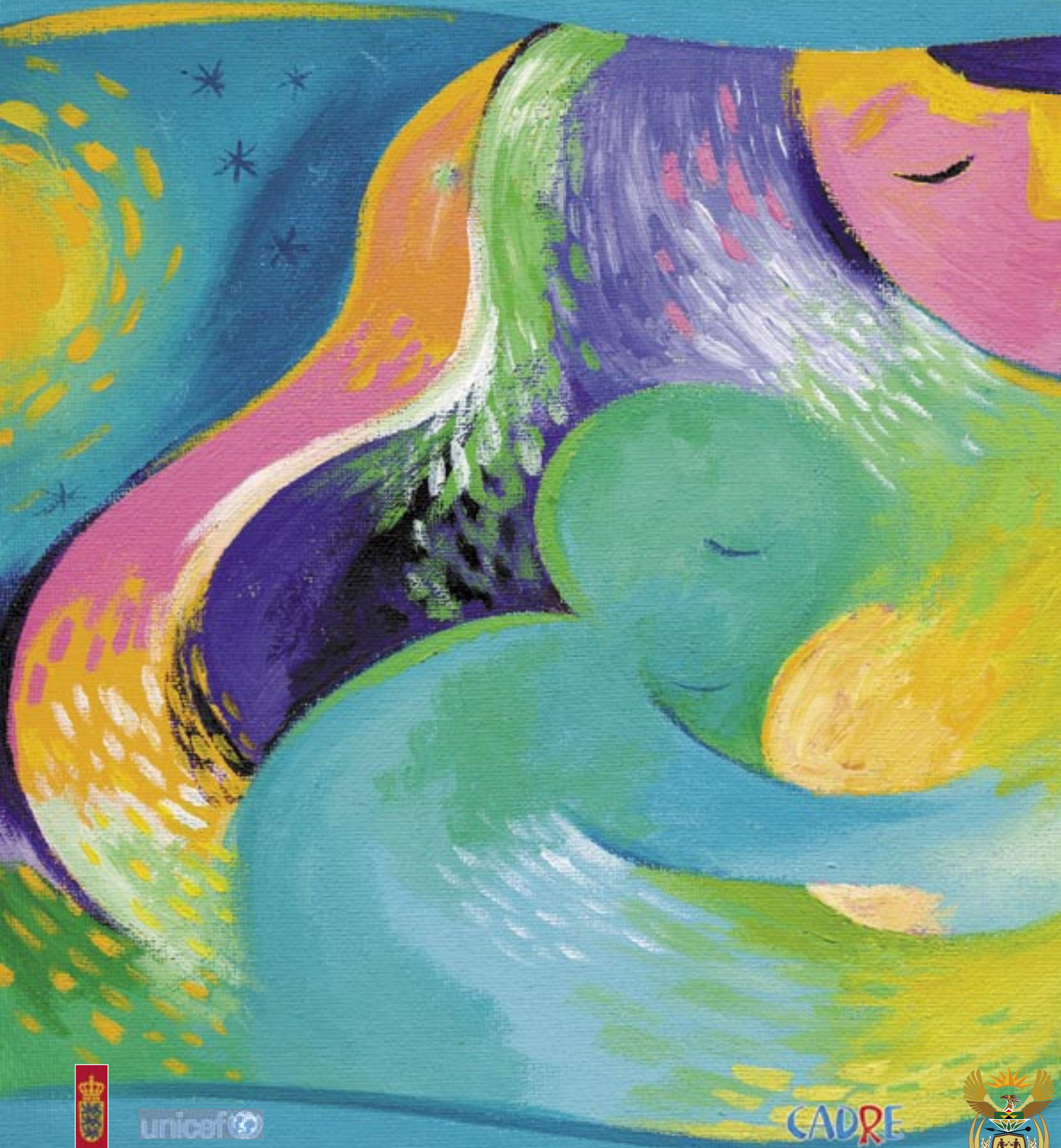


CHILD SEXUAL ABUSE AND HIV/AIDS IN SOUTH AFRICA A REVIEW



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CHILD SEXUAL ABUSE AND HIV/AIDS IN SOUTH AFRICA

A REVIEW

Developed by

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Note

This review is a companion document to a series of reviews of gender-based violence and HIV/AIDS in South Africa. These documents are available on the CADRE website www.cadre.org.za

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INTRODUCTION

Vulnerability of children to sexual abuse is linked to a range of contextual factors – including poverty and related poor living conditions, migration, and economic and social insecurity – which contribute to inadequacies in childcare arrangements. These conditions are exacerbated by the social impact of HIV/AIDS. Child sexual abuse is, however, not limited to conditions of impoverishment and may occur in any socio-economic context.

Risk factors for child abuse may be divided into two main categories:

- ❑ those factors that decrease the quantity and quality of primary care of children;
- ❑ those factors that produce emotional vulnerability in children.

In both cases, social and economic conditions of childcare are implicated.

However, vulnerability also includes exposure to perpetrators of child sexual abuse who specifically target children for sexual gratification. Although child sexual abuse frequently involves perpetrators with criminal psychopathologies, it is believed that the prevalence of such individuals is insufficient to account for the high incidence of child sexual abuse in South Africa.

Child sexual abuse has been reported more frequently in contexts where children are economically and socially deprived, where families are dislocated, where children live without one or both of their biological parents, where primary caregivers are inconsistently present, where children are placed in the care of distant relatives or unrelated persons, and where children are placed in foster care (see Mullen & Fleming 1998).

In South Africa, household and residence patterns are a product of the economic practices of apartheid, where families were fragmented and separated through labour migration, and where 'dormitory' townships were located some distance from places of employment. These patterns continue in the present period: although formal urban residence has stabilised for some households, rapid urbanisation is accompanied by burgeoning informal urban settlements, which contributes to fragmented social cohesion. Responsibility for childcare, actual childcare arrangements, and decisions over residence of children in relation to parents and primary caregivers are neither regulated nor stable. Children are, for example, frequently moved between rural and urban households, and caregiving arrangements are unstable.

HIV/AIDS is a factor in the insecurity that renders children vulnerable to sexual abuse. In the case of orphaned children, there is the potential of vulnerability to sexual abuse by shifts in caregiving arrangements. Fostered or adopted children may be disadvantaged in relation to other members of the household, and may face sexual abuse as well. Children whose care needs are not met may end up living on the streets and becoming vulnerable to prostitution.

Investigating child abuse in South Africa

Sexual acts perpetrated on children are considered to be abusive on the grounds of differentials of power – ie. they are not mitigated by the notion of 'consent'. Such power is predicated by differentials of knowledge, age and gratification (see Faller

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1993: 10-11). Feminist analyses of rape and other forms of gender-based violence argue that such acts are not predominantly sexually motivated, nor intrinsically sexual, but are in essence forms of power-based violence and control. However, the sexualised nature of these forms of violence cannot be disregarded, and the intersections of power, violence and sexual gratification cannot be understood separately from one another.

This report analyses child sexual abuse in the context of a continuum of forms of disempowerment, including economic, social and psychological deprivation, that render children – and particularly children affected by HIV/AIDS – vulnerable. The analysis specifically addresses the link between vulnerability, child sexual abuse, and HIV/AIDS. This stands in contrast to one-dimensional approaches that are oriented towards understanding child sexual abuse in terms of the psychopathological profile of perpetrators (which are often foregrounded in studies conducted in Western Europe and the United States).

Complications arising from traumatic experiences may not be dealt with consciously and/or cognitively, and may be structurally bound up with repression and symptom formation which is exacerbated in cases of sexual abuse where the abuser is a person with whom the child has formed a relationship involving trust.

In highlighting disempowerment, there is a need to understand the relationship between social/sociological and psychological explanations and aetiologies. Conflating different explanatory models risks overemphasis on contextualisation, with the result that the specificities of child sexual abuse are neglected. There are, however, structural grounds on which an interrelation can be put forward in less simplistic terms. For example, early childhood dependencies, experiences, and relations, in which the satisfaction of needs is tied to nuclear or primary relationships, form structural matrices for psychic and social trajectories. Traumatic experiences in childhood may be played out in later life, and may contribute to post-traumatic stress disorders. Complications arising from traumatic experiences may not be dealt with consciously and/or cognitively, and may be structurally bound up with repression and symptom formation which is exacerbated in cases of sexual abuse where the abuser is a person with whom the child has previously formed a trusting relationship.

Definition of 'children': who is counted as a 'child'?

In this report, 'children' are defined as young people up to the age of 18. This definition follows the age range defined by the African Charter on the Rights and Welfare of the Child (1990) and the UN Convention on the Rights of the Child (1979). While the age of 18 is generally accepted as the age of majority in most countries, legal provisions vary between nations and government systems and affect the protection of children, decision-making concerning children, legal accountability of children, and the capacity to consent that is imputed to children.

In South Africa, for example, a child may consent to medical treatment such as HIV treatment and termination of pregnancy, without parental consent, from the age of 14 onwards. On the other hand, rape or sexual assault perpetrated against a person under the age of 16 has to be reported to the police. The statutory definition of rape, as proposed by the South African Law Commission in the new Sexual Offences Bill, extends to sexual intercourse with a child where the age difference under the age of 16 is three or more years between partners, irrespective of consent. The legal age of consent to sexual intercourse is 16.

Although the interpretation of the term 'childhood' differs between cultures and countries, what is common to all is the idea that childhood is the period in early life marked by rapid growth and development. It is also a period of dependence

usually on parents and a family context – for immediate physical needs such as food, clothing and shelter, as well as emotional, social and intellectual support and care. Childhood is a period of physical growth, psychological development, and development of intellectual, social, spiritual and emotional characteristics. The circumstances within which this growth takes place can limit or enhance childhood development and influence psychosocial well-being in adult life.

**Definition of 'child sexual abuse':
the relationship between power, violence, and sex**

Sexual abuse is defined as a sexual violation perpetrated by a person who holds, or is perceived to hold, power over someone who is vulnerable. Because sexual abuse involves an abuse of power, children are more vulnerable than adults. Child sexual abuse involves an adult or significantly older person who interacts with a child in a sexual way for purposes of psychosexual gratification and for the assertion of power and control (Bayley and King in Mdu 2001: 1).

In South Africa, sexual relations between partners under 16 whose age difference is more than three years, constitutes statutory rape. This age difference is linked to power differentials. It suggests that the offender exercises control over the victim, and that the sexual encounter is not consensual – i.e. it is abusive.

The notion that sexual violence is perpetrated to fulfil non-sexual needs and goals of exerting power, domination, and self-affirmation (Vogelman 1990) is an important one. However, the specifically sexualised nature of this form of violence should not be overlooked, as it produces very specific vulnerabilities, conditions, effects, and responses. Equally, psychopathologies of perpetrators, for example, paedophilia cannot be removed from the framework of understanding sexual abuse.

Child sexual abuse is broadly defined as the inducement of sexual activity in children for the gratification of persons who are in more powerful positions. Child sexual abuse may include (SAT 2001: 1):

- ☐ actual or attempted penetrative (oral, anal, or vaginal, by penis or objects) sexual intercourse with a child
- ☐ non-penetrative sexual activity with a child
- ☐ oral or manual genital contact with a child
- ☐ masturbation between adult and child
- ☐ displaying or exposing a person's genitals to a child or inducing a child to display his/hers
- ☐ sexual threats or invitations
- ☐ the exploitative use of a child in prostitution or any other unlawful sexual practice
- ☐ the exploitative use of children for purposes of pornography.

Broader contextual aspects of sexual abuse include (Malala in Hall & Samuwiro: 12):

- ☐ sexual coercion with physical force or threats
- ☐ incest, stranger rape, date rape, etc.

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- ☐ sexual harassment and sexual contact with children
- ☐ child prostitution and forced marriage
- ☐ forced pregnancy, contraception, abortion
- ☐ genital viewing and recording
- ☐ exposure to pornography and adult genital exposure
- ☐ statutory rape.

Sexual abuse may occur once, or may occur repeatedly over a prolonged period of time. Repeated abuse is usually perpetrated by someone familiar to the child, or by a member of the child's family. The effects of the abuse may be more severe if the perpetrator is known and/or the abuse is chronic.

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While both girls and boys are vulnerable to sexual abuse, research tends to focus on the girl child, with adult males being identified as perpetrators. This near-exclusive focus on girls is problematic, as it perpetuates underreporting of sexual abuse of boys. It limits an understanding of the need for both research and interventions addressing child sexual abuse, irrespective of the gender of the child or the perpetrator.

History of the concept of 'child sexual abuse'

The term 'child abuse' – and more specifically, 'child sexual abuse' – reveals changing thinking about the relationship between the state, social agencies and institutions, and the individual. A historical analysis of the discursive emergence and transformation of 'social problems' shows that anxieties and moral panics are often associated with problems and failures in social policy. A moral panic is a transitory phenomenon that relies on stereotypical representations against which a range of elites position responses and which may lead to sustained processes of regulation (Cohen 1972). Hall et al note that this regulation process involves a "shift of attention from the deviant act... treated in isolation, to the relation between the deviant act and the reaction of the public and the control agencies to the act" (1978: 17).

The way in which moral panics are developed by various social formations and played out in the media often diverts attention from contradictions in assumptions about social problems. In the course of emerging moral panics, social pathologies and 'deviant behaviour' are often attributed to alleged psychologically perverse persons who are thereby rendered 'outsiders' threatening society. These 'outsiders' are constructed through a range of converging stereotypes, for example 'the molester', 'the child pornographer', 'the paedophile', 'the sex-slave trader'.

This should not be taken to mean that child sexual abuse is a construct with no basis in social reality. However, the changing constructs of child (sexual) abuse should alert us to the importance of studying the ways in which child sexual abuse is represented, how it is analysed, and how it is addressed.

In studying child sexual abuse in the context of social policy interventions, it is necessary take account of the conceptual history that has framed specific responses.

Hacking (2001) points out that the term 'child abuse' was uncommon before the 1960s. Prior to this, child abuse was referred to as 'cruelty to children' (analogous with 'cruelty to animals'). In the late nineteenth and early twentieth centuries,

‘cruelty to children’ was constructed as one of the vices of the lower classes, and such ‘cruelty’ came into the ambit of social policy when it was feared that rising levels of crime would pose a danger to the state (Hacking 2001: 79).

In later periods, child abuse was constructed as a serious hidden threat to ‘private’ life, requiring medical and psychological intervention (Hacking 2001: 82). This was overlaid with concerns about child mortality and juvenile delinquency. In 1962, a group of specialist paediatric researchers in Denver published their observations on ‘the battered child syndrome’, in which a correlation was conceptualised: ‘battered as a child, battering as an adult’. It was only in the 1990s that this conception was challenged.

Up until the 1970s, the notion of child abuse remained confined to ‘battering’ and other forms of infliction of bodily pain and suffering. Later in that decade a ‘sexual’ element was added.

Historical analyses of the changing definitions of ‘child abuse’ in the United States and Britain in the 1990s note that explanations shifted towards contextual vulnerability. This was linked to declining household incomes and social welfare provisions, which coincided with growing official concern and media attention given to child sexual abuse. However, the social and political contexts of child sexual abuse did not command equal concern or even mention. Rather, the discursive framework of child sexual abuse, and especially of child sexual abuse in the family, has been related to a tendency to idealise the nuclear family, and to equate immorality with its breakdown (Soothill & Francis 2002: 2).

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The concept of ‘child (sexual) abuse’ in South Africa

The zigzags in public discourse and interventions related to child sexual abuse in South Africa reflect a combination of media representations, explanatory models and policies. In the South African psychological literature, child sexual abuse was not widely recognised as a policy issue until the late 1980s. During the 1970s and 1980s, child abuse was considered to occur only in isolated cases, perpetrated mainly “by people who were psychiatric cases”. Although the South African Society for the Prevention of Child Abuse and Neglect was established in 1984, it was only in 1987 that the issue of child abuse moved to the political stage, amidst heightened media coverage. Media reports established an association between pornography, homosexuality, and HIV/ AIDS, and police Child Protection Units were established in Cape Town, Pretoria, Johannesburg, and other centres, with the support of then Minister of Police, Adriaan Vlok.

Although various States of Emergency from 1985 onwards saw thousands of children under 18 detained, this was not considered within the framework of child abuse (Sonderling 1993: 6). Public concern with children in detention was framed by the state as “an attempt to incite hatred towards the police and the security forces, [and] tarnish their image and credibility”, and was proscribed as “part of anti-government political propaganda” (Sonderling 1993: 6). In a further response, Vlok orchestrated a public relations campaign to enhance the image of the police. This campaign coincided with well-publicised police raids that disconnected the ‘abuse’ of children within the prison system and connected pornography with child sexual abuse. In the drive against “crime by and against children”, it was not a matter of protecting children, but rather of “protecting society” from abused children, who, it was found (by reference to studies from the 1960s), would themselves become abusers later in life. It was also a matter

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of getting parents to police their children, in the interests of protecting children from “vice” to which they were allegedly exposed while “roaming the streets at night” (Sonderling 1993: 9). Research during the late apartheid period focused on children as victims of violence; this shifted, post-apartheid, towards the construction of children as victims of violence and sexual abuse.

In relation to HIV/AIDS, emerging discourses have been framed by moral panic – for example, the rape of babies and very young children has been connected to the so-called ‘virgin myth’ which attributes blame to black men and which is associated with the cleansing and cure of HIV infection. Similarly, in some campaigns adolescents have been portrayed as hypersexual, and the driving force of the HIV/AIDS epidemic, with the consequence that the high prevalence of marked age differentials between sexual partners is hidden and is consequently rendered unproblematic.

The concept of ‘vulnerability’ in the South African context

Vulnerability of children, in the broadest sense, can be linked to a range of factors. In South Africa, a child is generally defined as vulnerable (see Smart 2003a: 6; Smart 2003b: 8; Department of Social Development 2003: 4) if s/he is:

- ☐ chronically or terminally ill
- ☐ orphaned, neglected, destitute or abandoned
- ☐ living by him/herself or as a member of a child-headed household
- ☐ living or working on the street, or in informal settlements
- ☐ using and/or selling alcohol and/or drugs
- ☐ trying to earn a living through child labour and/or survival sex
- ☐ the child of a terminally ill parent or guardian
- ☐ born of a teenage or single mother
- ☐ living with a parent or an adult who lacks income-generating opportunities
- ☐ abused or ill-treated by a (step-)parent or relatives
- ☐ disabled
- ☐ under the age of 15 and has lost his/her mother or primary care giver or who will lose his/her mother or primary care giver within a relatively short period.

The impact of HIV on children redefines the nature of childhood. As Smart points out:

Children [affected by HIV] are at increased risk of losing opportunities for school, health care, growth, development, nutrition, shelter. Moreover, with the death of a parent, children experience profound loss, grief, anxiety, fear, and hopelessness with long-term consequences such as psychosomatic disorders, chronic depression, low self-esteem, learning disabilities, and disturbed social behaviour (2003: 7-8).

Orphans

In most estimates and models, an orphan is defined as a child whose mother has died. The impact of parental death on orphans varies depending on whether the child has lost a mother or a father, or a caregiver in a broader category. The loss of a father may have a greater socio-economic impact than the loss of a mother (Foster & Williamson 2000: 275), while the loss of a mother may have greater emotional impact than the loss of a father. The loss of a mother also impacts on access to social security. Studies from both the United States (Case et al. 2000; Case & Paxson 2001) and South Africa (Case, Hosegood & Lund 2003) show that children with resident mothers were significantly more likely to be in the Child Support Grant system, in comparison with children whose mothers were not resident. That means that in South Africa, the absence of the mother due to illness or death from AIDS-related illnesses may lead to significantly lower probabilities of receiving a Child Support Grant.

In many African social systems, 'orphans' are not categorised as such if they live with adult relatives, and thus tend to be left out in national censuses. Foster and Williamson list additional factors that make orphan enumerations unreliable:

Under-enumeration may occur as a result of stigma or because many orphans are fostered away from their household of origin. Infants and young children may be subject to disproportionate under-enumeration. The orphan status of girls under the age of 18 who themselves become parents is unclear. Over-enumeration may occur because of hopes of secondary gain by respondents. Children in single mother households may be over-enumerated if they are counted as parental orphans or under-enumerated if paternal status is unknown (2000: 276).

Under-enumeration may also occur when orphanhood is defined as loss of a mother – a definition which Foster and Williamson suggest may underestimate orphan numbers by 45-70%.

In South Africa however, many children grow up in single-parent families as a result of a range of factors including high rates of teenage pregnancy, low rates of marriage, and absent parents due to labour migration. Exceptionalising single-parenthood, and suggesting that this constitutes an absolute definition of orphanhood, may also contribute to over-estimating rates of orphanhood in this context.

Children may be affected by HIV/AIDS before they are orphaned, as they assume caregiving, household, and nursing responsibilities when one or both of their parents or caregivers fall ill. Moreover, the financial strain may reduce the household resources to such an extent that children's schooling is jeopardised, through lack of money for school fees, transport costs, etc. In such situations, children often find it hard to cope with school work, miss days at school, or drop out of school altogether.

Research shows that expedient strategies adopted in situations where there are low levels of social cohesion often entail coping mechanisms that disadvantage and disable young people who are most vulnerable (Daniel 2003). It is in this context, compounded by AIDS-related illness and death in the family, that some girls face sexual abuse, and boys are exploited as cheap labourers (Daniel 2003), with severe consequences for their life chances and mental health.

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depression, anxiety, school failure and dropouts as well as deteriorating health.” (Daniel 2003). The extended family system, which traditionally provided a safety net for dependants of deceased relatives, has broken down, or is not in a position to fulfil this function, with the increased demand placed on it for providing nurture, care, and fulfilment of basic needs.¹

Children with disabilities

Studies have shown that disabled children are more vulnerable to abuse – physical, sexual and emotional. This is related to the intense and prolonged dependence of the disabled child on others for immediate care. According to the White Paper on Integrated National Disability Strategy, between 5% and 12% of the South African population is moderately or severely disabled (Department of Welfare 1997). A review by Kelly et al (2002a) found that disabled persons are vulnerable to abuse because of poorer access to information, dependence on others, and poverty. Sexual abuse is not unusual, and a review of visually impaired children’s stories and letters included the following observations:

[Some] do it because they think that a blind child will not know or see them. They think being disabled means that you are not able to speak for yourself in court and that they can win the case easily.

This is my opinion, someone who doesn’t see anything can be raped. The one who is sighted can take them to a dark area where they can be attacked. Someone who is blind is vulnerable and can be attacked anytime.

A STATISTICAL OVERVIEW

It was estimated that in 1998, approximately 60% of children in South Africa lived in poverty (Giese & Hussey 2002: 13; Smart 2003b: 9). In a provincial breakdown, the percentage of children aged 0-5 living in poverty is highest for the Eastern Cape (78%), followed by the Free State (73%), and Northwest (68%) (Giese & Hussey 2002: 13).

The social context of poverty and HIV/AIDS may account for the high number of children that find themselves without family support. The Nelson Mandela/HSRC Study of HIV/AIDS found that 13% of children aged 2-14 had lost a mother, father, or both parents, and that 3% of households were headed by children (of ages between 12 and 18 years). The highest number of child-headed households was found in urban informal areas (4.2%) – the areas which were also noted to have the highest HIV prevalence (Shisana et al 2002: 11).

In July 2002, the number of orphaned children in South Africa, defined as children under 18 who had lost their mother, was estimated at over 885 000; 38% were estimated to have been orphaned through HIV/AIDS (Dorrington et al in Smart 2003b: 11).

The exact number of children who are sexually abused in South Africa is unknown. Various factors contribute to underreporting. The disempowerment of child victims, their relationship to the abuser, and psychological trauma may result in the abuse being kept secret; if the abuse is revealed to a close family member, the abuse may not be believed or may not be reported to the authorities; laying of charges may be discouraged by the police, or may not be pursued as a result of potential further trauma to the child; and cases pursued in court may not result in convictions.

According to South Africa's Child Protection Services (CPS), the number of children who have been abused physically, sexually and who are involved in child prostitution has increased since 1997. Between 1997 and 1998, there were 5 500 reported cases of sexually abused children. This number increased to 8 044 between 1999 and 2000 (CPS 2002: 2). These increases may, however, be a result of a higher level of public awareness of child sexual abuse, of improvements and expansion of services, and of the foregrounding of child sexual abuse in HIV/AIDS education and awareness campaigns (Smart 1999: 30).

Organisations and individuals interviewed in the present review were unanimous in noting that child sexual abuse was prevalent in the communities in which they work. Social workers in Barberton said that there are at least 100 cases of child sexual abuse reported each month in a population of 40 000 – 45 000.² In 2002, the Greater Nelspruit Rape Intervention Project (GRIP) attended to 292 rape survivors under the age of 18. Of these, 125 were between 11 and 15 years old.³ At Natspruit Hospital near Johannesburg, between 60 and 70 rape cases are seen each month, and 40-45 of those are children; most are between 13 and 18 years old. A study by de Villiers (in Smart 1999) provides a profile of sexually abused children in South Africa. Eighty percent were girls, of whom 7% were younger than three years old, and 55% were under ten.

While children of any age are vulnerable, organisations in the field have noted an increase in reported sexual abuse of very young children. About 50% of children provided with support for sexual abuse by Childline in Durban in 2002 were

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under the age of seven (van Niekerk 2003b). In rural Mpumalanga, Masisukumeni Women's Crisis Centre reports that at least one case of baby rape is brought to their attention every two months. Instances of baby rape have received wide media attention, but it is unclear whether the frequency with which such cases are reported in the media can be ascribed to a rise in the overall incidence of sexual abuse of young children, or a rise in public awareness and reporting.

Both male and female children are vulnerable to sexual abuse. A study of urban black youth in South Africa (Richter 1996) found that 28% of female respondents indicated that they had been forced to have sex against their will, as compared to 17% of male respondents. Similar ratios – although at lower levels – have been noted in other studies (see Kelly & Parker 2000). The definition of 'forced sex' may, however, differ between genders and may not necessarily correspond with formal definitions of child sexual abuse. The findings do, however, raise the question of the prevalence of abuse generally, and of sexual abuse of males (potentially by perpetrators of either sex).

DISCLOSURE AND REPORTING OF CHILD SEXUAL ABUSE

Children do not readily disclose sexual abuse and are less likely to do so in cases where the perpetrator is known to the child. The child may be scared and confused about what happened, or the child may not clearly understand that what occurred was abuse. There may be little resistance offered by the child and he/she may want to keep the abuse secret (Lewis 1997). The abused child may have been sworn to secrecy by the abuser, amid threats of what will be done to him/her should the 'secret' be broken. The child who talks about sexual abuse may not be believed by his/her caregivers, or the caregiver may dismiss the disclosure or be afraid to confront the perpetrator. The child may blame her/himself, believing that s/he did something to bring about the abuse – for instance, by accepting gifts or favours from the perpetrator. The child may fear anger and rejection by the family. If the perpetrator is a family member, the person to whom the disclosure is made may pressurise the child not to report the abuse. As Faller (1993: 41) notes: "If [the mother] disbelieves the child, is unwilling to attend to the child's best interest, has a poor relationship with the child, or is dependent on the offender, then the child is at risk for emotional abuse and perhaps additional sexual abuse in the home". If the abusive family member denies the abuse, his/her continued presence in the home means a greater risk of abuse and emotional maltreatment of the child (Faller 1993: 41). The Teddy Bear Clinic in Johannesburg (2003) noted that the majority of their clients who disclose their experience of abuse speak to a non-abusing parent or family member (77%), whilst 7% disclose experiences of abuse to a peer and 3% to a teacher.

Sorensen and Snow (1991) found that only 11% of children disclosed sexual abuse without hesitation or retraction, while the majority of children denied the abuse and later talked about it with hesitation. Svedin (2002) found that 22% retracted their disclosure, and then later reasserted that the abuse had actually taken place.

There are two types of disclosure: intentional and unintentional. Research shows that most disclosures are unintentional, by way of the child being seen with the perpetrator, health problems brought to the attention of health practitioners, physical signs of abuse, sexualised behaviour in the child, behavioural problems with the child, or confession of the perpetrator. Unintentional disclosure is more common in younger children (Svedin 2002). An indirect indication of the level of unintentional disclosure is provided by a study on child abuse in Alexandra township, which found a relatively high percentage of STIs in children where no history of sexual abuse was given (Howard, Marumo & Coetzee 1991: 394).

Schools and other institutions and organisations can provide incentives for children to talk about experiences of sexual abuse, and to mobilise support for them. But even with the creation of safe conditions, it is common for the child not to disclose the full extent of the abuse.

The response of a parent, family member or other caregiver to a child's disclosure of sexual abuse is crucial in determining how the child will cope with the situation. According to the Friedrich coping model (1990), the parent reacts and the child responds in turn to the parent and modifies him/herself and his/her behaviour according to the parent's response (Svedin 2002). Friedrich takes into consideration the quality of the child's interaction with members of

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the family, and the child's own networks of friends, school and social care. A negative reaction may block access to social resources and medical treatment. Inadequacies in social, medical and judicial services may adversely affect the recovery chances of the child survivor.

The reasons for underreporting include:

- ❑ Many crimes against children, especially in rural areas, are not reported, as children and parents/caregivers do not have easy or confidential access to police stations and other points of entry into the criminal justice system.
- ❑ Most sexual abuse is committed within the family; therefore family members of the child may block access to resources for reporting the abuse. Families might also choose to deal with the abuse by themselves.
- ❑ Children may feel loyalty to their family, or pressure with regard to the financial situation, and refuse to disclose the sexual abuse or the identity of the perpetrator.
- ❑ Instances of payment for 'damages' by the perpetrator are not uncommon, especially in situations of poverty.
- ❑ The child may fear the perpetrator, or fear being blamed for the abuse, and therefore keep quiet (van Niekerk 2003a: 13).

Accounts of secondary victimisation and general insensitivity by police officers are not uncommon. Children and adults reporting cases of child abuse have experienced verbal abuse and, in some cases, officers have turned away children coming to report incidents of abuse, telling them that they do not have a case.

Another factor influencing underreporting is the lack of confidence in the criminal justice process. Accounts of secondary victimisation and general insensitivity by police officers are not uncommon. Children and adults reporting cases of child abuse have experienced verbal abuse and, in some cases, officers have turned away children coming to report incidents of abuse, telling them that they do not have a case. Another reason for the reluctance to report abuse is the expectation that it is 'not worth the trouble' and that it is unlikely to result in the prosecution of the perpetrator. This idea is not unfounded. According to police statistics in 2000, only 45% of rape or sexual assault cases were referred to court – 47% of these cases were withdrawn in court and 16.5% resulted in a guilty verdict (Department of Health 2003: 6).

Factors that might bolster the defence of a perpetrator include the notion that children's memories are unreliable; that children are open to suggestion; that they have difficulty distinguishing fact from fantasy; that they habitually make false allegations, particularly of sexual assault; and that they do not understand the duty to tell the truth (see Combrinck 1995: 327). However, this view has been discounted by studies supporting the conclusion that children are no less credible than adults in 'areas relevant for witness assessment such as suggestibility, memory, and distinguishing between reality and fantasy' (Combrinck 1995: 328).

RISK FACTORS FOR CHILD ABUSE

Risk factors for child sexual abuse may be summarised and divided into two main categories: those factors that decrease the quantity and the quality of parental care of children; and those that produce vulnerable, emotionally needy children. Both cases implicate the social and economic conditions of childcare and childrearing.

According to the South African Child Protection Services, there are a number of factors that place children at risk, including:

- ☐ abject poverty, including a high rate of unemployment
- ☐ unfavourable home circumstances or family violence
- ☐ breakdown in family and community support systems
- ☐ drug or alcohol abuse in the family or community
- ☐ lack of safety and protection services in the community
- ☐ negative or disempowering societal and cultural attitudes towards women and children
- ☐ lack of trust by parents
- ☐ lack of tolerance in the family
- ☐ lack of access to resources (that is, economic, social service, health, educational, and psychological) (CPU 2002: 7).

Child sexual abuse has been reported more frequently in cases involving children from socially deprived and dislocated family backgrounds, children living without one or both of their biological parents, children whose primary caregiver is absent or unavailable, children placed in the care of more distant or unrelated persons, children placed in foster care, and children who perceive their family life as unhappy (see Mullen & Fleming 1998). These factors place children orphaned by HIV/AIDS at particular risk of abuse.

International studies have identified similar risk factors. The World Health Organisation (2002) has cited a number of structural and societal factors that can be taken into account when assessing risk. These include:

- ☐ the responsiveness of the criminal justice system
- ☐ social and cultural norms regarding gender roles or parent-child relationships
- ☐ income inequality
- ☐ the strength of the social welfare system
- ☐ the social acceptability of violence
- ☐ the legitimisation of male decision-making in matters concerning sexuality, and control over the bodies and lives of women and children
- ☐ acceptance of rape as part of gang-initiation rituals
- ☐ the availability of firearms
- ☐ political instability.

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...children who remain uncared for or unsupervised because their parents have to be at work, or whose primary caregivers do not reside with them, are more vulnerable to sexual abuse. This is not to say that children in more affluent families are immune to sexual abuse. Sexual abuse of children occurs throughout the population, crossing racial, cultural and socio-economic lines.

In almost every society, poor people bear a disproportionate share of the burden of violence (WHO 2002). Conditions of poverty expose children to experiences that make them vulnerable to abuse. For example, children who remain uncared for or unsupervised because their parents have to be at work, or whose primary caregivers do not reside with them, are more vulnerable to sexual abuse. This is not to say that children in more affluent families are immune to sexual abuse. Sexual abuse of children occurs throughout the population, crossing racial, cultural and socio-economic lines.

Although there are no safeguards against the experience of sexual abuse in childhood, some protective individual psychological indicators have been identified. Children at lower risk of child sexual abuse, or with more developed recovery strategies, are considered to be those who are clear about their own boundaries and are capable of stating them; those who have sufficient ability to verbalise; those who are capable of recognising problems and talking about them; and those who are assertive and confident in voicing their own views and concerns despite some adult opposition.

PERPETRATORS OF CHILD SEXUAL ABUSE

There is no way to predict child abuse. It is not possible to reliably identify potential victims or potential perpetrators. Child sexual abuse is a diverse and complex phenomenon. In the context of perpetrators known to the child, observed behaviours have been identified as including:

- ❑ protective or jealous behaviour in relation to the child
- ❑ inappropriately attached to/protective over a specific child
- ❑ discouraging unsupervised contact between the child and his/her peers
- ❑ accusing the child of being sexually provocative
- ❑ misusing alcohol and/or drugs
- ❑ inappropriate sexual suggestions or behaviour towards a child (Monahan 1993).

There is no proof for the popular assumption that a child who has been sexually abused himself or herself will sexually abuse others later in life. In an evaluation of a number of surveys, Hansen and Slater found that one third of perpetrators guilty of sex crimes against children had suffered sexual abuse themselves as children. This was compared with the 10% found in a control group made up of men not convicted of sex crimes against children (Svedin 2002). It is acknowledged, however, that while not all child abusers were abused as children or had witnessed acts of abuse in childhood, many abusers were exposed to serious abuse as children (Steinmetz in CPU 2002: 3).

A study conducted by the South African Medical Research Council (MRC) in 2002 found that more than 60% of perpetrators of rape were teachers, family members, or friends of the child. In most of the cases, the offenders were found to be teachers (about 33%), in 21% of cases they were found to be family members, in 21% of cases they were found to be strangers or recent acquaintances, and in 10% of cases they were found to be friends (Jewkes et al. 2002). In 1996, the Child Protection Unit in the Western Cape reported that in 60% of reported sexual abuse cases, family members were the perpetrators – notably the father, stepfather, or mother's lover or partner other than the biological father of the child. The balance is made up mostly of other persons known to the child – uncles, older brothers, teachers, or doctors (Marshall & Herman 2000: 15).

The Teddy Bear Clinic in Johannesburg found that in 25% of cases investigated by the organisation, the alleged perpetrator was the biological mother's partner (either the biological father or another partner of the mother) and in approximately 20% of cases, the alleged perpetrator was a minor (acquaintance, sibling, or other relative). In 27% of cases, the perpetrator was an adult acquaintance, in 6% of cases, it was a stranger and in just under 2% – a teacher (Higson-Smith 2003).

In analysing sexual abuse by family members, the structures of households, the relations between household members, and the movement of children between households need to be taken into account.

Sexual abuse by family members or acquaintances usually involves multiple episodes over periods ranging from one week to several years. Children in this situation tend to remain quiet because they may have been threatened, or they may be afraid they will incur blame or more violence. In many cases, their

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livelihoods are tied up with provisions made by the person who abuses them. This is likely to leave the child victim traumatised and confused.

Long-term abuse may occur in cases where the perpetrator is the family breadwinner. The child may not report the abuse in order to protect the family. Abuse over a period of time may increase the child's vulnerability to STIs, including HIV infection. In the latter case, given that abuse is typically not reported immediately, it is difficult to assess HIV risk.

Teachers

The sexual abuse of children by teachers is an abuse of authority. According to a cross-sectional study of a nationally representative sample of women aged 15-49 years, conducted by Jewkes et al., school teachers were the most common child rapists, having been found to be responsible for 33% of rapes among school girls (2002: 319). Research by Human Rights Watch (HRW) found that the abusive relationship usually starts with a teacher being supportive, or giving a student special treatment that may include providing money to buy food or clothes. Another frequent theme was the promise of improved grades or other privileges in return for sex, or the threat of failing grades in the case of a refusal to perform sexual favours (HRW 2001: 27).

A study of sexual harassment in South African schools found that some teachers strategise to gain access to students in a private setting. In this study, such harassment resulted in female students fearing any attention received from male teachers and choosing to avoid enrolling or completing study for certain subjects (Abrahams 2003).

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Lack of parental power in the school context, and a lack of will on the part of school management, encourages teachers to flaunt rules of professional conduct. Often the only sanction for sexual abuse is paying for 'damages' or asking for a transfer. Laws relating to sexual abuse, or regulations stipulating acceptable levels of professional behaviour, are rarely brought into effect in such cases (Coombe 2001: 8). No onus is placed on schools to report rape and other forms of sexual abuse. The South African Human Rights Commission's Report on Sexual Offences Against Children (April 2002) found that in Gauteng, "teachers and principals were reported not to want to get involved with sexual abuse cases and ignore incidents reported to them or simply refer the abused child to the police station without reporting the matter themselves" (in Mawson 2004a: 7).

A report entitled *Dossier of Shame*, compiled jointly by child rights organisations (The Teddy Bear Clinic for Abused Children, Women Against Child Abuse, Childline KZN, the United Sanctuary Against Abuse, and Resources Aimed at the Prevention of Child Abuse and Neglect) in 2003, alleges that, in addition to alleged 'cover-ups' at individual schools, education authorities at the provincial level rarely take action on individual cases of child abuse reported to them. The report details 76 cases of sexual, physical, and emotional abuse from June 1999 to June 2003 that allegedly were reported to education officials, but were ignored by provincial education departments. Childline in Durban says that of the 58 cases reported in the KwaZulu-Natal province, only two have been investigated. The Teddy Bear Clinic notes that there was no response by the Gauteng Department of Education to 18 cases in the report (Mawson 2004a: 7). In response, provincial education departments in Gauteng and KwaZulu-Natal have denied a cover-up, citing a number of dismissals following reports of sexual abuse in schools (Mawson

2004a: 7). The South African Council for Educators (SACE) has also committed itself to investigating the cases cited in the report.

For students in sexual relationships with teachers, the risk of HIV infection is high, due to the higher adult HIV prevalence. Educators are thought to be particularly vulnerable to HIV because of their comparatively high incomes, remote postings, and geographic and social mobility (Coombe 2001: 3).

Children at school

Adults are not the only perpetrators of sexual abuse – perpetrators may themselves be relatively young. In 2001, 43% of sexual offences brought to the notice of Childline in Durban were perpetrated by youth under the age of 18 (van Niekerk 2003b).

Schools are often an insecure environment and children may be exposed to gang violence, rape, and assault. According to HRW, South African girls are far more likely to be sexually assaulted by one (or more) of their classmates than by a teacher. Violence frequently accompanies dating relationships, and some boys have used sexual violence to undermine girls who are leaders at school (HRW 2001: 31).

There are various places in the school environment where students are particularly vulnerable to abuse by teachers or other students. Hostels were noted as being unsafe for both boys and girls (Coombe 2001: 8), and female students prefer not to walk alone or near the staff room (Abrahams 2002). Human Rights Watch (2001) found that girls had been raped in school toilets, in empty classrooms and hallways, and in hostels and dormitories; they were fondled, subjected to aggressive and sexual advances, and verbally degraded. The study also found that girls from all levels of society and from all ethnic groups are affected by sexual violence at school.

A lack of systems to monitor learners, the use of physical violence as a form of discipline, inconsistent discipline, poor attendance, tardiness by educators, and unequal gender roles and responsibilities within schools all contribute to higher levels of violence against girls (HSRC 2003: 2).

Many cases are not reported. Those that do come to the attention of the authorities may be handled administratively, or by negotiation with parents or elders, and may be ‘resolved’ with the payment of a fine of as little as R20 (Mshengu 2003). In most instances, students and school administrators respond with silence. Rarely do school authorities take steps to ensure that girls have a sense of security and comfort at school; rarely do they counsel and discipline boys who commit acts of violence (HRW 2001: 33).

At community level

Perpetrators of sexual abuse may be neighbours or members of the community. Children who are working for an income may be subjected to sexual violence in this context. For example, young women who work as domestic workers, or are children of domestic workers, are vulnerable to sexual abuse (Smart 1999: 30). A number of organisations noted the vulnerability of girls in rural areas who make money by selling items door-to-door. Masisukumeni gave an example of a young girl selling vegetables to a neighbour who promised to buy the whole lot if she came inside. She was then sexually abused.

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SYMPTOMS, CONTEXTS AND CONSEQUENCES OF CHILD SEXUAL ABUSE

Identifying symptoms of abuse

Child sexual abuse is difficult to identify. Behavioural signs exhibited by children who have been sexually abused may be noted in many children and are not necessarily definitive. However, drastic behavioural shifts may alert a parent or caregiver to the possible occurrence of abuse.

The following may be physical indications of sexual abuse:

- ☐ swelling of vaginal tissue
- ☐ missing of periods/early pregnancy
- ☐ STIs (sores, discharge, itching in the genital area)
- ☐ genital or anal infections (unexplained bleeding, pain, swelling, or irritation of the mouth, genital or anal area)
- ☐ injury to the palate
- ☐ pharyngeal gonorrhea
- ☐ chronic urinary tract infections
- ☐ blood on underwear
- ☐ tearing in the genital/anal area; genital/anal injury or scarring
- ☐ increase in headaches or stomach aches
- ☐ walking in an unusual way (CSVR 2003).

The behaviour patterns of a sexually abused child tend to change drastically. Depending on the developmental stage of the child, which impacts on symptom presentation and responses, behavioural responses may include:

- ☐ increased irritability, temper tantrums, or aggression
- ☐ withdrawal, inhibition, passivity
- ☐ fear of a particular person or object
- ☐ stealing and lying
- ☐ wetting or soiling him/herself
- ☐ eating too much or too little
- ☐ school absenteeism or performing poorly at school
- ☐ repetitive themes in play
- ☐ sexualised play and/or acting sexually 'mature'
(CSVR 2003: 9; also SAT 2001: 4).

Behavioural changes in a child who has been sexually abused are dependent on the child's developmental phase. For example, children aged between two and six years may respond through sexualised play with toys, sexualised interaction with other children, and inappropriate or aggressive touching of others (Monahan

1993). Signs in older children include aggression, concentration difficulties, expression of fears, and disrupted sleep patterns.

Consequences of sexual abuse for children

Sexual abuse is a traumatic experience for children. There is, however, no necessary relation between the event of violence and the trauma experienced, nor is it uniformly experienced: "Events may become trauma not because of their nature but due to the psychological state of the subject, social circumstances and psychic conflict" (Mestrovic 1985: 841). The patterns and processes of stress and coping will differ according to the stage of the child's development.

There may be dramatic shifts in a child's sense of self, including changes in:

- ☐ the belief in invulnerability: 'it won't happen to me'
- ☐ the child's positive view of him or herself, which may be shaken through feelings of weakness, powerlessness, guilt, and shame
- ☐ the belief that the world is an orderly place and that events happen for a reason (CSVr 2003: 2).

Sexual abuse is especially difficult for a child to deal with when the perpetrator is someone the child depends on for nurture and security.

The extent and the nature of the trauma is related to:

- ☐ the age of the child and his/her understanding of what has happened
- ☐ the response of the primary caregiver and other 'significant others'
- ☐ the relationship with the abuser
- ☐ the duration of abuse
- ☐ gender
- ☐ coping strategies available to the child and the primary caregiver
- ☐ responses of people close to the child at disclosure (van Niekerk 2003a).

Some children who have experienced sexual abuse do not necessarily exhibit any major symptoms in follow-up assessments. This may be related to once-off trauma, which does not uniformly lead to long-term consequences. Some children may be more capable of recovering from difficult events (Svedin 2002).

Physical health and HIV infection

Given the high adult HIV prevalence in South Africa, there is a very real risk of HIV infection for children who are sexually abused. Other health risks include physical trauma, STIs, and pregnancy. These may have long-term physical and reproductive health consequences in later life. Risks are compounded if the abuse is sustained. Health risks may also be increased in later life through the adoption of high-risk coping strategies, such as risky sexual activity, alcohol and drug abuse.

Post-traumatic stress disorder

Post-traumatic stress disorder (PTSD) is a response to shock and trauma. Three

factors contribute to the likelihood of PTSD in children:

- ❑ the severity of the traumatic event
- ❑ the parental reaction to the traumatic event
- ❑ the physical proximity to the traumatic event (Hamblen 1998).

Short-term psychological responses in children exposed to sexual violence are well documented. Children may experience a number of emotions including shock, guilt, powerlessness, fear, shame, nightmares, fear of touching, depression and anger. PTSD is a common impact of sexual abuse. The experience of PTSD includes:

- ❑ re-experiencing symptoms such as intrusive memories, nightmares, dissociative flashbacks
- ❑ hyperarousal/hyperactivity symptoms such as tension, irritability, anxiety, vigilance, poor sleep, and impaired concentration
- ❑ avoidance symptoms such as emotional numbing, social isolation, and lack of life progress.
- ❑ PTSD may be accompanied by depression, substance abuse, eating disorders, generalised anxiety, and bipolar disorder (Kreidler 2002: 136).

PTSD may be identified immediately following the abuse, or may only be identified in later life. Responses to trauma vary between girls and boys.

PTSD may be identified immediately following the abuse, or may only be identified in later life. Responses to trauma vary between girls and boys. Studies have shown that girls are more likely to experience emotionally related symptoms, while boys are likely to develop cognitive or behaviourally related symptoms. Girls are more likely than boys to seek social support when they are exposed to violence (Rudenberg 1998).

Acute symptoms of stress, including nightmares and phobias, are often of relatively brief duration, while indications of emotional distress (aggression, anxiety, depression, withdrawal and suicide) may become manifest as long-term effects (Rudenberg et al. 1998).

Long-term effects

Trauma connected with child sexual abuse may have long-term effects, including self-destructive behaviour, depression, fatalism, sexual problems, cognitive and concentration difficulties.

Longer-term effects of sexual abuse during childhood include:

- ❑ *Traumatic sexualisation* (aversive or overvaluing feelings about sex, sexual identity problems)
- ❑ *Self-reproaches* (also termed 'damaged goods syndrome', involving feelings of guilt and responsibility for the abuse or the consequences of disclosure, often reflected in self-destructive behaviours such as substance abuse, risk-taking, self-mutilation, suicidal acts, or provocative behaviour designed to elicit punishment)
- ❑ *Sense of betrayal* (experience of undermining of trust in people who are expected to act as protectors and nurturers, reflected in lack of trust in others, manipulative behaviour, re-enacting the trauma through involvement in exploitative and abusive relationships)

- ❑ *Sense of powerlessness* (perception of vulnerability and attempt at mastery, often through identification with the aggressor, reflected in dissociation, anxiety, phobias, sleep and eating problems, and revictimisation). (see Fallor 1993: 19-20)
- ❑ *Difficulties with intimacy and sexual esteem*: A history of child sexual abuse is often associated with problems of sexual adjustment in adult life. This reduced 'sexual esteem' contributes to adult sexual relationships that are unsatisfactory.
- ❑ *High-risk sexual behaviour and HIV*: Some studies suggest that adolescents who were sexually abused as children are more likely than non-abused children to engage in high-risk sexual activity. They may be more likely to engage in unprotected sex, or have multiple partners. (Denenberg 1997).
- ❑ *Adolescent girls who have been abused* may have difficulty differentiating between sexual and affectionate behaviour. Research has found a link between child sexual abuse and earlier age of first pregnancy (Mullen & Fleming 1998), which may reflect a search for love and affection.
- ❑ *Revictimisation*: Some researchers claim that survivors of child sexual abuse have an above average chance of becoming involved in aggressive and violent behaviour as adolescents and adults. This finding is disputed, however, by other researchers claiming that no direct causal relationship can be established between the external occurrence of violence and subsequent violent behaviour (Gibson 1991). Sexual abuse during childhood or adolescence has been linked to suicidal behaviour (World Health Organisation 2002). An Australian study (Fleming et al. 1998) found child sexual abuse to be associated with an increased risk of being raped as an adult, and of becoming the victim of domestic violence. In a South African study of women at Soweto antenatal clinics, it was found that women who had experienced child sexual abuse or forced first intercourse faced more than double the risk of sexual abuse in adulthood (Dunkle 2003). This may be due to the possibility that survivors of child sexual abuse are less capable of self-protection. Another explanation is that coping methods in sexual abuse survivors include denial and repetition compulsion (repeating behaviours that lead to trauma), which become operative in risk-taking or in staying in an abusive relationship (Denenberg 1997).
- ❑ *Lower socio-economic status*: Some studies have found that adults with histories of child sexual abuse tend to be of lower socio-economic status than their family of origin. This decline is not explained as a result of educational failure, a reduced participation in the workforce, or a preference for part-time work. Mullen & Fleming (1998: 6) explain that abused women in low-paid jobs tend to underestimate and seek occupations below their capacities – indicating low self-esteem – or are less adept at translating training and opportunity into effective function in the workplace, indicating a failure of agency.

Some studies suggest that adolescents who were sexually abused as children are more likely than non-abused children to engage in high-risk sexual activity. They may be more likely to engage in unprotected sex, or have multiple partners.

Recovery strategies

Survivors who deal most effectively with sexual abuse trauma are those who take an active role in acknowledging the abuse, disclosing the incident to others, finding help, educating themselves about sexual abuse, and finding support from primary caregivers, family and friends, and from their school environment and other organisations (ReCAPP 2000). These strategies are important pointers for

counsellors and caregivers.

If medico-legal procedures are impending, the child should be prepared for those at every step. Beyond the immediate post-abuse phase, counselling should provide opportunities for enactment through play and drawing, in order then to embark on a process of 're-appraisal'.

Considering that the responses of the caregiver to the disclosure of sexual abuse of the child are crucial in the child's appraisal of the incident(s), it is important to counsel the primary caregiver to mobilise his/her support for the child. Counselling would initially have to focus on minimising the caregiver's own stress responses and the possibility of secondary traumatisation.

...sexual exploitation of children in South Africa is closely related to the socio-economic status of a family, household or community. The commercial activities that children perform as a result of poverty increase the risk of sexual abuse and HIV infection.

Sexual exploitation of children

Participants in the World Congress against Commercial Exploitation of Children (1996) indicated that poverty is not the only contextual factor in the commercial exploitation of children. Nevertheless, the sexual exploitation of children in South Africa is closely related to the socio-economic status of a family, household or community. The commercial activities that children perform as a result of poverty increase the risk of sexual abuse and HIV infection.

Child prostitution

Homelessness has a direct impact on the vulnerability of children to sexual exploitation. UNICEF estimates suggest that as many as 100 million children worldwide are homeless (Lyons 1997). Research on South African street children between the ages of 11 and 17 indicate that they engage in high risk behaviour not because they are uninformed about AIDS, but because of their marginalised status, their powerlessness, and their economic and social conditions. More than half of the boys and young men interviewed had engaged in sex for money, goods, and/or protection, and several had been raped. This study indicated that girls and young women under similar conditions also frequently engaged in transactional sex (Richter in Smart 1999).

The prevalence of child prostitution worldwide has not been adequately quantified. In 1996, it was estimated that more than a million children globally were entering the sex trade every year. In South Africa in 2002, the Child Protection Unit estimated that 28 000 children were engaging in commercial sex. This figure has grown from 10 000 estimated in 1993 (Smart 1999), particularly in major cities.

In the Cape Town area, Elsie's River Police Services reported handling an average of five cases of child prostitution per month and the Sex Workers Advocacy Taskforce (SWEAT) estimates that 25% of sex workers in Cape Town are children (CPU 2002: 6). According to Molo Songololo (2000), half of the children working as sex workers in Cape Town are between 10 and 14 years old, and half are between 15 and 18.

Street children of both sexes are commonly lured into commercial sex. But even children who are not involved in commercial sex are at risk of sexual abuse. Many street children are sexually exploited by gangs in exchange for money.

Studies indicate that HIV infection among child sex workers is high. Child sex workers are often stigmatised and marginalised, further undermining their status

and reducing their opportunities for asserting their needs and rights, and for accessing education, formal employment and marriage (Smart 1999). Children in these circumstances witness violence and abuse, and are themselves being violently abused. Some become pregnant at a young age, become dependent on drugs and alcohol, and find themselves trapped in a cycle of abuse and prostitution.

Trafficking

In many countries, the sex industry fuels the expansion of the tourist industry and is a significant source of foreign exchange earnings (UNICEF 2001). South Africa is a well-established country of origin, destination and transit for the trafficking of women and children from Mozambique, Thailand, Eastern Europe and China for sexual purposes.

This process involves a chain of actors, all of whom profit in some way. Organised criminal networks and gangs thrive on this trade, as do many others: hotel clerks, taxi drivers, police officers, government officials and family members (UNICEF 2001: 3).

According to the International Organisation on Migration (IOM 2003), South Africa hosts a diverse range of human trafficking activities, from the global operations of Chinese triad groups and Russian organised crime, to the local trade in persons across land borders perpetrated by local syndicates. An increasing number of children from countries in the region – Angola, Mozambique, Nigeria, Senegal, and Uganda – are known to have been trafficked to South Africa by Nigerian and Angolan gangs that either abduct the children or buy them from impoverished parents (The Protection Project 2002).

In southern Africa, traffickers have capitalised on the vulnerabilities created by war, poverty, minimal education, unemployment and a general lack of opportunity in the region (Robinson 2003). Children as young as seven years old have been kidnapped and trafficked within and across South African borders for commercial sex purposes (Molo Songololo 2000).

Women and children are enticed by promises of employment and opportunities, but often end up in abusive situations including the sex industry, drugs and forced marriages. Once in the industry, these women and children are forced to pay most of their wages back to the trafficker as ‘debt-bondage’ – the advance of money paid for the cost of the woman or child’s travel, accommodation and food (IOM 2003). Refugees have been identified as being both victims and perpetrators of trafficking to South Africa (IOM 2003). Trafficked children who are not refugees, do not receive protection under the refugees act. This leaves them vulnerable to abuse within the immigration system, which does not cater for children (Serra & Tlou 2003). The internal trafficking of children takes place between provinces, from city to city, and from rural areas to cities. Molo Songololo (2000) has identified child trafficking routes from KwaZulu-Natal and the Eastern Cape to Gauteng and the Western Cape. Only a minority of cases are reported and convictions of traffickers are rare (von Struensee 2000).

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‘Survival sex’ and ‘transactional sex’

A distinction has been drawn between ‘survival sex’ and ‘transactional sex’, corresponding to the distinction between ‘needs’ and ‘wants’. ‘Transactional sex’

has been described as the attempt of urban young women to enter the circuits of conspicuous consumption in the aspiration of acquiring 'lifestyle'-defining commodities, whilst 'survival sex' has to do with addressing basic needs such as food, shelter or clothing (Leclerc-Madlala 2003). In essence, these strategies expose children and young women to multiple partnerships, which in turn pose higher risks to HIV infection.

In South Africa, 'sugar-daddy' relationships between adolescent girls and older men may be formed with the approval of the girls' families. The age and power differential between partners in such relationships diminishes the young woman's status and decision-making powers.

Orphans

The situation of children who have lost their homes and/or families to HIV/AIDS-related illnesses and death is fairly well reported. These children may become easy targets for relatives or other families in whose care they are placed. Children who are taken into the care of another family may be used to provide extra income or free labour and can be treated like property or servants, kept out of school, and given inferior food and care (Lyons 1997: 6). This vulnerability extends to sexual abuse. Some children may also end up homeless, with consequent vulnerabilities to sexual abuse and HIV infection.

STRATEGIES TO PREVENT CHILD SEXUAL ABUSE

Child sexual abuse in South Africa occurs in contexts marked by social inequality, economic hardship and poverty, and social dislocation, although not exclusively in these contexts. Vulnerability is compounded by the impact of HIV/AIDS at household and community level. Programmes to prevent child sexual abuse need to be linked to broader socially transformative frameworks. This would include linkages to issues ranging from the prevention of stigmatisation, to food and educational security and other social service provisions, and to psychosocial support for children infected and affected by HIV/AIDS.

Efforts in preventing child sexual abuse have included a focus on children through group-based instruction, usually in schools, on how to take safety measures and protect oneself from or respond to sexual abuse or assault – i.e. “their primary focus is on strengthening the potential victim’s capacity to resist assault” (Daro 1994: 200). In some cases, these initiatives include parents and teachers, who are informed about identifying signs of possible child abuse; reporting child abuse; and accessing health facilities, medical procedures, and referrals to local health counselling and support services.

Programme content includes:

- ☐ the distinctions between good, bad, and questionable touching
- ☐ the rights of children to control who touches their bodies and where they are touched
- ☐ the importance of the child’s telling a responsible adult if someone inappropriately touches him/her, even if the child was told not to reveal the incident
- ☐ assertiveness skills, ranging from repeatedly saying “no” to the use of self-defence techniques (for example, yelling, kicking, fighting back); and
- ☐ the existence of support systems to help the child who has experienced any form of maltreatment (Daro 1993: 203).

These skills have been found to be taught most effectively through role-playing and participant modelling. It is difficult, however, to measure the effectiveness of such prevention programmes, or to gauge whether they have contributed to a decrease in the rate of child sexual abuse (Daro 1994: 203).

Public awareness programmes related to child sexual abuse need to be expanded. Specifically, there is a need to promote awareness of child sexual abuse as a crime. Awareness of available resources also needs to be raised to prevent, combat and address child sexual abuse. It needs to be stressed that there is help available, that there are physical risks to the child (including HIV infection), and that children can never consent to sexual relations. Public awareness programmes can foster recognition that child sexual abuse is not a ‘private’ matter to be solved within the family, but is related to legal frameworks and rights, and should be addressed to prevent recurrence. It would also be beneficial to actively promote understanding of the legal framework surrounding statutory rape, and the criminal aspects of sex with minors. Positioning of young people as the ‘driving force’ of the HIV epidemic as some HIV behavioural programmes do, actively removes adult culpability from the framework of understanding HIV infection amongst young people.

Vulnerability is compounded by the impact of HIV/AIDS at household and community level. Programmes to prevent child sexual abuse need to be linked to broader socially transformative frameworks.

To date, there have been very few purposive communication programmes on child sexual abuse, with much of the emphasis occurring in the news media around the more unusual instances of abuse, such as the rape of young children. Linkages to HIV infection have also been downplayed. It is important to point out that such communication interventions need to be sustained over several years and not confined to once-off ‘single message’ campaigns.

The rights of sexually abused children

Many current initiatives, such as Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN), focus on children’s rights and responsibilities for the prevention of sexual abuse. There are a number of conventions and legal frameworks that address children internationally and in South Africa. These include:

- ❑ The *United Nations Convention on the Rights of the Child (CRC)* (1979), ratified by South Africa in 1995 confirms that ‘a child is entitled to special care and assistance’, and that this assistance would be designed to promote and provide for, among other things, the ‘full and harmonious development of his or her personality’ so ‘that the child [is] fully prepared to live an individual life in society’ (in Lyons 1997: 2). The ‘best interests of the child’ is a key principle of the CRC. This principle embodies the idea that, in all actions, laws, policies, and practices that affect children and youth, the interests of the child him/herself are of primary consideration (Strode and Grant 2001: 20). The Convention commits member states to ‘take measures to combat the illicit transfer and non-return of children abroad’ (Article 11). More specifically on child abuse, the Convention provides that member states ‘shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child’ (Article 19 (1)).

The Convention provides that member states ‘shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, including sexual abuse, while in the care of parent(s), legal guardian(s) or any other person who has care of the child’

As a signatory to this Convention, South Africa undertook to introduce and implement legislation prohibiting the trafficking of children and to protect children from all forms of violence and abuse (Article 35). Article 39 emphasises the obligation to protect child survivors of sexual exploitation from further victimisation, and commits State parties to facilitate the recovery and reintegration of such children. The Convention recognises that inadequate standards of living might force children into situations of sexual exploitation harming their safety and well-being. It therefore commits its signatories to combating conditions of poverty (Article 27(1)). The CRC encourages the participation of the child in social life and states that children who are capable of forming their own views have the right to freely express these views in matters affecting the child.

- ❑ The *Convention on the Elimination of All Forms of Discrimination against Women (CEDAW)* was ratified by South Africa in 1995. The Gender Directorate in the Department of Justice committed itself to “creating a legal environment to eliminate all forms of the trafficking in women and children” (1995). It further commits itself to ensur[ing] that women and girls enjoy the right to freedom and security of the person regardless of economic or occupational status.

- ❑ The *Convention for the Suppression of the Traffic in Persons and the Exploitation of the Prostitution of Others* (1949), ratified by South Africa in 1951, has detailed provisions for combating the international traffic of women and children for purposes of prostitution, even if the persons concerned have given their consent. The Convention also makes provision for the extradition of offenders, to be prosecuted and sentenced in their own country.
- ❑ The *African Charter on the Rights and Welfare of the Child*, an international human rights instrument written by member states of the Organisation of African Unity (OAU), was ratified in November 1999. It is based on the rights of the child as set forth in the CRC, but focuses on children in an African context. South Africa ratified this Charter in 2000. The Charter obligates State parties to protect the child from all forms of sexual exploitation and abuse, and to prevent coercion or encouragement of a child to engage in any sexual activity, including the involvement of children in prostitution or other sexual practices, and the involvement of children in pornographic activities, performances, and materials (Article 27). Article 21 of the African Children's Charter protects the rights of children and youth from harmful and discriminatory cultural practices and traditions. This is considered particularly important with regard to HIV/AIDS, because it limits traditional practices that increase child and youth vulnerability to HIV/AIDS (Strode and Grant 2001: 12). It also addresses children's entitlement to equal enjoyment of rights and protects against discrimination, which extends to children who are infected and affected by HIV/AIDS.
- ❑ The *International Labour Organisation (ILO)* has developed various instruments concerning the rights of children. These include Convention 29 Concerning Forced Labour (1930) and Convention 105 Concerning the Abolition of Forced Labour. Both of these conventions were ratified by South Africa in 1996. Both of them are aimed at the prohibition and elimination of forced labour and other forms of labour harmful to children. They furthermore place an obligation on member states to rehabilitate and socially integrate survivors of harmful forms of child labour.

There are a range of laws, legislative processes, and legislative reviews concerning the rights of children in South Africa:

- ❑ The *Constitution of the Republic of South Africa* (1996) includes a number of basic rights for children. Section 28 deals with children's rights. It states that every child has the right to family or parental care, or to appropriate care when removed from the family environment; to basic nutrition, shelter, basic health and social services; to protection from maltreatment, neglect, abuse or degradation; and to protection from abusive labour practices. Section 28 stipulates that decisions affecting children must be taken with due regard to their best interests; children have the right to protection from maltreatment, neglect, abuse or degradation; and the survival and protection of children against exploitative labour practices must be promoted by the State. The Constitution also provides the right to equality and non-discrimination, stating that no person may be discriminated against on the basis of disability, age and gender. It also protects freedom of expression and enshrines the right to information.
- ❑ The *Child Care Act* (1983, amended in 1999) regulates consent and allows a child over the age of 14 to consent to medical treatment. It contains provisions for identifying and removing children in need of care, procedures

for adoption, and for moving children to 'places of safety'. It also prohibits commercial sexual exploitation of children.

- ❑ The *Guardianship Act* (1993) states that parents have joint guardianship over children born within a lawful marriage. If the child has no guardian, the High Court becomes the guardian of the child.
- ❑ The *National Health Bill* (2003) does not directly address the specific health care needs of vulnerable children, but seeks to protect patient rights, for example, confidentiality, informed consent, etc.
- ❑ The *Education Law Amendment Act* (2000) outlines actions which constitute serious misconduct by an educator (Section 17), in which case the educator must be dismissed if s/he is found guilty of sexual assault with a learner at the school where s/he is employed (Section 17(1)).
- ❑ The abolishment of corporal punishment in schools (1996).
- ❑ The *South African Schools Act* (1996) prohibits a school from unfairly discriminating against children in its admission procedures, and protects a child from unfair expulsion.
- ❑ The *Basic Conditions of Employment Act* (1997) sets the age of lawful employment as 15. It proscribes any work "that places at risk the child's well-being, education, physical or mental health, or spiritual, moral or social development" (Section 14(2)(b)). Section 48 of this act prohibits forced labour. These sections can be applied for the protection of trafficked children. Trafficking for purposes of sexual exploitation should be regarded as a form of 'forced labour' and should be prosecuted under this provision.
- ❑ The *Employment Equity Act* (1998) protects children over the age of 15 from unfair discrimination in the workplace based on their HIV status, and prohibits HIV testing in the workplace where the information will be used against the employee.
- ❑ The *Promotion of Equality and Prevention of Unfair Discrimination Act* (2000) prohibits unfair discrimination on the basis of gender, gender-based violence (Section 8(a)), and any practice aimed at undermining the dignity and well-being of a girl child (Section 8(d)). Chapter 3 of this act lays down specific procedures for deciding on the burden of proof and un/fairness. The burden of proof in cases involving discrimination on the grounds of gender (i.e. gender-based violence and the dignity and well-being of the girl child) lies with the respondent (the accused), and not with the complainant (the child-survivor of gender-based violence).
- ❑ The *Correctional Services Act* (1998) prevents the detention of children under the age of 14 in a prison, except in cases where it is in the interests of justice or where no alternative care can be found.
- ❑ The *Sexual Offences Act* (1957, amended 1988) applies, among other things, to the protection of victims of sexual offences and the prosecution of offenders. It provides for the prosecution of a parent or guardian of any child under the age of 18 who procures, orders, benefits from, or assists in bringing about the involvement of that child in sexual activity. The act prohibits any sexual coercion and sexual offences against children. This also covers activities related to abduction.
- ❑ The *Sexual Offences Bill* relates particularly to the protection of children from

sexual offences, sexual coercion, and sexual exploitation. It redefines rape to focus not so much on the absence of consent, but on the presence of coercive and unlawful circumstances. Coercion is defined to include violence and threats of violence against the complainant or other people, and/or against the property of the complainant or other people. The bill imposes severe penalties for crimes such as child prostitution, child sex tours, and the possession of child pornography (Ellis 2003).

In the bill, rape is no longer gender-bound. Its definition is broadened significantly. Among other criteria for rape, it stipulates that sexual activity of persons under 16 years, involving an age difference of more than three years, constitutes statutory rape.

The age of 16 is determined as the age of consent for sexual relationships. Thus, consent given by a child under the age of 16 to any sexual act will not be considered valid grounds for a defence. Apart from this provision, recognising power differentials accompanying age differentials, the bill makes no provision for sexual offences against children committed by children.

- ❑ The *Prevention of Family Violence Act* (1993) obliges “any person who examines, attends to, advises or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such a child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances to a police officer or to a Commissioner of Child Welfare or a social worker”.
- ❑ The *Domestic Violence Act* (1998) defines a domestic relationship very broadly, and defines domestic abuse to include any physical, sexual, emotional, verbal and/or psychological abuse; harassment; intimidation; and/or ‘any other controlling behaviour’. A domestic relationship in which violence can occur includes the parent of a child, or ‘persons who have or had parental responsibility for that child’. It allows for children to apply for a protection order.
- ❑ The *Films and Publications Act* (1996) provides for the protection of children against mental, physical and sexual exploitation or coercion to engage in the production of a pornographic film, publication or visual presentation. It was amended in 1999 to include protection against exploitation with regard to materials produced for and posted on the Internet.
- ❑ The *Child Justice Bill* (2002) is currently being considered in parliament. The review pertains, among other things, to the minimum age of imprisonment, the incorporate diversion of cases away from jail time, and the provision of child-friendly courts.
- ❑ The *Prevention of Organised Crime Act* (1998, amended 1999) deals with offences related to trafficking for purposes of sexual exploitation of children. Its provisions extend to criminal gang activity and racketeering.
- ❑ The *Aliens Control Act* (1991, amended 1995), the *Immigration Bill* (2000), and the *Refugees Act* (1998) contain provisions relating to cross-border, regional and international trafficking of children for purposes of sexual exploitation.

The Draft *Children’s Bill* (initially drafted over a time period starting in 1997, tabled in 2003) envisages regulating the childcare system, bringing the legal obligations to children in line with constitutional principles, and introducing a

comprehensive social security system for children (universal grant for all children under the age of 18, foster care grant, adoption grant, emergency court grant, supplementary special needs grant, subsidy for assistive devices for children with disabilities, and free basic services for children in court-ordered alternative care). However, the provisions of the bill are subject to cost factors and budgetary provisions.

The current Draft Children's Bill has eliminated some of the provisions for children's social security that were originally contained in the bill drafted by the South African Law Commission. Among them are the chapter stating various government departments' responsibilities towards children; the legal recognition of child-headed households; and the entitlement to child support grants and various other grants (as applicable) on behalf of all children under 18. The Department of Social Services argued that these provisions were better placed within the Social Assistance Act; however, the Social Assistance Act has not incorporated these social service provisions (Joint Submission 2003). The original draft version of the Bill, promotive, preventative and early intervention approaches were accorded preference over formal measures for the statutory care and protection of children. The set of measures designed to achieve this, has been removed, thereby rendering the formal protection system paramount. The Bill does not however, make any provision for adequate resourcing, coordination and management of the child protection system. Nor does the Bill spell out how the state plans to support informal networks of care and support.

The provisions concerning the age of consent to medical diagnosis and treatment in the Children's Bill have given rise to some controversy. The bill stipulates that the age of 12 should be set as the age of consent to medical treatment (if the child is found to be sufficiently mature and mentally capable of understanding the implications of the treatment). It further stipulates that consent for an HIV test can be given by a child from the age of 12 onwards, if the child is sufficiently mature and capable of understanding the benefits, risks, and social implications of the diagnosis. That would also mean that pre- and post-test counselling could be given to a child from the age of 12 onwards; and that a child from 12 years onwards could give consent to disclosing the HIV test results and his/her HIV status to others. Provided that confidentiality is ensured and that a medical examination has been performed, contraceptives other than condoms could be given to children from 12 years onwards. In contesting these provisions, it has been pointed out that a child of 12 years is not able to fully understand the implications of an HIV-positive diagnosis, and is not in a position to give (informed) consent to a range of medical procedures. Allowing a child to undergo an HIV test unsupported by a caregiver is considered by some as potentially detrimental to the mental health of the child. Moreover, a child of the age of 12 would need parental financial support, emotional support and guidance, and joint decision-making in matters concerning his/her health.

Social assistance draft legislation: Access to social grants

In 1998, the government started phasing out the remnants of the apartheid state's social security legislation, which had excluded black women – particularly black women living in rural areas. The Child Support Grant introduced in 1998 was targeted at primary caregivers of children under the age of seven from poor households. This new grant was significant in its attempt to remedy the urban bias, and in the recognition that it afforded to adult primary caregivers (as

opposed to biological parents exclusively). However, it was marred by failures in implementation. The fact that the distribution of Child Support Grants still falls short of its target might also be related to the absence of mothers. Studies in both the United States (Case et al. 2000; Case & Paxson 2001) and South Africa (Case, Hosegood & Lund 2003) have shown that children with resident mothers were significantly more likely to be in the Child Support Grant system, in comparison with children whose mothers were not resident. Although several organisations are distributing information on access to Child Support and other grants, it is not as yet widely known that primary caregivers do not need to be mothers to be eligible for Child Support Grants. With the current proposals to extend the Child Support Grant up to the age of 13 – where older children are less likely than their younger counterparts to be residing with their mothers – this would have to be taken into account to ensure more extensive take-up. Provision would also need to be made for the possibility that in the absence of the mother, the primary caregiver may be less able to access the relevant documents required for registering the child's birth and applying for the Child Support Grant (Case, Hosegood & Lund 2003). It has been noted that grants tend to be stopped with the death of the recipient adult caregiver, leaving the child destitute. Measures would have to be taken to ensure that the grant follows the child. Special consideration would have to be given to child headed households, including households in which children take on increased responsibilities in caring for terminally ill caregivers. This should also include households in which minor primary caregivers are trying to access grants on behalf of the children in their care.

The Alliance for Children's Entitlement to Social Security (ACCESS) has called for the universal provision of Child Support Grants to children up to the age of 18.

In January 2003, a new draft *Social Assistance Bill* was circulated for comment. However, this Bill does not take up the recommendations of the Taylor Committee Report, which stipulates wide-ranging reforms of social security.

A comprehensive report on the extent and the conditions of poverty in South Africa, and proposed social security provision, entitled 'Transforming the Present – Protecting the Future,' was released in March 2002 by the *Committee of Inquiry into a Comprehensive System of Social Security for South Africa*. The Committee found that fragmented social grants inherited from the apartheid era were inadequate to address poverty. This inadequacy is highlighted by the situation of children living in poverty. While some provisions had been made for children under the age of seven living in poverty, there was, until recently, no access to social assistance for poor children over the age of seven. The committee acknowledged that the social security programme presently in force "fails to satisfy constitutional imperatives and thus makes the state vulnerable to Constitutional Court challenges".

The committee recommended the introduction of three universal cash grants:

- ☐ Basic Income Grant
- ☐ Child Support Grant
- ☐ State Old Age Pension.

These universal grants were to be complemented by grants for people with special needs – that is, people with disabilities and children living in households in which there is no safeguard for a certain level of care and stability. In addition, the committee recommended that the adult disability grant, the care dependency

grant, and the foster care grant presently in force should be continued and reformed to make them more accessible to greater numbers of people in need.

A proposed timetable for phasing in universal social assistance grants was drawn up:

- ❑ 2002-2004: Extension of the Child Support Grant
- ❑ 2005-2015: Basic Income Grant extended to all South Africans.

The policy reform process has been stalled for some time since the release of the Commission Report. The Social Assistance Bill has not taken up the recommendations outlined in the Committee Report. Moreover, the provisions for basic social security for children contained in the Draft Children's Bill were removed, with the justification that these should be placed within the Social Assistance Act. But the Social Assistance Act does not include the social security provisions dropped from the Children's Bill.

Section 28(1) of the *Constitution* contains specific clauses for the protection of children's socio-economic rights. It accords every child the right to basic nutrition, shelter, health and social services. However, the judgements of the Constitutional Court so far provide limited guidance on how to interpret this clause. Despite the fact that South Africa is a signatory to numerous declarations and conventions on the rights of children, the majority of South Africa's children effectively remain without food security, and do not have access to adequate shelter, health and social services.

Access to education also remains a critical issue. There are many children who do not attend school because of the inability to pay fees or buy uniforms – despite policy disallowing non-attendance on these grounds. The right to education, despite poverty, could be made explicit in the Bill. Noting that between 45 and 55% of South Africa's population live in poverty; that 11 million children between the ages of 0 and 18 are living in dire poverty (i.e. on less than R200 per capita per month); that child poverty and adult unemployment have increased significantly; that the impact of HIV/AIDS is increasing the burden on households; and that 60% of the poor do not have access to any form of social security cash grants or benefits, a range of organisations made a *Joint Submission* to the Portfolio Committee on Social Development on the Social Assistance Bill (Taylor Committee).⁴ This submission outlined the shortcomings and gaps in the existing and proposed social security draft legislation which affect children infected with and affected by HIV/AIDS in particularly adverse ways. They identified the following groups of vulnerable children who, even with the provisions in the proposed new legislation, would remain without social assistance:

- ❑ poor children between the ages of 10 and 18 years
- ❑ children whose parents have died and who are being cared for by extended family members
- ❑ many poor children between the ages of 0 and 18 years whose caregivers do not pass the means test⁵
- ❑ children without adult caregivers (children living in child-headed households and street children)
- ❑ children with moderate disabilities and chronic illnesses who need assistance

- ❑ children living with HIV/AIDS (Joint Submission 2003).

Signatories to the Joint Submission endorse the committee's recommendation of a comprehensive package of social protection interventions, so as not to force recipients to choose between basic needs – prioritising one basic need at the expense of another. They also recommend that the Social Assistance Bill be brought in line with the proposals of the Committee Report. They launched a campaign for a *Basic Income Grant* “as a key intervention to combat poverty and to improve the lives of the majority of South Africans” (SACC 2001).

The Social Assistance Bill proposes the establishment of an independent *Inspectorate for Social Assistance*.

The draft *National Social Security Agency Bill* envisages the establishment of a public institution responsible for the delivery of social grants.

Parallel to the social security legislative process, a number of provisions have been instituted, or are in process or under review. Following review, the Child Support Grant was considered to be inadequate. In February 2003, the state president and the finance minister announced an increase in the child support grant to R160 per month with effect from April 2003; an increase of R10, to bring the Child Support Grant to R170 per month, was announced in February 2004. All children under the age of 18 were recommended to become eligible for this grant. The age of children eligible for child support grants would be progressively increased over the years 2003 and 2004:

- ❑ seven to eight year old children would qualify for these grants from April 2003
- ❑ nine to ten year old children would qualify for these grants from April 2004
- ❑ eleven to thirteen year old children would qualify for these grants from 2005.

The following additional criteria for eligibility have been laid down:

- ❑ The child and primary caregiver must be South African citizens and resident in South Africa.
- ❑ The applicant must be the primary caregiver of the child/children concerned.
- ❑ The applicant and spouse must meet the requirements of the means test.
- ❑ The applicant cannot apply for more than six non-biological children.
- ❑ The applicant must produce a 13-digit bar-coded ID document (of the caregiver).
- ❑ The applicant must produce a 13-digit birth certificate (of the child).

Following the call (in 2002) to have five million children registered by 2005, a drive has been initiated to register children eligible for Child Support Grants in the various provinces. The number of recipients of child support grants had increased to one and a half million by April 2002, but still falls far short of the target (Smart 2003b: 28, 33 n. 22, 23). Registrations have been hampered by the fact that many applicants cannot produce birth certificates, and by obstacles to service provision on the part of the Department of Home Affairs.

An additional grant for children with special needs was proposed.

It was recommended that recipients of social security be exempted from school fees (Smart 2003b).

A review of the *Foster Child Grant* is underway. In the past, procedures for applying for Child Support Grants and take-up were found to be poor. Foster Child Grant recipients have doubled between 1998 and 2002, but the grants still do not reach all those who would be eligible. In January 2001, approximately 52 000 children were receiving the Foster Child Grant. The amount allocated to a Foster Care Grant is R410 per month. The following documents have to accompany the application for a Foster Child Grant:

- ☐ 13-digit ID number in respect of the child (birth certificate or ID number)
- ☐ bar-coded ID of foster parent
- ☐ court order
- ☐ proof of income, if any, of the child; no means test for parent
- ☐ application forms from welfare offices
- ☐ proof of child's school attendance.

The Children's Institute at the University of Cape Town has called for the extension of the Foster Child Grant to extended family members who are informally caring for orphaned children.

The *Care Dependency Grant* is for children with severe disabilities requiring and receiving permanent home care, from 1 to 18 years. The amount is set at R570 per month. The following documents have to accompany the application for a Care Dependency Grant:

- ☐ 13-digit ID number in respect of the child (birth certificate or ID number)
- ☐ bar-coded ID of parent/foster parent
- ☐ medical forms (from state medical officer)
- ☐ proof of income and assets of parent/foster parent, or affidavit stating that parent/foster parent is unemployed
- ☐ application from welfare offices.

Policy

The National Integrated Plan for Children Infected and Affected by HIV/AIDS (2000) provides for intersectoral collaboration between the Education, Health, Social Development, and Agriculture Departments to "ensure access to an appropriate and effective integrated system of prevention, care and support services for children infected and affected by HIV/AIDS". It includes provisions for life skills education, home- and community-based care and support, training of home-based caregivers, voluntary counselling and testing, and poverty relief.

The Department of Social Development has developed *National Guidelines for Social Services to Children Infected and Affected by HIV/AIDS*, which are designed to address the needs of children of child-headed households, to ensure that basic needs are met, to link families and caregivers with poverty alleviation programmes and community services, to assist families with information in

attempting to access grants and other financial means, to address stigmatisation and discrimination, and to assist with procuring means to meet burial costs.

The Department of Social Development has encouraged the formation of Child Care Forums, in addition to producing policy documents and manuals on social service delivery to children infected and affected by HIV/AIDS, on home-based care, and on volunteer training (2003).

Voluntary Counselling and Testing (VCT) policies pertaining to children have been developed. Children under the age of 14 require consent from parents or legal guardians for an HIV test; young people over the age of 14 can consent to HIV testing without the permission or knowledge of their parents or legal guardians. Health providers conducting VCT should be trained to address the special needs of young people, and to provide adequate and appropriate information, counselling, support, and referral. A Declaration on VCT for Children was adopted in 2002, which takes account of special needs of vulnerable children.

Advice, support, assistance and legal services are needed for a range of vulnerabilities, and fall into the categories of juvenile offenders, pregnant children, undocumented child migrants, children with disabilities, children who are homeless, children who live on the streets, children who have survived sexual assault and rape, children in foster homes and places of safety, children in hospitals and clinics, children who care for their parents, siblings and other family members, children who are orphaned by HIV/AIDS, children who are placed in institutions for the mentally challenged and children who are attending nursery, primary and secondary school (Smart 2003b: 26-27).

A separate set of guidelines for children was suggested and it was recommended that government guidelines should be amended to include a specific section on children who need PEP (post-exposure prophylaxis, in cases of sexual assault), PMTCT (in cases of pregnancy) and treatment and prevention of opportunistic infections and STIs.

An Integrated Nutrition Programme was put forward at the ANC National Policy Conference in September 2002 as part of a comprehensive social security system. Proposals included a school nutrition programme.

A proposed Food Security Programme, to be led by the Department of Agriculture, is to provide some measure of food security to vulnerable groups in the form of food parcels. It was announced that families who do not have an income and who spend a maximum of R200 per month on food and basic household essentials would qualify for food parcels. It was estimated that 240 000 households would benefit from this provision during the 2003-2004 financial year.

However, organisations providing services to orphans and people living with HIV/AIDS report receipt of erratic and insufficient financial means to purchase basic foodstuffs for food parcels.

The Department of Labour, in co-operation with the International Labour Organisation's International Programme on the Elimination of Child Labour (IPEC), embarked on a Programme of Action Against Child Labour early in 2002. A Child Labour Action Programme is envisaged as an output of the consultations (Smart 2003b: 29).

A Child Protection Register has been implemented in all provinces.

ADDRESSING CHILD SEXUAL ABUSE AND HIV IN SOUTH AFRICA

Child abuse is multifactoral, entailing specific criminality as well as issues to do with the provision of a safe framework of care and supervision, family-related factors, economic factors, restricted opportunities for social learning, social dislocation, and lack of perspectives and opportunities for individual growth – among others.

It is difficult and socially problematic to highlight a particular strategy for addressing child sexual abuse and HIV. A one-dimensional analysis of the problem pointing in the direction of ‘the dysfunctional family’ should be avoided. Child abuse is multifactoral, entailing specific criminality as well as issues to do with levels of care and supervision, family-related factors, economic factors, restricted opportunities for social learning, social dislocation, and lack of perspectives and opportunities for individual growth – among others. A transitional society, urbanisation, high unemployment with limited access to social security, exacerbated intergenerational conflict, the effects of HIV/AIDS on household structures, and fewer social and familial resources for childcare are some of the broader social factors that demand attention. A combination of services should be envisaged, providing education, preventive measures, assistance to vulnerable individuals and families, support, and social security, to improve the overall social and economic context of households and families. Home-based and palliative care services are important in relieving children of caregiving duties, so that they can attend school and social activities. A further issue in protecting vulnerable children relates to the issue of property rights. Children affected by HIV/AIDS require assistance with the planning of inheritance and succession on the death of family members.

To render social service delivery to vulnerable children more effective would require addressing stigma arising from HIV/AIDS, orphaned status and receiving welfare; monitoring the distribution of food parcels to ensure that they reach and benefit those in greatest need; and providing both food security and psychosocial support to vulnerable children and their caregivers in the context of the entire household. While food security remains a critical issue for many households affected by HIV/AIDS, and has been recognised as a major problem, psychosocial support has, until now, been largely neglected. As Daniel points out, psychosocial support is no less crucial for survival:

Children are deeply affected by changes in their parents’ emotional and physical state. Upon the death of a parent children experience a profound sense of loss, grief, hopelessness, fear and anxiety. Unless children are helped – through counselling and therapy – to deal with their loss, they will suffer long-term consequences such as depression, low self-esteem, low levels of life skills and disturbed behaviour. ... Many of the caregivers have suffered the trauma of multiple deaths and struggle to cope with the responsibility of caring for very young dependents [sic] or aggressive teenagers. They, too, need guidance and support. (Daniel 2003: 16)

The symptoms of the stress on children affected by HIV are easily overlooked, as they are usually remain internal (depression, anxiety, and low self-esteem).

Trauma counselling

Health workers need adequate training and support in order to provide integrated and appropriate counselling to be able to determine a child’s capacity to consent to HIV testing. The Children’s Institute at the University of Cape Town has found that few health workers feel equipped for this task. The Institute’s research

further suggests that many health workers are unwilling to treat children who arrive at clinics unaccompanied. This situation is likely to arise more frequently with parental deaths from AIDS-related conditions. The Institute calls for clear policy guidelines to be issued to health workers on when and how to treat unaccompanied minors (Children's Institute 2003). Health workers also have a significant role to play in the early identification of potentially vulnerable children, and to mobilise preventative interventions.

Age-appropriate counselling and support would have to be provided to children on an ongoing basis, especially in situations where children face multiple losses of caregivers, siblings and other co-resident children. Counselling can prevent, mitigate or mediate the effects of trauma. It may not be possible for the child to talk about the incident immediately following the abuse. However, counselling taken up as soon as possible after the traumatic event promises to bring about a relatively speedy recovery.

If the child is not receptive to therapy shortly after the incident of abuse, it is recommended that the mother is counselled to look for signs of post-traumatic stress disorder (PTSD) and to bring the child back for counselling when he or she is ready. Counselling may be given a few days later once the child has adjusted psychologically to the trauma. Some practitioners suggest that the child or parent/caregiver keep a diary for therapeutic and court reasons (Interview: Meeni).

In counselling sexually abused children, it is necessary to form a trusting relationship with the child. This means that the counsellor has to be attentive to and learn to understand and communicate the language of the child on three levels: body language (including gestures and mime), the language of play, and verbal language. To let the child express what has happened to him/her, opportunities should be given to him/her for enactment through play or drawing. To this end, it is useful to have toy dolls or teddy bears, and drawing and painting materials available in the counselling facility. Young children have responded positively to play therapy.

It is important, for therapeutic and analytic purposes, to assess the age and developmental stage of the child survivor. The patterns and processes in stress and coping will differ according to the stage of the child's development. At greatest risk for traumatic effects are children abused between the ages of six months and four years. At this stage, children are completely dependent on adult caregivers for their survival needs; they also do not have the capacity for narrative memory that could help them to process the traumatogenic event. Their memories tend to be piecemeal and episodic.

Children in the latency phase, between the ages of five to six years, and eleven to twelve years, begin to develop organised memories. They tend to retrospectively construct reasons and causes for the occurrence of a traumatogenic event, and ways in which it could have been averted. In the process, they tend to blame themselves and feel intense guilt. This is often dramatised in various re-enactments in play.

Without any interventions, the experience of traumatogenic events can have long-term consequences. Cognitive-Behavioural Therapy is often used as an intervention. For children at the end or beyond the latency phase, this approach has identified the following procedures:

- ❑ directly discussing the traumatic event; emotional engagement with the trauma memory; organisation of the trauma story

It is important, for therapeutic and analytic purposes, to assess the age and developmental stage of the child survivor. The patterns and processes in stress and coping will differ according to the stage of the child's development.

- ❑ anxiety management techniques (relaxation and assertiveness training)
- ❑ correction of distorted trauma-related thoughts (Hamblen 1998: 2; see also Davidson et al. 2001: 491).

Eye Movement and Desensitisation Reprocessing Therapy (EMDR) is a therapeutic approach whose effectiveness is contested. It involves ‘visualising trauma images, while eye movements are induced as the client tracks rapid side-to-side movement of the therapist’s finger’ (Shapiro 1995 in Kreidler et al. 2002: 141).

Counselling caregivers

Parental involvement and counselling for parents/caregivers has been found to be beneficial in most cases (where a family member is not the perpetrator of the abuse). Support by the primary caregiver has been identified as an important predictor of recovery in child abuse cases. The caregiver’s own stress responses, which include feelings of fear, helplessness, and vulnerability, and diminished sense of her own efficacy as a parent, are factors that may hamper the recovery of the child survivor, and would have to be addressed in counselling. In addition, caregivers may be influenced – albeit unconsciously – by prejudicial rape myths, for example, about the victim’s role in the rape, and express ambivalent emotions that leave the child survivor in doubt about his/her own appraisal of the traumatic event, and about the caregiver’s trust. This could be an indication of secondary traumatisation of caregivers and family members. Somatic reactions of secondary traumatisation include sleep and eating disturbances, tension headaches, and fatigue. Psychological reactions of secondary traumatisation include guilt, fear, anger, feelings of loss of control, and intrusive thoughts and generalised fears. Caregivers and other family members suffering from any of these symptoms as a result of the traumatisation of the child survivor may be emotionally distant and unavailable to the child survivor, thus exacerbating the effects of trauma on the child survivor. This demonstrates the need for counselling and awareness-raising for caregivers.

There is no definite pharmacotherapy for PTSD (Kreidler et al. 2002: 143).

Prevention of secondary victimisation and traumatisation

Immediate interventions in child sexual abuse that are intended to address the problem and create an improvement in the victim’s situation can give rise to further problems, illness, and secondary victimisation. This is borne out by the experience of some victims and survivors and their caregivers, who point out that things became worse instead of better for them after they disclosed the abuse. They might have had to face further traumatising procedures and continued to experience loss of control over their lives. Added trauma may arise through insensitive and humiliating interviews, a frightening medical examination, an HIV-test, confrontation with the perpetrator, a placement designed for safety but experienced as dislocating and isolating, and court testimony forcing the child to re-live the trauma (Faller 1993: 7).

To reduce secondary victimisation and the child’s sense of powerlessness, it is advisable to prepare the child and the caregiver for every step of the subsequent procedures, and to give the child some measure of control over the process. It is important to make sure that the child and the caregiver understand the procedures, and that the child is sufficiently supported throughout the process.

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Further measures can be taken to reduce the trauma of the investigations for the child, in terms of the environment and the manner of conducting the procedures. The interview should be held in a location that the child perceives as a safe place. The number of interviews can be minimised by videotaping them, or conducting them in front of a one-way mirror, behind which all professionals concerned can hear the testimony. While the child should preferably be interviewed before and separately from the parents, the presence of a supportive caregiver throughout the remaining procedures could be reassuring to the child. Attention to the interior of the room in which the investigations take place – child-friendly furniture, decoration, and toys – can contribute to making the child feel at ease.

Impact of child sexual abuse on counsellors and therapists

Counselling that addresses the multiple contexts of and roleplayers in child sexual abuse is a demanding task involving the intrusion of the counsellor's personal feelings and responses. The counsellor should be assured of adequate support in this task – i.e. a referral system and debriefing.

In the process of child sexual abuse counselling, the gender of the counsellor is likely to influence responses to the client. Gender identification can make for greater empathy – or for rejection of the account of the abuse given by the child. A male counsellor may empathise with an accused male perpetrator, and have greater difficulty than a female professional in believing the allegation of abuse made by a girl child. A female counsellor, on the other hand, may give more credibility and empathy to the girl child and to the mother of the child. This tendency for identificatory patterns of responses is underlined by the finding that counsellors working with child abuse tend to be people who have had some direct or personal experience of abuse (Faller 1993: 4).

The multiple contexts of and roleplayers in child sexual abuse are likely to pull the professionals in various, and at times contradictory, directions:

Although most professionals want to help the victim, potentially competing concerns include the feeling that sex offenders should be punished, a concern that the offender may be dangerous to others, a belief that sexual abuse is a mental health problem, a concern about the impact of disclosure upon the mother, a belief that the mother is partly responsible for the abuse, an awareness of the effect of sexual abuse and intervention on non-victim siblings, and a feeling that everyone in the family needs help (Faller 1993: 6).

The decision as to whether to remove the perpetrator, or place the child in safety, must be balanced against considerations of retaining the family structure so as to ensure support for the child. In these cases, a victim-centred approach with consideration for the victim's best interest should be the guiding principle. If the family has been separated, the question of family reunification has to be addressed (Faller 1993: 8).

Counselling young offenders

In devising strategies to deal with young offenders, cognitive, psychosocial, and developmental aspects should be taken into account. Young persons typically

- ❑ are going through a unique phase of development

- ❑ are still developing their sense of self
- ❑ are at a point where their self-esteem is highly vulnerable
- ❑ are still emotionally and physically dependent on their parents (Morrison & Print 1995 in Kjellgren et al. 2001: 30).

Where young offenders have been treated, 'international experience shows that a multi-modal treatment model, with broad-based co-operation between different agencies, yields the best result, for instance through environmental therapy, focused group treatment, individual therapy, family sessions and work with the young person's network (...)' (Kjellgren et al 2001: 31). The following objectives have been identified as being central to therapy with young offenders:

- ❑ acceptance of responsibility for his/her behaviour
- ❑ reduction of denial
- ❑ development of empathy with the victim
- ❑ focus on factors triggering sexual abuse
- ❑ understanding of the abusive cycle of the offender
- ❑ challenging of cognitive distortions and rationalisations supporting abuse
- ❑ developing a positive self-image
- ❑ developing adequate social skills
- ❑ raising family aspects
- ❑ preventing recidivism
- ❑ exploring the offender's own vulnerabilities
- ❑ processing the offender's own vulnerabilities and any history of abuse (Kjellgren 2001: 32).

In addition to individual therapy, group therapy should be envisaged. One of the benefits of group therapy lies in the fact that the group can become a forum for confrontation and support, thus counteracting denial and facilitating disclosures. In ongoing group sessions and support, the isolation and secretiveness underpinning abuse can be broken (Kjellgren 2001: 33).

Obtaining a confession in individual cases of child abuse indicates an acceptance of responsibility of the abusive acts. This could be the first challenge in therapy. Along with it should come an appreciation of the harm that the abuse has caused the survivor and his/her family, and the perpetrator him/herself.

PROCEDURES FOR DEALING WITH CHILD SEXUAL ABUSE AND HIV/AIDS

Lodging a complaint and obtaining medical care

Survivors of sexual violence have several rights when lodging a complaint: the right to give statements in a place of privacy; the right to obtain a copy of their statement; and the right to give their statement to an officer of the same sex. The police do not have the right to determine if it is a legitimate case. The lack of privacy that abuse survivors have experienced in the past when reporting an incident of sexual abuse has been addressed by the provision of a separate room and female police officers at a number of police stations.

The statement must be taken in the child's home language, as the exact wording may be lost in translation.

Creating a supportive environment is important in encouraging children to report sexual abuse, or in questioning children about alleged abuse. Still, there are numerous impediments. For example, the child may have to wait for a long time to be able to speak to a female police officer, as there are relatively few women on the South African Police Services (SAPS) staff. Furthermore, a J88 form is required to report the case to the police; this is typically kept at the police station, and not hospitals.

With a new official approach and commitment to holistic rape care, there is an attempt to establish one-stop crisis centres at state hospitals, where all the required procedures and treatments will be administered. Reporting the incident to the police, the medico-legal examination, diagnosis and treatment of injuries, prophylactic treatment for pregnancy, STIs and HIV, an HIV test, pre- and post-test counselling, and trauma counselling can be administered at such one-stop rape crisis centres.

Even where there are no such one-stop rape crisis centres established at this stage, it is advisable to visit a health facility as soon as possible after an incident of sexual abuse, so as to initiate medical treatment for injuries, PEP for potential HIV infection, and prophylactic treatment for potential STIs. In many instances, hospital or clinic staff will call the police to the hospital or clinic for purposes of taking a statement. Reporting the case to the police is not a precondition for receiving PEP, and pregnancy and STI prophylaxis.

In rural areas, the distance to be traversed to the nearest police station or hospital may be a barrier to the timely reporting of the case, and to the initiation of treatment. Any delays in reporting and initiating treatment may jeopardise the effectiveness of treatment for the child and the ability of the police or forensic nurse to obtain evidence to support the case. Rape occurs more often over weekends and at night. Because there might not be public transportation at that time, the rape survivor might only come to the hospital or police station in the morning. It is important for the forensic examination that the survivor does not wash before the exam. Care packs are provided by many hospitals and police stations to enable the survivor to wash and change after the exam. Every effort should be taken to speed up, and effectively and sympathetically administer reporting, examining, testing, counselling and treatment procedures so as to prevent secondary victimisation.

Creating a supportive environment is important in encouraging children to report sexual abuse, or in questioning children about alleged abuse. Still, there are numerous impediments.

Where rape crisis centres have established co-operation with the SAPS, rape survivors have generally received more sympathetic responses and assistance upon reporting the case to the police. This co-operation has been initiated by many organisations providing post-rape care, including Masisukumeni and GRIP.

It is imperative for police to inform the social worker or related organisation of the release of the perpetrator, so as to facilitate supervision and prevent a recurrence of child abuse. Such notification and supervision has not been happening consistently (Interview: Meeni).

Medical/forensic examination

Children under 14 must have a parent or guardian to sign consent to the forensic examination, tests and other medical procedures. In the absence of a parent or legal guardian, the superintendent of the hospital, a police officer, a child commissioner, or a statutory social worker may sign the consent form. Consent for an HIV test on a child, and for treatment for conditions related to HIV/AIDS, may be signed by the child's caregiver.

Parents or legal guardians, or any of the persons specified above, have to provide consent to do the following:

- ☐ conduct the medico-legal examination
- ☐ take photographs
- ☐ release the report and evidence collected to the police
- ☐ communication with law enforcement agencies in instances where the case is not reported
- ☐ test for HIV
- ☐ provide treatment for injuries, and for the prevention of pregnancy, STI, and HIV transmission
- ☐ release information to referral agencies.

If the survivor does not want to report the case, health care practitioners should encourage the collection of evidence so that it is not lost if he/she decides to report it at a later date.

Initially, the child is given a general examination to diagnose any injury. Any physical injury is treated immediately. The emotional status is observed and documented, as well as the status of the clothing – for example, if it has tears or stains – for evidence that can be used in court. The presence of extra genital injuries should be documented with diagrams or photographs if possible. It is important to note that while genital trauma indicates both recent sexual contact and force, the absence of such trauma does not indicate that the survivor consented to the abuse.

If the survivor does not want to report the case, health care practitioners should encourage the collection of evidence so that it is not lost if he/she decides to report it at a later date (Department of Health 2003).

The child is screened for various STIs, including HIV, and for pregnancy. Because many STIs may not present immediately, the child should be re-tested after a month. The provision of PEP, likewise, necessitates repeated testing after six weeks, three months, and six months.

Many health practitioners and counsellors working with survivors of sexual abuse have noted that doctors are generally not trained to handle examinations

of children.

Seeking medical help can be a traumatic experience as many survivors find that the examination itself feels like being violated all over again. Sometimes children are severely traumatised and need a local or general anaesthetic to perform the examination. For example, at Ntalspruit Hospital, children under 13 are admitted as patients and undergo the exam under anaesthetic. Other organisations do not perform the medical examination on a severely traumatised child. Organisations such as GRIP give the child a care pack with personal hygiene items, a food parcel and a teddy bear.

The merits of admission have been debated because it involves separating the child from his or her parent/caregiver. If the abuse occurred at home, the child is not discharged until a safe place is found for the child, or until the perpetrator is arrested.

HIV counselling and testing

Pre- and post-test counselling is required for all persons undergoing an HIV test. The objective of pre-test counselling is to make sure that the client is making an informed decision, and to give information on HIV/AIDS and testing procedures. Post-test counselling assists the client in dealing with the result of the test.

There is no specific national protocol for pre- and post-test counselling for children, and many practitioners have developed their own guidelines. There is, however, a standard age of consent, which is 14. If the child is younger than 14, pre- and post-test counselling is provided to the parent/caregiver as well as the child. For children 14 or older, counselling is provided to children themselves.

As with adults, if the child tests positive, a confirmatory test is conducted. If the child tests negative, s/he should be re-tested for HIV six weeks, three months and six months following the incident of sexual abuse.

The effectiveness of providing HIV counselling immediately following sexual abuse has been questioned. The survivor and his/her parent or guardian may not be ready for the additional stress of an HIV test and may not be able to respond to counselling and to information and advice concerning the necessity of follow-up tests in the immediate aftermath of the traumatic event. In that case, follow-up visits would have to be scheduled.

The draft Sexual Assault Guidelines (DOH 2003) recommend that the survivor or parent/guardian should be given time to consider taking the child for an HIV test and return after three days or whenever s/he is ready for the test. Some organisations have already established this protocol, and the child returns in about three days for the HIV test result and to receive additional counselling. In this context, organisations hope that the child has a better chance of understanding the implications of either a positive or negative result.

Because PEP, administered for the prevention of HIV-infection after rape, is effective only where the client is HIV negative, the current protocol states that a negative HIV test is mandatory before PEP can be administered. The question of providing PEP to those clients who decline to undergo the test has as yet not been conclusively addressed by the Department of Health. Most organisations and health facilities have adopted the approach of providing a starter pack of PEP medication for either three days or one week, after which an HIV test with pre- and post-test counselling is administered, and the treatment is continued

There is no specific national protocol for pre- and post-test counselling for children, and many practitioners have developed their own guidelines.

Children who receive emergency treatment often do not return or are not brought back for their test results, medication or counselling.

pending the outcome of the HIV test. If the result is negative, the remaining treatment is given; if the result is positive, PEP treatment is discontinued and supportive counselling is offered instead.

Because of financial and logistical constraints, it is difficult to provide follow-up examinations and counselling. Children who receive emergency treatment often do not return or are not brought back for their test results, medication or counselling. In an effort to prevent children from 'falling through the cracks', GRIP has employed field workers who go out to the survivors' homes or community facilities to provide follow-up testing and counselling. Many field workers find that they spend more time on the road than they do seeing clients.

Post-exposure prophylaxis (PEP) after rape

To prevent the transmission of HIV after sexual abuse, children are given a dual therapy of 3TC and AZT, in the form of either syrup or tablets. The duration of the treatment is 28 days. It should be taken consistently to ensure effectiveness. A starter pack (usually for three days) is generally given immediately, with the rest of the treatment to be provided at the follow-up visits, for up to seven days at a time, at the health practitioner's discretion.

Post-rape treatment also includes contraception, antibiotics for the prevention of STIs, and other medication.

Because the drugs to prevent HIV transmission and pregnancy are effective only up to 72 hours after exposure, it is important for the child to access medical treatment as soon as possible after the abuse.

Children face various side effects from the drugs, including vomiting, tiredness, nausea, anaemia and aching joints. Although side effects are temporary and will not cause long-term harm, they can be intense and the child should be monitored while on treatment. In case of discomfort, medical attention should be sought immediately. There are drugs that can counter-act the side effects. For example, anti-emetic tablets may be provided to counteract nausea.

Follow-up and adherence to the drug regimen have generally been weak since the rollout of PEP for rape survivors in the second half of 2002. Many organisations spoke about their inability to follow up children to ensure they are taking the drugs appropriately. This may be attributed to various factors, including the distance between their homes and the hospital/clinic, misunderstanding of HIV test results, side effects of treatment, and financial constraints. Natalspruit Hospital has embarked on an initiative to facilitate follow-up. Counsellors at the crisis centre schedule a return visit for the child on the day before his/her treatment comes to an end. If the child does not appear for this appointment, the counsellor takes time to visit the child at his/her home. However, most organisations do not have the capacity to follow up their clients outside of the centre.

Some organisations provide transportation fare. If return visits are not feasible due to logistical constraints, the complete dosage may be given at once. This is, however, not an optimal solution due to issues of compliance, side effects and re-testing for HIV.

Calls have been made for continued lobbying and activism on the right of access to PEP drugs to prevent HIV transmission after rape and other forms of sexual abuse. Despite the announcement made by government in April 2002 to

make PEP available at all state health facilities by the end of December 2002, availability of PEP remains uneven. The 'PEP Talk' campaign undertaken by 25 NGOs during the 16 Days of Activism Against Gender-Based Violence in December 2003 conducted spot-checks on the availability of PEP. Campaigners found that 43% of the 32 hospitals and clinics investigated in seven provinces did not provide access to PEP. Paediatric formulations of the drugs were even less readily available. While the drugs were available at most hospitals, only a small number of clinics provided them. ANC MP Johnny de Lange, chairperson of the Portfolio Committee on Justice and Constitutional Development, responded by pointing out that PEP was available only at clinics and hospitals that already provide anti-retroviral drugs (in Mawson 2004b: 41).

The right to PEP to prevent HIV transmission after rape and other forms of sexual abuse was re-instated in the Sexual Offences Bill in February 2004, after being temporarily excised from that bill.

The court process

A long time period may elapse between reporting the rape and the case going to court. According to GRIP, it can take up to two years before a reported case of child sexual abuse is heard in court.

Masisukumeni noted that there is usually a two to three month gap before the case initially appears in court. During this time, the perpetrator may be released from jail, contributing to the child's sense of insecurity. During this time, it would be preferable to leave the child in his/her home environment. However, in most cases, the child is removed to a place of safety. In this case, it would be preferable to place the child with relations or foster parents who can offer the comforts of a home (Interview: Meeni).

Often the courts do not find sufficient grounds for convicting the perpetrator. For example, according to statistics from the Crime Information Analysis Centre, South African Police Services, between January and December 2000, there were 21 438 reported cases of rape and attempted rape of children between the ages of

GRIP provides pre-court training for the child and caregiver. This involves the use of puppets of the magistrate, prosecutor, perpetrator and survivor, as well as a picture of the court, in order to familiarise the child with the process and to make him/her comfortable. In answering questions, the child is encouraged to talk to his/her teddy bears.

In an effort to create co-operation between the organisation and other child protection services, such as the CPU and the Justice Department (prosecutor), an employee of GRIP has been placed as a 'friend of the court'. His office is at the courthouse.

As it is often difficult for clients to get to court, GRIP provides transportation as needed, and drinks and snacks while the child is waiting to testify. It has become standard in this court that children give evidence before 12 noon, as many of them have been up since early morning, and their capacity to concentrate can be expected to flag by the afternoon. While this is beneficial for the child's testimony, it limits the number of cases the court can handle in one day.

GRIP has found that active co-operation with other roleplayers has been successful in increasing the conviction rate.

0-17 years. Of these, 10 242 cases were referred to court; 1 851 cases returned guilty verdicts, and 6 602 were shifted to indecent assault (CPS 2002: 2). Organisations interviewed cited lack of evidence, inadequate police work, and technicalities as contributing to the low conviction rate.

The government has encouraged the establishment of 'child-friendly' courts, which are separate from the general courtroom, and based on the sexual offences court model. These courts involve specially trained prosecutors and judges, victim assistance services, a specialised court, and counselling services. In this model, the court would also involve a case manager, who monitors and facilitates the turnover of cases, and an intermediary, who works with the child when giving testimony.

In these courts, the child gives testimony in an adjoining room through a closed circuit television. Questions are asked through an intermediary, who may be a social worker. The first court of this kind was established in the Western Cape in 1993. At the beginning of 2003, there were 39 such courts with varying degrees of compliance with requirements.

Many other organisations now provide pre-court support for children. Social workers in Barberton practice giving testimony with the child. They find it important to advise the child that in bringing the case to court, he/she does not vilify the perpetrator, but rather makes the point that the abuse must stop.

HEALTH AND SOCIAL SERVICES FOR CHILDREN LIVING WITH HIV/AIDS

South Africa has a growing number of HIV-infected children. The comprehensive *National Guidelines* issued in 2000 by the Department of Health, under the title 'Managing HIV in Children', seem not to have been widely disseminated or taken up in the following period (Giese & Hussey 2002: 7). In a rapid appraisal of services and information conducted by Cape Town University's Children's Institute and Child Health Unit, prophylactic and supportive interventions were found to be poorly and ineffectively implemented:

- ❑ Only one third of the clinics had a policy in place for the administration of prophylactic cotrimoxazole to HIV-infected children and most of these clinics were prescribing the drug incorrectly. Clinics were also found to be administering cotrimoxazole inappropriately as treatment.
- ❑ Nationally, 35% of the clinics reported administering vitamin A to HIV-positive children. The administration of both vitamin A and cotrimoxazole was impeded by their availability at clinics (Giese & Hussey 2002: 7).

Prophylactic TB treatment for children was found to be incorrectly administered (by the standards of the National TB Control Programme recommendations). And the supply of milk formula and PVM porridge to children suffering from Protein Energy Malnutrition was irregular. The majority of the clients who came for assistance with applications for social security grants were referred elsewhere (Giese & Hussey 2002: 7, 8).

At the time, however, the study ended on a hopeful note, outlining the prospect that the roll-out Prevention of Mother to Child Transmission (PMTCT) programmes would allow for the early identification of the HIV-exposed infant. However, shortages and irregular supplies of baby formula and other food rations that are supposed to be distributed through the clinics have continued in many hospitals and clinics around the country.

COMMUNICATION RESOURCES ⁶

In recent years, the departments of Education and Health have issued guides for educators and for the training of home-based caregivers.⁷ The Department of Social Services has developed various resources on home-based care and support, including a training manual on setting up Child Care Forums.⁸ The Department of Justice and Constitutional Development has issued a brochure on children's rights.⁹ Lawyers for Human Rights have issued a booklet on policy and legal frameworks for assistance to children in child-headed households.¹⁰

The Save the Children campaign has compiled a directory of organisations providing services for infected and affected children, and a handbook for training service providers on children's rights.¹¹ People providing care to orphaned children will find information on applying for grants, and contact and resource lists in Noreen Ramsden's handbook, entitled *Community help for children living in an HIV+ world*.¹²

Soul City has produced a range of materials on children and HIV/AIDS, including basic information on HIV/AIDS and living positively with HIV, and life skills materials for children, parents, and teachers.

Limitations of responses to child sexual abuse

The Child Protection Services have identified a number of factors that prevent effective delivery of services to sexually abused children in South Africa. These include inadequate budgets and funding of Child Protection Services; slow implementation of policies and laws such as the new Child Care Act, the Sexual Offences Act, and the establishment of Sexual Offences Courts; Inter-sectoral gaps. Gaps include:

- ❑ *The health sector:* lack of specific training in child sexual abuse treatment, uncooperative and inaccessible district surgeons in some areas, different protocols in different hospitals, inadequate facilities in state hospitals
- ❑ *Police Services and Child Protection Units:* lack of specific training to work with children and sexual abuse survivors, lack of CPUs (especially in the rural areas), lack of resources, no arrest of perpetrators (resulting in children forced to remain in the vicinity of perpetrators), and inadequate collection of forensic evidence, resulting in unsuccessful prosecutions
- ❑ *The Justice Department:* long delays in court procedures (resulting in a period of two to three years before hearing of child's testimony), child-unfriendly courts, secondary abuse of children, ongoing harassment of the child by perpetrators, insensitivity of court magistrates or prosecutors, lack of legal representation for children
- ❑ *The educational system:* limited life skills training on child sexual abuse in many schools (CPU 2001).

Other limitations identified in this review include:

- ❑ *Few services in rural areas:* In rural areas, 'child friendly' services, or services specifically geared to survivors of gender-based violence, are rare. In these areas, stakeholders (police, courts, etc.) tend to be less informed about children's particular needs after being sexually abused. There may or may

not be a CPU that serves the area. For example, the Nelspruit CPU must attend to cases from Masisukumeni, which involves travelling long distances. As a result, the CPU is only called out for particularly difficult and severe cases of child abuse, for example, in a case where a child is raped and dies. In rural areas, it is difficult to place a child outside of the home in an anonymous place of safety because of the lack of confidentiality within close-knit communities.

- ❑ *Lack of co-operation between roleplayers:* Three years after the establishment of the Family Violence, Child Protection and Sexual Offences Unit (FCS), spokespersons from the Department of Safety and Security lament the lack of co-ordination between the Departments of Social Services and Justice at the level of police stations, a situation which hampers the delivery of services to survivors of sexual violence. The response from the national Department of Social Development (Lubisi 2003: 2) indicated that the lack of co-ordination extends also to the relationship between national and provincial government departments.

There are as yet few one-stop crisis centres that can offer all of the required medical, psychological, and legal services.

Organisations – for example, Masisukumeni and GRIP – pointed to a lack of co-operation between state health and social service and NGOs. Such co-operation could allow for a more holistic approach to children who have been sexually abused. Most organisations noted that the high caseloads of social workers limit their ability to address the needs of children and to follow up cases.

Some organisations have made direct efforts to improve relations between stakeholders. One example is the participation of local teachers, and the Departments of Education and Health, in Masisukumeni's Steering Committee. This has ensured regular interaction at the monthly meeting. Masisukumeni has also involved traditional chiefs and tribal councils in education programmes and consultation. Involving all community leaders and stakeholders is particularly important in this area of Mpumalanga where domestic violence is commonplace and where most violence is reported only to the chief.

- ❑ *Resources for HIV-positive children:* There is as yet very little information on the specific psychosocial and health requirements of children who face multiple stresses of poverty, potential abuse, and the impact of HIV. Initiatives for support groups generating emotional support, discussion of concerns and sharing information, educational activities, mutual support, income generating projects, community advocacy and activism should be encouraged and supported.
- ❑ *Lack of monitoring and evaluation of PEP for children:* There is very little information on PEP for children after rape, and even less on PEP treatment effectiveness in cases involving children.
- ❑ *Fragmentation of services between organisations:* Most organisations deal with rape of women, or with rape of children, or with people diagnosed and living with HIV, but only very few integrated strategies and interventions have been developed.
- ❑ *Lack of one-stop centres for children:* There are as yet only a few hospitals and clinics that have established one-stop rape crisis centres. NGOs, such as Masisukumeni, aim at providing integrated and comprehensive services.

They accompany the child through every step of the required procedures.

- ❑ *Volunteers:* The high number of volunteers in crisis centres may be problematic for the continuity of these programmes. Most of the people who volunteer for this work are seeking education and job experience that will lead to permanent employment. This contributes to the high turnover and high demand for training new staff. For example, about 30 people replied to an advertisement offering training to become volunteer diffusers for GRIP. About 15 attended the first day of a four-day training, but after two or three practical sessions in the Care Room, only four completed the course.

RECOMMENDATIONS

In the South African context, tolerance of gender-based violence against children at home, in schools and in the community not only compromises a safe environment for all children, it discourages them from seeking help and perpetuates the violence.

While acknowledging that there are limitations to what can be done due to financial, human resources and other restraints, a number of recommendations have been identified through this review. These include:

Education and training

There is a broad consensus that education and services are vital for addressing sexual abuse of children and young people. Family Health International (FHI) lists five recommendations based on its efforts in this field:

- ☐ preventing sexual abuse through training skills for refusing sex, improving communication and resolving conflict
- ☐ raising awareness
- ☐ advocating legal sanctions
- ☐ training health providers, teachers and peer educators to screen young people for signs of sexual abuse and including questions about abuse in health assessments
- ☐ supporting abuse survivors by creating a protocol for responding to clients who have been sexually abused, and developing a referral system (FHI website).

Lifeskills education for learners

The World Health Organisation (2002) has identified programmes that emphasise lifeskills and social competency, and that provide treatment for post-traumatic stress disorders and behavioural therapy designed to reduce suicidal behaviour, as promising approaches for addressing interpersonal violence.

Resources for parents and caregivers

The creation of an environment that enhances the ability of families to protect their children from violence is crucial. This may be assisted by the provision of information and resources for parents, caregivers, and teachers on raising and educating children more effectively and safely in the context of HIV/AIDS.

The fact that the child may not disclose or report the abuse him/herself highlights the need for awareness and preventive action on the part of those who see the child on a regular basis, including parents, teachers and other caregivers.

The reaction of an adult to disclosure of sexual abuse may affect the consequences of the abuse. A parent who experiences stress, or shows panic-stricken responses after finding out about the abuse of his/her child, will have reduced capacity to support the child. Some parents, when confronted with a child's disclosure, initially respond by blaming the child. It is important to provide support in the

form of information and counselling to help the parent cope with the situation, and thereby also the child.

Parenting and family therapies have been found to have positive, long-term effects for the parents and children concerned, and for households as a whole (WHO 2002).

Encouraging community agency and involvement

Beyond the family, the community is the next safety net for vulnerable children and households. It is important to establish a sense of responsibility for addressing child sexual abuse at the level of local interest groups and service organisations. Community groups can directly help vulnerable children and identify children who are in vulnerable situations. There is a need to address the general safety of children in communities.

Research in South Africa has indicated that while organisations based in various communities are willing to care for children in need, they lack material capacity, resources and support.

As community care usually means care by women, it may add to the burdens of women who are generally poor and are shouldering increasing care responsibilities within households and neighbourhoods. Resources and support services should be made available to enable women to cope with added responsibilities.

Addressing the vulnerability of orphans

According to the Centre for Actuarial Research, the number of AIDS deaths are expected to peak in about 2010, at about 800 000 deaths per annum. This will leave AIDS orphans (defined here as children under the age of 15 whose mothers have died from AIDS) living with less than optimal nurture and care. The number of orphans is expected to peak at about 1.85 million around 2015 (Johnson & Dorrington 2001). As orphans, a large part of this generation of children will be vulnerable to exploitation and sexual abuse in their immediate social environment. This scenario calls for interventions in the form of legal protection, for the provision of health, educational, and other social services, and for the provision of social grants to safeguard livelihoods, family cohesion, and care for vulnerable children.

Communication materials

There are a number of communication resources that have been developed with a focus on child sexual abuse. These have been developed mainly at the provincial or local level through a government department (for example, the publication *Busi goes to court*, which was developed by the Department of Justice) or non-governmental organisation (for example, *Kool Kids*, distributed by the Teddy Bear Clinic). Some resources are printed in relatively large quantities, while others are photocopied and distributed in a specific service area. Only a few of them address the interface between child sexual abuse and HIV/AIDS.

This review has identified a number of gaps in information for specific target groups. Specific information for each target group is outlined below:

Parents

- ❑ Parents require information on immediate post-abuse care for their children. This should include information on procedures and rights concerning HIV-testing, the provision of PEP and other medications for the prevention of pregnancy and STIs. It is important for parents to be fully informed about the conditions of PEP treatment effectiveness, and about the necessity for follow-up visits for further HIV-testing and counselling.
- ❑ Parents whose children test HIV positive need information on nutrition, support, opportunistic infections, and disclosure to the child. They require further information on health services and other service organisations.
- ❑ Most parents do not understand their rights with regard to police procedures. For example, if a child has been sexually abused, the parent/survivor has the right to receive a copy of his/her statement, to receive priority treatment at the police station, and to use a separate room to give his/her statement in privacy.

Children

- ❑ Lifeskills education should include an emphasis on child rights, rather than an emphasis only on the prevention of sexual abuse. Information on prevention should help children to protect themselves from high-risk situations.

School environments

As teachers see a child on a daily basis, they are likely to notice changes in the appearance, behaviour, interaction, and academic performance of learners; they should address these with the child concerned and with the caregivers (if the latter are co-operative and supportive).

Teachers themselves should be educated on the consequences of child sexual abuse and should be held accountable for the way in which they structure their interactions with students. Teachers should create an enabling environment to discuss issues of sexuality, responsibility, abuse, and other forms of gender-based violence. Equally, there is a need to ensure that children are not vulnerable to sexual abuse in the school environment.

- ❑ The toll-free Childline number should be displayed in places of high visibility at schools.
- ❑ Each school could construct a list of people, organisations, and materials on child abuse for use by both teachers and learners.
- ❑ Setting up a 'buddy system' among learners could enhance networks of mutual support. Learners should be taught to recognise situations for which the help and counsel of an adult should be sought.

Police

Communication resources should be considered in relation to sensitivity training on child sexual abuse-related trauma, its symptoms and effects; on supporting and protecting traumatised children through the police investigations; on collecting and handling evidence to be used in court; and on the importance of curbing child sexual abuse through effective police work.

Medical personnel

Doctors and nurses may feel inadequately prepared to perform an examination on a sexually abused child and communication resources would usefully supplement their ability to render appropriate care.

Endnotes

- 1 This does not automatically make institutional care provision a desired alternative. Institutional responses are often unsustainable and may be viewed as inappropriate by community members who recognise their potential to undermine existing coping mechanisms. Those planning interventions must understand existing norms and practices and seek to strengthen family and community capacities to protect and care for vulnerable children (Foster & Williamson 2000: 278).
- 2 Interview with Reena Meeni, a social worker at Barberton Hospital, Mpumalanga, 2003.
- 3 GRIP, 2003.
- 4 Signatories to this submission are the following organisations: Alliance for Children's Entitlement to Social Security (ACCESS), Children's Institute (UCT), Black Sash, Gender Advocacy Programme, Socio-Economic Rights Project, Community Law Centre (UWC), Congress of South African Trade Unions (COSATU), National Education Health and Allied Workers Union (NEHAWU), National Association of Democratic Lawyers (NADEL), Treatment Action Campaign (TAC), Rapcan, Southern African Catholic Bishops' Conference, South African Council of Churches, and Women's Legal Centre.
- 5 The means test does not take account of the number of people living off one income, or the extra vulnerabilities faced by a family, such as HIV/AIDS. Moreover, the means test threshold has not increased since 1998, despite increases in inflation and the cost of living (Joint Submission 2003).
- 6 Information in this section is drawn largely from Smart 2003b: 31-33.
- 7 Department of Health (2001) HIV/AIDS: Care and support of affected and infected learners; Department of Health (2001) Curriculum for the training of community-based home caregivers; Department of Health (2001) Learner handbook for the training of home/community-based caregivers; Department of Education The HIV/AIDS Emergency – Guidelines for Educators.
- 8 Department of Social Development (2003) Training Manual – Child Care Forums.
- 9 Department of Justice and Constitutional Development (n.d.) These are your rights.
- 10 Lawyers for Human Rights (2003) Legal and policy framework: children growing up in child-headed households.
- 11 Save the Children: The rights of children and youth infected and affected by HIV/AIDS.
- 12 This handbook is available from the Children's Rights Centre – Tel. 031 307 6075; e-mail: childrts@mweb.org.za.

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