2012). Sexual abuse commonly occurs in multiple episodes (Berliner & Elliott, 2002).

2.2.2.3 Emotional/psychological abuse

Emotional/psychological abuse is challenging to operationalise owing to the multitude of interchangeable terms. *Psychological maltreatment* represents "a category that is sufficiently broad to include both the cognitive and affective meanings of maltreatment (psychological) as well as perpetrator acts of both commission or omission (maltreatment)" (Hart, Brassard, Binggeli, & Davidson, 2002, p. 79). There is often an unrelenting pattern of poor interaction between the child and the abuser (Stoltenborgh, Bakermans-Kranenburg, Alink, & van IJzendoorn, 2012; Scholtz, 2001). Emotional abuse may be a precursor to other abuses (Hart et al., 2002). Stoltenborgh et al. (2012)

argue that verbal abuse is most common and always occurs with other forms of emotional abuse. It is often hidden and awkwardly judged on cultural standards, again confusing what constitutes abuse (Scholtz, 2001). Researching emotional abuse is equally problematic as psychological harm is relative and may be interpreted differently, reiterating individual judgement. There is the risk of immediate, negative consequences that may eventually affect a child's "behavioural, intellectual, emotional, social and psychological functioning" (Thompson & Kaplan, 1999, p. 192, as cited in Scholtz, 2001, p. 3). Emotional abuse is described as "non-accidental verbal or symbolic acts by a child's parent or caregiver that result, or have reasonable potential to result, in significant psychological harm to the child" (American Psychiatric Association, 2013, p. 719). Again, child perpetrators are ignored.

Activities include "berating, disparaging, or humiliating the child"; threatening the child; "harming/abandoning – or indicating that the alleged offender will harm/abandon – people or things that the child cares about"; and "confining the child" (American Psychiatric Association, 2013, p. 719). Other activities comprise of flagrant scapegoating; forcing the child to inflict pain on him-/her-self or otherwise excessive disciplinary measures (American Psychiatric Association, 2013). Rejection, extortion and teasing (Gibb et al., 2001), disapproving behaviours towards the child, using sarcasm, verbal abuse, harsh punishment or threats, insulting, name calling, denigrating, belittling and even hyper-parenting ("being overly involved and controlling and forcing the child into a myriad of activities" often as a consequence of attempting to live vicariously through the child) are types of this maltreatment (Scholtz, 2001, p. 2). Failing to meet the "child's needs for affection, attention or stimulation … [and] threats of violence or attempts to frighten the child also constitute emotional abuse, as do social isolation and humiliation" (Mohamed & Naidoo, 2014, p. 205). It involves failing to provide a supportive, developmentally appropriate environment and/or failing to provide a primary attachment figure (Stoltenborgh et al., 2012). Bullying is said to often occur in school-aged children, especially aged 5-12 years (Mathews & Benvenuti, 2014).

As with all abuse types, there is a power differential between the child and the perpetrator (Hart et al., 2002). Stoltenborgh et al. (2012) reiterate the control by a person in a position of trust and power, and that the abuse includes hostile, rejecting treatment towards a child. It includes repeated acts which negatively affect a child's self-esteem, making them

feel worthless, unwanted, not loved, blemished and only worthy of satisfying another's needs (Hart et al., 2002; Rao & Lux, 2012). Acts of spurning; terrorising; isolating; exploiting/corrupting (allowing a child to model inappropriate behaviour); denying emotional responsiveness and mental health, medical and educational neglect, through denying access to necessary treatments are also included (Hart et al., 2002). Psychological abuse encompasses "put downs, labelling, unrealistic expectations, humiliation, scapegoating, …, excessive responsibility, seductive behaviours, fear-inducing techniques, extreme inconsistency, ignoring, rejection and lying" (Scholtz, 2001, p. 2). Emotional abuse can destroy a child's competence and ability to act successfully.

Emotional abuse may negatively affect how a child responds to their educator, their school performance and whether he/she can make friends. Abuse can occur from unintentional interactions or an intentional desire (McIntyre & Silva, 1992). Children's self-images become negative; they may play less; comfort themselves with infantile acts like rocking and sucking; struggle to sleep; rarely smile; become aggressive or overly passive; have under-developed language and social development; avoid eye contact, become irritable and have a continuous desire for others' attention (de Witt, 2014).

2.2.2.4 Neglect

Internationally, child neglect is seen as "any confirmed or suspected egregious act or omission by a child's parent or other caregiver that deprives the child of basic age-appropriate needs" (American Psychiatric Association, 2013, p. 718). Corby (2000) and de Witt (2014) recognise the continued failure to meet a child's needs, which negatively impacts on a child's health or development, leading to physical, intellectual or emotional (psychological) damage. It includes abandonment, a failure to adequately supervise the child, not attending to a child's basic psychological needs and not providing basic education, medical care, nutrition, shelter or clothing, safety or hygiene (American Psychiatric Association, 2013; de Witt, 2014; Corby, 2000; Rao & Lux, 2012). Failing to protect the child from the cold, hunger or substance abuse also represent neglect. Poverty is a large contributory factor to abuse (Badoe, 2017). There is a fine line between being unable to provide for a child owing to poverty and choosing to not provide for a child, with the latter representing neglect. Neglect is often overlooked and/or disregarded, but it can negatively affect a child's development and the way in which they parent their own children. From poor feeding, a child may get into trouble for falling asleep in class;

or he/she may not have many friends owing to a parent neglecting basic hygiene. Failure to thrive (weight and length growth based on birth weight and size) may also form part of neglect (Corby, 2000). Neglect mostly occurs in children aged 0–4 years old (Mathews & Benvenuti, 2014).

2.2.2.5 Exploitation

Exploitation is contentious, with some defining it as falling into other abuse types and others classifying it as separate. For this dissertation, exploitation was not a separate category and was taken as included in sexual, emotional or physical abuse. It includes child labour and work exploitation (Mohamed & Naidoo, 2014).

2.2.3 Practising policies

International laws like the Hague Convention of 1980 was ratified by South Africa to guide its laws on child protection and to recognise children's vulnerability (Mohamed & Naidoo, 2014). The UN CRC sets universal rights and protective responsibilities for children and focuses on the importance of providing an environment that meets children's needs, survival and safety; encourage empowerment; provide a supportive environment in which optimal development is possible and provide children with the right to be listened to and actively take part in decision-making about their lives (Poblete, 2003). In Africa, different groups consider acts or events in distinctive ways as constituting abuse which leads to different interpretations of protection (Guma & Henda, 2004). The CRC's article 19 recognises the need for "all appropriate social and educational measures to protect the child from all forms of physical or mental violence, injury, neglect or negligent treatment, maltreatment or exploitation including sexual abuse" (Hendricks, 2014, p. 551). This reiterates the need for measures to identify, report, refer, investigate and treat abuse. Laws like the African Charter on the Rights and Welfare of the Child have created monitoring units re-emphasising the UN's beliefs (Hendricks, 2014). Southern African Development Community (SADC) countries signed a Declaration on Gender and Development in 1997 (Guma & Henda, 2004).

South Africa's violent history stems from the country's colonisation and history of Apartheid and marginalisation, which normalised violence and created a pervasive social recognition of violence (Mathews & Benvenuti, 2014; Viviers, 2013). Apartheid systems interpreted forms of abuse against Indian and African children as tribal matters that were dealt with separately, making it challenging for one universal system (Janssen et al.,

2013). The Apartheid regime also legitimised violence as a means for achieving goals (DSD et al., 2012). The post-Apartheid government developed new policies like the Constitution and Children's Act to protect children and their rights (Republic of South Africa, 2006). Despite constitutional, legislative and civic efforts, daily injustices continue and involve the complicity of services, police and families, particularly owing to the culture of violence that is simply accepted (Richter & Dawes, 2008).

Existing acts and policies make South Africa an archetypal context for children's rights. The country adopts a rights perspective and has multiple government programmes and services in the areas of health, child development and education (Mokoae, Roberts, & Ward, 2012). But abuse continues. "South Africa at this time still suffers from a lack of clear guidelines and coherent policies on the recognition and handling of the psychological abuse of children" (Scholtz, 2001, p. 2). Policies emphasise unique aspects making it confusing and practically challenging to know the correct avenues for reporting, to have 'accurate' knowledge and to follow correct legal procedures. Section 110 of the Children's Amendment Act "compels certain professional sectors to report any child abuse, neglect or maltreatment that is suspected on reasonable grounds" (Hendricks, 2014, p. 551) This reporting has a moral and legal imperative. The Prevention of Family Violence Act (No. 133 of 1993) requires anyone with a level of child responsibility to report suspicions of abuse (Dawes & Mushwana, 2007). These reports occur via a Form 22 to a child protection organisation, the provincial DSD, a non-governmental organisation (NGO) (e.g. Child Welfare), a social worker or a SAPS official, failing which, the said individual may receive a fine or a maximum of 5 years in jail or both (Hendricks, 2014; Mohamed & Naidoo, 2014).

Professionals must document abuse/possible abuse, maintain records, refer the victim for necessary treatment and alert the relevant authorities. This is not always done as professionals lack confidence in handling these matters, particularly because of a lack of clear, specific guidelines (Badoe, 2017). When reporting abuse, the patient's details, photographs and radiographs with the use of a scale ruler, dates, times, location, appearance of injuries, healing stages, severity of the injuries and diagrams should be recorded (Mohamed & Naidoo, 2014). Determining if such reporting is occurring does not seem to be a priority. Section 54 of the Sexual Offences and Related Matters Act requires any person with suspicion of sexual abuse against a child or a mentally

handicapped person to report it to SAPS (Hendricks, 2014). People are not educated on their rights and responsibilities. Irrespective of these guiding documents, social issues (e.g. alcohol and drug abuse) lead to people, particularly adults, being violent towards children, reiterating that the policies are not enough (Viviers, 2013). Partriarchal values and gender stereotypes move beyond laws (DSD et al., 2012). Socio-cultural values, practices of coercion and perceptions persuade people towards violence and abuse which are viewed as 'customary' (Guma & Henda, 2004). The language used to describe abuse helps in understanding it, but also legitimises and perpetuates it. South Africa's social issues like income inequality, poverty, unemployment and HIV/AIDS influence children's wellbeing (Mokoae et al., 2012).

South African abuse represents a major problem (Mohamed & Naidoo, 2014), with GBV being commonplace (Leoschut & Kafaar, 2017; Mokoae et al., 2012). Feelings of nonchalance and injustice are rife. Under-reporting and the possibility of covering up injuries means that action is not always taken against the perpetrator (Janssen et al., 2013). Physical abuse commonly occurs in the home (49.1%); followed by the school and/or preschool (26.4%) (Janssen et al., 2013). Janssen et al.'s (2013) study found that most abusers (62.9%) were not known or could not be traced; that 22% of perpetrators were other children; 7.6% were parents; another 3.9% were relatives and 3.7% were someone the child knew or a family friend. The high statistic of unknown perpetrators is questionable as it is often a consequence of the fear of reprisals, which precludes the victim from identifying or reporting the abuser. CSOs assist with child protection (e.g. Children's Rights Centre; Centre for Child Law; and Childline) and there is now increased media coverage and activist work (Richter & Dawes, 2008). These initiatives attempt to mobilise people and educate them about abuse and the laws around it to enhance parenting and encourage reporting, particularly because many caregivers are not open to accepting what their children say and minimise the disclosed abuse, thereby allowing it to continue. The laws are present, but practicality is lacking.

2.2.4 Reporting abuse

Physical abuse victims are often referred to medical practitioners because of the visible presence of evidence of abuse, for example marks or scarring (Janssen et al., 2013), or behavioural characteristics, including attention-seeking behaviour, poor social relations, withdrawal, tantrums and delayed learning (de Witt, 2014). Sexual and emotional abuse

are often hidden, especially when they occur in the private settings of homes (DSD et al., 2012). Neglect varies but the likelihood of reporting is reduced by caregivers who are already failing to act. Referrals may be the result of children learning about abuse at school, but disclosure also depends on the "child's age and personality, the relationship between the perpetrator and the victim, the nature, type, duration, frequency and intensity of the crime, and eventually on the reaction of those closest to the child when he [or she] does reveal the situation" (de Witt, 2014, p. 332). Some children find it difficult to verbalise the events, and instead, may exhibit stress; increased sexualised behaviour, knowledge and interest in sex; a negative self-image; social detachment and/or withdrawal (de Witt, 2014).

Finkelhor, Wolak and Berliner (2001) present a model of crime reporting arguing that the first stage is problem recognition and the second is consideration. The former relates to recognising the abuse as a problem. Research argues that many victims are groomed and do not recognise the violence. The abuser normalises the behaviour, so much so that "40% of children indicated that they were unaware that they were being sexually abused" (Sas & Cunningham, 1995, as cited in Collings et al., 2005, p. 271). Unaware victims cannot be expected to report abuse and those in a position of responsibility are also likely to be unaware. Abuse recognition may be hampered by caregivers failing to believe the victim, seeing the incident as the victim's fault, or minimising the seriousness of the abuse (Finkelhor et al., 2001; Collings et al., 2005). In the consideration stage, abuse is acknowledged, but the benefits and costs of reporting abuse are weighed up (Finkelhor et al., 2001). Benefits may pertain to gaining access to psychological and medical healthcare and justice; whereas the costs relate to spending money, further victimisation, fear of additional trauma and the fear of the unknown (Collings et al., 2005). The abuser may threaten to cut financial assistance if the abuse is reported. Often, the child may be ignored, silenced, punished or not believed (Collings, 2009). This lack of acceptance means that children feel guilty and confused about why trusted people perform these acts (Prinsloo, 2016). Failure to report stems from difficulties, risks, and a lack of understanding and resources to investigate, resulting in apathy (Dawes & Mushwana, 2007). The threat of secondary victimisation is present (Collings, 2009).

Cultural practices and social taboos also influence reporting (Legano et al., 2009). Social norms cross generations and portray men with power over women and children, and

gender stereotypes legitimise violence. They continue ideologies of a patriarchal society, de-sensitise children and normalise violence. For example, early marriage practices, rites of passages and initiations, physical abuse as discipline, obedience to adult figures, patriarchal societies and gender-based power relations influence reporting and disclosure (Guma & Henda, 2004). South African ideologies have created the idea of respecting and obeying elders, and so children feel guilty reporting elders, consequently disrespecting them, and/or fear the consequences (Stoltenborgh et al., 2012). The power dynamic reiterates the forceful nature of abuse and is influenced by age, gender and social status (Viviers, 2013). Other children are too young to tell someone, fearful/afraid, unsure of what will happen to them, and do not know who such abuse should be reported to (Viviers, 2013). Reporting is affected by perceptions of who is to blame (Guma & Henda, 2004). Hesitancy comes from the potential stigma and shame from being a victim resulting in much un-/under-reporting (Richter & Dawes, 2008; Viviers, 2013).

Other issues concern misunderstanding legislation, a lack of understanding or knowledge about child maltreatment, and past adverse experiences when reporting (Hendricks, 2014). Professionals may minimally assist as they fear becoming legally involved or offending their patients, are fearful of losing patients owing to it negatively affecting the professional relationship with the child and his/her family, are embarrassed, feel that suspicions are not enough to act upon, have not had enough training on abuse and/or do not know how to intervene correctly (Mohamed & Naidoo, 2014).

2.2.5 Profiling abuse victims and abusers

Profiling abuse victims and perpetrators is challenging. RAPCAN (Resources Aimed at the Prevention of Child Abuse and Neglect) "'proves' that rape and child sexual abuse happen amongst all class groups, all racial categories, regardless of affluence, religion, poverty or any other broad societal category" (Townsend & Dawes, 2004, p. 69). Others purport that poverty, economic disadvantage and living in townships and informal settlements exacerbate the possibility of violence and maltreatment (DSD et al., 2012). It seems that contradictory perspectives exist.

2.2.5.1 Child abuse victims

Child abuse is believed to happen to children of any culture, race, religion or socio-economic class (Panjwani, 2013). Social grouping is not necessarily a risk factor, but a 1998 Scottish study found that lower socio-economic groups were more likely to suffer

abuse (Bebbington et al., 2011). DSD et al. (2012) concur with this. Girls and boys seem to be affected at different rates, and age influences the abuse suffered. Tortolani and Lanti (2009) report that girls are more affected than boys, but that girls are also more open to condemn abuse and consequently report it, which may account for the higher numbers, whereas boys are less inclined to report sexual and physical abuse, especially during adolescence. Girls seem to experience more sexual abuse, whereas boys are more affected by physical and psychological abuse and even neglect (Tortolani & Lanti, 2009). There is a high risk of being exposed to multiple forms of abuse, sequentially or concurrently. Children living with one parent, in urban areas, or those with absent parents are often abuse victims (Leoschut & Kafaar, 2017). Children who engage in substance abuse or risky sexual behaviour are also more at risk (Leoschut & Kafaar, 2017). Victims may be those children that a perpetrator views as weak, weepy, demanding, sickly, difficult to manage or may be born because of an unwanted pregnancy (de Witt, 2014). Children with physical, medical, developmental or intellectual handicaps are at an increased risk; as are children who show immature behaviour; are hyperactive; passive; aggressive; overly acquiescent; overly dependent and/or avoidant of confrontation (de Witt, 2014). Profiling is challenging as it is all-encompassing.

2.2.5.2 Perpetrators' of child abuse

Perpetrators appear to be "ordinary people who, for any possible number of reasons humiliate or physically injure children. Child abusers cut across all ages, gender, race, social classes and family structures" (Kostelnik et al., 1999, p. 473, as cited in de Witt, 2014, p. 327). This also makes perpetrator profiling challenging. Tortolani and Lanti (2009, p. S204) report that "more than 75% of perpetrators are relatives and/or persons living within the family (father alone 9.9%, mother alone 11.2%, both parents 40.4%, relatives other than parents 13% and common-law partners 1.3%)". Collings (2009) argues that $\frac{1}{3}$ of the sexual abuse studied was performed by someone in the victim's family. Richter and Dawes (2008) acknowledge parents and educators as common perpetrators of physical abuse; and neighbours, community members and family members as frequently perpetrating sexual abuse. Most abusers are known by the victim. Primary caregivers, especially biological parents, most often commit abuse, as a result of them experiencing abuse as children (de Witt, 2014).

Abusers are believed to have poor self-concepts and self-images; do not understand their own emotions and feelings; act impulsively and immaturely and may be “dependent, egocentric, demanding, isolated and depressed” (de Witt, 2014, p. 328). They are likely to have experienced abuse as a child and may “exchange emotional roles with their children, in other words, they expect and demand love and nurturing from children owing to having been deprived of the love of their own mothers during childhood” – they have insecure attachments (de Witt, 2014, p. 328). Perpetrators are a heterogenous group, but most have completed their schooling, and some attain tertiary qualifications (Townsend & Dawes, 2004). Research by Briggs and Hawkins (1996) and Elliott et al., (1995) as cited in Townsend and Dawes (2004) suggests that perpetrators may be unskilled, unemployed or professionally employed. Fifty-six percent of the sexual abuse cases in Collings’ (2009) study occurred in semi-rural areas and 36% in rural areas. Perpetrators in this study ranged from age 15 to 72.

2.2.6 Consequences of child abuse

The consequences of abuse are negative and far reaching, affecting the child’s physical and mental health and the child may possibly experience negative social, emotional, economic and occupational consequences (Rao & Lux, 2012; Mathews & Benvenuti, 2014). Moreover, abuse may result in behavioural, emotional, cognitive or mental disorders (Papalia et al., 2006). Negative effects include medical, health and psychiatric costs; loss of earnings; productivity losses for the economy; welfare costs; disability; special education expenses; premature death; a diminished quality of life and legal costs (Janssen et al., 2013; Rao & Lux, 2012). An individual may be affected throughout his/her life and various areas of the child’s life are affected. Children become confused over who to trust, who to listen to and who to allow to look after them (Vallone et al., 2009). Trusting others may become challenging. These emotional burdens risk having intergenerational effects. Exposure to abuse and not reporting it means the possibility of a lack of receiving the support needed (Collings et al., 2005).

Abuse in very young children can influence brain development, intellectual and physical development and psycho-social adjustment which puts the child at a higher risk of developing violent or anti-social behaviours (Mathews & Benvenuti, 2014; Prinsloo, 2016). Their immune systems and nervous systems may be compromised (Janssen et al., 2013). Vallone et al. (2009) explain that psychiatric difficulties (anxiety, depression,

conduct disorder, anti-social personality disorders, substance use disorder and suicide); eating disorders; generalised aggression; difficulties with peers; Attention-Deficit/Hyperactivity Disorder (ADHD); feelings of impotence; Oppositional Defiant Disorder (ODD); phobias; separation anxiety disorder and panic disorder may develop. Depression and Post-traumatic stress disorder P(TSD) were found as "the most prevalent psychological consequences of trauma and both were significantly associated with childhood sexual abuse, while hyperactivity/impulsiveness was significantly associated with physical abuse" (Vallone et al., 2009, p. S207). Children may develop hopelessness, low self-esteem, poor satisfaction with life, a poor sense of social support and an insecure attachment style following emotional abuse (Stoltenborgh et al., 2012). Prinsloo (2016) recognises that the child may experience self-blame and pessimism. There is also an increased risk of children running away (Bebbington et al., 2011).

Emotional abuse, more than other abuse forms, is related to episodes of non-endogenous major depression and hopelessness depression (Gibb et al., 2001). Persistent and multiple forms of abuse risk manifesting into a negative cognitive style, giving the child a cognitive vulnerability, and negative cognitions are reiterated by the abuser, making the child more susceptible to experiencing later symptoms (Gibb et al., 2001). Gibb et al.'s (2001, p. 444) study found that "childhood emotional maltreatment may be the most detrimental of the three types of childhood maltreatment for the development of cognitive vulnerability to depression". Abuse may affect the child's desire to achieve in other contexts; they may struggle to concentrate; may perform self-harming activities; experience enuresis or encopresis; turn to prostitution or lying and stealing, or may develop an extreme sense of guilt (Scholtz, 2001; Viviers, 2013). Victims may experience changes in their stress response system, a reduced prefrontal cortex volume, bipolar disorder, borderline personality disorder symptoms, and other "delinquent behaviours …; … externalizing behaviour, diminished resiliency, and ego under control" from emotional abuse (Stoltenborgh et al., 2012, p. 871).

Children who experience neglect are prone to poor emotional control and may show difficulty understanding others' emotions, which risks affecting interpersonal relationships and personality development (Mathews & Benvenuti, 2014). Suffering from abuse may lead to a failure to thrive, delayed development, withdrawal, behavioural disruptions, diminish the child's intellectual performance or he/she may experience

emotional deprivation (Scholtz, 2001). The victim's learning style may be altered, and they could use dissociative mechanisms as defences against experienced violence and trauma (Vallone et al., 2009). Janssen et al. (2013, p. 222) state that the "marked increase in sexual assault and rape … results in potentially serious physical injuries and profound emotional and psychological trauma". Children may later experience sexual dysfunction, impotence, orgasm difficulties, poor sexualised behaviour, sexual abuse of other children, homosexuality or confusion over sex-role identity (de Witt, 2014; Tortolani & Lanti, 2009). Victims are left powerless. These consequences are felt especially by victims who report abuse but whose cases are not referred for prosecution. Dawes, Borel-Saladin and Parker (2004) acknowledge that only 50% of reported cases make it to court and of these, 49% are withdrawn and 7% are settled in court. Convictions occur in only 10% of cases that are originally reported (Dawes et al., 2004). According to Collings (2007), these children experience increased distress, depression and anxiety. Risk-taking activities may increase, they may be more inclined to participate in criminal activities, experience more victimisation and risk committing violence on others (Rao & Lux, 2012). "Today's victims become tomorrow's perpetrators" (Scholtz, 2001, p. 5).

The heavy emotional burden can create intergenerational effects (Rao & Lux, 2012). A loss of interest in personal activities and school may emerge which could affect future opportunities, and abuse may influence future parenting practices (Mathews & Benvenuti, 2014). Sexual abuse victims may develop aggression, peer relationship challenges and feelings of helplessness (Vallone et al., 2009). Victims may turn to smoking and alcohol or drug abuse to cope; and may develop possible cognitive deficiencies, unplanned pregnancies, high-risk sexual behaviour, and a greater risk of cancer, ischemic heart disease, chronic lung disease and possible reproductive health issues (Janssen et al., 2013). Self-destructive behaviours and distress are common (Scholtz, 2001). Children risk having speech difficulties, school truancy, and may not develop adequate social skills (Papalia et al., 2006).

The pervasiveness of the consequences suggests proactive action is needed to reduce the incidence of abuse. Furthermore, there does not appear to be a common set of consequences. Sleeper effects from abuse mean that the consequences risk emerging during late adolescence or adulthood – early intervention is therefore critical (Vallone et

al., 2009). Physical evidence assists with prosecution, but dismal guilty verdicts and case withdrawals exacerbate the consequences of abuse (Collings, 2007).

2.3 Review of foreign empirical studies

Abuse has become so commonplace that it is conceptualised as part of an individual's life, with inevitable exposure in some way.

> Until we accept that our children have much more of a risk of being sexually abused than drowning in a pool, being struck by a car, stricken with cancer, hurt by a vaccination, or diagnosed with ebola, we contribute to a culture of panic and ignorance. Second, we know the abusers are most often not the stranger in the bushes. Brasco (2014)

2.3.1 Internationally

Finkelhor (2002) argues that there has not been an epidemic increase in the scope and/or nature of abuse. Yet, with the rising world population, more abuse cases are likely to emerge. Nevertheless, it is unknown whether the current rates of abuse have increased from more reporting or more incidences (Guma & Henda, 2004), but accurately depicting the rates of abuse is challenging owing to various definitions, and the exhaustiveness and quality of the official statistics and surveys, which may be influenced by systematic bias (Rao & Lux, 2012; Richter & Dawes, 2008). Different sources draw on different evidence bases resulting in broad incidence estimates (Dawes & Mushwana, 2007). A lack of consensus on what to include is a global problem resulting in abuse having multiple constructions. These constructions, the measures used to obtain data, events studied, population, sample and methodology all influence the epidemiology rates (Bebbington et al., 2011). More information is available in higher-income countries such as Australia, Canada, USA and the UK.

Child abuse is a "significant worldwide problem" (Rao & Lux, 2012, p. 459). Over the past few decades, emotional abuse has come to be a distinctive category (Stoltenborgh et al., 2012). Despite some surveys in low- and middle-income countries, a lack of data persists. According to the World Health Organisation (2016), "international studies reveal that a quarter of all adults report having been physically abused as children and 1 in 5 women and 1 in 13 men report having been sexually abused as a child". Bebbington et

al. (2011) report that Finkelhor estimated the global rate of child sexual abuse in 1994 at 20% for females and 10% for males. Worldwide estimates suggest a cumulative risk of 5-35% for physical abuse, and sexual abuse at 25.3% for girls and 8.7% for boys (Rao & Lux, 2012). Foreign studies alert that more women are affected, particularly by sexual abuse. In 1999, a WHO study indicated that globally, 40 million children under 15 had been victims of abuse and neglect, and needing healthcare and social support (Guma & Henda, 2004). Many researchers contend that independent surveys report higher than anticipated rates of abuse often a result of the failure to recognise abuse, a paucity of standard terminology and shortcomings in investigation procedures (Legano et al., 2009). A 2010 WHO report that found that 25-50% of children in the world report experiencing physical abuse at some point in their lives (Janssen et al., 2013). Approximately 95 million children are victims of abuse annually, with the African region being the worst (Badoe, 2017). The studies do not explain whether it is a consequence of differing cultural values or a result of a more violent society.

Internationally, the prevalence of psychological maltreatment is considerably lower than physical and sexual abuse, possibly from poor reporting, poor visibility or lower incidence. Statistics on the former suggest that approximately 0.3% of children suffer when using informants, but this figure becomes 36.3% with self-report measures (Stoltenborgh et al., 2012). The rates vary between 0.07% to 93% in different self-report studies (Stoltenborgh et al., 2012). Recalling abuse makes these studies questionable as there is a risk of over-reporting. Some studies have found that girls are more often the victims of emotional abuse and that geographical location may influence its incidence (Stoltenborgh et al., 2012). Stoltenborgh et al.'s (2012) meta-analysis found that the combined prevalence from 29 publications for emotional abuse was 26.7% with it affecting both genders almost equally. International initatives have focused on improving understanding and reducing the number of cases (Scholtz, 2001). In the USA, rates were around 0.5-1 per 1000 in 2009, with boys, single parent households and families with lower socio-economic status having more emotional abuse (Legano et al., 2009; Rao & Lux, 2012). Gender confusion is apparent and rates are likely higher and often affected by poor idenfication from databases (Legano et al., 2009).

Barker and Hodes (2004, p. 13) describe a British estimate that "between 2 and 4 children die every week as a consequence of abuse and/or neglect and many more suffer

irreversible long-term effects". Bebbington et al. (2011) cite a British study that found that child sexual abuse ranged from 12% to 17% for females and 5% to 8% in males; whilst another cited broader ranges of 8-30% and 2-16% respectively. Bebbington et al.'s (2011) British study found that sexual abuse on children under 16 was common in 17% of girls and 8% of boys and another study showed a 10% prevalence in the UK. A study cited in Scholtz (2001) found that 16% of UK children that presented at child psychiatry clinics had been psychologically abused. In the USA, state and local child protection services agencies reported approximately 896 000 cases of child abuse and neglect in 2002 but acknowledge that this figure is likely to be higher (Papalia et al., 2006). Roughly 1 400 children died of abuse in the USA in 2002. These figures suggest strong variability.

In an Italian study, Tortolani and Lanti (2009) found 1 917 cases of child abuse reported at one hospital in Rome between 1977 and 2007. Richter and Dawes (2008, pp. 81-82) cite an Indian study which found that "more than half of all children in India were subject to one or other form of sexual abuse, the vast majority of which were perpetrated by parents", and "[e]very second child had experienced emotional abuse", highlighting the influence of culture and social ideologies in identifying abuse. Indian children are regularly kicked or hit with an object and threatening a child with a knife or gun is common in India and the Philippines (Janssen et al., 2013). Stoltenborgh et al. (2012) argue that cultural differences between collectivist or individualist values can also be influential. People following collectivist dogma may be more likely to use emotionally abusive discipline strategies and value interdependence, which "could prevent people from disclosing … abuse with the goal of preventing shame to the family" (Elliott & Urquiza, 2006, as cited in Stoltenborgh et al., 2012, p. 873). Individualistic values, which are often followed in the West, may make victims feel isolated.

Another estimate of abuse describes that boys under 12 months and between 5 and 9 years old are more often victims of abuse; and girls are mostly victims after turning 15 (Tortolani & Lanti, 2009). Bebbington et al. (2011) highlight that sexual abuse is frequent in puberty but occurs more in adolescence. Children born out of marriage are treated poorly and risk suffering from sexual abuse (Richter & Dawes, 2008). Mathews and Benvenuti (2014) argue that sexual abuse is common in children between 5 and 12 years old and the power differential often makes girls more vulnerable to such abuse. Victims lose their ability "to take control of [their] own body and to be able to choose suitable

sexual partners once [they have] reached physical and emotional maturity (de Witt, 2014, p. 327). Approximately 2.3% of cases in the USA in 2006 related to medical neglect and 0.78% were general neglect (Legano et al., 2009).

2.3.2 Africa and sub-Saharan Africa

Very little child abuse literature has been published in Africa (Badoe, 2017; Janssen, et al., 2013; Guma & Henda, 2004). Badoe (2017) recognises that the extent of abuse in Africa is underestimated and that approximations vary depending on the country studied, the abuse type, definitions, and quality of data used. In Africa, child labour, domestic violence and corporal punishment further exacerbate the prevalence of abuse found in homes and schools, as people do not understand the legal parameters of abuse (Badoe, 2017). Badoe (2017) presents statistics for Africa (Table 2.1) and cites cultural ideologies of child marriage, female genital mutilation (FGM) and patriarchy as large risk factors for the occurrence of abuse.

Table 2.1

Statistics of child abuse in Africa

Country	***Type of abuse***	***Percentage/prevalence/rate***
Zambia	Child abuse from child marriage	33.3% of children experience spousal violence
Egypt, Sudan, Somalia, Ethiopia and Djibouti	Child abuse from FGM and genital excision	3 million girls
West and Central Africa	Child abuse through child trafficking	200 000 children per annum
Nigeria	Sexual assault	47% of female child labourers have been sexually abused. Child labour represents a form of emotional and possible physical abuse as well
Ghana	Transactional sex and children watching pornographic images	Reported as above average

Stoltenborgh et al.'s (2012) meta-analysis found that Africa's emotional abuse prevalence rate is 46.7%, and the victims' location and ethnicity did not alter the rates. A national study in Tanzania found that 30% of girls and 13.4% of boys reported sexual abuse in 2009; and that 72% of girls and 71% of boys reported physical abuse (Mathews & Benvenuti, 2014). The Malawian government uses "the maximum amount of available resources for health and education for children and the minimum amount on military expenditure" (Janssen et al., 2013, p. 219). Protecting from and educating children about abuse are prioritised. Mauritius, Namibia, Kenya, Malawi, Cape Verde, Tunisia, Morrocco, Algeria and South Africa acknowledge children's rights, have legal provisions,

and have large budget allocations towards protecting children and combatting abuse (Janssen et al., 2013).

In sub-Saharan Africa, a Zimbabwean study found that 26% of reported rape cases involved children aged 12-15 and that this statistic became 59% for children older than 16 (UBS Optimus Foundation, 2016). Another study concluded that 33% of girls and 9% of boys reported sexual abuse (Mathews & Benvenuti, 2014). Initiation rites and myths around curing HIV also increase the prevalence of sexual abuse in Africa (Stoltenborgh, et al., 2012). Culturally specific activities like physical discipline and forms of child labour may be viewed as acceptable under the guise of one culture. Different perceptions also exist intra-culturally. The area's social problems further exacerbate the number of abuse cases. In Swaziland, it is estimated that 20% of women experience physical abuse in their lifetime, with 5% being so brutal that they need medical care.

2.4 Review of local empirical studies

2.4.1 South Africa

South Africa's DSD argues that the country must enhance its ability to measure child abuse (Dawes & Mushwana, 2007). According to Prinsloo (2016), no accurate statistics exist regarding the scale of abuse and existing information is minimal, but ways to identify abuse have improved and figures are rising at a disturbing frequency. "South Africa lacks both national empirical data on the exact magnitude of the problem, and a limited research base on the causes and effects of violence against children" (Mathews & Benvenuti, 2014, p. 26). South Africa has been described as having dramatic rates of sexual and physical abuse (Richter & Dawes, 2008), while emotional abuse and neglect continue to remain less explored, possibly because they are more difficult to detect.

South Africa's child protection framework recognises caregivers and service providers in protecting children but not enough seems to be happening (UNICEF South Africa, 2013). Establishing the incidence of abuse in the country is complex, because it is multi-faceted, illicit and often hidden, and there are intricacies in definitions, understandings and levels of reporting (Richter & Dawes, 2008). Definition variations come from multiple stakeholders (police, communities, and other professionals) and affect which types of assault are counted, making the accuracy of findings questionable. Sampling may also influence the rates of abuse (Stoltenborgh et al., 2012). Poor record-keeping, child abuse monitoring and a sense of distrust are further exacerbating features stemming from

South Africa's ineffective policing services and criminal justice system. The DSD backlog often results in under-reporting, delays in reporting, or prioritising cases that are perceived as more important (UBS Optimus Foundation, 2016). The lack of clear guidelines makes it challenging for professionals to recognise and handle cases of abuse (Scholtz, 2001). Research needs to confirm, challenge and expand existing information. "There have been few large-scale or systematic studies of child abuse in South Africa, and many … [focus on] young adult recall" and so accuracy is questionable (Richter & Dawes, 2008, p. 84). South Africa has grown its budget for child protection from R295 million in 2009 to R440 million in 2012 (Janssen et al., 2013), reiterating that government recognises the need to support children.

Current literature portrays a dramatically negative, violent image of South Africa, confirmed by the country's nickname of "rape capital of the world" (Artz et al., 2016, p.15), so much so, that GBV has become 'silently accepted' (Guma & Henda, 2004). "Widespread poverty, inequality and high levels of unemployment combined with a weak culture of law enforcement, rapid urbanisation, inadequate housing and poor education outcomes all contribute to social dynamics that fuel violence" (Mathews & Benvenuti, 2014, p. 26). The subordination of women and children and the way children are socialised maintain gender inequalities and abuse. Men justify non-consensual sex with a child through compensation and this 'allows' for continued abuse. Other beliefs like having sex with a virgin will heal a man from HIV/AIDS, perpetuates sexual abuse (Richter & Dawes, 2008). The three most severe types of abuse in South Africa are sexual abuse, child prostitution and selective negelct; and physical abuse ranks 11th out of 17 abuse types (Janssen et al., 2013).

One in four children suffer physical punishment at home and about 20% of sexual abuse occurs in a residential street in a surburb/township (Viviers, 2013). Mohamed and Naidoo (2014) believe that sexual abuse in South Africa is most common in children under age 4. Most violence and child abuse are perpetrated in home or community settings (Mathews & Benvenuti, 2014). UNICEF South Africa (2013) cite that "in 84 per cent of cases involving violent acts against children, the perpetrator is known or trusted by the victim" and that sexual abuse is widespread in many disadvantaged schools. The assertion is that South Africa's violence is amongst the highest in the world (Janssen et al., 2013) and that abuse is "one of the biggest paediatric public health challenges" in the

country (Joyner, 2016, p. 1159). Yet evidence paucity persists, including on children with disabilities, but these children seem to be at a two-fold risk for abuse (Viviers, 2013). Homosexual children are also likely to experience more emotional abuse (Viviers, 2013).

Badoe (2017) and Scholtz (2001) argue that the figures of emotional abuse are likely to be higher, especially owing to the inconspicuous nature of emotional abuse and since it is often disregarded, ignored or under-diagnosed. Most sexual abuse statistics come from SAPS, the judicial system and other agencies who receive abuse reports (Dawes & Mushwana, 2007; Richter & Dawes, 2008). Police records are debatable and inconsistent owing to varied reporting and recording procedures. A SAPS' captain, who wished to remain anonymous, believes that high statistics make the SAPS station look like a failure and so statistics are altered (Anonymous, personal communication, October 02, 2018). A Western Cape study showed that 82% of SAPS reports on rape in 2005 did not record the victim's age (Richter & Dawes, 2008). It is hypothesised that other critical information may also be erroneously left out, which may affect apprehending the perpetrator, conviction rates and accurate data collection. This may be due to a lack of training, erroneous/careless notetaking, knowing the perpetrator or not asking the 'correct' questions.

The DSD aims to record characteristics of the victim and abuser, details of the victim's caregivers and the type(s) of abuse in the National Child Protection Register (CPR) (Republic of South Africa, 2006; Joyner, 2016; Dawes & Mushwana, 2007). Yet the CPR seems ineffective as it is expensive to maintain; lacks human, financial and technical resources; and is mostly punitive (Dawes & Mushwana, 2007). The functioning of the KZN system is unknown. Most health institutions have developed good mechanisms for collecting routine data, but minimal data on child protection are apparent, which influences how much is known about abuse, violence and exploitation in Africa (Badoe, 2017). Diverse socio-economic statuses, residential locations, children's agency and caregiver-child relationships must also be considered (Mokoae et al., 2012, p. 5). Other factors like rapid social changes, e.g. urbanisation, have left families isolated, without primary caregivers, and have contributed to abuse (Stoltenborgh et al., 2012). Concepts of community and knowing one's neighbours are less evident, exacerbating the risk of exposure to abuse. The lack of proximity to extended family means that children are often left alone and unsupervised, making them more vulnerable to abuse.

One of the earliest African studies on abuse was completed in South Africa in 1984 by Westcott et al. (1984) regarding 18 cases of sexual abuse at a hospital in Cape Town (Badoe, 2017). More recently, few studies have drawn on national incidence of child abuse. The Optimus study is a national benchmark study that was completed in 2015, which found "lifetime rates of 34% for physical abuse, 16% for emotional abuse and 20% for sexual abuse amongst 15-17-year olds" (Badoe, 2017, p. S32; UBS Optimus Foundation, 2016). Again, the focus was on sexual abuse.

Figures of abuse prevalence vary considerably and how statistics are arrived at is not always known. According to De Witt (2014), in 2005/2006, 24 000 children were sexually abused, 1 075 children were murdered and there were 20 879 cases of molestation. In 2008, Childline estimated receiving 4 827 calls from abuse victims and 3 883 calls from neglect victims (Viviers, 2013). In 2009, approximately 453 children were murdered through abuse (Leoschut & Kafaar, 2017) and 102 child murders occurred because of sexual violence, which almost entirely affected girls (Mathews & Benvenuti, 2014). SAPS' statistics show more than 50 000 crimes against children in 2010/2011 (Viviers, 2013). Of these, 52% were sexual, and 61% of the total were committed on children under 15 and 29% on children aged between 0 and 10 (Viviers, 2013). SAPS' statistics do not include cases that have been reported to social workers or other healthcare workers, suggesting that the figures are higher (Janssen et al., 2013). Mathews and Benvenuti (2014, p. 27) state that the "2011/2012 crime statistics report nearly [26 000] child victims, which account for 40% of all sexual offences". Viviers (2013) found that the 2011/2012 SAPS statistics showed 50 688 child victims of violent crimes, 12 645 children experiencing common assault and 10 630 assaults with grievous bodily harm.

It is estimated that 18 524 sexual abuse cases were reported to SAPS during the 2013/2014 period (Artz et al., 2016). The Optimus Study revealed that "more than 3 million young people nationally have experienced some form of child abuse or neglect, a quarter of them in the last year" (UBS Optimus Foundation, 2016, p. 44). Leoschut and Kafaar (2017) identified that 35.4% of children are sexually abused before turning 17 and Mohamed and Naidoo (2014) found 2 753 cases of ill-treatment and neglect from April 2012 to March 2013, which were reported at police stations nationally. Hendricks (2014) estimates 495 540 crimes against children in 2012-2013. In 2012, UNICEF reported that almost 22% of children suffer from hunger always, often or seldomly (UNICEF South

Africa, 2013). Hendricks (2014) states that the above statistics may be at least nine times lower than the real statistics. Cases of rape and physical abuse “are reported in newspapers every day. Babies and toddlers are being rented out to unemployed illegal immigrant women who use them to evoke sympathy from passers-by from whom they need money and food” (Carte Blanche on M-Net, 23 May 2010; Focus on SABC 2, 2 May 2010, as cited in Prinsloo (2016, pp. 60-61)).

This reiterates the abuse and exploitation that children in South Africa are experiencing. An Eastern Cape study found that 38% of women and 17% of men were sexually abused as children (Mathews & Benvenuti, 2014). National data on physical abuse are lacking, with smaller studies like ones conducted in Mpumalanga and the Western Cape finding that 55% of children reported a lifetime prevalence of physical abuse performed by caregivers, educators and relatives, which often included the use of a belt, stick, or whip (Mathews & Benvenuti, 2014). Fifteen percent of children suffer neglect and 16.1% are exposed to emotional abuse (UBS Optimus Foundation, 2016). Scholtz (2001) asserts that emotional abuse is considerably common in the family environment and is believed to create more chaos for the child than any other abuse.

Physical discipline continues at school. “[M]ost of these cases go unreported and schools fail to enforce the ban on corporal punishment adequately, and [fail] to take steps against educators who violate the ban” (Mathews & Benvenuti, 2014, p. 28). Institutional abuse is common, particularly emotional abuse, where educators use aggression, sarcasm or deflate a child’s self-esteem (Scholtz, 2001). Power differences between educators and children make sexual abuse hidden. Children under five are at a high risk of being murdered during abuse and their abusers are usually someone close to them. A 2011 study found that witnessing violence against maternal caregivers occurred in 35-45% of children (Mathews & Benvenuti, 2014). Scholtz (2001) contends that abuse between siblings is common but often unacknowledged.

2.4.2 KwaZulu-Natal (KZN)

Statistics for the province are minimal and challenging to obtain. Only a handful of small-scale studies for areas in the province exist. Mohamed and Naidoo (2014) report SAPS’ statistics between April 2012 and March 2013, which found that there were 306 cases of neglect and ill-treatment reported at police stations in KZN. These figures seem deflated

and may be influenced by a lack of reporting and victim fear. Hospitals receiving abused children do not always report cases to SAPS, particularly because caregivers choose not to disclose the abuse (Dawes et al., 2004). This may be from a fear of stigma or beliefs that SAPS is ineffective. A study in the north of Durban cited 1 737 cases of sexual abuse between January 2001 and December 2013, with 93% of the victims being girls (Collings et al., 2005). These figures were for one area. The situation is dire, and girls may be more affected by sexual abuse in KZN.

Pietermaritzburg is the capital of KZN and in the Msunduzi municipality, with the latter being considered to have a high incidence of rape (Info4africa, 2014). Pietermaritzburg contains a TCC based at one of the government hospitals serving one area of the city, Edendale Hospital. The TCCs are part of the Sexual Offences and Community Affairs Unit (SOCA) of the National Prosecuting Authority (NPA) and prioritise sexual offences and GBV (Info4africa, 2014). There are approximately 54 TCCs in South Africa and 8 in KZN (ISSSASA, 2018). Edendale hospital's TCC provides holistic care through the provision of emergency medical care, including ARV treatment, counselling and court preparation for abuse cases (Info4africa, 2014). Despite the organisation's focus on rape, other victims may visit the TCC and be redirected/referred as necessary. The TCC plays a key role in the area and works independently to the HSP.

Data from Edendale Hospital's TCC indicate that from January 2010 to September 2017, the centre saw 7 984 child rape victims and 4 child violations[1] which included sexual assault (section 5 offence), compelled sexual assault (section 6 offence) and compelled self sexual assault (section 7 offence) amongst others (K. Mbakaza, personal communication, November 20, 2017). This is shown in Table 2.2. The figures are likely to be an under-representation of the area as other victims may visit other hospitals and clinics, but gives some indication of the severity of child maltreatment in one area. More girls are affected than boys but the TCC cannot account for the sex of some children, reiterating poor recording and showing the difficulty in obtaining 'true' statistics (K. Mbakaza, personal commuication, November 20, 2017). The TCC has consistently received more sexual abuse cases year-on-year. There is either an increased incidence or more people reporting their abusive experiences at the TCC.

[1] Violations represent sexual offences other than penetration (K. Mbakaza, personal communication, November 20, 2017).

Table 2.2

Incidence of sexual abuse reported at Edendale TCC

Year	***Total number of rapes reported***	***Total number of violations reported (as per footnote 1)***
2010	321	1
2011	733	1
2012	828	1
2013	900	1
2014	1 223	0
2015	1 391	0
2016	1 499	0
2017 (Up to September 2017)	1 089	0
Total	**7 984**	**4**

2.5 Summary and synthesis of the foreign and local reviews

The information presented in sections 2.3 and 2.4 suggest that child abuse is out of control and of magnificent proportions. International literature focuses mostly on Western countries and all four types of abuse. Culture plays a considerable role in African epidemiology of abuse. In South Africa, little national research exists, and the research has mostly focused on sexual abuse, with minimal research on physical abuse and almost none on emotional abuse and neglect. The variations in the figures indicate problems with discovering the true prevalence and incidence of abuse in the country. Comparative studies are therefore difficult. Girls consistently appear to be victims of abuse more often than boys, particularly of sexual abuse. In KZN, even less research exists, making it difficult for stakeholders to intervene and to educate people about abuse. Literature reiterates the need for further research at local and national levels to enhance knowledge and interventions.

2.6 Theoretical framework

Owing to the heterogeneity of abuse victims and perpetrators, models were studied that tried to incorporate the broad variety of people, consequences and risk and protective factors. Tolan and Guerra's 1998 model of physical violence recognises the multiple factors that influence child abuse (Townsend & Dawes, 2004) and acknowledge that a child develops in relation to various contexts (Gorman-Smith & Tolan, 1998). Becker and Kaplan's (1994) model recognises individual factors, family factors and socio-economic variables in abuse (Townsend & Dawes, 2004). However, these models are not as comprehensive as Bronfenbrenner's theory, which recognises multiple environments and role players extending beyond the individual, and incorporates the person, micro-, meso-, exo-, macro- and chrono-systems, thereby enhancing the levels of influence.

2.6.1 Urie Bronfenbrenner's ecological systems theory

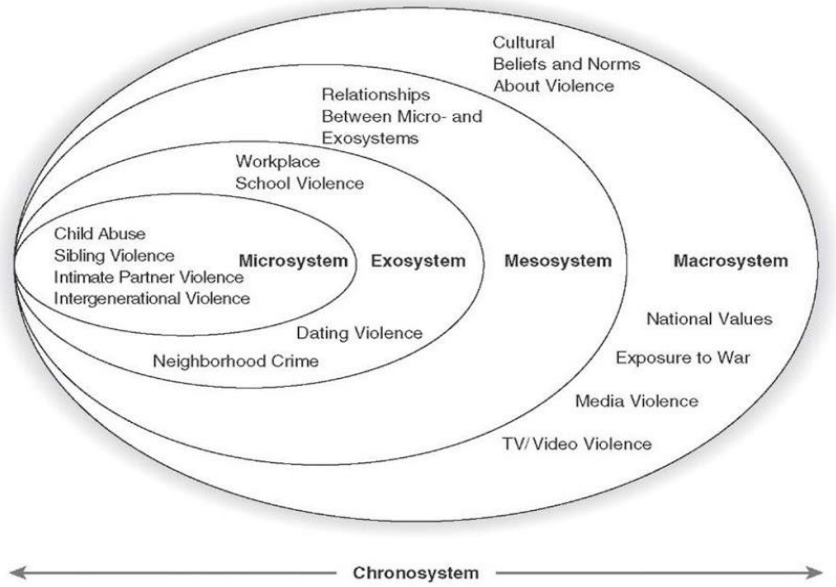
Bronfenbrenner's theory is believed to best describe the "dynamic interplay between the child and the social context such as how the family, school and community influence the child's development and long-term outcomes" (Mathews & Benvenuti, 2014, p. 30; Papalia et al., 2006). Interpersonal and family dynamics and the socio-cultural context in which a person finds him-/herself leads to different perceptions and interventions (Guma & Henda, 2004; Fontes, 2008). Bronfenbrenner's model reiterates interconnection through comparison to a set of Russian nested dolls, with abuse being seen as affecting and being affected by other systems (e.g. family, community, and ethnic, cultural and social service systems) (Fontes, 2008). The different 'dolls' are interdependent hierarchal levels that affect the individual in various ways (de Witt, 2014), such that a change in society, family and broader norms and value systems can place children at a greater/lesser risk for abuse (de Witt, 2014).

Bronfenbrenner's model is robust in understanding abuse and shows potential in assisting with intervention (Scholtz, 2001). The model recognises risk and protective factors that impact on the individual's resilience and other environments (Swart & Pettipher, 2016). The model allows for the in-depth analysis of where the problem is, which can assist in centralising intervention work at the appropriate level. Likewise, it shows the various levels of influence on behaviour (Janssen et al., 2013). The model is a "multidimensional, contextualist model of human development", reiterating that a positive change in one system, can positively change other systems as the systems are reciprocal (Elliot & Tudge, 2007, as cited in Swart & Pettipher, 2016, p. 11). Interventions are also influenced by time and context, requiring a narrower or broader focus, and the theory is flexible for this (Fontes, 2008).

Panjwani (2013) argues that child abuse does not have a specific or unique causal factor, but rather has various risk factors. There is "no link to any one culture, ethnicity, race, religion or socio-economic class" (Panjwani, 2013, p. 110). However, Papalia et al. (2006) argue that non-White children are at a higher risk for abuse, especially in South Africa where 92% of the population is non-White (Statistics South Africa, 2017b). The migrant labour system, with many absent fathers; racial oppression; unequal power as well as unbalanced economic prospects are risk factors for gender inequalities which can affect one gender over the other (Mathews & Benvenuti, 2014). Rao and Lux (2012)

argue that life factors predict acts of abuse and echo the problems coming from a migrant labour family. Children born and living in migrant areas are considered less valued, putting them at a greater risk for abuse (Guma & Henda, 2004). An ecological perspective recognises that “parents and teachers are the most common perpetrators of physical abuse”, that many sexual abuse incidents implicate “teenagers and young adults, many of whom live in the household with the child or nearby, and are known to the child” (Richter & Dawes, 2008, p. 87).

Despite the realisation of an African ecological perspective (see Tabane, 2014), it was decided that Bronfenbrenner’s ecological systems theoretical framework would be used as it is more relevant and applicable to research on abuse (Swart & Pettipher, 2016). The model recognises that “a person’s development is the product of a network of interactions between the person and their social contexts … and not merely psychological” factors (Swart & Pettipher, 2016, p. 12). Figure 2.1 below is an example of Bronfenbrenner’s theory on abuse. The image fails to show the integration of the different levels.



(What-when-how, 2018)

Figure 2.1. Graphical representation of Bronfenbrenner’s theory on child abuse. Personal factors, relationships with others, society’s values and events, as well as things that the child may be unaware of, all influence the risk and protective factors of abuse.

2.6.2 The individual and the microsystem

A child typically finds him-/herself enmeshed into multiple systems including his/her family, school, community and the broader society and culture (Psychology Notes HQ, 2013). The child functions within the microsystem.

2.6.2.1 Individual (victim and perpetrator)

The individual, with his/her genetic composition, personal experiences and developmental phases, functions within bigger systems of the family, school and peer groups (Fontes, 2008). Child factors relate to their behaviour, medical weakness/poor health, having non-biological relationships with caregivers, prematurity, behavioural difficulties and special needs (Vallone et al., 2009). Individual characteristics include gender, "age, education, income, …, or history of abuse, that increase the likelihood of becoming a victim or perpetrator of violence" (Mathews & Benvenuti, 2014, p. 30). For example, younger children are believed to be at a greater risk of physical abuse (DSD et al., 2012). Research recognises the influence of gender on the type of abuse suffered (Legano et al., 2009). Girls are more likely to be exposed to sexual abuse whereas boys suffer more physical abuse (Janssen et al., 2013; Legano et al, 2009). If boys are abused during childhood, they are more likely to experience similar abuse in their adult years (Bebbington et al., 2011). Other variables include "poor impusle control, low self-esteem, lack of empathy for victims, and/or sexual dysfunction" (Townsend & Dawes, 2004, p. 63). Early abuse is also a risk factor for later abuse or for becoming an abuser (Mathews & Benvenuti, 2014). Children who are premature, a twin, or have a disability are at an increased risk for physical abuse owing to possible challenges in bonding, crying, or other special needs (Janssen et al., 2013). Emotionally demanding children and those experiencing parental projections are often powerless to abuse (Prinsloo, 2016). Children who have been exposed to drugs in the uterus are harder to handle owing to developmental problems, making their chances of being abused much higher (Mohamed & Naidoo, 2014). Having a difficult temperament puts a child at further risk.

Children abused by family members are less likely to disclose and report the abuse; younger children are more likely to disclose abuse, and boys are less likely to report abuse owing to social stereotypies (Collings et al., 2005). Children who are not raised with both biological parents until age 16 have double the chance of being victims to sexual abuse – there is increased opportunity and decreased constraint (Bebbington et al., 2011). According to Badoe (2017, p. S33), "maternal death prior to age 13, having lived with three or more families during their childhood, and having experienced emotional abuse prior to age 13" are risk factors for physical abuse. Bebbington et al. (2011) express that social class and ethnic group are not risk factors but that Black women do report more abuse. The child's culture and family dysfunction exacerbate

emotional abuse (Scholtz, 2001). Other risk factors include being an unplanned baby, having a low birth weight, and other developmental problems like speech delays, autism, cerebral palsy, and psychological or behavioural difficulties (Rao & Lux, 2012). Being unwanted, the undesired gender or an orphan/street child places the child at further risk owing to the lack of parental support he/she may receive (Prinsloo, 2016).

Vallone et al. (2009) argue that a child who falls victim to abuse has roughly a 50% chance of abuse reoccurring and an increased risk of dying if the abuse continues. Re-victimisation occurs from secondary victimisation and the fear of the unknown, which influences how many individuals report abuse (Collings et al., 2005). Powerlessness and secrecy 'forced' into victims by the abuser contributes to providing an enabling context for continued abuse, thereby causing further damage to the child from self-blame, beliefs in the perpetrators' lies and the use of negative defence mechanisms (Collings et al., 2005). Child victims of abuse require their feelings to be normalised and need support, reassurance and acknowledgement of surviving the incident(s) (Joyner, 2016).

The above factors may positively or negatively affect the child and his/her interaction patterns with others (de Witt, 2014). Protective factors can minimise the chances of becoming a victim of abuse and/or assist the child in being resilient. These relate to factors that help mitigate against the negative event and are often limited to the social environment in which one finds oneself (Richter & Dawes, 2008). They pertain to any strengths and/or resources that the child can access, including a positive self-concept and self-esteem, social skills, the level of awareness as well as the social support networks that are available (Panjwani, 2013; Scholtz, 2001).

The microsystem concerns interactions between and influences by individuals and other systems that the child is actively involved in, and represents the child's immediate living environment where he/she learns about the world and has reciprocal interactions (Swart & Pettipher, 2016). It comprises of the family, school and peer groups (Psychology Notes HQ, 2013). The microsystem operates as a risk factor or as a protective factor, which could provide love, support, acceptance and belonging.

2.6.2.2 Family

Family factors that can exacerbate the risk for abuse include a history of/current involvement in crime, unrealistic expectations of the child, family members with mental health problems, substance abuse, and poor parenting practices (Vallone et al., 2009). Substance abuse affects an abuser's inhibition, resulting in reduced impulse control (Richter & Dawes, 2008), which can lead to bullying, hitting or asserting power over a child sexually. Caregivers' educational level, if low, as well as them having the desire to satisfy unmet emotional needs, are risk factors contributing to possible abuse (de Witt, 2014). A caregiver who experienced abuse is more likely to abuse their child (Janssen et al., 2013; de Witt, 2014; Prinsloo, 2016) – a past history of "intra-familial abusive relationships has been found to predispose the abuser to perpetration", which contributes to intergenerational abuse (Townsend & Dawes, 2004, p. 74).

Single, unemployed and young parents are more likely to implement physical abuse (Janssen et al., 2013). Legano et al. (2009) propose that single, young (under age 20) mothers who lack adequate finances and prenatal care and who smoke during pregnancy have an increased risk of maltreating their children. "[T]here is no single fact about child abuse and neglect that has been better documented and established than their strong relationship to poverty and low income" (Pelton, 1994, p. 131, as cited in Townsend & Dawes, 2004, p. 75) and these children have more risk for adverse outcomes (Panjwani, 2013). Poverty and stress are said to have the greatest relationship with abuse, and drug and alcohol abuse are also considerably related to abuse (Rao & Lux, 2012). Difficult financial situations create stress which affects the child and caregivers' responses (Prinsloo, 2016). Increased stress creates parental irritability which can lead to abuse (Harty & Alant, 2016).

Parental emotional issues, alcohol abuse, and family violence are said to be linked to continued physical abuse in children under 3 (Legano et al., 2009). Caregivers' warped views of the I-you relationship, feelings of inadequacy and humiliation, and viewing their child as a monster can create abuse (Prinsloo, 2016). Parental attitudes and norms allow others to have opportunities to abuse. Parents who express negative behaviours and focus on punishment and threat could experience negative responses from their children, making them more likely to react abusively from frustration (de Witt, 2014). Children become their parents' 'punching bags' and receive emotionally distant care or neglect.

Marital and/or other conflict may be expressed aggressively or violently and projected onto the child (de Witt, 2014). Physical abuse risk factors include stress from parents changing jobs, a loss of income and social isolation (Janssen et al., 2013). Disappointing sex lives and not accepting mental illnesses can exacerbate child abuse (Prinsloo, 2016).

Social statuses, cultural ideologies, age and gender result in many intra-familial sexual assaults (Guma & Henda, 2004). Force and deception are the modus operandi for abuse. Parental absence owing to illness, living with one parent, and child-headed households place children at increased exposure to the threat of abuse (Leoschut & Kafaar, 2017; Swart & Pettipher, 2016). Lacking social support, overcrowded homes and poor living conditions negatively influence the family dynamic in which the child interacts (Viviers, 2013; Mohamed & Naidoo, 2014). "[P]rior history of abuse, prematurity, prolonged hospitalization, lack of extended family, … and employment instability" may also lead to abuse (Legano et al., 2009, p. 31.e3). Harsh and inconsistent parenting means that children are not taught 'correct' values and are easily influenced (Leoschut & Kafaar, 2017). Homeless families lack a safe environment causing increased interactions with strangers which increase the risk of harm to children (Viviers, 2013; Mohamed & Naidoo, 2014). A family's cultural and religious beliefs may run counter to human rights' perspectives. Some women are expected to treat their husbands as a God alternative, and obey and revere their husbands, regardless of their behaviour, which perpetuates violence (Guma & Henda, 2004). Family dysfunction places children in danger.

The family environment aims to teach the child values and norms and is influential in the child's upbringing (Mathews & Benvenuti, 2014). A supportive family provides acceptance, support and other protective factors but also minimises the chance of the child becoming an abuser. Parents who are educated about raising children create safe environments and use positive parenting (Panjwani, 2013; DSD et al., 2012). Such parenting can relate to caring for their child, keeping their child healthy; or knowledge about behaviour management and the development of positive relationships with their children. Stable homes and strong parent-child bonds reduce the likelihood of abuse and neglect (DSD et al., 2012). Risk and protective factors are influenced by social norms and customs, which often come from the family (DSD et al., 2012, p. 44). Abuse interventions that include family members and work with the victim and abuser together can be useful (Fontes, 2008). The family's cultural beliefs must also be considered.

2.6.2.3 Schools

Schools are becoming a location for increased victimisation and abuse particularly because children's interactions are less protected (Leoschut & Kafaar, 2017). Perpetrators can be other children or adults including educators, who may be abusers or people of support and protection (Swart & Phasha, 2016). South African schools experience "poor infrastructure, a lack of resources, and various safety-related concerns" as well as having to teach large classes, with many learners experiencing behavioural or emotional difficulties (Leoschut & Kafaar, 2017, p. 3). Sexual, physical and emotional abuse are common. Schools are said to experience 20% of sexual abuse cases and about 33% of rape perpetrators are said to be educators (Viviers, 2013). Physical punishment was experienced by approximately 17.2% of learners in 2011, and it is believed that learners in KZN have a 25% chance of experiencing corporal punishment (Viviers, 2013). Twenty percent of boys and 1 in 6 girls were victims of bullying according to a 2008 study (Viviers, 2013). Experiencing abuse can affect the child's ability to achieve academically or on the sports field, or affect his/her peer relationships (de Witt, 2014). Owing to the lengthy interactions that educators share with children, they are role models and role players in understanding the dynamic interactions between the caregiver and victim; physically observing the child's behaviour and noticing any physical signs of abuse (de Witt, 2014). Schools can provide consistent, supportive relationships with children and allow children to grow up and develop in a safe, social environment (Leoschut & Kafaar, 2017). They act as a refuge for children where support and protection should be provided (Prinsloo, 2016).

2.6.2.4 Peer group

Peer groups function in a similar way to families and the school environment. They can provide support and guidance but also risk being or having perpetrators of abuse (Swart & Pettipher, 2016). Children often learn about themselves and their cultures and are taught to value and respect these beliefs through their peers (Swart & Pettipher, 2016). A peer group may use abuse for initiation, group acceptance and may negatively influence the individual into abusing others. Peer pressure can play a major role. Involvement in peer activities as well as recreational activities (also in the exosystem) can build protective factors (DSD et al., 2012).

2.6.3 Mesosystem

The mesosystem represents the relationships and interactions between the microsystems, which influence each other and the child's vulnerability and response to abuse (Janssen et al., 2013; Swart & Pettipher, 2016). Risk and protective factors in each of the microsystems can influence the other systems. For example, poor relationships, a lack of emotional support and disinterest in the caregiver-child relationship can result in the caregiver physically abusing the child. But, having a caring, interested educator may assist the child find support to disclose the abuse. There is a reciprocal interaction and influence between the microsystems. These contexts are also influenced by the larger exo- and macro-systems (Swart & Phasha, 2016). Good relationships encourage support where children can express concerns of abuse (Mathews & Benvenuti, 2014).

Insecure attachments and alcohol and drug abuse affects the parent-child relationship and the likelihood of abuse, which in turn affects behaviour in the community (Janssen et al., 2013; DSD et al., 2012). However, a social structure may help keep poor behaviour under control. Children who have secure attachments to caregivers, access to social support services and knowledge of right and wrong behaviour and how to protect themselves can mitigate the risk of abuse from other systems (e.g. educators or peers) (Mathews & Benvenuti, 2014). Contact between the school and family can mitigate some of the harmful influences and risks in being witness to or experiencing abuse (Harty & Alant, 2016). A stable family, good communication, positive role models and strong attachment relationships can protect a child from abuse and from becoming an abuser (DSD et al., 2012). Being socially included, having social networks to draw on and having social capital are resources of resilience (Harty & Alant, 2016).

2.6.4 Exosystem

The exosystem relates to interactions between different systems that the individual is indirectly involved in and influenced by because of more distant relationships (Psychology Notes HQ, 2013; Swart & Pettipher, 2016). It includes the greater neighbourhood area, parents' work environments and extended family members, which may expose the child to other interactions and settings that may shape whether a child becomes a victim or perpetrator of abuse (Mathews & Benvenuti, 2014; Psychology Notes HQ, 2013). Areas with high levels of "poverty, underdevelopment, mobility, unemployment, high population density and crime are risk factors for becoming a victim or perpetrator" of abuse (Janssen et al., 2013, p. 224). Communities with insufficient

housing and easy access to substances increase the opportunity of abuse (Janssen et al., 2013). Poverty is strongly correlated to physical abuse, and poverty and violence result in many children witnessing violence, reiterating 'normal' behaviour which becomes expected and copied (Mathews & Benvenuti, 2014). Children's and adults' frustrations from violence could risk them taking out their frustration on others (Harty & Alant, 2016) or encourages more violence through vigilantism. This may be a result of their loss of 'freedom'. Community cultural practices may negatively affect the child. Children may be forced to perform activities or may be harmed or killed for body parts which are used for *muthi*[2] or witchcraft. Cellular telephones increase the risk of cyberbullying and emotional abuse (Viviers, 2013).

Having few community institutions (like community centres, churches, aftercare programmes and sport programmes) to assist the family with support, social isolation and community apathy risk influencing those who become abusers (de Witt, 2014). Having formal and informal support groups to assist children and their families as well as employment opportunities for adults can mitigate the risks (de Witt, 2014). Any systems in the community that can reduce personal stress are protective, including service accessibility, supportive communities, adequate child care, strong justice systems, policies, laws and social norms (Mathews & Benvenuti, 2014).

In African communities, parenthood is viewed as a collective social responsibility and consequently those who are related to the biological parents or of the same or an older age, command respect and obedience from children which allows such adults to perpetrate offences (Guma & Henda, 2004). These cultural practices should be implemented in moderation and children need to know that reporting abuse trumps respecting elders. However, this extended parenting may also ensure that a child is cared for and not left unattended for others to perpetrate violence against him/her. Children in urban areas are said to have a greater risk of experiencing poly-victimisation (Leoschut & Kafaar, 2017). Violence and gang involvement in communities expose children to increased risk (Viviers, 2013). Disorganised communities without clear structures and support are also influential (Leoschut & Kafaar, 2017). A plethora of family and friends "who can offer assistance, take care of the children, or provide entertainment and relaxation" can greatly protect children from abuse (de Witt, 2014, p. 329).

[2] *Muthi* is an African word that denotes traditional medicine.

2.6.5 Macrosystem

The macrosystem comprises of “broad societal factors such as health, economic, educational and social policies that help create a climate in which violence is encouraged or inhibited and help to maintain economic or social inequalities between groups in society” (Mathews & Benvenuti, 2014, p. 30). The country’s laws, politics, policies and the socio-economic situation form part of the macrosystem (Swart & Phasha, 2016). This is the most distal factor from the child and includes “the attitudes, beliefs, values and ideologies inherent in the systems of a particular society and culture” (Swart & Pettipher, 2016, p. 15). Cultural ideas like the acceptance of violence and physical force to solve problems continue the abuse cycle (de Witt, 2014). Papalia et al. (2006) argue that societal violence and physical punishment are two cultural factors that require change. Economic policies can negatively affect unemployment rates which can create increased violence owing to increased desperation. The system also influences how interactions on other levels occur as it provides structure and content to these systems (Swart & Pettipher, 2016). Education, health and social systems, and social and professional organisations may affect or be affected by other systems that include the child (Swart & Phasha, 2016). The education system and curriculum provide the opportunity to educate and empower children about abuse (Swart & Pettipher, 2016). Health services and media are also relevant and can provide enlightenment and support services, but these need to be run correctly (Swart & Pettipher, 2016). Poor health services mean that children who are chronically ill cannot receive assistance, making them vulnerable to abuse and this makes reporting abuse a challenge. Fontes (2008) emphasises the importance to consider ethnicity, culture and religion.

Exposure to violence in South Africa, through witnessing acts or through exposure from the media, normalises these acts and desensitises people, creating a culture of violence that encourages people to use violence to remedy ills, leading to increased abuse and restlessness (de Witt, 2014). Implicit and explicit social hierarchies determine the relationship between the perpetrator and victim and the culture’s taboos are also influential (Guma & Henda, 2004). In the isiZulu/isiXhosa cultures, it is taboo to marry a sister, brother or cousin; but this is accepted in the Sotho and Tswana cultures (Guma & Henda, 2004). Cultural norms and values affect how families respond to societal pressures which influence the prevalence of abuse (Janssen et al., 2013). Values like

social justice, respect for people, equality and non-violence must be promoted to discourage abuse (Swart & Pettipher, 2016).

Living in a war-torn area can influence exposure to violence and abuse. Poverty, the HIV/AIDS pandemic, unequal groups and unemployment in South Africa affect parenting, social norms, and education availability amongst other things. HIV and AIDS have resulted in myths of cleansing and more orphaned children which increase the risk of abuse, particularly sexual abuse (Townsend & Dawes, 2004). Rites like cutting off a child's small finger and facial sacrifications need to be questioned (Guma & Henda, 2004). Gender socialisation and child rearing practices influence the overarching ideologies and the normalisation of some acts continue to silence children in reporting abuse (Townsend & Dawes, 2004). Other risk factors include a culture's expectations, the absence of opportunities and organic factors (Scholtz, 2001). Laws are vital to place some boundaries over cultural ideologies.

Arrested children risk being treated inhumanely or being abused when put into prison cells with adults, even though the Child Justice Act does not allow it (Viviers, 2013). The country has policies regarding formal labour to protect children – e.g. a minimum age of 15, and work must be unharmful and not interfere with their schooling (Viviers, 2013). Overarching ideologies influence how people behave. Feminist theorists reiterate the unequal gender-based power relations (Townsend & Dawes, 2004), but this does not account for women who initiate abuse. Society's proverbs can also be influential. A Tswana proverb, "*ba tiisa mokwatla"* ("strengthening the child's back") relates to preparing the child for life, which can legitimise physical and sexual abuse (Guma & Henda, 2004, p. 104). South African services focus more on responding to reported cases than on proactive, preventative measures (Mokoae et al., 2012). The ultimate goal is to move towards community interventions that "address the majority of citizens' socioeconomic contexts within which social problems … [occur] and be rights-based" (Mokoae et al., 2012, p. 4). These have not yet been put in place.

2.6.6 Chronosystem

The chronosystem concerns the conception of time and the influence of the past and how it affects other systems (Psychology Notes HQ, 2013). Time across these systems relates to continuity, days and weeks, as well as intergenerational periods. The

chronosystem is particularly important in relation to the micro-, meso- and macro-systems (Swart & Pettipher, 2016). For example, increasing lengths of time with the abuser is likely to lead to increased risk of abuse and multiple abusive acts. South Africa's history of colonial rule and Apartheid has influenced the development of violent beliefs and an unequal socio-economic climate which influences communities and families and perpetuates violence (Mathews & Benvenuti, 2014). Apartheid legitimised violence as a means to achieve an end. It influenced values, ideologies, the provision of different opportunities because of race and gender, different social classes, strained relationships between ethnicities and living locations which all exacerbate the possibility of abuse. This system influences other systems and may include "a change in family structure, address, parent's employment status, in addition to immense society changes such as economic cycles and wars", which may exacerbate abuse (Psychology Notes HQ, 2013). Previously, the country was less rights-oriented, giving less protection to children. Past cultural and traditional practices influence current practices and child-rearing, which if not changed, risk creating abusive situations and continuing intergenerational abuse.

2.7 Summary of the chapter

Child abuse has evolved over the years and is now more inclusive, focusing on the rights of the vulnerable child. The debate about what is included in defining abuse is constantly developing but this study aims to use the WHO's broad definition owing to its exploratory nature. It was decided that physical, sexual and psychological abuse and neglect would be the focus. Whilst numerous international and national laws, acts and policies have been created to help with the crisis, these laws lack practicality and are optimistic only in theory. The issues of reporting abuse suggest that there are many victims whose abuse remains unreported and such children cannot receive the necessary assistance. The consequences of child abuse are far-reaching and case-dependent, and more information is needed.

The body of knowledge, specifically in South Africa, needs to be expanded so that stakeholders can be identified and become involved in interventions as a matter of urgent public health. Interventions need to be tailored and a one-size-fits-all intervention will not assist all victims. These facets all relate to the chosen theoretical model, Bronfenbrenner's ecological systems theory, which recognises multiple, intertwined facets. There does not seem to be adequate alignment between theory and empirical

studies. Working from a bottom-up approach hopes to elucidate small-scale rates of abuse and consequences which can act as a basis for exploring larger areas. International data are useful for comparative purposes especially for policy development and legislation, but small-scale studies are needed first. This research is an attempt to explore the field at a local level - the Msunduzi municipality. The study will now turn to describing the methodology that was used in this project.

CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter explains how the study was conducted and how data were obtained. The focus is on detailing the study's location, research paradigm and design, sample, aims of the study as well as the instrument used and its validity and reliability. The way the data were analysed will also be discussed to orient the reader to the results chapter which follows. Ethical considerations were numerous, and a section is devoted to this. The location of the study will now be introduced.

3.2 Location of the study

As of July 2017, it is estimated that South Africa has a population of 56.52 million people (Statistics South Africa, 2017b). Of this, 28.9 million people are female. Statistics South Africa (2017b) states that KZN has the second largest population of 11.1 million (19.6%). Data were only available up to age 15 on Statistics South Africa, the national statistics service. They estimate that 29.6% of the country's population is younger than 15 years and of this 16.7 million, 3.5 million live in KZN (Statistics South Africa, 2017b). Mokoae et al. (2012) cite statistics that about 38% of the country's population are children (i.e. under 18). UNICEF's annual report for 2012 found that 21.9% of the child population resides in KZN (UNICEF South Africa, 2013).

Owing to the size of the population in KZN and its accessibility to the researcher, the study took place in the city of Pietermaritzburg, the capital city of KZN. Data were obtained from a specialist doctor (HSP) in private practice based in the urban area of Pietermaritzburg. The site was chosen because the specialist was willing to partake in the study and because of the practice's location and accessibility for both the researcher and the community where the incidence of abuse is believed to be high. Whilst it is acknowledged that the setting may be limited, owing to it being a private practice, other organisations were approached and were unwilling to participate. The practice works with victims with and without medical aid and works in conjunction with referring parties.

3.3 Paradigm and research design

The research project followed a quantitative research design as it assessed nominal data using descriptive and inferential statistics (Durrheim, 2006). The quantitative research aligned to the post-positivist paradigm which acknowledges that the researcher and her background knowledge, theories and values can influence what is observed (Robson,

2011). Power, politics and ideology are recognised as influencing the knowledge gained and knowledge is directed by the best evidence available at the time. This viewpoint allowed the researcher to be cognisant that the study is only building towards the truth about child abuse and is influenced by her own and the HSP's perceptions (Robson, 2011). The study is a non-experimental fixed design owing to the use of a questionnaire, which entailed no manipulation of variables (Robson, 2011).

The study aimed to assess predetermined categories with the hope of creating data for use in broader, generalisable studies that may then be used for comparisons (Durrheim, 2006). For example, developing data that can be used in the future to compare Pietermaritzburg with other areas (in the same and other municipalities) to discover any patterns of high abuse incident areas. Owing to the dearth of epidemiological studies on abuse in South Africa, KZN and Pietermaritzburg, and based on the research questions, the research was exploratory and descriptive. Exploratory research aims to enhance knowledge and "achieving a clear description of a poorly understood area can reasonably be the priority" (Robson, 2011, p. 39). The study aimed to develop a basic understanding of abuse referred to the HSP in the Msunduzi municipality and hoped to make preliminary investigations and describe the current situation (Durrheim, 2006). Consequently, the study was inductive.

3.4 Study population

The study's population pertained to all of the case files of child abuse reported at the HSP's private practice. The researcher aimed to be as inclusive as possible and included cases of physical, sexual and emotional abuse as well as neglect in the sample. The population and sample consisted of children who had sought services from the HSP owing to suffering abuse or owing to abuse being suspected and then diagnosed, which were studied over three days. Being a private practice, there was the implicit requirement that victims' families had funds to pay for the consultation else medical aid. No participants were recruited for the study, particularly due to the research's sensitive nature and owing to the need for anonymity when reporting abuse.

3.4.1 Inclusion/exclusion criteria

To be included, individuals needed to be exposed to any of the four types of abuse and be 18 years old or younger at the time of seeing the HSP. The child had to have seen the HSP for abuse between 2010 and April 2018. The sample included children of both

sexes and all races. There was no limitation as to where the person resided, but he/she had to have seen the HSP through their private practice. The sample included case files of children where abuse was suspected and found, reported explicitly/implicitly, and the court status was irrelevant. Within a three-day sampling period, 333 cases were analysed, and 52 cases were found to contain abuse. These formed the study's sample.

3.5 Sampling techniques and sample size

Owing to the sensitivity of the study, secondary sources in the form of case files, where the HSP had recorded abuse, were used. Whilst this method may be viewed as less effective than interviewing victims, it has been used in other research (see Tortolani & Lanti (2009) and Collings (2009)). This method reduces the possibility of secondary victimisation and allows for anonymity. As a result of the uncertainty of the number of possible cases available, it was decided that the sample be from 2010 to April 2018 and the aim was to get the maximum number of cases in the three-day sampling period. A minimum of 30 cases were required. A total of 52 cases were obtained.

Non-probability sampling was chosen due to the practicality of the method in terms of cost and time limitations. Non-probability sampling involves sampling where the choice of elements is not decided on based on the statistical principle of randomness (Durrheim & Painter, 2006). More specifically, purposive sampling was chosen as the study required cases to be available and typical of the population that was being studied (Durrheim & Painter, 2006). The study focused on cases diagnosed with abuse at the HSP's practice.

3.6 Research questions and objectives

The study was explorative regarding the information that emerged and aimed to describe such information. From the literature review, the following research questions emerged:

1. What is the prevalence of abuse sampled from the HSP's private practice's database in Pietermaritzburg, in the Msunduzi local municipality?
2. What are the characteristics of the child abuse cases reported at the HSP's practice in Pietermaritzburg?
    a. Child characteristics
    b. Parents and context
    c. Perpetrator characteristics
3. What are the pathways of intervention for reported abuse cases?

4. What risk and protective factors exist from the cases reported at the private practice?
5. Who are the major stakeholders that could assist in prevention and promotion interventions for child abuse?

Accordingly, the following objectives existed for the study:

1. To investigate the various forms of abuse reported at the HSP's private practice in Pietermaritzburg through the use of case files.
2. Using those case files, explore the characteristics of abuse to try profile such cases.
3. To attempt to identify the pathways of intervention for reported child abuse cases.
4. To identify risk and protective factors from the abuse cases reported at the HSP's practice.
5. To recommend the key target population/stakeholders in various fields which can effectively create preventative programmes and promote early intervention for child abuse.

3.7 Data collection

Data collection took place over three days using the case files of abuse victims that were recorded at the HSP's practice between 2010 and the data collection period (April 2018).

3.7.1 Research instrument

Data were collected using a questionnaire that was developed by the researcher specifically for the study, which was guided by the literature reviewed. The researcher was assisted by her supervisor. Despite the acknowledgement that questionnaires are not best suited to exploratory work owing to how much information they can gather; they are well suited to descriptive work (Robson, 2011). Consequently, the researcher provided a space for other responses and information to be recorded which did not fit into the predetermined categories (continuous analysis for adjustment) to gather as much information as possible. The questionnaire aimed to discover a prevalence/incidence rate of child abuse in part of the Pietermaritzburg area, profile victims and abusers, discover possible risk and protective factors qualitatively, and gather information pertaining to reporting and prosecution. These aims were similar to Tortolani and Lanti‘s (2009) study which also used case files. The researcher made every effort to consistently record data from the files and assessed and recorded all information herself. Consequently, she was

reflective throughout the process. The researcher's supervisor checked in occasionally to ensure that data collection ran smoothly.

Data from the questionnaires were coded based on the quantitative coding technique of *content analysis*, which pertains to the "objective, systematic and quantitative description of the manifest content of communication" (Bryman, 2012, p. 289). This coding is indirect, unobtrusive and non-reactive as the use of case files does not affect the case file content (Robson, 2011). It was deemed most useful owing to the process identifying dimensions pertaining to abuse (Collings et al., 2005). This technique was chosen to assist other researchers to reproduce information (Rose, Spinks, & Canhoto, 2015). Content analysis is normally used with printed texts and documents; but aligns to the use of case records as well (Bryman, 2012). However, data that are collected are not structured for the needs of the researcher and thus may be more general, which make it more challenging to extract pertinent areas (Robson, 2011).

The coding schedule aimed to record all of the necessary data about each case on multiple dimensions (Bryman, 2012) (Appendix C). For each subsection, various options were presented and the most applicable was selected. A coding scheme was developed, which creates rules on how to classify data into coding categories (Rose et al., 2015). For example, the age category of 6-10 years was coded with a unit of 2 and the 11 to 14-year category had a unit of 3. The coding schedule, coding scheme and coding manual were the same, and owing to the researcher completing the work, coding instructions were not provided, but "all the possible categories for each dimension being coded" were included (Bryman, 2012, p. 299). These were found in the study's questionnaire, for ease of working with the data (Appendix C). Coded dimensions aimed to answer the research questions and included the victim's age, race, and sex; the type of abuse and where it took place; the perpetrator's age, race, and sex; and the relationship between the perpetrator and victim. Other dimensions included where, how and when the child abuse occurred and was reported and any possible symptoms of the abuse. The questionnaire and coding schedule, coding scheme and coding manual were not piloted as all cases needed to be included in the study. However, they were reviewed extensively by the researcher's supervisor and the HSP to ensure that the categories were mutually exclusive and exhaustive and to identify possible problems prior to commencing with data collection.

3.7.2 Validity and reliability

Validity assesses whether a tool measures what it claims to measure (Bryman, 2012). Owing to the researcher not choosing a standardised measure, it was difficult to assess how valid the instrument was.

> There are particular challenges with establishing the validity and reliability of data-collection instruments in the field of child and adolescent sexual abuse since direct questioning about experiences of sexual abuse is associated with complex methodological, legal and ethical difficulties. (Rao & Lux, 2012, p. 460)

Since the research focused on describing and exploring abuse, descriptive categories were chosen as factors pertaining to abuse which emerged from the literature reviewed. This gave the research face validity as the tool reproduced the content of abuse (Bryman, 2012). The issue of not directly questionning or interviewing victims can bring questions to the validity of the data collection method (Rao & Lux, 2012). Continually reviewing the questionnaire acted as a content validity measure because it allowed the researcher, her supervisor and the HSP to check which other categories needed to be included and to discover insignificant categories. Since the content was taken directly from case files, the data pertained to the victim's/HSP's understanding of abuse. This form of validity emphasises the originality of the research. The questionnaire was reviewed by the researcher's supervisor and the HSP, who are viewed as experts in the field.

Owing to the small and specific sample that was used in the study, generalisability (external validity) is limited. There is some possibility of other researchers replicating the study if they were to go back and review the case files (Robson, 2011), but owing to the setting being a private practice, it cannot be generalised to all child abuse victims in Pietermaritzburg because many more individuals probably access public or other private healthcare. Racial differences may also exist and limit generalisability owing to the country's history of Apartheid whereby more White people are likely to have access to private healthcare and many more African and Coloured individuals are likely to use public healthcare (Statistics South Africa, 2013). The methodical and reflective way in which data were collected and analysed aimed to assist the research in being more

objective, but objectivity in itself is limited, as acknowledged in the post-positivist paradigm (Robson, 2011).

Reliability relates to the consistency of the tool and concerns intra-observer reliability, which pertains to reliability within the researcher (Bryman, 2012). Participant error and bias were not problems for this study but researcher error and bias may have been (Robson, 2011). The researcher was cognisant of her influence on data collection and attempted to be as objective as possible. From the post-positivist paradigm, the researcher was also aware of her influence on the research (Robson, 2011). The researcher recorded data from case files herself and was the sole recorder, which she hoped would ehnance reliability. This was ensured through her generating an in-depth questionnaire to assist with data collection and completing data collection over three days. All recordings were checked with the case file and then coded and checked against a template to ensure that categories of responses fell into consistent groups. The researcher's supervisor checked in occassionally to ensure that the researcher recorded and coded the data correctly. Consistency was also achieved by liaising with the HSP, which was a quality control measure. The HSP clarified aspects of case files as required. At times, the researcher made decisions based on the recorded notes regarding whether abuse had occurred or not, and this may have influenced the reliability of the findings.

The researcher's awareness of the study as a matter of public health made her aim to be as rigorous as possible. Meetings were regularly arranged with her supervisor and she liaised with the HSP throughout data collection to ensure that the study was as valid and reliable as possible. Obtaining gatekeeper consent from the HSP (Appendix A) and signing a confidentiality agreement (Appendix B) aimed to ensure protection of the individuals whose case files were studied, by ensuring that any identifying information was not divulged. This again related to the validity of the study. Attending an MS Excel statistics course aimed to make the findings more trustworthy and more statistically valid and hoped to make data analysis more reliable as the researcher then knew what statistical tests needed to be performed and how to conduct them. The researcher hoped to enhance the study's rigour by having a minimum number of case files (30), but strived for the maximum number in the three-day data collection period. There was no concern

about the response rate/response bias (Robson, 2011) as case files were used. Rigour was also achieved through having a statistician study the findings.

3.7.3 Reviewing the questionnaire

A pilot study was not conducted owing to the small number of case files that were used. However, the questionnaire was continuously reviewed and there were constant discussions with the researcher's supervisor and the HSP. Prior to commencing with data collection, the questionnaire was reviewed and adjusted as necessary.

3.8 Research/operational hypotheses

Hypotheses were developed prior to conducting inferential statistics. The null hypothesis (H_0) stated that there was no association or relationship between the rows and columns of the cross-tabulations where the rows and columns represented different criteria (Freeman & Campbell, 2007). The null hypothesis states that the two criteria are independent (Mehta & Patel, 2012). For example, H_0 would state that there is no association/relationship between whether the child has a disability or not and the type of abuse experienced. The alternative hypothesis (H_1) states that the two criteria are related or dependent (Mehta & Patel, 2012). For example, H_1 would recognise that there is a relationship between the perpetrator's age and the type of abuse perpetrated. H_1 aimed to elucidate risk and protective factors as well as areas that require more intervention.

3.9 Data analysis

The coding scheme discussed under the data collection section (Section 3.7) was used as the basis for data analysis. This scheme coded all of the nominal data categorically. The data were synthesised into a data set on Google which provided basic summaries of the data, and this was then used to create a computer file that was imported into MS Excel and SPSS (Robson, 2011). The data were mostly used in nominal scale (Leoschut & Kafaar, 2017). Cross-tabulations/contingency tables were then created.

The data were first analysed to create descriptive statistics in the form of contingency tables on MS Excel to understand the prevalence/incidence of child abuse in Pietermaritzburg as well as to 'profile' victims and abusers. The use of frequency distributions was useful in this regard. Descriptive statistics aimed to enhance the exploratory and descriptive nature of the study. Inferential statistics were planned for using the chi-square test, which is considered useful to measure how related two

variables are (Robson, 2011). However, Fisher's exact test was used instead to assess relationships/associations between variables and to determine if any statistical significance existed because of the study's smaller sample size and the desire for more than approximations (Mehta & Patel, 2012). McDonald (2014) recommends that Fisher's tests are used for studies with a sample size of less than 1 000. Fisher's exact test is generally conducted on 2X2 contingency tables but can also be conducted on tables with more rows and/or columns (Mehta & Patel, 2012). A p-value of less than 0.05 means that H_0 is rejected and the two criteria are related (i.e. H_1 is accepted); and when the p-value is greater than or equal to 0.05, H_0 is accepted, i.e. the two criteria are independent/not related (Freeman & Campbell, 2007).

Owing to the researcher's limited statistical knowledge, an MS Excel course for statistics was attended at UKZN. The assistance of Mr. Kaseke, a statistician, was used for the inferential statistics, which were performed on SPSS, a statistical package (F. Kaseke, personal communication, October 10, 2018). The results were interpreted using Bronfenbrenner's theory, which aimed to put the results into context and hoped to provide insight into the consequences of abuse, risk and protective factors, and to identify the necessary stakeholders for intervention. This hoped to elucidate the different levels of influence and the interactions at the individual, micro-, meso-, exo- and macro-system levels (Janssen et al., 2013).

3.10 Ethical considerations

Full ethical approval was obtained for the study from the Human & Social Sciences Research Ethics Committee at UKZN (Appendix D). The study risked facing some ethical dilemmas owing to the sensitive topic and the use of case files relating to childhood abuse. Ensuring that the research was ethical was crucial. Confidentiality was the first step since data were obtained from individuals' case records. Case files contained identifiable victim and perpetrator information and confidentiality ensured no further victimisation. Access to the files was limited to the researcher, her supervisor and the HSP (Collings et al., 2005; Collings, 2007). To ensure and maintain confidentiality, the three parties signed a confidentiality agreement (Appendix B). Identifying information was not reported as it was irrelevant, and this ensured anonymity. The abuse files remained at the HSP's practice and there was no risk of external exposure (Collings et al., 2005). Questionnaires were kept in a locked cabinet, and data were then transferred

onto Google Drive and MS-Excel (both were password protected) on a password-protected computer (Leoschut & Kafaar, 2017).

The researcher ensured that there was no deception through remaining in open communication with her supervisor and the HSP throughout. Deception normally pertains to deceiving participants of the nature of the study, but there was no access to participants, and honesty was maintained with the HSP continuously. The researcher acted in the best interests of those involved by maintaining anonymity and having the goal of providing a knowledge base as priority. Gatekeeper permission was obtained from the HSP (Appendix A) (Collings, 2009; Janssen et al., 2013). A participant consent form and information sheet were not required (Robson, 2011). The lack of direct contact assisted in reducing the risk of harm (Collings, 2007; Collings, 2009).

The researcher used Wassenaar and Mamotte‘s (2013) eight ethical elements to ensure that ethical research was conducted. There was collaborative partnership with the community and other relevant stakeholders including the HSP (Wassenaar & Mamotte, 2013). There was no direct contact with the victims (Collings et al., 2005) and the research aimed to inform other stakeholders of the findings. The researcher worked collaboratively with the HSP and attained the doctor’s understanding as necessary. The study is believed to have social value by providing some benefit whether directly or indirectly (Wassenaar & Mamotte, 2013). Whilst this research did not help the abuse victims; it hoped to provide knowledge into understanding abuse and discovering the necessary stakeholders for intervention to help reduce the likelihood of future children suffering from such abuse.

The research aspired to be scientifically valid through the research design, sampling, data collection method and analysis attempting to answer the research questions in a justifiable and rigorous manner (Wassenaar & Mamotte, 2013). The researcher was cognisant of the need for uniformity and ensured that the quantitative design matched the sampling technique, and the data collection and analysis methods. The questionnaire used for data collection underwent considerable review. There was fair selection of participants as those in the sample were relevant to the research questions (Wassenaar & Mamotte, 2013). All of the case files in the sample experienced some form of child abuse, regardless of the type of abuse recorded. The focus was on cases that were

reported/discovered, with or without prosecution from 2010 to April 2018. Another element of ethical behaviour is the favourable risk/benefit ratio, which relates to the principles of beneficence and non-maleficence. No harm including wrongs emerged from the study as there was no contact with the victims (Wassenaar, 2006). The potential benefits stemmed from conducting this exploratory and descriptive study, which hoped to increase insight into understanding and working towards minimising child abuse at a local, provincial, national and international level.

The sixth element, an independent ethics review (Wassenaar & Mamotte, 2013), aims to protect participants and ensure good quality research. The study was assessed by the School of Applied Human Sciences in the discipline of Psychology, and the College of Humanities Ethics Committee at UKZN to ensure that it met the necessary standards. Full ethical approval was granted (Protocol reference number: HSS/1886/017M) (Appendix D). The element of informed consent did not pertain to this study. Lastly, ethical research maintains ongoing respect for participants and the community being studied (Wassenaar & Mamotte, 2013). The victims were respected and valued throughout, and the researcher was sensitive towards the data collected and respectful of the HSP's work. The goal of helping reduce this public health issue also showed respect, as did not disclosing any identifying information despite the research being disseminated. The researcher did not have any concerns or risks regarding her safety because of the sensitivity of the topic and felt safe conducting data collection (Robson, 2011).

3.11 Summary of the chapter

An overview has been provided of how the research was conducted and provided some insight into the location of the study and the sample that was used. The methodology attempted to align to the literature review, and it is believed that this was successfully achieved. The research questions and objectives were practical and achievable. The study attempted to be as valid and reliable as possible, but it is acknowledged that generalisability of the study is limited. Ethical considerations were vitally important for the researcher, who believes that the study was conducted ethically, with the victims, specialist doctor, and larger stakeholders in mind. Chapter four that follows will present the results of the study.

CHAPTER FOUR: RESULTS OF DATA COLLECTION

4.1 Introduction

This chapter presents the study's results from the data collection that took place at the HSP's practice. The information is presented according to the research questions found in Chapters 1 and 3 and relates to the sample of case files. Approximately 908 cases were available for data collection and of these, 36.7% (333 cases) were analysed for evidence of abuse. A total of 52 cases showed the presence of abuse and/or neglect, which represented 15.6% of the case files. Cross-tabulations, also known as contingency tables, are presented below. Cross-tabulations and Fisher's exact tests were used to create the results and a 5% level of significance was used. H_0 is rejected when the p-value is less than 0.05, which says there is a relationship between the variables. If the p-value is greater than or equal to 0.05, H_0 is accepted and there is no relationship between the variables. Results are reported cautiously owing to the large number of univariate analyses conducted and the small sample sizes in some cases. Abbreviations used in the Tables, e.g. AcurrSkl and Dcollectinfo, represent the section of the questionnaire and the coding schedule (A, B, C, D, E or F) and the abbreviation of information collected from that question in that section. This is evident in Appendix C (the topic of information studied aligns with the abbreviation in the "Office use only" column).

4.2 Prevalence of child abuse at the HSP's practice

Table 4.1

Prevalence of child abuse at the HSP's private practice

Type(s) of abuse	***Frequency (count)***	***Percentage (%)***
Sexual	38	73.1
Physical & sexual	1	1.9
Emotional/psychological	7	13.5
Emotional & physical	1	1.9
Emotional & neglect	1	1.9
Physical	4	7.7
Total	**52**	**100.0**

Sexual abuse was most prevalent, occurring in 75% of the sample. Only one case experienced physical and sexual abuse, another physical and emotional abuse and another case emotional abuse and neglect. No episodes of only neglect were reported. Psychological abuse was second most apparent, followed by physical abuse. Forty-nine victims experienced a single type of abuse, equating to 94% of the sample.

4.3 Characteristics of child abuse reported at the HSP's practice

4.3.1 Child characteristics

Child characteristics included the victim's age, race, gender, disability, HIV status, schooling, presenting problem and symptoms on presentation at the HSP. In terms of age, H_0 states that the abuse type is independent of age; whilst H_1 states that the type of abuse is dependent on the victim's age.

Table 4.2

Cross-tabulation between age and abuse type

		Type of abuse						***Total cases /52***
Age		***Sexual***	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
0- 5 years	Count	12	0	0	0	0	0	12
	% by Aage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	23.1%
6-10 years	Count	21	1	5	1	1	2	31
	% by Aage	67.7%	3.2%	16.1%	3.2%	3.2%	6.5%	59.6%
11-14 years	Count	4	0	2	0	0	2	8
	% by Aage	50.0%	0.0%	25.0%	0.0%	0.0%	25.0%	15.4%
Don't know	Count	1	0	0	0	0	0	1
	% by Aage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	1.9%
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% by Aage	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

All victims below the age of 5 experienced sexual abuse. For the 6-10-year olds, abuse types varied, but over two-thirds of these children suffered from sexual abuse and another 16.1% were emotional abuse cases. The neglected child was in this category. In the 11-14-year-old group, half the children experienced sexual abuse and 25% each suffered from emotional abuse and physical abuse. One child, whose age was unknown suffered sexual abuse. Sexual abuse was highest in each age group. Fisher's exact test had a value of 19.245 and a corresponding p-value of 0.463. H_0 is therefore accepted; and the type of abuse is independent of age group. Children of any age can be victims of any abuse. Table 4.3 shows the comparison of victim's race and abuse type.

Table 4.3

Cross-tabulation of abuse type and race

		Type of abuse						
Race		***Sexual***	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	***Total cases /52***
African	Count	29	0	5	1	1	2	**38**
	% within Arace	76.3%	0.0%	13.2%	2.6%	2.6%	5.3%	**73.1%**
Indian	Count	2	0	0	0	0	1	**3**
	% within Arace	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%	**5.8%**
White	Count	7	1	1	0	0	1	**10**
	% within Arace	70.0%	10.0%	10.0%	0.0%	0.0%	10.0%	**19.2%**
Coloured	Count	0	0	1	0	0	0	**1**
	% within Arace	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	**1.9%**
Asian	Count	0	0	0	0	0	0	**0**
	% within Arace	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**

African children had the highest prevalence of abuse, particularly sexual abuse, followed by White children. More African children experienced sexual abuse and emotional abuse in comparison to White children. Indian and Coloured children showed small numbers of abuse. Fisher's exact test yielded a value of 22.769 and a p-value of 0.267. H_0 is accepted and it is concluded that the type of abuse is independent of race. Table 4.4 shows the abuse type and the victim's gender.

Table 4.4

Cross-tabulation of abuse type and victim's gender

		Type of abuse						
Gender		***Sexual***	***Physical & Sexual***	***Emotion-al***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	***Total cases /52***
Male	Count	16	0	6	1	1	4	**28**
	% by Agender	57.1%	0.0%	21.4%	3.6%	3.6%	14.3%	**53.8%**
Female	Count	22	1	1	0	0	0	**24**
	% by Agender	91.7%	4.2%	4.2%	0.0%	0.0%	0.0%	**46.2%**
Total for each abuse type	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% by Agender	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

Interestingly, there was more male abuse than female abuse. The Table shows that 57.1% of males suffered sexual abuse compared to 91.7% of females, suggesting that when females are abused, they have more chance of experiencing sexual abuse. More males experienced emotional abuse (21.4% compared to 4.2% of females). No females suffered from emotional and physical abuse, emotional abuse and neglect, and physical abuse. Fisher's test of independence yielded a value of 10.584 and a p-value of 0.014. At the 5% level of significance, H_0 is rejected, suggesting that the type of abuse is related to gender. Table 4.5 presents the abuse type and victim disability.

Table 4.5

Cross-tabulation between abuse type and victim disability

		Type of abuse						Total cases /52
Disability		Sexual	Physical & Sexual	Emotional	Emotional & Physical	Emotional & Neglect	Physical	
Disabled	Count	4	0	2	1	0	1	**8**
	% within Adisabled	50.0%	0.0%	25.0%	12.5%	0.0%	12.5%	**15.4%**
Not disabled	Count	34	1	5	0	1	3	**44**
	% within Adisabled	77.3%	2.3%	11.4%	0.0%	2.3%	6.8%	**84.6%**

The cases from the HSP's practice show the majority of abuse as occurring with children without disabilities. Fifty percent of children with disabilities experienced sexual abuse and emotional abuse was the next frequent. This same pattern emerged in children who are not disabled. Fisher's exact test had a value of 7.584 and a p-value of 0.146. There is no dependency between disability and type of abuse at the 5% level of significance. Table 4.6 shows the type of abuse and the known conditions victims had.

Table 4.6

Cross-tabulation of abuse type and known conditions/illnesses of victims

		Type of abuse						Total cases /52
Known conditions/illnesses and specify		Sexual	Physical & Sexual	Emotion-al	Emotional & Physical	Emotional & Neglect	Physical	
Physical & medical	Count	1	0	0	0	0	0	**1**
	% within Acondition	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Physical, medical & other	Count	1	0	0	0	0	0	**1**
	% within Acondition	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Emotional	Count	0	0	1	0	0	0	**1**
	% within Acondition	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	**1.9%**
Psychological	Count	3	0	1	0	0	0	**4**
	% within Acondition	75.0%	0.0%	25.0%	0.0%	0.0%	0.0%	**7.7%**
Psychological & medical	Count	0	0	0	0	0	1	**1**
	% within Acondition	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	**1.9%**
Medical	Count	2	0	2	0	0	0	**4**
	% within Acondition	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%	**7.7%**
Other	Count	0	0	0	1	0	1	**2**
	% within Acondition	0.0%	0.0%	0.0%	50.0%	0.0%	50.0%	**3.8%**
Not applicable	Count	31	1	3	0	1	2	**38**
	% within Acondition	81.6%	2.6%	7.9%	0.0%	2.6%	5.3%	**73.1%**
Total per abuse type	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Acondition	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0 %**

Most child victims of sexual abuse did not have any known conditions or illnesses. Victims with physical conditions (left hemiparesis and dysmorphism as well as a gaping mouth) experienced sexual abuse. The child with emotional problems (behavioural difficulties) was exposed to emotional abuse. Five victims presented with psychological conditions including ADHD, PTSD and social phobia, and experienced sexual, emotional and physical abuse separately. Regarding medical conditions of absent seizures, other seizures, Down Syndrome, Trisomy 21, Autism Spectrum Disorder (ASD) and hemiparesis, four children experienced sexual abuse and two were victims of emotional abuse. Other disorders included learning difficulties, speech difficulties and intellectual impairment. These were found in victims of emotional and physical abuse and physical abuse. Fisher's exact test yielded a value of 67.932 and a p-value of 0.208 and so H_0 is accepted. There is no dependency between known conditions/illnesses and abuse type. The cross-tabulation that follows presents victims' HIV statuses prior to exposure to abuse.

Table 4.7

Cross-tabulation of abuse type and victim's HIV status prior to abuse

		Type of abuse						***Total cases /52***
HIV Status		***Sexual***	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
Negative	Count	2	0	0	0	0	0	**2**
	% within AHIVbef	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.8%**
Unknown	Count	36	1	7	1	1	4	**50**
	% within AHIVbef	72.0%	2.0%	14.0%	2.0%	2.0%	8.0%	**96.2%**

Two children (4%) were known to be HIV negative before they experienced abuse. Both children suffered sexual abuse. Ninety-six percent of the victims' HIV statuses were unknown before they were abused. Of these, almost three-quarters were sexually abused, with 14% being emotionally abused and another 8% being physically abused. The case of neglect occurred with a child of unknown HIV status. Fisher's exact test showed as 5.548 and had a p-value of 1.00. H_0 is accepted and there is no dependency between the variables. The sample size would not allow valid conclusions to be drawn as most HIV statuses were unknown. After experiencing abuse, eight more sexual abuse victims discovered their HIV statuses as negative. Table 4.8 shows the victims' schooling and the types of abuse experienced.

Table 4.8

Cross-tabulation of abuse type with victims' schooling

Current schooling		*Type of abuse*						*Total cases /52*
		Sexual	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
None	Count	10	0	0	0	0	0	**10**
	% within AcurrSkl	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**19.2%**
Grade R to Grade 3	Count	13	0	2	1	1	1	**18**
	% within AcurrSkl	72.2%	0.0%	11.1%	5.6%	5.6%	5.6%	**34.6%**
Grades 4-6	Count	7	0	3	0	0	2	**12**
	% within AcurrSkl	58.3%	0.0%	25.0%	0.0%	0.0%	16.7%	**23.1%**
Grades 7-9	Count	1	0	0	0	0	1	**2**
	% within AcurrSkl	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	**3.8%**
Don't know	Count	5	1	2	0	0	0	**8**
	% within AcurrSkl	62.5%	12.5%	25.0%	0.0%	0.0%	0.0%	**15.4%**
Not applicable	Count	2	0	0	0	0	0	**2**
	% within AcurrSkl	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.8%**

The results show that children without formal schooling (in preschool or below grade R), only experienced sexual abuse. For children in grades R to 3, 72.2% were victims of sexual abuse and 11.1% victims of emotional abuse. Fifty-eight percent of children in grades 4-6 suffered sexual abuse, a quarter emotional abuse and almost 17% physical abuse. Grade 7 to 9 victims equally experienced sexual abuse and physical abuse. Another five children experienced sexual abuse, but their level of formal education was unknown. Those in the "not applicable" group included one child not attending school and another attending a special school. Children most affected were in grades R to 3, followed by grades 4-6. H_0 specified that the type of abuse is independent of the victim's schooling level and H_1 stated that the type of abuse is related to the current schooling level. Fisher's exact test gave a value of 29.27 and a corresponding p-value of 0.436. H_0 is accepted and the type of abuse is concluded as independent to the victim's schooling.

The HSP saw victims for numerous presenting problems. Whilst some children presented with one concern, most victims presented with multiple concerns. Table 4.9 shows the presenting problems with the type of abuse.

Table 4.9

Cross-tabulation of the presenting problems with the type of abuse

Presenting problem(s)		*Type of abuse*					
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*
Physical	Count	0	1	0	0	0	0
	% within Cpp	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%
Direct trauma	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Other	Count	3	0	2	0	0	1
	% within Cpp	50.0%	0.0%	33.3%	0.0%	0.0%	16.7%
Don't know	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical & medical	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, medical & emotional	Count	2	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, medical, emotional & psychological	Count	3	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, medical, emotional, psychological & direct trauma	Count	2	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, medical, emotional & direct trauma	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, medical, psychological & direct trauma	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical & emotional	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, emotional & psychological	Count	6	0	0	1	0	0
	% within Cpp	85.7%	0.0%	0.0%	14.3%	0.0%	0.0%
Physical, emotional, psychological & other	Count	2	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical, psychological & other	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical & direct trauma	Count	2	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Physical & other	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Medical, emotional, psychological & other	Count	0	0	1	0	0	0
	% within Cpp	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%
Medical & direct trauma	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
	Count	5	0	0	0	0	0

Emotional & psychological	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Emotional, psychological & direct trauma	Count	1	0	1	0	0	0
	% within Cpp	50.0%	0.0%	50.0%	0.0%	0.0%	0.0%
Emotional, psychological, direct trauma & other	Count	2	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Emotional, psychological & other	Count	0	0	2	0	1	2
	% within Cpp	0.0%	0.0%	40.0%	0.0%	20.0%	40.0%
Emotional & other	Count	0	0	1	0	0	1
	% within Cpp	0.0%	0.0%	50.0%	0.0%	0.0%	50.0%
Psychological & other	Count	1	0	0	0	0	0
	% within Cpp	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**
	% within Cpp	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**

Twenty-five victims (48.1%) presented with physical symptoms, 23.1% showed medical problems and 67.3% complained of emotional difficulties. Thirty-two children (61.5%) had psychological challenges and 12 children (23.1%) presented with direct trauma. Twenty-one cases (40.4%) fell into the other category, showing difficulties that did not fit into the above-mentioned categories. One victim's presenting problem was unknown. Table 4.10 shows how these symptoms were classified.

Table 4.10

Victims' symptoms

Symptom	*Examples of complaints*	*Total cases*	*Percent-age (%)*
Physical/ Somatic	Rashes; unusual, destructive or sexualised behaviour; swollen genital areas; difficulty sitting and walking; offensive genital smells; genital tears; enuresis and urinary incontinence (dysuria); touching genital areas; faecal soiling/incontinence; ulcers; vaginal bleeding; itchiness; discharges; erythema; touching self/others inappropriately/sexualised play; insulting others; violent towards others; pain; body weakness; soiling self; seizures; bruises	**30**	**57.7**
Psycho-logical/ emotional	Fearful; forgetful; talkative; anger outbursts; distant; weary; emotional; suicidal ideation and self-injurious behaviour; aggressive; distressed; bullying; disruptive; fidgety; nervous; anxious; childhood emotional disorder; ODD behaviours; disrespectful; mood lability; irritability; negative behaviours like smoking, stealing and gang involvement; outbursts; lying; not following authority; nightmares; fear of meeting people; defiant; reckless; impulsive, short-tempered; eating problems; withdrawn; hypervigilant; uncooperative; behavioural regression; restless; loner	**45**	**86.5**
Motivational	Aloofness; poor sleep; fatigued; not making friends; school suspension; loss of appetite	**3**	**5.8**
Cognitive	Difficulties concentrating; learning difficulties; ADHD symptoms and diagnoses; difficulties following instructions; using vulgar language; school difficulties; speech and language difficulties; unable to complete work; letter inversions; distractibility; developmental delays; poor scholastic progress/performance; poor memory; auditory processing difficulties	**20**	**38.5**
Don't know (not provided)		**1**	**1.9**

The total number of cases are more than those reported in Table 4.9 as many victims presented with multiple symptoms. Statistics according to gender reveal that most boys (9) and girls (10) presented with physical and psychological symptoms. Many boys (10) showed signs of psychological and cognitive symptoms, and only girls presented with somatic symptoms. The discussion will now move to parent characteristics.

4.3.2 Parent characteristics

The section relates to the primary caregiver, their employment statuses and the family's context including location, living arrangements, sharing of rooms and the type of housing. Medical aid details are also presented. Table 4.11 provides a breakdown of victims' primary caregivers.

Table 4.11

Victims' primary caregivers

Primary caregiver	*Frequency (count)*	*Percentage (%)*
Biological mother and/or father	49	94.2
Sibling	0	0
Grandparent	6	11.5
Aunt/uncle/cousin	3	5.8
Neighbour	0	0
Friend	0	0
Family friend	0	0
Stepmother/stepfather	1	1.9
Partner (girlfriend/boyfriend)	0	0
Adopted	0	0
Foster parent	1	1.9
Other	1	1.9
Don't know	1	1.9
Total	**52**	**117.2**

Caregivers are greater than 100% as some children included more groups in the primary caregiver set. One child's primary caregivers were a biological parent and another person; another child had a biological parent and a stepparent. Four children had a biological parent and a grandparent as their primary caregivers and two had a biological parent, a grandparent and an aunt/uncle/cousin as primary caregivers. In the other category, a domestic worker was labelled as the primary caregiver. Concerning parents' employment statuses, Table 4.12 and 4.13 show the victim's mothers' and fathers' employment statuses in relation to the type of abuse suffered.

Table 4.12

Cross-tabulation of mother's employment status and abuse type

Mother's employment status		*Type of abuse*						*Total cases /52*
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
Employed	Count	32	0	5	1	1	4	**43**
	% within Aparwork Mom	74.4%	0.0%	11.6%	2.3%	2.3%	9.3%	**82.7%**
Un-employed	Count	2	0	1	0	0	0	**3**
	% within Aparwork Mom	66.7%	0.0%	33.3%	0.0%	0.0%	0.0%	**5.8%**
Don't know	Count	4	1	1	0	0	0	**6**
	% within Aparwork Mom	66.7%	16.7%	16.7%	0.0%	0.0%	0.0%	**11.5%**

Table 4.13

Cross-tabulation of father's employment status and abuse type

Father's employment status		*Type of abuse*						*Total cases /52*
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
Employed	Count	28	0	5	1	0	4	**38**
	% within Aparwork Dad	73.7%	0.0%	13.2%	2.6%	0.0%	10.5%	**73.1%**
Un-employed	Count	0	0	1	0	1	0	**2**
	% within Aparwork Dad	0.0%	0.0%	50.0%	0.0%	50.0%	0.0%	**3.8%**
Don't know	Count	10	1	1	0	0	0	**12**
	% within Aparwork Dad	83.3%	8.3%	8.3%	0.0%	0.0%	0.0%	**23.1%**

Children who suffered from sexual abuse had mothers who worked in 74.4% of the cases. Children of working mothers also experienced more emotional abuse and physical abuse. The Fisher's exact test gave a value of 11.955 and a p-value of 0.409, and so H_0 is accepted and the type of abuse is independent of the victims' mother's employment. Regarding the father's employment status, just under three quarters of sexual abuse cases, just over 13% of emotional abuse cases and just under 11% of physical abuse cases occurred when fathers were employed. Fisher's exact test yielded a value of 18.776 and a p-value of 0.036. H_0 is therefore rejected and H_1 is accepted. There is a relationship between abuse victims' fathers working and the type of abuse experienced at the 5% level of significance. In both Tables, more abuse occurred when parents were employed. Table 4.14 presents the living location of victims and their primary caregivers.

Table 4.14

Living location of victims and primary caregivers

Town	*Local Municipality*	*District municipality*	*Frequeny (count)*	*Percentage (%)*
Greytown	Umvoti	Umzinyathi	**3**	**5.8**
Pietermaritzburg	Msunduzi		**37**	**71.2**
Hammarsdale	Mkhambathini		**2**	**3.8**
Dargle	uMngeni		**1**	**1.9**
Impendle	Impendle	uMgungundlovu	**1**	**1.9**
Mooi River	Mpofana		**1**	**1.9**
Richmond	Richmond		**1**	**1.9**
Dalton	uMshwati		**1**	**1.9**
Cato Ridge	Mkhambathini		**1**	**1.9**
Umzimkhulu	uMzimkhulu	Harry Gwala	**1**	**1.9**
Kloof	eThekwini municipality	eThekwini metropolitan	**1**	**1.9**
Pinetown	eThekwini municipality	municipality	**1**	**1.9**
Stanger	KwaDukuza	iLembe	**1**	**1.9**

Although coming from towns outside of Pietermaritzburg and the local municipality of Msunduzi, most victims came from the greater uMgungundlovu district municipality (87%). Fourteen victims came from areas that are further than 35 kilometres away from Pietermaritzburg and the HSP's practice (26.9% of victims). It is unknown why they travelled so far for assistance. Table 4.15 presents the number of people living with the child victim and the type of abuse experienced.

Table 4.15

Cross-tabulation of people living with the child victim and abuse type

Number of people living at home including the child		***Type of abuse***						***Total cases /52***
		Sexual	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
1-3	Count	10	0	3	1	0	1	**15**
	% within Atotalhome	66.7%	0.0%	20.0%	6.7%	0.0%	6.7%	**28.8%**
4-6	Count	23	0	3	0	0	2	**28**
	% within Atotalhome	82.1%	0.0%	10.7%	0.0%	0.0%	7.1%	**53.8%**
7-10	Count	0	0	0	0	0	0	**0**
	% within Atotalhome	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
11-15	Count	0	0		0	0	0	**0**
	% within Atotalhome	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
15+	Count	0	0	0	0	0	0	**0**
	% within Atotalhome	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Don't know	Count	5	1	1	0	1	1	**9**
	% within Atotalhome	55.6%	11.1%	11.1%	0.0%	11.1%	11.1%	**17.3%**

Most abuse cases emerged when children lived in dwellings with 4-6 people. Living with 1-3 people showed more than $\frac{2}{3}$ of sexual abuse cases, followed by 20% experiencing emotional abuse. Living with 1-6 people held more abuse risk. Table 4.16 presents the number of people sharing a room with the child at home in relation to the type of abuse.

Table 4.16

Cross-tabulation of people sharing a room with child victim and abuse type

Number of people living at home including the child		*Type of abuse*						*Total cases /52*
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
1-3	Count	2	0	0	0	0	1	**3**
	% within Atotalshare	66.7%	0.0%	0.0%	0.0%	0.0%	33.3%	**5.8%**
4-6	Count	0	0	0	0	0	0	**0**
	% within Atotalshare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
7-10	Count	0	0	0	0	0	0	**0**
	% within Atotalshare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
11-15	Count	0	0		0	0	0	**0**
	% within Atotalshare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
15+	Count	0	0	0	0	0	0	**0**
	% within Atotalshare	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
None	Count	2	0	1	0	0	0	**3**
	% within Atotalshare	66.7%	0.0%	33.3%	0.0%	0.0%	0.0%	**5.8%**
Don't know	Count	34	1	6	1	1	3	**46**
	% within Atotalshare	73.9%	2.2%	13.0%	2.2%	2.2%	6.5%	**88.4%**

The HSP recorded little information regarding the living environment of the victims. Too many victims fell into the "Don't know" category and Fisher's exact test could not be calculated. The type of dwelling the victims and their families live in is found in Table 4.17.

Table 4.17

Cross-tabulation of the family's dwelling and abuse type

Type of dwelling		*Type of abuse*						*Total cases /52*
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
Homeless	Count	0	0	0	0	0	0	**0**
	% within Atypedwel	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Shack/inform-al settlement	Count	1	0	0	0	0	0	**1**
	% within Atypedwel	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Hostel	Count	1	0	0	0	0	0	**1**
	% within Atypedwel	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Room/garage	Count	0	0		0	0	0	**0**
	% within Atypedwel	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Flat/cottage	Count	11	0	1	0	0	3	**15**
	% within Atypedwel	73.3%	0.0%	6.7%	0.0%	0.0%	20.0%	**28.8%**
Shared house	Count	0	0	0	0	0	0	**0**
	% within Atypedwel	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
House (not shared)	Count	13	0	5	1	0	1	**20**
	% within Atypedwel	65.0%	0.0%	25.0%	5.0%	0.0%	5.0%	**38.4%**
Don't know	Count	12	1	1	0	1	0	**15**
	% within Atypedwel	80.0%	6.7%	6.7%	0.0%	6.7%	0.0%	**28.8**

Most victims lived in an unshared house, followed by those living in a flat/cottage and the type of dwelling being unknown, suggesting again that little information on living conditions was recorded. The type of housing does not appear influential on the risk of exposure to abuse. Finally, Table 4.18 provides information on whether the victims' families had medical aid.

Table 4.18

Victims' families and medical aid

Families with medical aid	*Frequency (count)*	*Percentage (%)*
Yes	43	82.7
No	1	1.9
Transacted with cash	3	5.8
Don't know	5	9.6
Total	**52**	**100.0**

Most families belonged to a medical aid scheme, including Bonitas (5), Discovery (11), GEMS (19), Medihelp (1), Paramed (1), Polmed (3), SABC Medscheme (1) and Wooltru medical scheme (1). A total of 44.2% of the schemes were for public servants. The total figure with medical aid is expected to be high owing to the HSP running a private practice.

Those who transacted in cash had an unknown medical aid status which was separated from the "Don't know" category. Results relating to the perpetrator are now presented.

4.3.3 Perpetrator characteristics

In most cases, one or two perpetrators were involved in perpetrating abuse. This section provides information on the abusers/perpetrators including their age, gender, race, HIV status, education level, if they had any mental illnesses or criminal records, the relationship to the victim and their possible exposure to substances. Very little information about the perpetrator was recorded in many of the case files. It is unknown if this is a result of little knowledge, the victim/their family not sharing information, or the HSP not asking. Results of the perpetrator's age will be studied first.

Table 4.19

Perpetrator's age and abuse type

		Type of abuse						***Total cases /52***
Perpetrator age (in years)		***Sexual***	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
Under 12	Count	9	0	6	1	1	1	**18**
	% within Bage	50.0%	0.0%	33.3%	5.6%	5.6%	5.6%	**34.6%**
12-15	Count	1	0	0	0	0	0	**1**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
16-18	Count	1	0	0	0	0	0	**1**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
19-21	Count	1	0	0	0	0	0	**1**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
22-30	Count	1	0	0	0	0	0	**1**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
31-40	Count	0	1	0	0	0	2	**3**
	% within Bage	0.0%	33.3%	0.0%	0.0%	0.0%	66.7%	**5.8%**
41-50	Count	0	0	0	0	0	0	**0**
	% within Bage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
51-60	Count	0	0	0	0	0	0	**0**
	% within Bage	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
61+ years	Count	1	0	0	0	0	0	**1**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Age not given	Count	16	0	1	0	0	0	**17**
	% within Bage	94.1%	0.0%	5.9%	0.0%	0.0%	0.0%	**32.7%**
Older than 18	Count	7	0	0	0	0	0	**7**
	% within Bage	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**13.5%**
Younger than 18	Count	1	0	0	0	0	1	**2**
	% within Bage	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	**3.8%**

A total of 42.3% of abusers were under 18 (children). There were 12 sexual abuse perpetrators, six emotional abusers and two physical abuse perpetrators who were children. Perpetrators' ages were missing for 17 cases (16 sexual abuse cases and one emotional abuse case). Fisher's exact test gave a value of 71.493 and a p-value of 0.017.

H_0 is rejected and the type of abuse is dependent on the abuser's age. Table 4.20 delineates the abusers' genders and the type of abuse.

Table 4.20

Cross-tabulation of abuse type and the perpetrator's gender

Perpetrator's gender			*Sexual*	*Physical & Sexual*	*Emotion-al*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	*Total cases*
Gender	**Male**	Count	20	1	4	1	1	2	**29**
		% within Bgender	69.0%	3.4%	13.8%	3.4%	3.4%	6.9%	**55.8%**
	Female	Count	3	0	0	0	0	1	**4**
		% within Bgender	75.0%	0.0%	0.0%	0.0%	0.0%	25.0%	**7.7%**
	Un-known	Count	15	0	3	0	0	1	**19**
		% within Bgender	78.9%	0.0%	15.8%	0.0%	0.0%	5.3%	**36.5%**
Total		**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
		% within Bgender	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0 %**

Thirty-six and a half percent of the perpetrators' genders were unknown, 55.8% were male and 7.7% were female. Male perpetrators committed mostly sexual abuse. Despite the small number of female abusers, three-quarters of them committed sexual abuse. Fisher's exact test yielded a value of 7.51 and a p-value of 0.896. Consequently, H_0 is accepted and there is no relationship between the abuse type and the abuser's gender. Table 4.21 presents the abuse type with the perpetrators' races.

Table 4.21

Cross-tabulation of abuse type with perpetrators' races

		Type of abuse						*Total cases /52*
Perpetrator race		*Sexual*	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
African	Count	12	0	1	0	1	1	**15**
	% within Brace	80.0%	0.0%	6.7%	0.0%	6.7%	6.7%	**28.8%**
Asian	Count	0	0	0	0	0	0	**0**
	% within Brace	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Indian	Count	2	0	1	0	0	0	**3**
	% within Brace	66.7%	0.0%	33.3%	0.0%	0.0%	0.0%	**5.8%**
White	Count	3	1	1	0	0	1	**6**
	% within Brace	50.0%	16.7%	16.7%	0.0%	0.0%	16.7%	**11.5%**
Coloured	Count	0	0	0	1	0	0	**1**
	% within Brace	0.0%	0.0%	0.0%	100.0%	0.0%	0.0%	**1.9%**
Other	Count	0	0	0	0	0	0	**0**
	% within Brace	0.0%	0.0%	0%	0.0%	0.0%	0.0%	**0.0%**
Not specified	Count	21	0	4	0	0	2	**27**
	% within Brace	77.7%	0.0%	14.8%	0.0%	0.0%	7.4%	**51.9%**
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Brace	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0 %**

Over 50% of the perpetrators' races were unknown which can affect apprehending the perpetrator(s). Of the African abusers, 80% committed sexual abuse and another 6.7% each committed emotional abuse, emotional abuse and neglect, and physical abuse. The Indian abusers committed sexual abuse and emotional abuse; and 50% of the White perpetrators committed sexual abuse with another 16.7% each committing physical and sexual abuse, emotional abuse, and physical abuse. One perpetrator was Coloured. Fishers exact test had a value of 42.204 and a corresponding p-value of 0.054. At the 5% level of significance, H_0 is accepted. At the 10% level, there is statistically significant evidence of dependency. Table 4.22 shows the abusers' HIV status and abuse types.

Table 4.22

Cross-tabulation of abusers' HIV statuses and abuse types

		Type of abuse						***Total cases /52***
Abusers' HIV statuses		***Sexual***	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
Negative	Count	0	0	0	0	0	0	**0**
	% within BHIVstatus	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Positive	Count	0	0	0	0	0	0	**0**
	% within BHIVstatus	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Unknown	Count	38	1	7	1	1	4	**52**
	% within BHIVstatus	73.1%	1.9%	13.5%	1.9%	1.9%	7.7%	**100.0%**

None of the perpetrators' HIV statuses were known. Table 4.23 displays the perpetrators' level of education and the abuse perpetrated.

Table 4.23

Cross-tabulation of abusers' education levels and the abuse perpetrated

Perpetrator education level		*Type of abuse*						*Total cases /52*
		Sexual	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
Grade 7 or below	Count	10	0	7	1	1	1	**20**
	% within Bedlevel	50.0%	0.0%	35.0%	5.0%	5.0%	5.0%	**38.5%**
Grade 12	Count	1	0	0	0	0	1	**2**
	% within Bedlevel	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	**3.8%**
College/ Technikon	Count	0	0	0	0	0	1	**1**
	% within Bedlevel	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	**1.9%**
University degree	Count	0	0	0	0	0	0	**0**
	% within Bedlevel	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**0.0%**
Postgrad-uate qualification	Count	2	0	0	0	0	0	**2**
	% within Bedlevel	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.8%**
Don't know	Count	25	1	0	0	0	1	**27**
	% within Bedlevel	92.6%	3.7%	0.0%	0.0%	0.0%	3.7%	**51.9%**
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Bedlevel	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

Over half of the abusers' education levels were unknown and these mostly performed sexual abuse. Thereafter, the next largest set of abusers held a grade 7 or below level of education. One of the perpetrators committing physical abuse had a college/Technikon qualification. No abusers emerged with university degrees but two held a postgraduate qualification and both perpetrated sexual abuse. Fisher's exact test yielded a value of 43.033 and a corresponding p-value of 0.001, thereby rejecting H_0. Therefore, there is a relationship between a perpetrator's education level and the type of abuse perpetrated (H_1 is accepted).

There was no information concerning whether abusers had any mental illnesses. One abuser had Trisomy 21; another was intellectually impaired; and a third was described as a problem child, who had been expelled from school, and had issues with drinking, drugs, truancy and stealing. No information was recorded about whether the abusers had a history of a criminal record. Abusers' prior personal exposures to abuse were also unknown in all of the cases. Perpetrators having alcohol or substances in their body at the time of the abuse is seen in Table 4.24.

Table 4.24

Cross-tabulation of abusers under the influence of alcohol/substance and the type of abuse

Perpetrators under the influence of alcohol or a substance		*Type of abuse*						*Total cases /52*
		Sexual	***Physical & Sexual***	***Emotional***	***Emotional & Physical***	***Emotional & Neglect***	***Physical***	
Yes	Count	1	0	0	0	0	0	**1**
	% within Balcoholsub	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
No	Count	0	0	1	0	0	0	**1**
	% within Balcoholsub	0.0%	0.0%	100.0%	0.0%	0.0%	0.0%	**1.9%**
Unknown	Count	37	1	6	1	1	4	**50**
	% within Balcoholsub	74.0%	2.0%	12.0%	2.0%	2.0%	8.0%	**96.2%**
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Balcoholsub	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

Fifty cases (96.2%) showed unknown information concerning being under the influence of alcohol or a substance at the time of committing the offence. One perpetrator was known to be under the influence when perpetrating sexual abuse and another was known to not be under the influence during the act of emotional abuse. Owing to the lack of data, conducting a test for dependence was impossible. Table 4.25 presents the relationship between the abuser and the victim along with the abuse type.

Table 4.25

Cross-tabulation of the abuser's relationship to the victim and the type of abuse committed

Perpetrator's relationship to the victim		*Type of abuse*						*Total cases*
		Sexual	*Physical & Sexual*	*Emotion-al*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
Family	Count	3	0	0	0	0	1	**4**
	% within Brelationship	75.0%	0.0%	0.0%	0.0%	0.0%	25.0%	**7.7%**
Family (father); Other (peers)	Count	1	0	0	0	0	1	**2**
	% within Brelationship	50.0%	0.0%	0.0%	0.0%	0.0%	50.0%	**3.8%**
Stepparent	Count	1	0	0	0	0	0	**1**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Stepparent; family friend	Count	0	1	0	0	0	0	**1**
	% within Brelationship	0.0%	100.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Family friend	Count	1	0	0	0	0	0	**1**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Friend	Count	3	0	1	1	1	0	**6**
	% within Brelationship	50.0%	0.0%	16.7%	16.7%	16.7%	0.0%	**11.5%**
Educator	Count	1	0	0	0	0	0	**1**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Stranger	Count	6	0	0	0	0	0	**6**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**11.5%**
Other	Count	12	0	6	0	0	2	**20**
	% within Brelationship	60.0%	0.0%	30.0%	0.0%	0.0%	10.0%	**38.5%**
Not specified (Don't know)	Count	9	0	0	0	0	0	**9**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**17.3%**
Family friend; friend; Other (other school children)	Count	1	0	0	0	0	0	**1**
	% within Brelationship	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Brelationship	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

Multiple relationships were found when there was more than one perpetrator. Family abusers included a cousin and two half-brothers. Stepparents perpetrated sexual abuse and sexual and physical abuse against children. A child was prostituted for money by a stepparent and was also sexually abused. One family friend (a neighbour) knew the family for three years prior to abusing the child. One educator committed sexual abuse on a child attending a special school. All children who had strangers as abusers suffered sexual abuse. The 'other' category included 12 peer abusers, an employee at a school

camp the child had visited, 2 as the school counsellor, 1 domestic worker, 2 in the primary support group and 2 were known to the victim but the relationship was not specified. In nine cases, the relationship to the perpetrator was unknown. Over two-thirds (69.2%) of the victims knew their abuser in some way, either as family members, peers or someone in their micro- or meso-systems. Conducting a test of independence produced a Fisher's exact score of 80.452 with a corresponding p-value of 0.147. Therefore, H_0 is accepted and there is no dependence between the child-abuser relationship and the type of abuse.

4.4 Pathways of intervention for reported child abuse cases

This section provides the timeline for reporting abuse. Findings concerning who the child first disclosed the abuse to, who reported the abuse to the HSP, the education level of the person reporting the abuse, who collected the information and the location of the abuse are presented. Moreover, the dates of the most recent abuse and of when the abuse was reported are provided as are the interventions that occurred and the process of prosecution.

Table 4.26

Breakdown of the victim's first report

Person reported to	*Frequency (count)*	*Percentage (%)*
Caregiver	30	57.7
Caregiver & nurse/doctor	1	1.9
Caregiver/ Other family member	2	3.8
Nurse/Doctor	2	3.8
Other	1	1.9
Not reported	13	25
Other family member	2	3.8
Other family member/other	1	1.9
Total	**52**	**100.0**

Victims varied regarding who they first reported the abuse to. Most victims first disclosed the abuse directly to a caregiver, which in three cases, was specified as being the victims' mothers. Another child disclosed the abuse to the caregiver and the specialist doctor together, and two other victims disclosed the abuse to a primary caregiver and another family member (a cousin; an uncle). Two cases first disclosed the abuse to a doctor (one to the HSP and another to another doctor). One child first disclosed the abuse to a counselling psychologist and 13 cases did not report first disclosure or it was not specified, and the HSP found the abuse. In one case, the abuse was reported to a grandmother and a domestic worker. Two cases reported to family members first – an

aunt and his/her mother's cousin, and the second to a set of grandparents. The Table that follows (Table 4.27) shows who first reported the abuse to the specialist doctor.

Table 4.27

Breakdown of who first reported the abuse to the HSP

First abuse reporter to gatekeeper	***Frequency (count)***	***Percentage (%)***
Victim him-/herself	2	3.8
Victim and caregiver	5	9.6
Other (Counselling psychologist)	1	1.9
Not reported (doctor found)	16	30.8
Caregiver	23	44.2
Caregiver, Doctor found	1	1.9
Caregiver and other family member (Uncle)	1	1.9
Sibling	1	1.9
Other family member	2	3.8
Total	**52**	**100.0**

Just under half of the victims had caregivers report the abuse to the HSP and just under a third of the victims' abuse was not reported, but instead, the HSP discovered it. Around 10% of cases were reported to the HSP by the victim and his/her caregiver. Other family members that reported the abuse were an aunt and a grandmother. Table 4.28 shows the education level of the person reporting the abuse.

Table 4.28

Education level of the person reporting the abuse to the HSP

Education level of person reporting abuse	***Frequency (count)***	***Percentage (%)***
Grade 7 or below	2	3.8
Grade 12	2	3.8
College/Technikon	5	9.6
University degree	2	3.8
Postgraduate qualification	21	40.4
Don't know	20	38.5
Total	**52**	**100.0**

Twenty-eight people who reported abuse held a tertiary qualification. Seventeen of those with a postgraduate qualification, however, reflected the specialist HSP. Two individuals held a grade 7 or below education level, another two had a grade 12 qualification. The education level of 20 individuals was unknown. Table 4.29 presents the recorded location of the abuse. In some instances, the abuse occurred in more than one location.

Table 4.29

Location of the abuse

Location of the abuse	*Frequency (count)*	*Percentage (%)*
Home environment	7	13.5
Other family member's house	1	1.9
Neighbour's house	2	3.8
School environment	19	36.5
School environment and perpetrator's place of living	1	1.9
Home environment and school environment	2	3.8
Perpetrator's place of living	1	1.9
Public location (Party)	1	1.9
Don't know (Not specified)	18	34.6
Total	**52**	**100.0**

The school environment represented a clear hotspot for abuse. At school, four perpetrators were victims' friends, one was an educator, 14 were peers or other learners at the school, two incidences related to the school counsellor and one was a camp instructor from a school excursion. The abuse's location was unknown in 18 cases and the home environment had 13.5% of the sample's abusive acts. The location of where the abuse was first reported is found in Table 4.30.

Table 4.30

Location of where the abuse was first reported

Location of first report of abuse (Excluding home)	*Frequency (count)*	*Percentage (%)*
Gatekeeper healthcare service provider	40	76.9
Edendale hospital	2	3.8
Private hospital	2	3.8
Other	2	3.8
Don't know	6	11.5
Total	**52**	**100.0**

Most of the abuse was reported at the HSP's practice. None of the cases were first reported to a police station or another government (public) hospital. Two cases were reported at Edendale Hospital and were referred to the HSP; and another two cases were reported at a private hospital, which the specialist doctor had access to. One case was first reported at a psychologist's office and another at a different medical practice. Six cases lacked information regarding the first report location. Tables 4.31 and 4.32 provide the occurrence date of the most recent abuse and the date of when the most recent abuse was reported respectively.

Table 4.31

Date of the most recent abuse occurrence

Date of occurrence of most recent abuse	*Frequency (count)*	*Percentage (%)*
2010	0	0.0
2011	2	3.8
2012	2	3.8
2013	1	1.9
2014	2	3.8
2015	8	15.4
2016	7	13.5
2017	16	30.8
2018	4	7.7
Unknown	10	19.2
Total	**52**	**100.0**

Table 4.32

Date the most recent abuse was reported

Date when most recent abuse was reported	**Frequency (count)**	**Percentage (%)**
2010	0	0.0
2011	2	3.8
2012	3	5.8
2013	2	3.8
2014	2	3.8
2015	13	25.0
2016	6	11.5
2017	18	34.6
2018	4	7.7
Unknown	2	3.8
Total	**52**	**100.0**

Figure 4.1 shows a comparison of the recent abuse and recent reporting (Tables 4.31 and 4.32). In 2010, 2011, 2014, and 2018, the dates of recent abuse and recent reporting are equal suggesting that the cases were reported in the same year that they occurred. For 2012, 2013, 2015, and 2017, the number of recent reporting is higher than the same year's recent abuse, suggesting that these cases were reported in subsequent years (delayed reporting). In 2016 and the unknown category, the numbers/graphs switch, where the date of most recent report is lower than the date of recent abuse, suggesting that not all cases were reported.

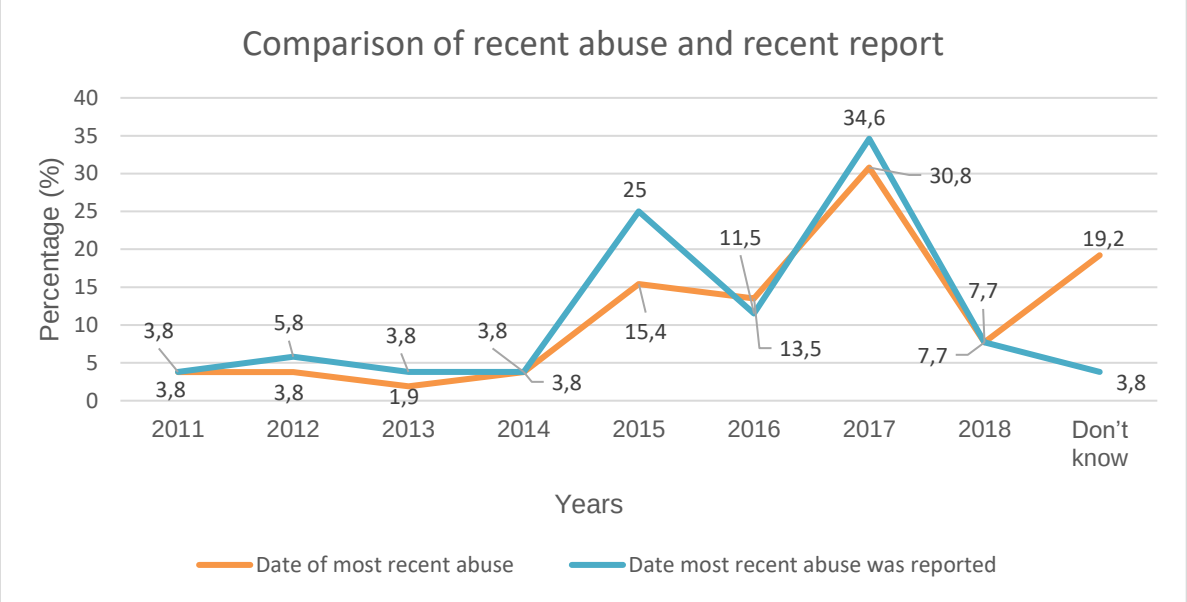


Figure 4.1. Comparison of recent abuse and recent reporting.

Table 4.33

Who collected the information pertaining to the abuse

Who collected information pertaining to the abuse		*Type of abuse*						*Total cases /52*
		Sexual	*Physical & Sexual*	*Emotional*	*Emotional & Physical*	*Emotional & Neglect*	*Physical*	
Nurse	Count	1	0	0	0	0	0	**1**
	% within Dcollectinfo	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Doctor	Count	34	1	7	1	1	4	**48**
	% within Dcollectinfo	70.8%	2.1%	14.6%	2.1%	2.1%	8.3%	**92.3%**
Nurse and doctor	Count	1	0	0	0	0	0	**1**
	% within Dcollectinfo	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**1.9%**
Doctor and other	Count	2	0	0	0	0	0	**2**
	% within Dcollectinfo	100.0%	0.0%	0.0%	0.0%	0.0%	0.0%	**3.8%**
Total	**Count**	**38**	**1**	**7**	**1**	**1**	**4**	**52**
	% within Dcollectinfo	**73.1%**	**1.9%**	**13.5%**	**1.9%**	**1.9%**	**7.7%**	**100.0%**

Concerning collecting information, 2 nurses were involved in two cases. Of the doctors collecting information, most information was collected by the HSP. The other category included a clinical psychologist and a counselling psychologist.

Regarding the number of children that have been abused more than once, very little data were available. The researcher discovered at least six victims that had been abused on at least two occasions. Thirty-nine cases (75%) expressed sexual abuse as their primary abuse type. Of these, 13 did not specify the type of sexual abuse, 15 cases were

described as blunt/chronic anal penetration, 3 victims experienced chronic vaginal penetration, one experienced sexual abuse and physical assault, 3 were exposed to inappropriate touching and four were exposed to chronic anal and vaginal penetration. Nine victims experienced psychological abuse as their primary abuse (17.3%) and eight of these experienced it as bullying. For physical abuse, 6 cases (11.5%) suffered scratching, beating and physical force. One victim's primary abuse form was neglect, which related to feeding. This figure is low, but it is expected as such children's chances of seeing a professional are small. Six children presented with secondary sexual abuse. These victims experienced inappropriate touching as well as anal and vaginal penetration. Five children were exposed to secondary emotional abuse, with bullying and name-calling. Seven children (12.6%) presented with secondary physical abuse, including hitting, branding and corporal punishment. Another child suffered sexual and emotional secondary abuse; another's was sexual, emotional and physical in nature; and another suffered emotional and physical abuse. Below, Table 4.34 delineates the interventions recommended/performed by the HSP following reporting the abuse. In most cases, more than one intervention was implemented.

Table 4.34

Interventions taken following the reporting of the abuse

Pathways / interventions taken	***Frequency (count)***	***Percentage (%)***
Medical treatment	5	9.6
Psychological attention (therapy)	1	1.9
Medical treatment; psychological attention	4	7.7
Social worker intervention	1	1.9
Medical treatment; psychological attention; psychoeducation; social worker intervention	1	1.9
Medical treatment; psychological attention; social worker intervention; court proceedings; other	1	1.9
Medical treatment; psychological attention; social worker intervention; other	11	21.2
Medical treatment; psychological attention; court proceedings	1	1.9
Medical treatment; psychological attention; court proceedings; other	1	1.9
Medical treatment; psychological attention; other	9	17.3
Medical treatment; psychoeducation; social worker intervention; other	1	1.9
Medical treatment; social worker intervention; other	1	1.9
Medical treatment; other	6	11.5
Psychological attention; psychoeducation	2	3.8
Psychological attention; psychoeducation; court proceedings	1	1.9
Psychological attention; other	2	3.8
Other	2	3.8
Don't know	2	3.8
Total	**52**	**100.0**

Forty-one victims received medical care including medication/antibiotics; family members being counselled; blood tests for hepatitis B, HIV and Herpes amongst other concerns; and/or urine tests. Occasionally, the victim was referred to a medical practitioner or for hospital admission. Thirty-four children (65.4%) received psychological interventions (victim and sometimes the family); or trauma debriefing. In most cases, these referrals were to counselling or clinical psychologists. Five children and their families received psychoeducation. At times this was very general regarding caring for and supervising the child; but also related to parenting skills. Sixteen children received social worker intervention, but little information was provided regarding what this entailed. Seventeen percent of children had a case opened by the HSP/their caregivers which led to initiating court proceedings and another four victims were referred to SAPS, however, the process of prosecution was unknown. Thirty-four child victims (65.4%) were classified as having other interventions. These included completing J88 forms; referring the child and his/her family to a TCC; referrals to Childline; letters written to the victim's school; approaching the school for follow ups; referrals to SAPS; a referral to the dentist; a referral to a psychiatrist and in-patient psychologist; a referral to the NPA for school issues; psychological and occupational therapy assessments; dietician referrals; and referrals to hospitals. Another case did not have a J88 completed. Lastly, Table 4.35 shows the process of prosecution.

Table 4.35

Process of prosecution

Process of prosecution	***Frequency (count)***	***Percentage (%)***
Not occurring	11	21.2
Started	8	15.4
Went to court but dropped - reason	1	1.9
Don't know	32	61.5
Total	**52**	**100.0**

Most cases had an unknown status, possibly owing to the little follow up that is taking place. Eleven victims and their families decided not to prosecute. Based on the HSP's knowledge and the case files, no cases showed as being completed with or without convictions. One case showed as going to court, but the case was dropped owing to a lack of evidence and 8 victims had started court proceedings. Section 4.4 qualitatively describes the risk and protective factors that emerged from the study, answering research question 4.

4.5 Risk and protective factors

The following factors emerged from the information available in the case files.

Table 4.36

Risk factors appearing from case files

Family related	School related	Child related
Parental death Being unsupervised/lack of parental supervision (at neighbour's house/in streets/playing near strangers/in the afternoons)	Truancy Poor schooling environment and poor school performance	Having older/adult friends Behavioural problems; rebellious; defiant; disruptive behaviour
Corporal punishment	Bullying	Major Depressive Disorder
Family size (a bigger family seems to have more risk)	Initiation	Learning disabilities; IDD (Intellectual Developmental Disorder)
Parent/family member substance abuse (e.g. a parent drinking)	Children showering with others and being left alone with an educator	Absent seizures
Broken home Living away from parents (e.g. with a carer)		Concentration difficulties Mood changes
Family members involved in crime		Gang involvement
Parents leaving the family; parent(s) being uninvolved		
Stepparents; foster parents		

Very few protective factors emerged from the case files. The major factor was a supportive family and an extended family. Close family bonds act as a protective factor as parents and grandparents that noticed their child acting strangely intervened. Good relationships meant that adults assisted the child by taking him/her to the specialist doctor or assisted with reporting or prosecuting, and emotionally supporting the child. Another factor was whether children had been taught right from wrong as this helped them come forward to tell caregivers/others about the abuse and thereby put a stop to recurrent episodes of abuse. Having supportive educators and schools also assisted with building resilience as did having access to support services. Positive role models in the family, school or community environment also assisted the children.

4.6 Summary of the chapter

The results of the study clarify that despite sexual abuse being the most prevalent, other forms of abuse are also perpetrated at considerable rates in Pietermaritzburg. Some statistically significant relationships existed and influence the type of abuse, for example, the victim's gender, a child's father's employment status, the age of the abuser and the

perpetrator's education level. The findings also elucidate that more information needs to be recorded concerning the living conditions of the victim as well as more details about the perpetrator. This information, particularly the latter, could be extremely helpful in apprehending the perpetrator. Little is known regarding prosecution of these cases, and this is possibly a result of the HSP dealing with the medical domain and not the justice domain. Findings to answer research question five, regarding the major stakeholders to become involved in alleviating the problem of child abuse will be discussed in chapter 5, which presents a discussion of the findings, which is where the study now turns.

CHAPTER FIVE: DISCUSSION OF THE FINDINGS

5.1 Introduction

This chapter discusses the findings of the research considering the literature reviewed and Bronfenbrenner's ecological systems theoretical framework. The chapter aims to situate the findings in context and to elucidate their significance. The findings from each section of chapter 4 will be elaborated on. The study's results somewhat align with current international and national findings concerning abuse. One particularly concerning finding was the number of abuse cases occurring at schools. Again, owing to the large number of univariate analyses conducted and the small sample sizes in some cases, the discussion of the findings is presented with some caution.

5.2 Findings from the research

5.2.1 Prevalence of child abuse at the HSP's practice

Of the cases sampled, almost 16% showed experiences of abuse and were included in the study. The incidence of sexual abuse in the case file population totalled 11.4% which is close to the numbers reported in the UK (Bebbington et al., 2011). Sexual abuse represented 75% of the sample suggesting that it frequently occurs (Richter & Dawes, 2008). Abuse in South Africa is argued to be mostly sexual and the research's findings align to this (Mohamed & Naidoo, 2014). The figures are lower than those reported by Leoschut and Kafaar (2017) who estimate rates of 35.4% of children being sexually abused before turning 17. The findings of all children under the age of 5 experiencing sexual abuse relates to Mohamed and Naidoo's (2014) findings. The study's findings run contrary to international literature that argues that physical abuse and sexual abuse are the most common types of abuse. Instead, the current study found sexual abuse and emotional abuse (13.5%) as the most common. Laws such as the South African Schools Act and the new law about corporal punishment in homes may have affected the lower rates of physical abuse or the reporting thereof (Mathews & Benvenuti, 2014; Swanepoel, 2017). The findings suggest lower rates of emotional abuse in comparison to Stoltenborgh et al.'s (2012) meta-analysis. This may be from a lack of awareness or from it being the country's way of life (Guma & Henda, 2004).

The small number of cases imply that disclosure is the "exception rather than the norm, with estimates of non-disclosure varying from 33% to 92% for girls … and from 42% to 100% for boys (Collings et al., 2005, pp. 270-271). These figures imply that the study's

findings only touch on elucidating abuse in Pietermaritzburg. There are likely to be many more victims, who owing to personal circumstances, cannot report the abuse or seek help, especially at the HSP's private practice. Non-disclosure increases the risk of repeated abuse and makes it more challenging to access mental health and other resources. Mohamed and Naidoo (2014) argue that children are often powerless individuals and require adults in positions of trust to assist in protecting them. As expected, there was very little findings of neglect. Neglect's lack of care and interest means that neglected children are unlikely to see a professional (Corby, 2000).

5.2.2 Characteristics of child abuse reported at the HSP's practice

5.2.2.1 Child characteristics

The study found a close incidence of abuse perpetrated on males and females, with boys accounting for 28 cases and girls 24 cases (54% and 46% respectively). This is contrary to research like Tortolani and Lanti (2009) who argue that more girls are affected by abuse. The high incidence of abuse in South Africa may account for the numbers of both male and female victims. The authors also purport that girls experience more sexual abuse; and boys experience more physical and psychological abuse and even neglect. This study found sexual abuse to be most prevalent in boys and girls, but only boys suffered physical abuse, apart from one girl suffering physical and sexual abuse. Boys are believed to be more likely to experience physical abuse (Gibb et al., 2001). The more numerous boys suffering from emotional abuse and physical abuse thus relates to the literature. Boys in the study experienced six times more emotional abuse than girls.

Fisher's exact test for independence showed that abuse type is influenced by the victim's gender. A child's gender can influence the type of abuse experienced. Females appear more at risk for sexual abuse and boys have an increased risk for emotional abuse and physical abuse. Boys are also more likely to suffer combinations of abuse including emotional and physical abuse, and emotional abuse and neglect. The figures are contrary to the World Health Organisation's (2016) figures which acknowledge more men being sexually abused as children. Bebbington et al.'s (2011) research aligns to the current study with more girls experiencing sexual abuse. These findings imply that prevalence rates are challenging to determine and vary considerably. The high incidence of African children (73.1% of the sample) relates to the country's racial demographics (Statistics South Africa, 2017b), but those who experienced sexual abuse were lower than other provincial studies (e.g. Collings, 2009).

Another estimate of general child abuse describes that boys are more often the victims of child abuse when under the age of 12 months and when 5 to 9 years of age; however, girls are more often victims when 15 years and older (Tortolani & Lanti, 2009). The current data were not specific enough for children under 12 months. However, more boys fell into the 6-10-year category, which relates to Tortolani and Lanti's (2009) findings. The study found no data in the 15-18 years age category. Girls also fell mostly into the 6-10 age category, followed by the 5 years or less category. Prinsloo (2016) argues that children below the age of four and adolescent children are most at risk for child abuse, but this study found 31 cases in the 6-10-year-old category, 12 children under the age of 5 and 8 cases in the 11-14 age category. This may be a result of the HSP focusing on younger children. Children in grade R to grade 6 appear to be most at risk for exposure to abuse. It is unknown why, but these children are still trying to discover themselves and may be easy, vulnerable targets. Moreover, younger children understand less about their rights and have less of a voice (DSD et al., 2012). Despite literature arguing that children who are disabled are at an increased risk for abuse, the study found children without disabilities as more affected by abuse. However, this may be a result of children with disabilities not being brought to the practice, i.e. being unknown cases of abuse, particularly owing to cultural views about such children.

The HSP documented the victims' symptoms and presenting problems well and showed insight into knowing the importance of these concerns. It is unknown if other medical professionals are similarly competent. There were some inconsistencies between the cases regarding the information that was documented. Most victims showed some difficulty after the abuse had occurred. Such difficulties fitted into the categories of physical/somatic; psychological/emotional; motivational; and cognitive problems. Girls showed more physical symptoms and boys showed more psychological and cognitive symptoms. Prinsloo's (2016) warning signs of negative school, behavioural and academic changes; unusual and excessive emotional responses; motivational challenges; poor behaviour; physical injuries; psychological difficulties including enuresis, self-destructive behaviour, and depression; and possibly suicidal behaviour, aligned to the study's categories.

Most often, victims showed complaints of emotional and psychological challenges and their symptoms were often psychological or physical/somatic. The symptoms varied

though and children presented in multiple ways. In most cases, behavioural signs were evident which were noticed by caregivers or educators. It is likely that these emerged because of the victim experiencing fear or concern over who to trust or difficulty dealing with the abusive trauma (Mohamed & Naidoo, 2014). Mohamed and Naidoo (2014, pp. 251-252) recognise the following as indicating the possibility of abuse:

> withdrawal, lack of eye contact, refusal to speak/communicate, fear of being touched, wariness of the parent/guardian, misses school often, displays behaviour that parents cannot cope with or control, inappropriate aggression and temper tantrums, child displays extremes in behaviour, child is over-anxious, child wears inappropriate clothing.

Many of the above symptoms showed up in the study's abused children and were often a reason for visiting the HSP, because caregivers were concerned over their children's changes in behaviour and could not account for these changes.

5.2.2.2 Parent characteristics

Statistically, the study's findings showed abuse to be related to the victim's father's employment status, in that employed fathers seem to influence the likelihood of abuse. Figures regarding abused children with employed fathers totalled 73% against those with unemployed fathers which totalled 4% and another 23% were unknown. These findings are not in line with other research, like that of Janssen et al. (2013) and Legano et al. (2009), who argue that having unemployed parents is a risk factor for abuse. The current study found more sexual abuse occurred when mothers and fathers worked (74.4% and 73.7% respectively), although the child's father's employment status was only statistically significant. de Witt (2014) argues that employed caregivers are a protective factor. However, when fathers are working, they have less available time to spend with their children. Single parent households, which may be a consequence of many fathers working excessive hours or working away from home can increase abuse (Rao & Lux, 2012). Absent fathers have been discussed as a risk factor for abuse in Matthews and Benvenuti (2014). Employed parents also mean that children are left unattended which can exacerbate the risk for abuse (Townsend & Dawes, 2004). Employed parents, particularly fathers, who have traditionally followed patriarchal values, which are evident

in the country, risk not disciplining their children adequately or teaching them morals and values ingrained in their fathers' cultures (Guma & Henda, 2004; Richter & Dawes, 2008). More abuse occurred when the victim lived in housing containing 4-6 people. Overcrowded environments increase opportunities for abuse, particularly from co-sleeping arrangements, and increase children's risk of witnessing sexualised acts (Townsend & Dawes, 2004; Viviers, 2013). The study did not find the type of housing to be influential on whether more abuse occurred, which authors like de Witt (2014) argue is an increased risk factor. Little information was recorded in the case files regarding the child and their primary caregivers' living conditions. Recording this information may assist healthcare professionals in better understanding the reasons and risks for abuse.

5.2.2.3 Perpetrator characteristics

Inferential statistical analyses showed that abuse perpetrations reported at the HSP's practice are affected by the abuser's age and education level. The study found that 18 cases had perpetrators who were under 12 years old. Of these, 9 committed sexual abuse and 6 emotional abuse. Twenty-two cases from the sample (42.3%) showed abusers under 18 (i.e. children as perpetrators). This is an alarming and terrifying statistic. Of the 22 cases, 55% committed sexual abuse, 27% emotional abuse, 5% each emotional and physical abuse and emotional abuse and negelct, and 9% physical abuse. Narrow definitions focusing on adult abusers may need to be reconsidered. The figures suggest that early childhood intervention is needed to educate children about abuse and their rights, and to teach children healthy ways of coping apart from acting out on others.

Janssen et al.'s (2013) study found that children accounted for 22% of abusers; parents 7.6%; another 3.9% were other relatives and 3.7% were someone else that the child knew or a family friend. The current study's figures are higher - approximately 23% of the study's victims held familial or family friend relationships with abusers. Only 25% of abusers were adults (over 18 years) and the remaining 32.7% had unknown ages. More accurate information gathering concerning perpetrators is needed. The study found that just under 40% of perpetrators held a grade 7 education or lower. This is likely to have been influenced by the many child perpetrators. However, people with lower education levels are likely to struggle with more social ills which may link to an increased risk of becoming an abuser. The findings do not discount those who are educated. About 6% of abusers had a college/Technikon or higher educational qualification. At the 10% level of

significance, abuse was also dependent on the perpetrator's race, with African and White abusers being most common from the case files.

The relationship between the abuser and the child was independent of the abuse type. However, most abusers (69.2%) were known to their victims in some way, either as a family member, a peer or someone else in their micro- or exo-systems. This relates to local research suggesting that most sexual abuse is committed by a person known to the victim, especially in his/her family (de Witt, 2014). Prinsloo (2016) argues that 60% of abusers are from the child's family and only 6% are strangers to the child. However, in this study, 21.2% of abusers were from the child's family and 13.5% were strangers. The finding of 7 strangers reiterates UNICEF South Africa's (2013) statistics. Data were non-existent regarding perpetrators having a criminal record, suggesting that little is known about re-offending criminals.

The level of peer abuse was alarming and indicates that school programmes are needed. The research highlighted that initiation ceremonies continue with devastating effects, despite such acts being prohibited from schools (KZNDOE, 2015). Regulations aim to prohibt these practices in schools as the practice

> endangers the mental or physical health or safety of the learner; undermines the intrinsic worth of learners; [submits the learner] to humiliating or violent acts which undermine the dignity of the child; undermines the fundamental rights and values that underpin the Constitution; [and] destroys public or private property.
>
> (KZNDOE, 2015, p. 10)

Some of the personal comments from victims highlighted their humiliation and degradation, for example, basing friendship on abuse. The power dynamic is re-emphasised (Prinsloo, 2016), with abusers preying on needy victims through prostituting them for money, only being their friend after allowing abuse to happen and gaining their trust/friendship and then manipulating it. The narrow definition of the perpetrator representing an adult that hurts/abuses a defenceless child (Prinsloo, 2016) needs to be re-evaluated as this study has found that many children are also perpetrators. A broader account of the abuser needs to be taken with future studies.

5.2.3 Pathways of intervention

Whilst most victims reported their abuse to a primary caregiver, 25% of the victims did not report their abuse, suggesting discomfort, fear of the consequences, or being unaware that abuse had occurred. It is unknown if cultural practices, social taboos, beliefs about abuse being the norm, or society's patriarchal values affected reporting (Legano et al., 2009; Mathews & Benvenuti, 2014; Guma & Henda, 2004). The children's age, their fear, and their lack of knowledge may have also been influential (Viviers, 2013). The 16 cases (30.8%) in which the HSP found abuse reiterates a lack of knowledge or fear of reporting. Children must be educated on abuse and the avenues for reporting it.

A dramatic 36.5% (19 cases) of cases experienced abuse in the school environment, with 42.2% of cases involving the school environment in some way. This figure is disturbing and suggests that schools are not the safe environments that they are assumed to be. Janssen et al. (2013) found that physical abuse occurs 49.1% of the time at home; 26.4% at the school and/or crèche; 15.6% in public places; and 8.9% in other and unknown locations. This implies that the current statistic is hugely problematic and needs additional research into where abuse is occurring and into abuse at schools. In Pietermaritzburg, DoE interventions, roadshows and workshops are needed to tackle this problem. School abusers are not only educators, but also victims' friends, peers, school counsellors and camp instructors. Not all locations were known, possibly owing to the victim being unaware of the abuse or it not being reported/recorded. This information is again critical for intervention strategies. The figures infer that home life does not appear as negative or problematic as other literature reports. Children do not always report their abuse soon after it has taken place as Figure 4.1 shows. There is little information to explain this, but the findings intimate the need for qualitative research concerning what makes children report abuse, so as to try determine why some delay reporting.

Multiple, varied interventions took place and a strength of the results is that interventions were tailored for each victim. Surprisingly, only four victims proceeded with SAPS interventions, or this was only recorded in four cases. The details of the actual intervention seemed limited and no follow up is performed, unless the victim and his/her family return to the HSP. Consequently, whilst the interventions may have been recommended, it is unknown how many are pursued. The real statistics of how many victims and families receive help beyond medical assistance are unknown.

Of valuable information is the process of prosecution. The findings alluded that very little information was available for 61.5% of the cases, again suggesting poor follow up. However, it could be argued that this is not in the HSP's scope of practice. Twenty-one percent of cases decided not to press charges. To the HSP's knowledge and based on the case files, no cases showed as being completed with or without convictions. Only eight cases had started prosecution and only one had gone to court, but was dropped due to a lack of evidence. These figures are very problematic and require more research.

With over two-thirds of victims knowing their abuser in some way, one would assume that this would make apprehending the perpetrator easier, as more information is available. However, at times, basic information such as the abuser's race or age range or name was omitted from the case file. This affects prosecution. Only 17% of the HSP's cases had commenced the prosecution process. Sixty-two percent of the cases did not have enough information to know if the victim was prosecuting and the stage of prosecution. Collings (2007) reiterates these prosecution difficulties, along with a lack of knowledge about the legal system as being influential. Collings' (2007, p. 14) research regarding child rape found that "45% of the cases had been referred for prosecution; 16% of cases referred for prosecution had resulted in the offender being convicted". These figures are higher than the current research's figures but are still too low.

The study showed that girls and boys were both involved in disclosing abuse. In fact, more boys disclosed in this study. This runs counter to much of the research and it is unknown if this is a South African trend or more specific to Pietermaritzburg. Legano et al. (2009) argue that the physical examination has a medical aim (physical checks), a psychological aim (giving a sense of safety) and a legal aim (collecting and documenting for evidence purposes). During such an examination, bruising, bite marks, peri-oral injuries, intra-oral injuries, burns or fractures, STIs or oral infections should be attended to and reiterate the importance of professionals including doctors and dentists (Mohamed & Naidoo, 2014). The HSP aimed to do as much as possible as a medical professional, but South Africa has limited capacity in terms of human and financial resources. Hendricks (2014) estimated 1 social worker to 3 187 members of the country's population and 1 police officer to 336 members of the population. These shortages limit the assistance received.

The limited resources may explain the limited follow up on cases, making it difficult to determine the well-being of the child post-abuse. The interaction between the systems argues for “multi-sectoral responses [which] are likely to be the most effective if they involve ongoing, reciprocal collaboration between all interested parties (various professionals, the child, and the child’s caregivers)” (Shaw et al., 2007, as cited in Collings, 2009). Yet, the current study shows professionals working in isolation, with minimal inter-group communication, feedback or follow up. This lack of integrated professional engagement goes against “the coordinated multi-sectoral response envisaged by Section 62(1)” of South Africa’s Criminal Law (Sexual Offences and related matters) Amendment Act, suggesting that government needs to implement procedures to ensure that actions align to laws (Collings, 2009, p. 144). Vallone et al. (2009) argue for the need of psychiatrists, psychologists and neuropsychologists to be part of the collaborating team. By involving the necessary professionals, better quality provisions and investigations could occur, which would likely minimise additional trauma and improve the conviction rates (Mohamed & Naidoo, 2014).

The HSP performed sufficient victim evaluations but lacked co-ordinated care with other professionals and at times did not always perform laboratory tests (blood tests) and radiographic studies, despite these being recommended in the literature (Legano et al., 2009). The date of reporting abuse may have influenced this. Risk assessments for post exposure prophylaxis, photographic evidence and a full report were not always completed/found in the file (Badoe, 2017). The HSP always recorded the presenting problem, symptoms, and a brief sequence of the events, but did not always record information about birth and developmental history, the family’s method of disciplining, and living arrangements, which are vital for physical and emotional abuse. Minimal follow up meant that no conclusion could be made about assessing the child’s developmental needs and the progression of healing (Badoe, 2017). This may be a consequence of the HSP’s role as a professional that individuals visit when there is a problem. Moreover, since the HSP is in private practice, financing follow-ups may also be challenging.

5.2.4 Risk and protective factors and stakeholders for intervention

Risk and protective factors that emerged from the case files aligned to those in the literature review. The HSP’s practice appears to be on par with international and national literature. Both the literature review and the study’s findings imply that risk and protective

factors are broad and unique to each victim, making documenting them a challenge. Limited information was found in the case files regarding explicit risk and protective factors, requiring some to be deduced. DSD et al. (2012) highlight that such risk factors not only exacerbate the risk for increased violence/abuse, but that the effect of abuse can occur across the child's lifespan. They re-emphasise the importance of strong attachment bonds with primary caregivers and other adults (e.g. from schools and the community) to promote resilience and to teach children norms, values and attitudes that are influential on their own behaviour and belief systems. Protective factors can "include high self-esteem, an internal locus of control, sense of humour, empathy, spirituality, easy temperament and good communication skills" (DSD et al., 2012, p. 44).

5.3 Proactive and reactive interventions applicable to South Africa

Bronfenbrenner's ecological systems theory recognises the various levels of interaction that influence an individual. Corby (2000) and Townsend and Dawes (2004) recognise how abuse extends beyond the individual, affecting others in the child's life and contexts (e.g. school and community). This model identifies multi-level consequences, risk factors to be monitored and addressed and protective factors to be drawn upon (Richter & Dawes, 2008). Protective factors within individuals, families, communities and society must be built on and developed (Mathews & Benvenuti, 2014).

Individual flexible models are needed to assist the child depending on the need. There cannot be a one-size-fits-all approach that originates from a Western individualistic orientation, but rather, there needs to be an acknowledgement of the role of other systems including the child's culture, norms and values (DSD et al., 2012). This will assist when working with multicultural victims and appeared evident in this study. A professional's ecosystem may not be the same as the victim's ecosystem, which may influence perceptions and the approach used, and this requires cultural sensitivity.

> I will need to have some understanding of that child's ethnic culture before I can get close to him or her. On the other hand, I am also influenced and my work is constrained by forces larger than myself including state and national policy, concerns about reimbursements and so on. (Fontes, 2008, p. 4)

Clinical judgment and needs-analyses must be used to determine what is best for the child. Strategies need to involve the community, focus on protecting the child and need to strengthen the family unit (Papalia et al., 2006). At times, it seems that not all interventions that should have been put in place were done so. At the most basic level, interventions should focus on the child, but be in line with eco-systemic theory and consider all other systems involved. For example, the necessity of including the family in interventions, acknowledging how the abuse may affect the child's interaction with his/her peer group and his/her school performance, but may also influence how the culture of violence grows in the child and his/her surroundings.

5.4 Summary of the chapter

Chapter five has aligned the study's findings to relevant literature. Bronfenbrenner's theory was touched on and will be highlighted in the following chapter where recommendations are introduced regarding what can be done to assist with this public health concern of abuse. This chapter has aimed to contextualise some of the study's findings concerning the prevalence of abuse, some of the profiling and characteristics discovered regarding abuse, as well as the pathways for intervention and risk and protective factors. The findings of the study converge and diverge with other abuse literature. Sexual abuse was the highest type of abuse, followed by emotional abuse. Some interesting statistical findings also emerged and of greatest concern is how much abuse is occurring in the school environment. The study will now turn to the final chapter, which will discuss some of the recommendations, limitations to the study, further research and concluding remarks.

CHAPTER SIX: RECOMMENDATIONS, LIMITATIONS, FURTHER RESEARCH AND CONCLUSIONS OF THE STUDY

6.1 Introduction

This final chapter integrates the study's findings into some recommendations on what can be done regarding the crisis of child abuse in KZN and nationally. Following from this, the chapter will critically assess some of the study's limitations and how these limitations were addressed. Lastly, areas/topics for further research will be introduced and the chapter will finish with conclusions of the study. Section 6.2. will now introduce some recommendations for proactive and reactive interventions for child abuse and will discuss some of the necessary stakeholders that need to become (more) involved.

6.2 Recommendations – proactive and reactive interventions

The recommendations that follow are guided by the study's theoretical framework of Bronfenbrenner's ecological systems theory.

6.2.1 At the individual level

Children must be taught against stereotyped sex roles that teach girls to be subservient (de Witt, 2014). These perpetuate the different and highly rigid sex roles and risk exacerbating child abuse, particularly sexual abuse. Such ideas continue throughout life. These roles also minimise the importance of recognising human rights. Children require an awareness of their rights, they must develop abilities of insight and decision-making about their lives, and need to be able to express their discomfort and malaise with others (de Witt, 2014). They require education on how to respond when they feel threatened (Prinsloo, 2016) and on the need to act sensitively towards others, but also need to have a better grasp on their health and psychological well-being (Harty & Alant, 2016).

Children require supervision by a trusted adult constantly. Whilst there may be opposing cultural views on this, safety and abuse prevention prevails (Fontes, 2008). Over the years, taboos around sex have significantly reduced, and exposure to the topic of sex is now part of the academic curriculum, even in primary school. Sex and abuse must be included in curriculums to allow for open exploration and to educate children (de Witt, 2014; Ferreira, 2017). However, the information must be in line with their psychological development. Children should learn about the reality of abusers, physical safety programmes including where others should not touch a person, and 'stranger danger' (de Witt, 2014). Children who are abused need to be treated kindly, confidentially,

respectfully, and should not be blamed for the events (Prinsloo, 2016). This reiterates the necessity of professional training for healthcare workers. Situations and people in the child's life (through direct or indirect interaction) have a significant influence on childhood development, and an awareness of this influence is needed (Harty & Alant, 2016).

6.2.2 Microsystemic level

The study recognises the need for interventions from and for others in the child's life. In most cases, parents brought the child to the HSP owing to him/her having varied symptoms. Most of the cases had vague or ambiguous comments causing them to seek medical services.

6.2.2.1 Caregivers and the family

Parents/primary caregivers need to be educated, supported and encouraged. Preventative work should aim to assist in crippling the recurrent abuse that is found particularly within the family (Joyner, 2016). Parenting skills need to be shared and should aim to assist families based on their individual needs (Panjwani, 2013). Parenting assistance should be specific, as it is often misinterpreted as involving monetary social assistance in lieu of parenting education programmes, where the focus is to "enhance the development and wellbeing of children" (Mokoae et al., 2012, p. 5). In South Africa, DSD services need to focus more on working with families in a proactive manner and not only reactively. Caregivers need to develop an awareness of legally and ethically correct ways of parenting and disciplining and need skills and knowledge (Prinsloo, 2016). For example, teaching parents about the new laws that have emerged regarding smacking one's child and consequently, informing them that such corporal punishment is now considered assault (Swanepoel, 2017).

Families require education and support for individual difficulties, for example, having a child with cerebral palsy or an expressive speech disorder (Harty & Alant, 2016). Helping these families and others can aid in better understanding the child and their limited ability to actively engage. This may reduce personal frustrations and consequently possible abuse. Parents must be informed of the correct referral systems and legislation (Prinsloo, 2016). Moreover, caregivers require support when they discover that their child has been abused by someone, as they risk not coping.

6.2.2.2 Educators and schools

Early intervention is necessary to buffer repeated experiences of abuse. Schools tend to be more stable environments and have more resources than many homes, and so concentrating on this environment may be more beneficial. Resources and initiatives can be targeted at groups and/or individuals of any age who are in need (Leoschut & Kafaar, 2017). School environments also positively influence a child's developmental trajectory, especially owing to the amount of time educators spend with children (Leoschut & Kafaar, 2017). Those working in this environment must create positive interactions with children. Training staff about abuse warning signs and their identification, ways to report their concerns, ways to support the child and procedures that should be followed need to be shared (Prinsloo, 2016). Educators play a major role in identifying causes of concern for some children (de Witt, 2014), especially since they are often the go-between between children and caregivers. Consequently, educators must have access to up-to-date information regarding referral systems and legislation (Prinsloo, 2016). Educators should move towards proactive efforts in teaching children about abuse and monitoring for it. They are in a position of trust and their interests should serve rather than take advantage of children (Guma & Henda, 2004).

Educators must be reminded of their roles as protectors and nurturers and must recognise this role and not avoid any concerns they may have (Guma & Henda, 2004). In line with this, educators need to be appreciated, recognised and supported by management. They experience high levels of stress and frustration and if this is not well handled, it could result in abuse perpetrations or ignoring signs of abuse. Support structures at schools can be avenues for promoting resilience and can assist in combating abuse (Prinsloo, 2016). With the vast occurrence of school abuse, stricter laws and consequences must be developed to protect children. For example, making national laws about who can work with children. The DoE, DoH and DoJ plays a crucial role in policy formation, involvement and provision.

6.2.2.3 Peers and community

Collings et al.'s (2005) research found that 61% of their researched cases made use of community members' detection rather than direct child disclosure. In the current study, many cases of abuse became evident following the HSP's examination based on a referral for consultation. Consequently, findings emerged from indirect disclosure and accidental detection more than purposeful disclosure. The community has a vital role to

play in abuse detection. Collings et al. (2005, p. 279) argue that more preventative work is required to “actively engage members of the broader community in the process of detecting and responding to the problem” of abuse. Children’s communities must be educated on children’s vulnerabilities, how they need to be protected and ways to report abuse (Badoe, 2017; Janssen et al., 2013). The community must become interested in and concerned for its children. Leaders and community activities may assist in igniting interest. Community involvement must include chiefs, prominent leaders, businesspersons, healthcare workers, churches/mosques and schools and educators so that people can be educated through “targeted awareness, sensitisation and capacity building … to improve the confidence of community members” and open discussions on these topics should be encouraged (Badoe, 2017, p. S34).

Abuse should not be seen as taboo. Educating people on these ‘taboos’ will reinforce their rights and teaches them how to stand up for others’ rights (Guma & Henda, 2004). Short courses in communities can be presented regarding topics like parenting, marriage counselling for parents, family enrichment, family therapy, divorce, and building resilience (Prinsloo, 2016). Child-friendly areas and ‘safe zones’ are encouraged in communities to assist children with disclosing and reporting abuse (Badoe, 2017). Communities should arrange after-school activities to provide supervision and bonding opportunities (DSD et al., 2012). For example, aftercare, development centres, or sport activities. The involvement of the DSD, DoJ and local heads of government would be useful to create programmes for the community.

6.2.3 The mesosystem, exosystem level and beyond

Children are best supported when the school, family and community work together with the mutual aims of solving problems and reaching goals (Swart & Phasha, 2016). The systems need to refer to each other for support and guidance and draw on each others’ resources.

On the exosystemic and macrosystemic levels, an awareness of abuse and promoting safer practices within the population are needed. A shift towards healthier attitudes and social norms that run counter to abuse and accepting violence are needed (de Witt, 2014; Badoe, 2017; Mathews & Benvenuti, 2014). This is not easy but changing perceptions of violence will make it less normalised. The broader community must help implement this, including government, NGOs, businesses, leaders, media, CSOs and the general

population (Mathews & Benvenuti, 2014). For example, having child protection week and the 16 days of activism campaign aim to raise awareness of and change perceptions about children's rights and violence against women and children (Janssen et al., 2013). But this is not enough. Television and radio programmes should be created. Harmful cultural and societal norms that go against the child and his/her rights must change and consequences must be enforced (Badoe, 2017).

The community and broader population must be educated on abuse including the definitions that the country adopts, the types, causes, symptoms, consequences, prevention techniques and solutions (de Witt, 2014). Interventions must include the pereptrator (Harty & Alant, 2016). "Apart from families, …, the broader community in which the children live plays a major role in facilitating early childhood intervention" (Harty & Alant, 2016, p. 119). Housing and access to social services assist in reducing the level of violence in the country (Collings, 2009).

Increased research at different levels is needed to determine the severity of the problem, locations/environments that are most affected as well as other factors that may play a role (Richter & Dawes, 2008). This research must be scientific. Current interventions should be studied to determine their effectiveness and shortcomings, and these should be improved on. These can influence multiple levels/systems. Vulnerable groups must be supported to reduce exposure to abuse and additional resources need to be mobilised (Richter & Dawes, 2008). Substance abuse treatment, education and prevention initiatives and parenting support programmes can assist in child protection (Leoschut & Kafaar, 2017). Health programmes, particularly about keeping a person's body healthy and valuing one's body will be useful (Prinsloo, 2016). Active engagement through "awareness campaigns through television, other media forms, posters …"; "promotions by churches and welfare organisations"; "informal training for marriage and parenthood"; and "more intensive training for all parties … who work with children, with the specific purpose of early identification of "high risk" factors and immediate implementation of preventative measures" should be implemented (de Witt, 2014, p. 336). Enforcable laws regarding screening those who work with children should beome a national endeavour. Campaigns and pre- and peri-natal programmes could be used to improve the population's awareness in taking proactive and preventative steps in reducing abuse (Scholtz, 2001).

Higher prosecution and conviction rates are needed to objectively describe the law as an effective child protection strategy (Collings, 2007). Rao and Lux (2012, p. 463) further argue that there "remains substantial work to be done on identifying the most effective means of preventing, detecting and effectively intervening with child maltreatment at individual, family and population levels". This project aims to take a small step in this direction. Scholtz's (2001) primary recommendation is for government to develop institutional and legal frameworks and to allocate funding to assist with convictions. Legal frameworks like the Children's Act 38 of 2005 and the Sexual Offences and Related Matters Amendment Act 32 of 2007 have emerged since Scholtz's recommendations and suggest that government has been proactive (Hendricks, 2014). However, it is questionable whether enough has been done to reduce the poor conviction rates (Collings, 2007), poor funding and the lack of human resources (Hendricks, 2014). Scholtz (2001) emphasises the need for smaller programmes, preventative strategies and for CSOs and businesses to assist by providing manpower and funding.

The number of cases that instituted court proceedings is dismal and suggests that interventions to assist with prosecution and laying charges are needed. It is unknown whether the small number of cases that initiated proceedings in this research was a result of fear, possible secondary victimisation or a lack of assistance. More research is needed on whether this is a provincial or national problem and into what can be done to enhance the initiation of criminal proceedings. The DoJ requires increased manpower in supporting and preparing victims for trial. Reasons for proceedings not going to court related to not reporting abuse to SAPS, withdrawing charges and SAPS having difficulty locating the accused (Collings, 2007). The author's research reiterates that South Africa is on par with other first world countries in processing child rape cases.

Professionals must develop common, universal definitions and more complete ways to report abuse (Richter & Dawes, 2008). CPRs in South Africa need to become more functional to assist in monitoring at risk children (Richter & Dawes, 2008). A planning and mangement committee may possibly assist in this regard. Campaigning could also act as a strategy, but in South Africa, the focus cannot be solely on child sexual abuse but must also focus on other types of abuse. Referral channels should be created in the public space (Tortolani & Lanti, 2009). For example, schools, religious institutions, social services and medical facilities should have the appropriate knowledge to refer or report

abuse and should guide people on using referral channels. TCCs are an example but are over-burdened and limited to sexual abuse. Education about the importance of initiating proceedings is needed because failing to do so often results in increased distress, depression, anxiety and increases the chance of a family member becoming an abuser (Collings, 2007).

Secondary victimisation remains a problem whilst reporting, and needs to be addressed at a district, provincial and national level. This is said to be a major problem in SAPS whose apathy must be addressed to minimise further victimisation. Action is required for SAPS' staff's lack of training, feelings of being overburdened and/or lack of empathy. Collings (2009, p. 139) delves into the forms of secondary victimisation and includes non-supportive reactions, denying basic services, "insensitive treatment, survivor-blame, disregard of the survivor's needs, and failure to provide adequate social services" which influence the victims' mental health outcomes. Such victimisation occurs at reporting, service provision and during court proceedings. More therapeutic services and training should be implemented in the country. Vallone et al. (2009, p. S210) state that "therapy for the traumatic area is indispensable, giving the child the means to cope with his or her own suffering". More research should be done into the effectiveness of group therapy for abuse as this would reduce waiting lists and limit superficial assistance. It may also empower victims by them helping each other.

Collings (2009) recognises that not enough services for child maltreatment victims exist and that services need to be available 24-hours-a-day. Receiving poor responses from workers can lead to secondary victimisation (Collings, 2009). "Violated patients most need a human being on the other side of the clinical encounter", they need support, reassurance that they are having normal responses to trauma, love and not criticism (Joyner, 2016). There is local recognition, in KZN, that little counselling and social work services are being provided and that if they are provided, they are delayed and only once-off (Collings, 2009). Service provision to victims of abuse appears low, which further exacerbates the consequences of exposure to abuse. In this study it was evident that whilst the HSP was seen, other necessary professionals such as social workers, counsellors and psychologists were not always referred to or seen. Collings (2009, p. 140) cites multiple authors who argue that "the provision of counselling/social work services to CSA [child sexual abuse] survivors is generally regarded as an essential

component of effective secondary prevention programming", and that sexual abuse victims who received post-abuse counselling believed that counselling was "one of the 'more helpful' professional interventions that they receive".

By sending professionals such as nurses, psychologists, educators and social workers on training programmes, their knowledge could aid with increased recognition of maltreatment and consequently assist in the number of cases that are reported or referred (Tortolani & Lanti, 2009; Prinsloo, 2016). Collaboration is most effective, but services are not currently integrated, nor do they assist each other or work together (Collings, 2009). Tortolani and Lanti (2009) argue that introducing telephone counselling services for parents, educators, social workers, courts of justice and the police could also provide greater access for victims to report their abuse and to assist them in dealing with the aftermath. Some services are available in South Africa (e.g. Childline and Lifeline), but more training and services are needed. Standardised hospital protocols should be developed (Janssen et al., 2013). It may be useful to develop such a protocol for all health professionals to use or one protocol per profession to ensure recording standardisation. This would assist other professionals in undertsanding a case. Dawes et al. (2004) argue that a standardised protocol should include definitions of abuse and neglect; be easy-to-complete allowing for rapid and easy follow-up and management; be widely distributed; and specify the reporting periods.

Another effective strategy could be for the NPA to open more TCCs because these centres provide all of the necessary professionals and services at one site, which could help maltreated victims in reporting abuse and receiving the necessary assistance. For example, having psychiatrists, psychologists, social workers, nurses and doctors at one site (Tortolani & Lanti, 2009). Having more TCCs would mean that the centres would need to move away from focusing only on sexual abuse and would need to prioritise all forms of child abuse. Either the centres need to become more accepting of other types of abuse, or other, similar centres for other abuse forms should be opened.

Enhanced mandatory reporting must be emphasised and professionals who are likely to be exposed to such disclosures must be trained (Richter & Dawes, 2008). Article 19(2) of the CRC expects signatory states to have procedures for identifying, reporting, referring and investigating possible cases of abuse and neglect and to develop effective

programmes (Richter & Dawes, 2008). Such programmes should support vulnerable children to eliminate intergenerational abuse. This should be prioritised by the DSD and DoH. Resource capacities must be enhanced, and predisposing and precipitating factors must be addressed (e.g. social and economic challenges). Resources must be allocated, delays reduced, and capacities of professionals, infrastructure and services be built up (Richter & Dawes, 2008).

Prevention and reactive work are required. The former is best likely to break the cycle of abuse that is currently present in South Africa (Joyner, 2016; UNICEF South Africa, 2013). Legano et al. (2009) suggest that initiating prevention programmes with youth can assist in reducing the risk of subsequent abuse. Mohamed and Naidoo (2014, p. 251) argue that "raising awareness of the warning signs of abuse and educating health care workers" is likely to "empower them to play a more active role in the prevention of child abuse and the protection of vulnerable children". This is echoed in Hendricks (2014). Trained professionals must be more easily accessible when reactive work is required.

The DoE should become involved in developing workshops and education programmes that assist educators and learners in learning about and dealing with abuse, particularly because so much is happening in the school environment. Educators must incorporate knowledge into the curriculum and share the importance of protecting oneself with learners. The DSD must intervene within all systems to proactively educate and guide, and to reactively assist when the environment is dysfunctional. However, it is up to microsystemic actors to report concerns for the DSD to become involved and to follow up on. This will ensure children's well-being and protection and will assist with early childhood intervention. The DoH is another obvious stakeholder owing to the medical interventions required. More centres need to be set up to assist, particularly in underprivileged areas. Accessibility is another factor. Laws that have been created through the Constitution and the acts must be upheld and the DoJ and NPA must implement these more concretely.

Once interventions have been created, NGOs and CSOs can assist in implementing the interventions on a more local level. Resources need to be made available and government needs to adjust expenditure to ensure that financing is available. Community centres must be set up to assist. Organisations including public services need to make it

less challenging to obtain information. Collings (2007) also notes information accessibility challenges. There was so much red tape in the current research that more general statistics were not provided. The lack of relevant statistics and the red tape in this study reiterated the challenge of growing literature in the field.

6.3 Limitations

As with all studies, the current research project has some limitations. It is firstly limited by the type of abuse that was studied and the "comprehensiveness and quality of official statistics and of surveys" that were used or produced (Rao & Lux, 2012, p. 459). The study only looked at four types of abuse, and excluded exploitation and forced labour, owing to it being for a Masters dissertation, time-limited and other forms of abuse being difficult to detect in a medical practice. Furthermore, the study used case files from one private practice, which Collings (2009) acknowledges is limited in terms of generalisability. The question of the quality of the data was addressed by approaching the HSP for clarification as needed and by the researcher collecting the data herself. Having one site also restricted the amount and type of information that was available, which limited the generalisability of the findings. The research consequently cannot be generalised to the Pietermaritzburg area, KZN or the country. Comparisons between the data and the Edendale TCC is not possible either as the latter focuses on sexual abuse. Limited data exist for the city and province, but comparisons were not the goal of this study. Instead the study aimed to generate local-level knowledge.

The time-limited nature of the study meant that only a selection of cases could be assessed. This disadvantage was reduced by having an intensive three-day data collection period, completed by the researcher, to ensure that the data obtained were consistently and accurately recorded and that the same selection criteria were consistently applied. The study's purpose was to develop exploratory and descriptive data which could inform knowledge generation around issues of abuse and be used for comparative purposes and larger studies. The study did not inform data about Pietermaritzburg, but focused on the HSP's practice, which is a sub-category of the city. It is seen as a starting point for larger-scale city-based studies. Moreover, the exploratory nature of the study guided the data collection process to gather as much information as possible. It aimed to enlighten where more research is needed. For example, regarding the reporting procedures, prosecution and school abuse.

The sample size was small, which also made generalising the findings challenging. Whilst a larger sample was hoped for, the researcher's personal difficulties, time constraints and resource limitations limited the sample size. However, the sample size does align to other research findings. The questionnaire was uniformly applied to all case files to ensure that the data were reliable and provided valid scientific information.

Systemic biases in official statistics make it challenging to inform knowledge (Guma & Henda, 2004). The use of retrospective cases meant that the specialist doctor provided authentic sources and the researcher's awareness of the possibility of biases guided the study. Retrospective analysis based on memory was not a concern as information was recorded in the case files. This assisted with accurate data collection and clarification was sought as needed. Being a private practice biased the cases analysed to reflect those who are privileged to have medical aid or pay medical fees. Poorer people are likely to have attended a government hospital and so the site limited accessibility to victims from all socio-economic levels. People with medical aid are said to represent only 17% of the population (Statistics South Africa, 2017a) and so most of the public sector was not accounted for. This was difficult to overcome owing to the limited scope of this study and limited site accessibility, but some representation of different socio-economic groups was apparent through not all victims' families having medical aid. Nevertheless, the sample is not a true reflection of the city's population but again, generalisability was not the primary aim of this study. Disclosure studies have found that "although 72% of victimised children disclose their abuse to someone at some stage of their lives …, only 12% of cases are ever reported to the authorities" (Collings et al., 2005, p. 282). This begs the question of the accuracy of the statistics, as they could be far worse owing to the majority of victims not seeking help.

Data that emerged from case files were at times limiting. For example, it was not always known if a J88 form was filled in, what the presenting problem was, or the status of the case. Information could not be clarified with the victims and follow up regarding the consequences of the abuse and the current intervention pathways was impossible. Case files lacking information made it challenging to record all of the necessary data, and some cases did not have an explicit statement about abuse. This was mitigated by obtaining clarification and follow-up from the HSP, which required the HSP to rely on recall, and so access to information focused on what was in the files. The lack of consistent recording

meant that data collection was a timely process and did not always show all of the necessary data, including the interventions that were put in place. The researcher may have missed information from case files despite trying to be as methodical as possible. Each questionnaire was checked after completing a case file and the file was revisited to check for missing information as needed.

There was little evidence regarding the effectiveness of the interventions and so this could not be reported on. Such information can inform where to target services, where to focus intervention strategies and to also provide the opportunity to use evidence-based practice to inform prevention strategies (Mathews & Benvenuti, 2014). Other research studies such as Collings (2009) and Collings (2007) also made use of case files. If these are to be used for research purposes, it may be highly useful for government to develop a consistent questionnaire to capture all of the abuse information.

The questionnaire used for the study was created by the researcher based on numerous articles that were read. Consequently, there may be limitations in terms of what information the questionnaire collected and the questionnaire's validity. Owing to the limited cases, the questionnaire was not pilot tested, but was continuously referred back to and adjusted, with case files being revisited as needed. Using broader or more narrowly defined definitions and conceptualisations may have influenced the number of abuse cases that were recorded (Bebbington et al., 2011). The DSD's broad definition was employed but there was still some uncertainty as to what constituted abuse for the HSP. Clarification and open discussions were held with the HSP for this reason. More caution should have been taken when reporting the results owing to the large number of univariate analyses and the small sample sizes. Another limitation was the level of input from the researcher's supervisor and specialist doctor. The researcher made sure to contact them as required but responses following data collection were challenging at times. There is a considerable amount of literature in the field and deciding what to incorporate into the study and what to leave out was a challenge for the researcher. The study required constant revisions.

6.4 Further research

A similar study could be conducted in another private practice in the area to assess if similar findings emerge. This would provide insight into the current issues of the city.

Similar research in the public sector could access poor/lower income individuals or individuals who do not have access to medical insurance to ascertain their incidences of abuse and profiles. Assessing different socio-economic backgrounds of victims may enlighten whether abuse is reported equally across socio-economic levels as the literature suggests, and may create trends regarding abuse prevalence in different socio-economic groups (Richter & Dawes, 2008). This may require other research methods, as the information was not available in the case files. Larger areas or other areas in the municipality or province could be researched with/without the same questionnaire for comparative purposes. This data could be included with other data in the city to broaden knowledge about the city, which would provide insight into the Msunduzi municipality and the province. The housing situation should also be reviewed to determine if there is an increased risk of abuse if the number of people living at home increases.

Further research could extend sample sizes of the current location or other locations. As a result of the findings of this dissertation, the different schooling systems should be looked at in more detail – for example, does private schooling versus public schooling influence the rate of abuse in schools, or do the different quintiles influence the number of abuse cases? Different education phases should also be studied, e.g. foundation, intermediate, senior and FET phases. Such research could assist with future planning, developing better services for the population, informing curriculum development and allowing for the creation of projects that may help reduce these high statistics (Viviers, 2013). The same files could be analysed using broader/narrower definitions to ascertain how this influences statistics.

Interviewing victims, families or stakeholders could shed more light into their experiences with abuse. Interviewing victims to find out more about why they disclose and report abuse and their choices around prosecution decisions could also be worthwhile. The current project could not determine the consequences of abuse on the child, their family or their community. More longitudinal studies are needed to track interventions to determine their effectiveness, those interventions that need prioritising and those that are not essential. These longitudinal studies may also assist in elucidating whether victims ever return to their state of ‘normal’. Research into following up on victims could also be beneficial. The questionnaire should also be validated through further research. The same questionnaire should be used in other samples and contexts to determine if

similar epidemiological findings exist. The robustness of the questionnaire should also be determined.

6.5 Conclusion

Child abuse is not a phenomenon of the 21st century. It has existed since time began but has consistently become a more prevalent problem. The definitions continue to evolve and change regarding what is included or excluded. These are affected by society, culture and time. Understanding child abuse is also influenced by ethnocentric principals. These factors as well as the far-reaching consequences of child abuse led the researcher to use Bronfenbrenner's ecological systems theory to conceptualise child abuse.

The prevalence of child abuse remains challenging to discover. International literature argues that sexual abuse and physical abuse are the most prevalent forms of abuse. Less is known about the South African context, but the current study found sexual abuse and emotional abuse as most prevalent. The research found a considerable proportion of cases affecting children between 6 to 10 years of age, which is contrary to literature arguing that most abuse occurs on children under 5 and in adolescence. Almost equal numbers of boys and girls made up the sample, indicating that boys also need to be considered for proactive and reactive interventions (54% and 46% respectively). Current intervention strategies may need to be relooked. Most of the victims were of the African race, which may be a consequence of the country's demographics. Victims that appear most at risk, as seen from the HSP's practice in Pietermaritzburg, seem to be in grades R to 6. Victims presented with multiple presenting problems and had varied symptoms. At times caregivers were unaware that abuse had occurred and the HSP identified it. Specific symptom sets did not relate to specific forms of abuse. An interesting finding, that runs counter to literature in the field, is that more children are abused when mothers and fathers are employed. There was a level of dependence between the victims' gender and abuse and the father's employment status and whether abuse occurs. More abuse occurs in houses where 4 to 6 people live; however, the type of housing was not influential. Little data were recorded regarding the victim's living arrangements.

The study's inferential statistics found a dependency between abuse and the perpetrator's age, and abuse and the abuser's level of education. Considerable abusers (42.3%) were minors which is a major concern. A total of 69.2% of victims held a

relationship of some sort with the perpetrator, suggesting that only 30.8% of perpetrators were strangers. Peer and school abuse are at alarming rates, with 23% of abusers being peers, and another 14% coming from the school environment. Perpetrators seem to come from varying educational and age backgrounds and the number of child offenders is concerning. The continued use of trust, threat or coercion was apparent. Many victims report abuse to primary caregivers, but some were unaware that abuse had occurred.

Varied interventions emerged from the findings, suggesting that tailored interventions are being put in place, however, whether the interventions are being used or not, is an area for further research. The risk and protective factors varied but poverty, stress, lack of sufficient housing and access to substances are known risk factors. Protective factors mostly emerge from within the child and his/her microsystems. Multiple national and provincial departments, including the DoE, DoH, DSD, DoJ and the DHET need to work collaboratively to assist in pooling resources to reduce this crisis. Government cannot do it alone and there needs to be corporate and CSO intervention as well as a significant change in societies' ideologies.

It is a human right to be protected, and this needs to be prioritised. So "long as child abuse is viewed and addressed through a local cultural lens, children will remain victims" (Guma & Henda, 2004, p. 107). A broader and more encompassing approach is needed, despite recognition of individual cases. Stakeholders from legal, economic, political, social, educational and cultural sectors need to come together to address child abuse. Stakeholders need to work together to implement programmes and initiatives. This should occur on national, provincal and district levels.

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APPENDICES

Appendix A: HSP (gatekeeper) consent

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August 31, 2017

The University of KwaZulu-Natal

Pietermaritzburg

Dear Madam/Sir

Re: Jounelle Gibson Student number 9001290072080

I have received Jounelle Gibson's study protocol and have no objection to her conducting her research work in my practice at XXXXXXXXXXXXXXXXXXXXX

Kind regards

XXXXXXXXXXXXXXXX
XXXXXXXXXXXXXXXX

Dr XXXXXXXXXXXXXXXXXXXXXXX

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Appendix B: Confidentiality agreement

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

A confidentiality agreement between:

A healthcare service provider at private practice in Pietermaritzburg
and
Jounelle Gibson (researcher) and Nontobeko Buthelezi (supervisor)

This agreement is to certify that I, Jounelle Gibson, and my supervisor, Nontobeko Buthelezi, hereby agree to maintain confidentiality with all information that is divulged to us upon my time working with the healthcare service provider at private practice in Pietermaritzburg in my capacity as researcher and student psychologist and Nontobeko's capacity as my supervisor.

I agree that I am an HPCSA registered student educational psychologist in training and that despite this title, I agree to uphold all aspects of professional conduct as laid out in the Health Professions Council of South Africa's (HPCSA) Form 223: Ethical Rules of Conduct for Practitioners Registered under the Health Professions Act, 1974. I acknowledge working under the supervision of Nontobeko Buthelezi and that consequently, she may be privy to such information as well.

I agree that any victim/perpetrator personal identifying information obtained during the course of my research work will not be divulged in the final research report and should any information pertaining to such be divulged, pseudonyms will be used. It is acknowledged that the research, "An analysis of child abuse cases referred to a healthcare service provider in Pietermaritzburg: An evidence-based study", may be published as a report or presented at conferences.

Should any issues arise during my collection or analysis of the data, I will contact the healthcare service provider in Pietermaritzburg as well as my supervisor immediately. Regular meetings will be held with my supervisor to ensure that such a confidentiality agreement is adhered to throughout.

Organisation

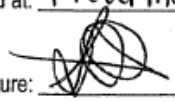
Signed at: Pietermaritzburg on 31st day of August month of 2017

Signature: (XXXXXXXXXX

Full name: XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX
(XXXXXXXXXXXXXXXXXXXXXX
(XXXXXXXXXXXXXXXXXXXXXX

Researcher

Signed at: Pietermaritzburg on 07 day of September month of 2017

Signature:  Full name: Jounelle Amy Gibson

Supervisor

Signed at: Pietermaritzburg 07 day of September month of 2017

Signature:  Full name: Nontobeko Buthelezi

Appendix C: Questionnaire and coding schedule

The questionnaire includes the coding schedule and the coding manual.

Case # _____ **A. Recording information regarding the victim (child)**			**Office use only**
1.	Age	□ 5 years or less_____ □ 6 - 10 years_____ □ 11 - 14 years_____ □ 15 - 18 years_____ □ Don't know _____	Aage □ 1 □ 2 □ 3 □ 4 □ 5
2.	Gender	□ Male □ Female □ Unknown □ Other	Agender □ 1 □ 2 □ 3 □ 4
3.	Race	□ African □ Asian □ Indian □ White □ Coloured □ Other: _____ □ Not specified	Arace □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
4.	Disability	□ Yes _____ _____ _____ □ No	Adisabled □ 1 □ 2
5.	HIV status before child abuse	□ Negative □ Positive □ Unknown	AHIVbef □ 1 □ 2 □ 3

6.	HIV status after child abuse	□ Negative □ Positive □ Unknown	AHIVafter □ 1 □ 2 □ 3
7.	Known conditions/illnesses and specify	□ Physical _____ _____ □ Emotional_____ _____ □ Psychological _____ _____ □ Medical _____ _____ □ Other: _____ _____ □ Not applicable	Acondition □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
8.	Current schooling	□ None/special school □ Grade R to Grade 3 □ Grades 4 to 6 □ Grades 7 - 9 □ Grades 10 – 12 □ Don't know □ Not applicable	AcurrSkl □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
9.	Primary caregiver(s) (caregiver child lives with)	□ Biological mother/father □ Sibling □ Grandparent □ Aunt/uncle/cousin □ Neighbour □ Friend □ Family friend □ Stepmother/stepfather □ Partner (girlfriend/boyfriend) □ Adopted □ Foster parent	Aprimcare □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11

		□ Other _____ □ Don't know	□ 12 □ 13
10.	Parent employment status	Mother: □ Employed □ Unemployed □ Don't know Father: □ Employed □ Unemployed □ Don't know	Aparwork Mo Fa □ 1 □ 1 □ 2 □ 2 □ 3 □ 3
11.	Total number of people living at home (including child)	□ 1 - 3 □ 4 - 6 □ 7 - 10 □ 11 - 15 □ 15+ □ Don't know	Atotalhome □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
12.	Total number of people sharing room with child at home	□ 1 - 3 □ 4 - 6 □ 7 - 10 □ 11 - 15 □ 15+ □ 0 □ Don't know	Atotalshare □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
13.	Type of dwelling	□ Homeless □ Shack/informal settlement □ Hostel □ Room/garage □ Flat/cottage □ Shared house □ House (not shared) □ Don't know	Atypedwel □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8

14.	Location of living (including ward, location, municipality)	_____ _____ _____ _____ _____	Alocation

(Please turn over for Section B)

B. Recording information regarding the perpetrator				Office use only
	Number of perpetrators	_____		BNoofperp
1.	Age	□ Under 12 _____ □ 12 - 15 _____ □ 16 - 18 _____ □ 19 - 21 _____ □ 22 - 30 _____ □ 31 - 40 _____ □ 41 - 50 _____ □ 51 - 60 _____ □ 61 + years _____ □ Not given _____ □ 18 + years _____ □ < 18 years _____		Bage □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12
2.	Gender	□ Male □ Female □ Unknown □ Other		Bgender □ 1 □ 2 □ 3 □ 4
3.	Race	□ African □ Asian □ Indian □ White □ Coloured □ Other: _____ □ Not specified		Brace □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
4.	HIV status	□ Negative □ Positive □ Unknown		BHIVstatus □ 1 □ 2 □ 3

5.	Educational level	□ Grade 7 or below □ Grade 12 □ College/Technicon □ University degree □ Postgraduate qualification □ Don't know (not specified)		Bedlevel □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
6.	Any mental illness?	□ Yes _____ _____ □ No □ Unknown		Bmentalill □ 1 □ 2 □ 3
7.	History of criminal record	□ Yes _____ _____ □ No □ Unknown		BHxcrim □ 1 □ 2 □ 3
8.	Perpetrator known to victim	□ Yes □ No □ Unknown		Bknown □ 1 □ 2 □ 3
9.	Relationship between victim and perpetrator	□ Family □ Stepparent □ Live-in partner □ Boyfriend/girlfriend □ Ex-boyfriend/ ex-girlfriend □ Family friend □ Friend □ Educator □ Coach/ sports instructor □ Community member □ Community leader □ Religious leader		Brelationship □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12

		□ Traditional healer □ Stranger (unknown) □ Other _____ □ Don't know		□ 13 □ 14 □ 15 □ 16
10.	Perpetrator under the influence of alcohol or substance	□ Yes _____ _____ □ No □ Unknown		Balcoholsub □ 1 □ 2 □ 3
11.	Perpetrator with exposure to abuse	□ Yes_____ _____ □ No □ Unknown		Bexposabuse □ 1 □ 2 □ 3
12.	Other noticeable features of the perpetrator	_____ _____ _____ _____ _____ _____ _____		Bfeatures

(Please turn over for Section C)

C. Recording information regarding the presenting problem			Office use only
1.	Presenting problem	□ Physical _____ □ Medical _____ □ Emotional _____ □ Psychological _____ □ Direct trauma _____ □ Other _____ □ Don't know	Cpp □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
2.	Symptoms	□ Physical/somatic _____ _____ □ Psychological/emotional _____ _____ □ Motivational _____ _____ □ Cognitive _____ _____ □ Don't know	CSym □ 1 □ 2 □ 3 □ 4 □ 5

(Please turn over for Section D)

D. Recording information regarding the reporting of the abuse				Office use only
				Dfirstdisclose
1.	Who the abuse was first reported to	□ Caregiver □ Sibling □ Other family member □ Educator □ Friend □ Family friend □ Community member □ Traditional healer □ Religious leader □ Nurse/doctor □ Police member Specify rank: _____ □ Other _____ □ Not reported		□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □11 □ 12 □ 13
				Dwhorep
2.	Who reported the child abuse (to Doctor)	□ Victim him-/herself □ Caregiver □ Sibling □ Other family member □ Friend □ Family friend □ Educator □Community member □ Community leader □ Religious leader □ Traditional healer □ Other _____ □ Not reported (Gatekeeper doctor found)		□ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10 □ 11 □ 12 □ 13

3.	Education level of person reporting abuse	□ Grade 7 or below □ Grade 12 □ College/Technicon □ University degree □ Postgraduate qualification □ Don't know		Dedlevel □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
4.	Location of the abuse	□ Home environment □ Other family member's house □ Neighbour's house □ Community member's house □ School environment □ Place of worship □ Perpetrator's place of living □ Public location _____ □ Don't know		Dlocate □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9
5.	Location of first report of abuse (Excluding home)	□ Gatekeeper healthcare service provider □ Police station □ Edendale hospital □ Other government (public hospital) □ Private hospital □Other _____ □ Don't know		Dlocatfirstrep □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
6.	When abuse first occurred (initial abuse) (including age)	_____ _____ _____ _____ _____		Dfirstoccur

7.	Number of reported times of abuse and when	_____ _____ _____ _____ _____		DNo.times
8.	Date of most recent abuse	□ 2010 □ 2011 □ 2012 □ 2013 □ 2014 □ 2015 □ 2016 □ 2017 □ 2018 □ Don't know		Drecabuse □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10
9.	Date most recent abuse was reported	□ 2010 □ 2011 □ 2012 □ 2013 □ 2014 □ 2015 □ 2016 □ 2017 □ 2018 □ Don't know		Drecrepdate □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ 8 □ 9 □ 10

10.	Who collected information pertaining to the abuse	□ Nurse □ Doctor □ Social worker □ Lawyer □ Police member Specify rank: _____ □ Other _____		Dcollectinfo □ 1 □ 2 □ 3 □ 4 □ 5 □ 6
11.	Type of abuse (1)	□ Sexual □ Emotional/psychological/mental □ Physical □ Neglect □ Other maltreatment _____ _____ _____		Dtypeabuse(1) □ 1 □ 2 □ 3 □ 4 □ 5
12.	Type of abuse (2)	□ Sexual □ Emotional/psychological/mental □ Physical □ Neglect □ Other maltreatment _____ _____ _____		Dtypeabuse(2) □ 1 □ 2 □ 3 □ 4 □ 5

(Please turn over for Section E)

E. Recording information regarding the status of the case			Office use only
1.	Pathways / interventions taken	□ Medical treatment □ Psychological attention (therapy) □ Psychoeducation for victim or others □ Social worker intervention □ Court proceedings □ Other _____ □ Don't know	Eintervene □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7
2.	Process of prosecution	□ Not occurring □ Started □ Went to court but dropped - reason _____ _____ □ Completed with conviction □ Completed without conviction □ Don't know	Eprosecute □ 1 □ 2 □ 3 □ 4 □ 5 □ 6

(Please turn over for Section F)

F. Recording additional information			Office use only
1.	Risk factors noted	_____ _____ _____ _____ _____ _____	Frisk
2.	Protective factors noted	_____ _____ _____ _____ _____ _____ _____	Fprotective
3.	Stakeholders for intervention	_____ _____ _____ _____ _____ _____ _____	Fstkholder
4.	Anything else	_____ _____ _____ _____ _____ _____ _____	Felse
5.	Medical Aid	□ Yes □ No □ Cash □ Don't know	FMedAid □ 1 □ 2 □ 3 □ 4
6.	Medical Aid Name	_____	MedAidNam

Appendix D: Ethical approval letter

UNIVERSITY OF KWAZULU-NATAL
INYUVESI YAKWAZULU-NATALI

12 October 2017

Ms Jounelle Amy Gibson (217080491)
School of Applied Human Sciences – Psychology
Pietermaritzburg Campus

Dear Ms Gibson,

Protocol reference number: HSS/1886/017M
Project title: An analysis of child abuse cases referred to a healthcare service provider in Pietermaritzburg: An evidence-based study

Approval Notification – Expedited Approval

In response to your application received on 03 October 2017, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL.**

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment/modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

The ethical clearance certificate is only valid for a period of 3 years from the date of issue. Thereafter Recertification must be applied for on an annual basis.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Dr Shenuka Singh (Chair)

/ms

Cc Supervisor: Nontobeko Buthelezi
Cc Academic Leader Research: Dr Jean Steyn
Cc School Administrator: Ms Ayanda Ntuli

Humanities & Social Sciences Research Ethics Committee
Dr Shenuka Singh (Chair)
Westville Campus, Govan Mbeki Building
Postal Address: Private Bag X54001, Durban 4000
Telephone: +27 (0) 31 260 3587/8350/4557 **Facsimile:** +27 (0) 31 260 4609 **Email:** ximbap@ukzn.ac.za / anymanm@ukzn.ac.za / mohunp@ukzn.ac.za
Website: www.ukzn.ac.za

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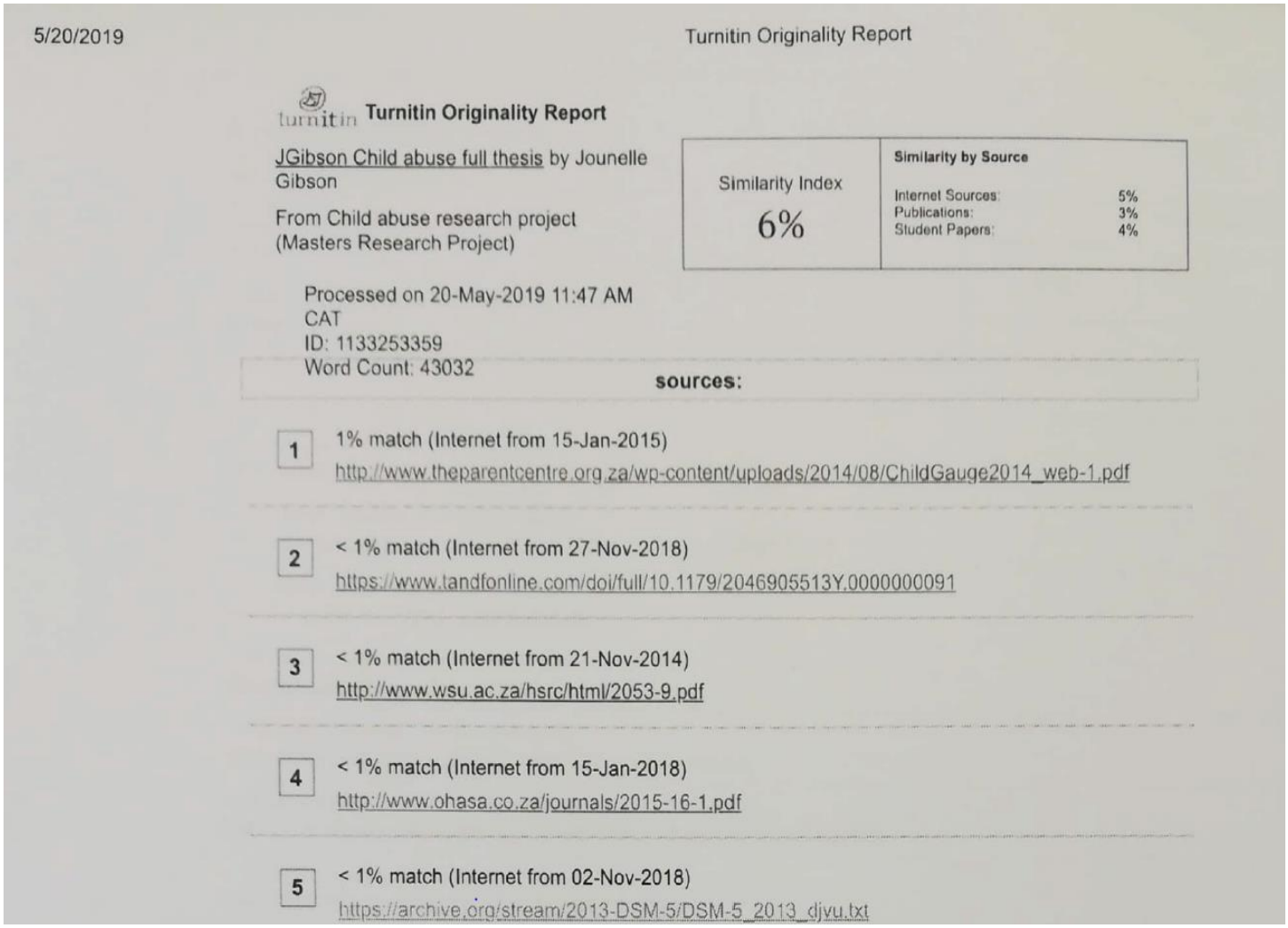
100 YEARS OF ACADEMIC EXCELLENCE

Appendix E: Turnitin plagiarism report for handed in copy of dissertation



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