RESEARCH ASSIGNMENT

PROJECT TITLE

Child Abuse: Patterns of Physical and Sexual Child Abuse presenting at Karl Bremer Hospital and the knowledge and perceptions of the Ravensmead Community on child abuse.

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Declaration

I, Dr. Lynne Wicomb, hereby declare that this dissertation is my own idea and the result of my own original research; that it has not been submitted for any degree or examination at any other University, and that all the sources I have used or quoted, have been indicated and acknowledged with complete references.

Dr Lynne Wicomb

Abstract

Background

Child abuse is a serious and devastating problem rooted within our communities. According to the South African Police Services (SAPS) crime statistics of 2006 & 2007, the four most common crimes committed (and attempted) against children were rape, common assault, and assault with attempt to do grievous bodily harm. Because this problem has it's roots within our homes and communities it must be unpacked from a community level.

Aim and objectives:

This study aims to describe the patterns of child abuse in the Northern Suburbs of Cape Town and to gain insight into the knowledge and perceptions of the Ravensmead Community regarding child physical and sexual abuse.

Methods

This was done by exploring the knowledge and perceptions of the Ravensmead community on various aspects of child physical and sexual abuse including perceptions of victim and perpetrator profiles, responses to victims of child physical and sexual abuse, their knowledge of and access to avenues of help. The study also describes the patterns of child abuse in the Northern Suburbs of Cape Town as documented in the case record reviews of children presenting to the Karl Bremer Hospital at the Rape crises Centre.

In order to explore the knowledge of the Ravensmead community of child physical and sexual abuse, the researcher designed a structured questionnaire and conducted a door-to-door survey. A total of 279 respondents were obtained. Specific areas of enquiry included knowledge of definitions, perceptions of perpetrators, perceptions of predisposing circumstances and perception of avenues for help and where education programs should be aimed.

Patterns of Child physical and sexual abuse presenting at the Rape Crises Centre at Karl Bremer Hospital was determined by conducting a case record review. Information regarding victim and perpetrator profiles, injuries sustained and home circumstance as documented in these case records was described. An in-depth interview conducted at the Rape Crises centre with parents of child victims of physical and sexual abuse provided qualitative information relating to patterns and perceptions of child physical and sexual abuse. Data from these three methods was then triangulated.

Study design

The researcher has chosen to do a descriptive study using methodological triangulation. The aim of the research is to describe the patterns of child abuse (physical and sexual) and to gain further insight into the perceptions and knowledge of the Ravensmead Community regarding child sexual and physical abuse. This was undertaken using a descriptive study design. A combination of qualitative and quantitative methods was used to enhance the overall validity of the results.

Setting

Ravensmead is an impoverished community in the Northern Suburbs of the Western Cape. The high rate of crimes committed against children in this community is a reflection of the situation in the rest of the country. The Karl Bremer hospital Rape Crisis Center is the centre to which all cases of child sexual abuse and child physical abuse occurring in the northern suburbs of Cape Town presents. Staff is trained in offering the necessary medical, medico legal and psychological support to victims abuse.

Results

Only 15% of respondents to the questionnaire survey demonstrated a comprehensive understanding of what constitutes child abuse. Although respondents demonstrated understanding of some characteristics relating to victim and perpetrator profiles they failed to recognize certain circumstances that predisposes to child abuse. The In-depth interviews also found that most families of victims of child sexual abuse did suspect that the abuse could occur under the circumstance, which it did. The perception that children are sometimes to blame for the abuse is still held by some members of the community although they are in the minority. Few respondents were able to identify avenues for help other than the police station. However, the in-depth interviews demonstrates that several fears exist regarding reporting abuse to the police, reducing the practical accessibility of this service. The mean age of victims presenting to the Karl Bremer Hospital Rape Crises centre was 6.18yrs and 36% of cases presented was during the period from November to January. Absence of visible injuries could not exclude the diagnosis of sexual or physical abuse. Information relating to home circumstances and perpetrator profiles was lacking.

Conclusion

The research suggests that knowledge regarding child physical and sexual abuse in the Ravensmead community is lacking. Barriers exist to accessing avenues for help within the community. Greater community empowerment is required in order to effectively combat the problem of child physical and sexual abuse.

Project Title

Child Abuse: Patterns of Physical and Sexual Child Abuse presenting at Karl Bremer Hospital and the knowledge and perceptions of the Ravensmead Community on child abuse.

Research Question:

- What are the patterns of child physical and sexual abuse presenting over a one year period to the Rape Crises Center at Karl Bremer hospital?
- What is the knowledge and perceptions of the Ravensmead community on child physical and sexual abuse?

Introduction, Background and motivation

Child Abuse is an extremely broad topic and takes several forms. Child sexual, physical and psychological abuse is seen to be the most common forms of abuse. However neglect and other forms of non-physical maltreatment also constitute child abuse.

According to the South African Police Services (SAPS) crime statistics of 2006 & 2007, the four most common crimes committed (and attempted) against children were rape, common assault, and assault with attempt to do grievous bodily harm. A total of 44.4% of all reported incidents of rape and 52% of reported incidents of indecent assault were against children. SAPS believe that only about a third of rape cases are currently reported.

The Bill of Rights in the South African constitution considers the best interest of children to be of paramount importance. The Criminal Law (Sexual Offences and related matters) Amended Act No 32 of 2007, aims to intensify South Africa's efforts to fight sexual offences committed against vulnerable groups. It outlines the creation of statutory sexual offences to criminalize all forms of sexual abuse and incorporates special protection measures for children and persons who are mentally disabled.

Several studies have examined patterns of child abuse and perpetrator profiles with some consistency of results. Such research is important in identifying circumstances that predisposes to child abuse and in targeting prevention programmes. Little research has been conducted regarding

community perceptions and knowledge of child abuse. The research that has been undertaken illustrates a wide variation in knowledge and perceptions in different communities. Thus understanding the perceptions and knowledge of a particular community is important in educating and empowering that community to prevent child abuse.

Literature Review

The most commonly reported and studied forms of abuse are child sexual and physical abuse. P. Lachman[1] highlights his findings that in the early 90's more than half of all reported cases of child abuse were for child sexual abuse. He offers possible explanations for these high percentages of reported child sexual abuse cases as either being due to underreporting of physical abuse, due to acceptance of violence against children as being the norm or the actual higher prevalence of child sexual abuse. A clinic based retrospective study by P. Howard et al.[2], conducted in Alexandra over a three year period included 140 cases of child abuse and found that 81.5% were child sexual abuse, 9.3% physical abuse, 7.2% neglect and 2.1 % combined forms of abuse.

L. Pierce et al.[3] explored and compared the view points of lay persons and those working with victims of child abuse on 17 categories of child abuse found that all respondents ranked child sexual abuse as most serious. However physical abuse was ranked as the eleventh most severe category of child abuse reflecting that several forms of physical abuse may be acceptable to many South Africans, even those working with child abuse. This study was however limited in that questionnaires were used to collect data, only 181 respondents returned their questionnaires and the sample population was not random but was drawn from middle and upper class South Africans only. Although there seems to be a general acceptance of child physical abuse it remains a serious form of abuse, which has dire physical, emotional and behavioral consequences for its victims.

The true prevalence of child abuse in the Western Cape is still difficult to determine. Underreporting of incidents of child abuse remains a challenge in South Africa (and other countries) despite legal requirements for reporting of child abuse in terms of the Child Care Act. Efforts have also been made by several role players in the Western Cape, including the Child Health unit of the University of Cape Town and the regional office of the Department of National health and Population Development, to improve the reporting of child abuse in the Western Cape, according to P. Lachman et al.[4]. Although data on prevalence is scanty most authors are in agreement that most forms of child abuse are grossly underreported. A literature review by K.Lalor [5] exploring a non-clinical sample mainly of university students in Sub-Saharan Africa found a high prevalence of child sexual abuse across the board, but found it difficult to draw solid conclusions due to different definitions and severity of child sexual abuse in different sample populations.

Ravensmead is a community of low socio-economic status in the Western Cape. It has a population

of approximately 35 800 people of which 35% are children under the age of 18 years. During the 2004/2005 period, 66 cases of rape,48 cases of indecent assault, 37 cases of neglect and ill-treatment of children and 9 cases of kidnapping and abduction were reported to the Ravensmead Police Station. According to the SAPS 2006/2007 annual report[6] more than 16 068 cases of child rape, 3 517 cases of indecent assault, 19 687 cases of assault to do grievous bodily harm and 21 736 cases of common assault were reported during this period This however is probably not a true reflection of the scale of the problem as several cases of abuse and neglect remain unreported, this according to the report of incidence of the South African Police Services[6].

Various studies conducted in South Africa and the Western Cape has looked at patterns of child abuse including predisposing factors, profile of perpetrators and patterns of injury. All of these are hospital based retrospective studies based on clinical case notes.

A study conducted by S. Andronikou et al.[7] at Red Cross War Memorial Children's Hospital (RXH) in Cape Town looked at incidents of violence against children under the age of 13 years from January 1996- April 1999. They found the mean age of victims to be 6 years and 9 months. A total of 56% of victims of violence were male while 90% of victims of violent sexual assault were female. In 11% of cases the perpetrator's identity was known to the victim and 46% of violent acts occurred inside and around the victim's home. The study also found that abuse takes place in homes in which violence occurs. Another study conducted at the same hospital, conducted by A. Fieggen et al[8], looked at Non accidental head Injuries sustained over a three year period from 1998-2001. Seventy assaults were recorded. In 53% the children were the intended targets. The remaining 47% were "caught in the crossfire" and sustained so-called "shield injuries'. In the 70 assaults 81% of perpetrators were male usually the child's father (44%) or another family member (20%). In 85% of cases the assault occurred in the child's home. In those sustaining shield injuries the perpetrator was male in all cases and in 85% of cases the intended victim was female, usually the child's mother. Lachman[1], in his study conducted in Cape Town in the early 90's also found that males were more prone to physical abuse and that violent assaults were usually intra-familial. The Alexandra[2] study found the peak age of victims of violence to be 6-8years, the incidence of male to female victims to be almost equal and the perpetrator to be the child's father in 5/13 (38%) of cases. The perpetrators were relatives of the child in 5 remaining cases and a neighbour and a teacher in one each. Alcohol played a role in three cases.

A Study on Child Rape conducted by A. van As[9], over a nine year period at RXH included 200 victims of sexual assault. A proportion of 87% of these victims were female, the mean age of

victims was 6.3 years and 3.5% had pre-existing physical and mental disabilities. Injuries sustained ranged from minor requiring minimal intervention to severe requiring laparotomies and other major surgery. The authors note that sexual abuse can never be ruled out by normal findings on physical examination. In 70% of cases the perpetrators were known to the victim. Of these 26% of assailants were neighbours, 18% family friends/acquaintances, 6% the biological father. The assailants were male in 99% of these cases. One assailant was noted to be mentally ill and 2 assailants were previous sexual offenders. A Study conducted in Alexandra[2] found that 96% of sexually abused children were girls. The majority of abused children were under the age of five with the second highest age category being between the ages of 6-8years. The perpetrators were known in 58% of cases. Of these 7% were family members, 6% were neighbours and 35% were known but not linked to the family. The literature review by Lalor 2004[5], reviewed six clinical studies of child sexual abuse in Sub-Saharan Africa. These demonstrated that the majority of victims of child sexual abuse were below the age of 8 years, more than 80-95% of the victims of such abuse were female and in more than 50% of cases of sexual abuse the perpetrator was known to the victim. The largest category of perpetrator in most studies was neighbours followed by fathers.

P.D. Carey[18] in 2008 explored risk indicators and psychopathology in traumatized children with a background of sexual abuse and found female gender ($P = 0.002$) to be a predictor for child sexual abuse.

Although Child abuse is a clear problem in South Africa, no published studies were found which evaluated preventative measures in our setting. Studies evaluating public perceptions and understanding of child abuse are also limited and with the exception of the L.Pierce et al[3] study exploring definitions of abuse. Only studies which were conducted in other parts of the world were found, such as studies by R. Rubin et al.[16] and B. Thomlison[10].

B. Thomlison[10] evaluated nine studies of child maltreatment interventions in order to determine what characteristics of child maltreatment programmes lead to improved practice outcomes for maltreated children. All interventions were community based and took place either in the home, pre-school, head start classrooms or neighbourhood and targeted the child, adolescent, parent-child interaction or parent and family. The programmes served families with very young physically abused and neglected children, parents who used coercive parenting strategies and young or first time parents who were at risk of parenting stress. Each study evaluated a specific intervention and measured reduction in child maltreatment and in problem behaviours in maltreated children and their parents. The results showed that families benefit most from interventions targeting specific behaviours (antecedent) and consequences of maltreatment. The strongest evidence-base that supports positive outcomes emerge from home-based services targeted at “at risk” families in early

childhood. Approaches use parent management skills and training, cognitive behavioural strategies to improve parenting practices; and techniques for improving parent child interactional and relational skills. A meta-analysis conducted by J. MacLoed et al.[11] reviewed 56 studies of programs aimed at preventing child maltreatment and found that those interventions which were home-based, early in childhood, of longer duration than six months, consisting of greater than 12 visits and those using an empowerment approach, achieved higher effect sizes than those without these features. These studies are limited due to a paucity of studies; the fact that very few looked at long-term outcomes of interventions although all evaluated post-intervention or follow–up effect sizes; and in that research intervention programmes are difficult to put into practice in real world settings. The results of these studies do however suggest that intervention programmes aimed at reducing or preventing child maltreatment should be population specific, targeting at risk families, early in childhood, using home/community based programmes which are evidence-based, pro-active and empowering.

A study conducted by J. Jacobs et al.[12] evaluating children's perceptions of the risk of sexual abuse points out that improved knowledge and perceptions may not necessarily improve behavior or reactions to potentially abusive situations. It also points out that interventions must not cause more harm (for example in this case; excessive fear) than good and thus must seek to be evidence-based and target-group specific.

Although changing a community's perception and knowledge of child abuse may not necessarily change community's actions it is an important starting point in deciding which prevention programs would best suite a particular community. Enhancing a community' knowledge of child abuse, to whom known or suspected cases of child abuse should be reported and of primary and secondary prevention strategies that have proven to be effective is in itself empowering and may also serve to gage and improve the community's acceptance of a proposed intervention.

Exploring the community's perspective and knowledge of child abuse will also serve to increase our understanding of why abuse rates are so high and what factors contribute to underreporting in a particular community. Few studies have been conducted on communities' perspectives of child abuse and neglect. Most of these have been conducted in Western civilizations. A study conducted by L. Pierce et al.[3] in Cape Town, looked at public perceptions on definitions of abuse and a study conducted in Botswana and Swaziland explored the perceptions and knowledge of parents regarding child sexual abuse[14].

Other studies that are included in this literature review are three studies conducted in the USA on community perspectives and knowledge of child abuse and maltreatment [11, 14,] and one focusing on a Community's perceived barriers to responding to child maltreatment[15].

In general the respondents in the above mentioned studies [3, 13, 14; 15] were knowledgeable about definitions of abuse and behaviours which are considered abusive. Acts of physical abuse were generally seen as less severe than child sexual abuse and acts of neglect. For example acts of physical abuse such as slapping or hitting a child as a form of punishment for unruly behaviour was more often perceived as not being abusive. The South African study[3] also explored perceptions on child labor and social abuse and found that these were seen as less serious than child sexual abuse and neglect. However the only study[17] where vignettes of abusive situations were not used to prompt responses sexual abuse was only mentioned by 12% of respondents as a form of child abuse. This could be due to respondents seeing sexual abuse as a separate entity to other forms of abuse.

The studies explored opinions on factors predisposing to abuse. One study[15] explored child characteristics predisposing to abuse. Most respondents in this study thought that child characteristics did not play a role. Men were more likely to correctly describe predisposing factors in children as being female sex (sexual abuse), low intelligence, child temperament and poverty. In the study conducted in Botswana and Swaziland[14] some respondents thought that children could predispose themselves to abuse by manner of dressing and behaving in sexually mature ways. This however was a small minority of respondents in a very small study.

Perceived characteristics of perpetrators of abuse were also explored. Most respondents in all studies believed that alcohol abuse was a significant predisposing factor. Many respondents believed that poverty played a role. Few respondents believed that individual factors such as abuse as a child, low moral values and family structure predisposed to abusive behaviour. Socio-economic status, gender and ethnicity of respondents generated different perceptions on predisposing factors.

Communities' knowledge on likely perpetrator profile was also explored. Most respondents thought than men were more likely perpetrators. Most respondents thought the perpetrators would most likely be known by the victim but a few respondents still believed that strangers were the more likely perpetrators of abuse. A study on children's perceptions of abusive situations[12] found that they associated danger with strangers rather than neighbours or family members.

Studies also explored community responses to known or hypothetical cases of abuse in order to establish whether action would be taken, what action would be taken and who would be informed. The majority of respondents indicated that they have or would report cases of abuse but 20-30% of respondents indicated that they would not. A study exploring perceived barriers to responding to child abuse found the largest barriers to be; fear of retaliation by parents, fear of making the situation worse and not wanting to interfere[16]. The same study found that the most likely responses would be reporting the abuse to Child Protection Services, talking to the child's parents or reporting the abuse to the police or other law enforcement. In a study on community perceptions conducted in Klamath Falls (USA) [13] most respondents indicated that they would report cases of child abuse to their physician, then police and then child protection services. It is important that community members are properly informed as to who is best equipped to deal with cases of abuse.

Communities' perceptions on child abuse prevention were also explored. A study in the USA[16] found that most respondents believed that abuse could be prevented. Services believed to be most helpful, however, were those for which there is no evidence base. Home visitation to new parents was perceived as least helpful although research has shown success of this intervention. The study referred to earlier in Klamath Falls[13] explored community opinion on personal safety training (teaching children guidelines on interacting with others, acceptable and unacceptable touching and safety precautions). Most respondents thought that personal safety training should start after the age of 5years, 62% were of the opinion that only adults should be targeted (who would in turn teach their children), 53% believed such training should be school-based and few favoured in-home instruction.

These studies on community perceptions and knowledge thus support the need to inform and educate community's specific to their knowledge deficits and misconceptions. This is the first step to community empowerment and sets the basis on which to implement community focused prevention programmes.

Aim and Objectives

Aim

To describe the patterns of child abuse in the Northern Suburbs of Cape Town and to gain insight into the knowledge and perceptions of the Ravensmead Community regarding child physical and sexual abuse.

Objectives

1. To determine the knowledge and perceptions of the Ravensmead Community on what child sexual and physical abuse constitutes.

2. To describe the patterns of child abuse in the Northern suburbs of Cape Town as documented in the case records of children presenting to Karl Bremer Hospital (Rape Crises Centre).

3. To obtain deeper understanding of the perspectives of the Ravensmead Community on the profile of perpetrators, factors predisposing to child abuse, patterns of abuse in the area and where educational and prevention campaigns should be aimed.

4. To determine what their responses to a victim of child abuse would be.

5. To determine their knowledge of avenues of help and places of safety for children who are abused.

6. To explore their access to avenues of help and places of safety.

Methods

The researcher has chosen to do a descriptive study using methodological triangulation. The aim of the research is to describe the patterns of child abuse (physical and sexual) and to gain further insight into the perceptions and knowledge of the Ravensmead Community regarding child sexual and physical abuse. This was undertaken using a descriptive study design. A combination of qualitative and quantitative methods was used to enhance the overall validity of the results.

Quantitative Method – Questionnaire Survey of members of the Ravensmead Community

This component of the research had a descriptive study design. The study population consists of adult members of the Ravensmead community, an impoverished community in the Northern suburbs of Cape Town. Cases of child sexual and physical abuse occurring in this community are also expected to present to the Rape Crisis Center at Karl Bremer Hospital.

All Ravensmead community members over the age of 18 were eligible for inclusion into the sample. Community members under the age of 18 were excluded from the research because the perceptions and knowledge of adult members of the community was sought in relation to issues of child physical and sexual abuse.

The door-to-door survey was firstly piloted on a single street in Ravensmead. A Structured questionnaire was compiled. Combinations of open-ended and closed questions were used. Closed and open questions were used to assess the same parameters in order to improve the reliability and quality of information gained from the questions. Vignettes were used for closed questions to assist ease of answering. (See Appendix 2). The questionnaire sought to capture the perceptions and knowledge of the community regarding child sexual and physical abuse based on their definitions, victim profiles, perpetrator profiles, avenues for help and education regarding the subject.

The final door-to-door survey was then conducted. A research team consisting of six volunteers with an interest in the subject was constructed. Each member of the team received appropriate training regarding the objectives of the study, the actual questionnaire and interviewing techniques. Researchers approached the houses in teams of two. Informed consent was obtained from every participant and questionnaires were completed in the presence of the researcher. It required

researchers to approach respondents at their homes requesting a few minutes of their time to complete a questionnaire survey (Interviewer-administered). Informed consent was obtained. A written explanation of the study aims, basic methodology and selection criteria was handed to participants to read and sign in the presence of the researcher. Questions were answered by the researcher presenting the questionnaire to the participant. Subjects approached were reminded that participation is voluntary.

The sample was randomly selected based on geographical location. An alphabetical index of all street names in Ravensmead was created. Streets to be targeted were then randomly selected from this list. Every third house on each street was approached to answer an interviewer-administered questionnaire. Three hundred and twenty houses were targeted on 30 streets in Ravensmead. In so doing a sample size of 279 respondents was obtained.

The survey was conducted primarily on weekends with a few being conducted after 16H00 on weekdays. No one was excluded on the basis of language or illiteracy as the presence of field workers fluent in both English and Afrikaans ensured that all respondents even those who were unable to write were able to partake in the study. Consent forms and questionnaires were also available in both English and Afrikaans. Although an interpreter capable of speaking Xhosa was approached to assist as needed, this service was not required. In this way adult members in the community under study was targeted and a representative sample was obtained.

The data obtained from the survey was coded and captured onto excel. Information was then analyzed. Evolving themes will be described and analyzed. Data obtained from the questionnaire surveys will be compared with that obtained from the other sections of the research.

Quantitative Method – Data collection from case records of victims

The first section of the research is quantitative and aims to describe patterns of child physical and sexual abuse. It is a retrospective descriptive study. All victims of child physical and sexual abuse who presented to Karl Bremer Hospital over a one year period (1 January 2009 – 31 December 2009) were eligible for inclusion in the study. A child, for the purposes of this study is defined as any person under the age of 13 years.

Only cases presenting to the Rape Crises Centre at Karl Bremer hospital were included. Cases of

both child physical and child sexual abuse present to this hospital.

Informed consent was firstly obtained from the superintendent of Karl Bremer Hospital to conduct the research at the Rape Crisis Centre. The clinical manager and other clinical and reception staff were also informed of the intended research and their co-operation appealed for.

The names and folder numbers of all cases presenting to the Rape Crisis Centre are recorded in a reception book. A log was compiled of all child cases of physical and sexual abuse presenting over the period January 2009- December 2009. A total of 582 cases of child sexual and physical abuse presented over this period. From these a sample of 291 cases presenting were systematically selected for inclusion in the study. Every second case logged was selected. Case records were then retrieved from the hospital records department. Of the requested case records, 41 were not obtainable and were thus excluded from the research, leaving a sample size of 250 case records. Data collection sheets were designed allowing for easy recording of relevant information from case records. Information regarding the profiles of victims and perpetrators, where known, and injuries sustained as documented in these case records, was recorded. The researcher also recorded information relating to referral and follow up of child victims of sexual and physical assault. Anonymity and confidentiality was maintained throughout the study as use was made of study codes and no identifiable information was recorded on data collection sheets.

Five case records were obtained in order to pilot the feasibility of this method of accessing case records and to determine whether adequate information is obtainable from these case notes. Records that were unobtainable were checked against those obtained regarding age, gender and month of presentation to ensure that there was no identifiable bias due to these cases being left out of the study.

Data was captured on computer using excel. Statistical analysis testing was conducted with the help of a statistician attached to research and faculty of health sciences, University of Stellenbosch.

Qualitative Method – In depth Interviews of families/ caretakers of victims of abuse

The qualitative research consists of in – depth interviews, which were conducted with family members or guardians of child victims of sexual and physical abuse presenting to the rape crises

centre at Karl Bremer Hospital. The assistance of the clinical and clerical staff of the Rape Crisis Centre was appealed for. They were requested to contact the researcher on presentation of cases meeting the inclusion criteria of the study. All child victims who were under the age of 13yrs and who were accompanied by their parents or legal guardians presenting to the rape crises centre during the period of study were eligible for inclusion. In-depth interviews were conducted over a two month period and ceased once an adequate sample size of 10 interviews was obtained and qualitative information gained from the interviews reached saturation. A semi-structured questionnaire was designed to ensure that issues relating to home environment, circumstances surrounding the actual abuse, reactions and feelings to the abuse, reporting and further help received were adequately explored.

The semi-structured questionnaire was piloted by a single interview conducted with the parent of a child victim of sexual abuse presenting to the rape crisis center prior to commencement of the research. Informed consent to conduct and record the interview was obtained from the parent/legal guardian of the child, at the time of presentation. The interview was conducted in the preferred language of the person being interviewed. Interviews were conducted in a private room at the KBH Rape Crisis Centre at the time of presentation or at an arranged follow-up appointment as close as possible to the time of presentation at the hospital.

Interviews, once conducted were transcribed word-for-word from the dicta phone recording to a computer text document. The qualitative interviews (n=10) were analyzed using the framework thematic analysis. The coding was done independently using the four stages of: Familiarization; Indexing; Grouping data and Development of themes. Common themes emerging from each interview relating to each of the parameters explored were identified. These themes were then triangulated with data from the interviews and questionnaires.

“He took away my innocence ...I want to see him in jail” Thus echoes in my mind the words of an 11year old girl, the victim of a sexual assault by the hands of her grandfather. Stripped of her innocence by someone most trusted and most dear to her. Stripped of the trust, stripped of the love built up over years... in an instant,.. or in this case a series of instants- Replaced by hatred.

Screams of fear and pain fill the emergency room at the community health centre, as I pull up the sweater of a 4 year old boy to expose his chest for a routine examination. He had been playfully engaging with me until that moment. I was shocked at what I saw. Multiple wounds inflicted by the

cigarette buds of his most trusted care givers, his parents. Injured, time and time again by the ones he trusted the most.

This the tragedy shared by so many other child victims of sexual and physical abuse. Tragedy occurring every day within our society, within the communities in which we work the communities from which we were birthed. And what is being done to stop it?

It should not be difficult to imagine that anyone involved in caring for people be moved by scenes such as those described above. How much more motivation do we need than the cries of our children to elicit a knee jerk reaction and to get up and do something. Or at least to try and unpack the reasons why tragedies such as these is so prevalent in our society and why the trend is ever increasing.

Reflexivity

Perhaps the reason for being so disturbed by the tragedy of being hurt by those you love the most is because it is an idea so foreign to me. I was raised in a loving and caring home by both my parents. No sacrifice seemed too great for them to ensure the well being and happiness of their four children. Although raised in this secure environment it did not make me blind to the sufferings or hardships experienced by others around me. Being a Christian called to care for all God's creations, as we all are, I always felt drawn to those in a seemingly less fortunate position than myself, those in need of friendship and support, those even more silent than myself (being a quiet person by nature), silenced by their circumstances or their position in society.

As a young adult my greatest concern was for the children, innocent and still rich with potential to rise above their circumstances. Shortly after I matriculated I enrolled as a Sunday school teacher, playing a small role in providing a safe, caring environment for learning, pleasant childhood memories to reflect on and hopefully little life lessons to draw from, to a few children.

When I graduated from University, becoming a medical doctor, my greatest interest was still in caring for the children in our communities. After my internship I spent two years working at community health centers and then another two years working in pediatric wards at tertiary hospitals, improving my knowledge and skills but missing the interaction with communities and families. It is during the time spent working at Ravensmead CHC that the significance of the problem of child abuse and neglect became so apparent to me.

As a woman, I see myself as a caregiver, nurturer, protector and provider. I see myself as strong. I see women as strong. Perhaps we are strong because we have been raised in a society historically repressive. Perhaps we are strong because of the life lessons learnt through hardship and sufferings. Perhaps we are strong because we have had to be strong for the sake of our children. Strength is what they need to feel loved and secure. Strength is what we need to adequately nurture and protect. Perhaps we are strong because of the men in our lives, our fathers, our brothers and our husbands who have stood up and played their role effectively. Who lovingly provide, loyally protect and consistently care for the women and children in their lives. I have been fortunate in this regard. As a wife and a daughter to caring men. I can testify to the security and strength that has come from the men in my life who provide, protect and care, who have built me up through their strength, love and constant support. To a great degree, I also attribute my strength to my mother, who embodies all that a woman is; caring , nurturing, protective, strong.

The tragedy however occurs when hands that are meant to protect ,inflict pain, when trusted love betrays and manipulates, when the strong use their strength to break down. We break as individuals, and a vicious cycle starts; we break as a community and as a society.

Child abuse is heart wrenching and tragic not only to individuals and families but to communities and society as a whole. Becoming a mother in the last year had probably the most significant impact on my life and my attitude towards children. It is true that one never knows what it means to love a child until one becomes a parent. Never have I felt more love, more joy, more excitement or more fear for the life of another human being. Never before have I been more baffled by how we manage to hurt or stand back and watch as others hurt these most precious members of our society. Never before have had I felt more drawn to remember the plight of the mothers and children in our communities. Thus the motivation to start delving into the depths of the problem of child abuse in our society by starting to scratch the surface.

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This qualitative section of my research project looks at how child abuse actually happens (patterns of abuse) within homes and communities, what the circumstances are under which the abuse occurs, who the victims are, who the perpetrators are , what were the reactions and the fears of the parents and how was help sought. This study uses interviews conducted with the parents of child victims of sexual assault who presented at the Rape Crisis center at Karl Bremer hospital to elicit this information.

Ethical Considerations

The study consists of three methods of collecting data. Each has its own ethical considerations.

Questionnaire Survey

Protecting Interest

The questionnaire survey aims to gain information on the current knowledge and perception of the Ravensmead community on Child Physical and Sexual abuse. The questionnaire survey was conducted within the community in order to gain information and make recommendations on the most effective ways to educate and empower the community and gain information needed regarding accepted and effective preventative strategies. Thus the community being studied is also the community that stands to benefit from the results of the study.
The Rape Crises Centre at Karl Bremer hospital was informed about the study prior to its commencement and guidance obtained on procedure to follow should incidents of abuse be reported as a result of the study. No incidents of child abuse were reported to the research team during the course of the research.

All subjects selected by the process of randomization and meeting inclusion criteria regarding age were eligible for inclusion in the study. No one was omitted due to language barriers or illiteracy. Thus all data collectors were trained to assist illiterate individuals who were randomly selected to understand and answer the questions posed without prompting answers thus creating bias.
All respondents approached were fluent in either English or Afrikaans and questionnaires and consents were provided in their preferred language. The research was **conducted during the day and on weekends so as to include working members of the community in the survey.**

Safety measures for fieldworkers conducting the questionnaire surveys included the following:

- Fieldworkers were only present in the area from 10h00 am till 16h00 pm on weekends and no later than 19h00 on week days.
- Fieldworkers operated in pairs consisting of at least one male fieldworker per pair.
- All fieldworkers operated on the same street.
- Fieldworkers were inducted regarding safe behavioural practices such as: not carrying any valuables with them into the area, dress code, being knowledgeable regarding where the nearest police station is located and having emergency police telephone numbers accessible

on speed dial.

Informed Consent: (Appendix 5 and 6)
Each participant was provided with a covering letter explaining the nature, aims and basic methodology of the research project, which they were allowed to read through and sign. Copies were available in English and Afrikaans. The contents were read and explained to those who could not read. All fieldworkers were knowledgeable about the research project and able to answer questions posed. The consent forms were signed by both the researcher and the participant. Voluntary participation was emphasized.

Confidentiality of personal Information:
No identifying information was recorded on the questionnaires. Each questionnaire was numbered. As participants were approached according to residential address, questionnaire numbers were linked to the addresses and this information kept separately. No names or other identifiable information were recorded on the questionnaire. However, demographic information including age, gender, marital status, parental status and educational status was requested.

Descriptive study of case records of physically and sexually abused children

Protecting Interest

This section of the research simply describes cases of abuse as they presented to Karl Bremer hospital. The researcher thus obtained information regarding the prevalence and patterns of abuse over the period of study. A systematic sample of records of cases presenting over a one-year period was used. This provides a quantitative base upon which to evaluate and compare qualitative results. As no identifying information was recorded the children whose records were used were not harmed by this research. Because they form part of the community, which will benefit from the recommendations made at the end of the research study, they stand to benefit indirectly.

Informed consent

A research code was used to identify records. This code was filed separately from the information obtained from folders. No identifying information was recorded on the data capture sheets. In this manner informed consent was not needed from each individual, as this will be extremely difficult to obtain for this type of retrospective data collection. Consent was obtained from the superintendent

of the Karl Bremer Hospital, to access these files.

Confidentiality of personal information

As described above a research code was used and no identifying information was recorded on the data capture sheets. All identifying information has been filed separately. All records were treated with the strictest of confidence. The researcher collected data in a private room in the hospital records department. Once the relevant data had been collected, all records were returned to the clerk and filed away. No files were left unattended or accessed by any non-medical members of the research team or hospital staff.

In-depth Interview

Protecting Interest

The in-depth interviews were conducted with subjects who were randomly selected as they presented to Karl Bremer Hospital. Information gained from these interviews will be used to make recommendations that will benefit the community at large regarding child physical and sexual abuse. Thus, individuals participating in the interviews may not directly benefit from the research but the community of which they are a part will benefit from the research. No new issues of abuse were identified during the interviews. All participants had already reported the abuse to the SAPS. Participants who had not yet received counseling but were in need of it were referred to the psychologist based at the Rape Crisis Centre via the staff at the center. The researcher conducted interviews in a comfortable and private location at the Hospital. All information obtained from the interview was treated with strict confidentiality; no identifying information was recorded on the dictaphone and has been anonymously reported on in the results of this research.

Informed Consent

All individuals who were selected to be interviewed consented at the time of presentation or at their first follow up appointment. Medical staff at Karl Bremers' Rape Crisis centre were requested to telephonically notify the researcher, when cases meeting the research criteria presented (initial or follow up). A letter of informed consent was presented to each individual to be read through and signed. Consent forms were provided in the preferred language of the person being interviewed. An interpreter was available to assist with interviews but the aid of an interpreter was not necessary as all participants interviewed were fluent in either English or Afrikaans. The researcher conducting the interviews questioned the participants. Voluntary participation was emphasized and assurance provided that their care would in no way be compromised should they choose not to participate. Participants were also informed that the interviews would be recorded for the purposes of research.

Permission to conduct the research was also obtained from the clinical manager of the rape crises centre and the superintendent of Karl Bremer Hospital.

Confidentiality of Personal Information

Interviews were conducted in private and only the researcher was present at the interview. A dictaphone was used to record information. An Interview number/code was linked to each interview and no identifying information was recorded. All identifying information was recorded and filed separately. Confidentiality was strictly adhered to. Disclosure of information was necessary only in one case where the interviewee expressed earnest intent to harm the perpetrator. The interviewee was informed of the researcher's obligation to disclose this information. The nursing sister and police officer on duty were informed of the participants' expressed intent so as to allow for the necessary precautions and counseling to be offered.

RESULTS

Questionnaire Survey

A total sample of 279 respondents was obtained. Although 320 houses were approached to be included in the sample, 41 of these had to be excluded. This exclusion was due to inaccessibility of houses due to gated premises, individuals not answering the door or individuals declining to partake in the study. The sample obtained is however representative of the community under study and matches the general population for age and gender as per demographic data obtained from the questionnaires versus census data for 2006. (Appendix 8)

Figure 1: Age (yrs)

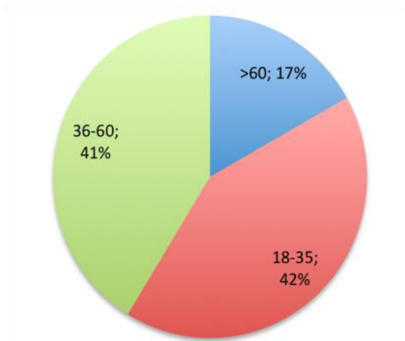


Figure 2: Gender

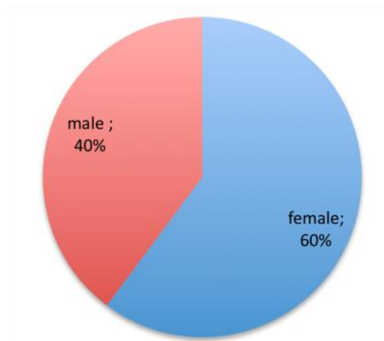


Figure 3: Education

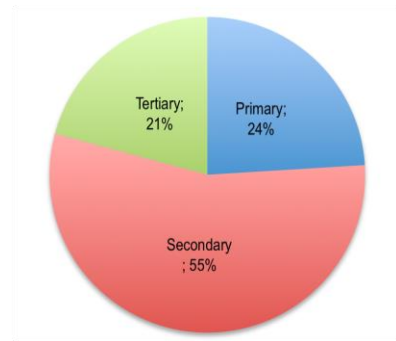


Figure 4: Marital status

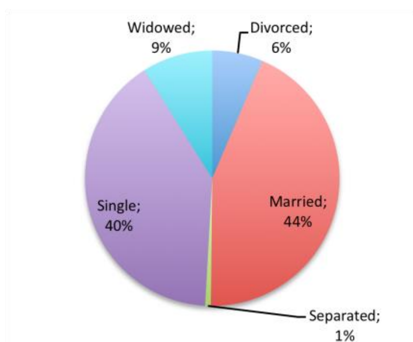
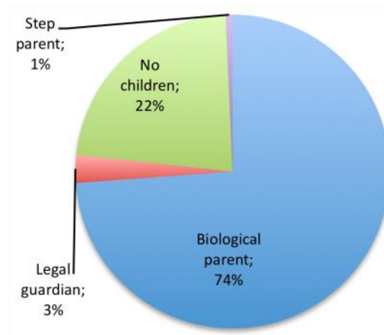


Figure 5: Parental status



Findings of Questionnaire Survey

The questionnaire survey tested the knowledge and understanding of the Ravensmead community based on eight aspects of child sexual and physical abuse. These are Definitions of child sexual and physical abuse, victim profiles, predisposing circumstances, perpetrator profiles, injuries sustained, reporting of abuse and education.

For the purposes of this study, Child Sexual abuse is defined as any sexual offence committed against children. This includes child rape and statutory rape being any act of sexual penetration committed by any person with a child, sexual assault and statutory sexual assault being any sexual violation of the child and sexual grooming which incorporates preparing a child (mentally) to engage in a sexual act. Flashing and compelling a child to witness sexual acts are also seen as abusive. All the above acts have been outlawed in the criminal law (sexual offences and related matters) amendment act 32 of 2007.[17]

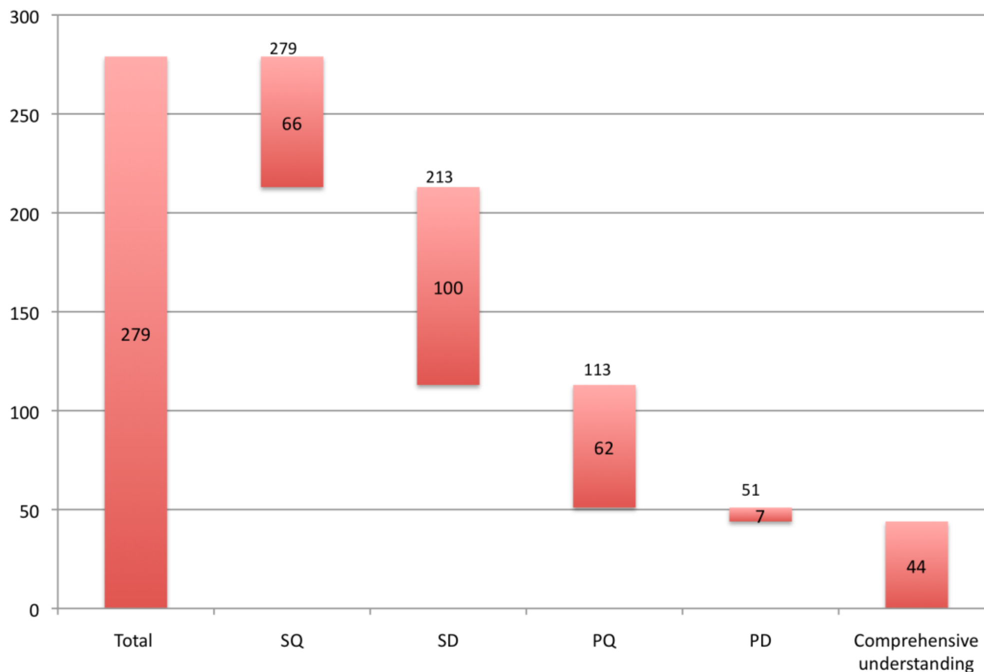
Child Physical Abuse according to the SAPS is defined as the intentional infliction of an injury on the child.[6] Child physical abuse also incorporates acts of child exploitation and neglect that result in physical injury to the child.

Four questions tested respondents' knowledge regarding the definitions of child sexual abuse and child physical abuse. Two were open ended questions and two made use of vignettes describing acts which may be seen as abusive, to test respondents knowledge. The data obtained from both sets of questions were then analyzed and respondents' answers categorized as having complete, partial or poor understanding of sexual abuse. Those respondents with some (reasonable) understanding of the definitions of child physical and sexual abuse were separated from those having a poor understanding of the definition of child sexual and physical abuse.

The total number of respondents' demonstrating a reasonably good understanding of the definition of child sexual abuse based on the vignettes was 213 (SQ). Of these 213 respondents, 100 did not demonstrate a good understanding of sexual abuse when answering the open-ended questions. This left a total of 113 (41%) respondents demonstrating a reasonably good understanding of sexual abuse (SD). Of these 113 (41%) respondents demonstrating a good understanding of sexual abuse, 62 (22%) did not demonstrate a good understanding of child physical abuse based on the vignettes (PQ) and a further seven did not demonstrate an understanding of the definition of child physical

abuse based on the open ended questions (PD). This left a total of 44 respondents (15.7%) with a comprehensive understanding of the definitions of child sexual and physical abuse.

Figure 6: Analysis of participants with comprehensive understanding of sexual and physical abuse



Education status of respondents had the biggest influence on understanding of child physical and sexual abuse definitions with a greater understanding demonstrated by those with a tertiary education.

Figure 7:Respondents' understanding of sexual abuse, based on a non-prompted definition

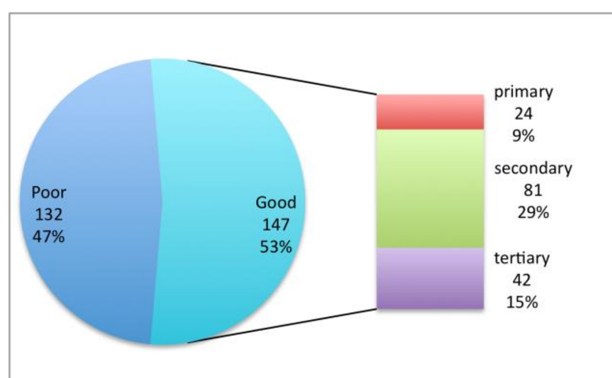
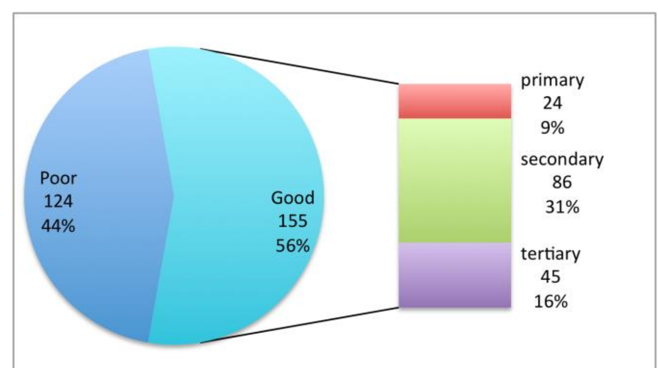


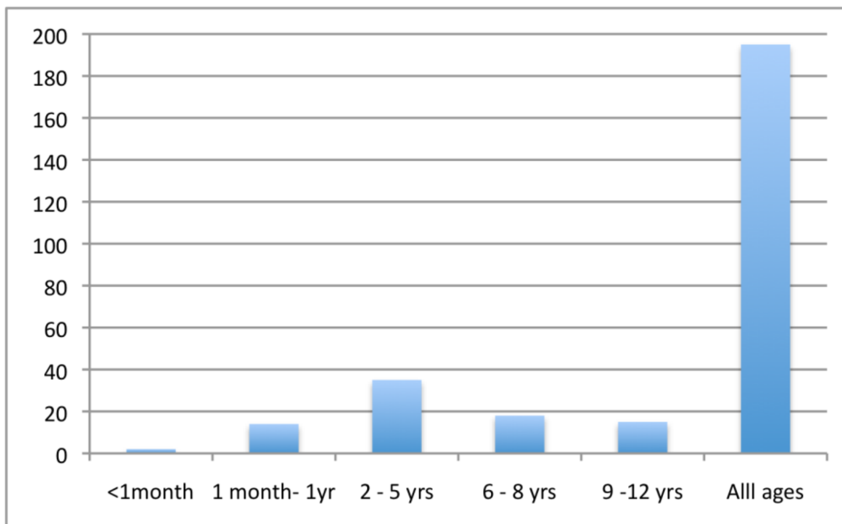
Figure 8: Respondents understanding of physical buse, based on non-prompted definition



Perceived victim profiles were assessed by considering respondents' perceptions of age and gender bias relating to victims of child physical and sexual abuse. Most respondents indicated that child sexual and physical abuse occurred in all age groups equally (70%).

Of those respondents who perceived an age bias relating to victim profile, 60 % thought children under the age of 5 years old and younger were more likely to be victims of child abuse. Most of these respondents viewed the 2-5yr olds as being at highest risk for abuse.

Figure 9: Perceived age distribution of child abuse victims



Most respondents, (62% and 69% respectively) thought that both child sexual and physical abuse occurred equally in girls and boys. 35% (98) of respondents thought that victims of child sexual abuse were more likely to be female and 33% (92) of respondents thought that victims of child physical abuse were more likely to be male. The remaining 3% and 8% respectively thought that boys were most often victims of child sexual and child physical abuse respectively.

Figure 10: Perceived gender of child physical abuse victims

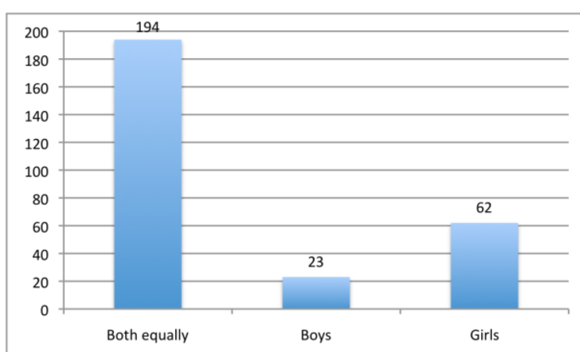
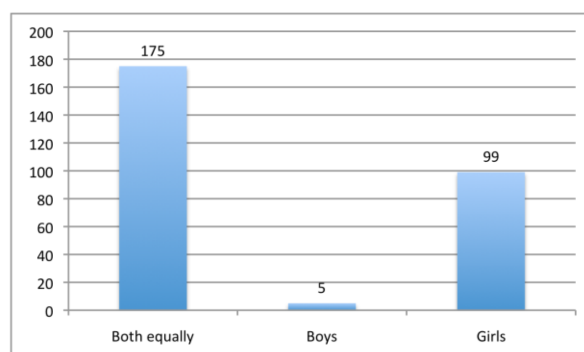


Figure 11: Perceived gender of child sexual abuse victims

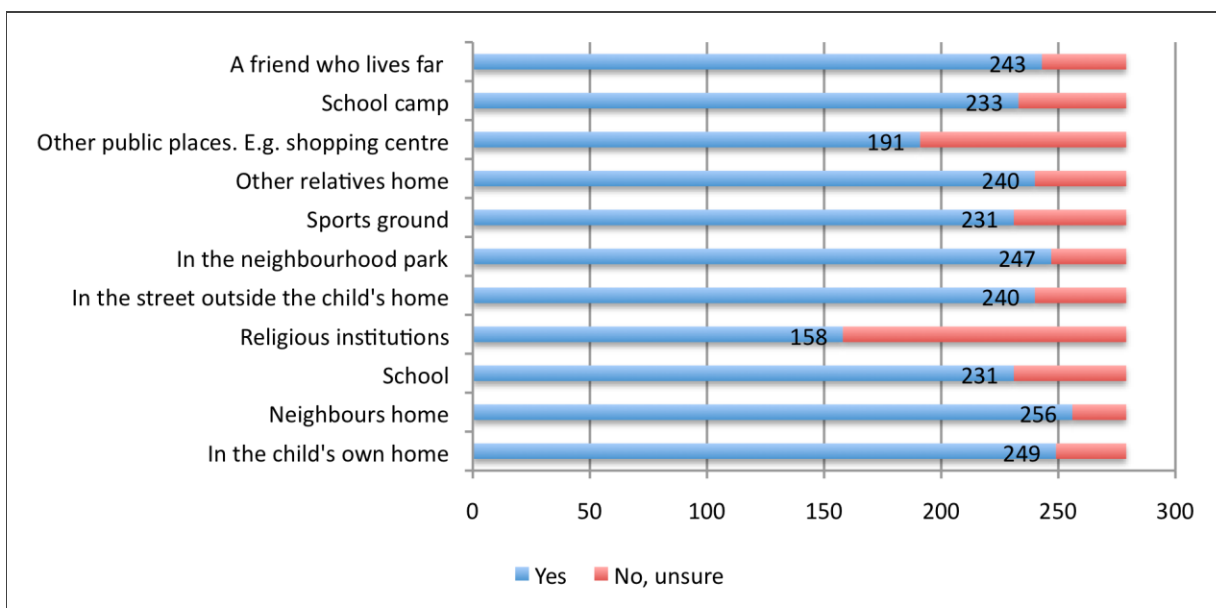


Perceptions regarding circumstances predisposing children to be victims of physical and sexual abuse were also assessed. An assessment of perceptions relating to threatening home environments showed that most respondents (90%) perceived alcohol abuse by adults in the home and lack of adequate parental supervision to be threatening environments. Fewer respondents also perceived extended families living together and step parent families (70% and 58% respectively) as

threatening environments. Most respondents did not perceive single parent families, traditional family units and parents being well-educated and employed as imposing any additional risk for child sexual and physical abuse.

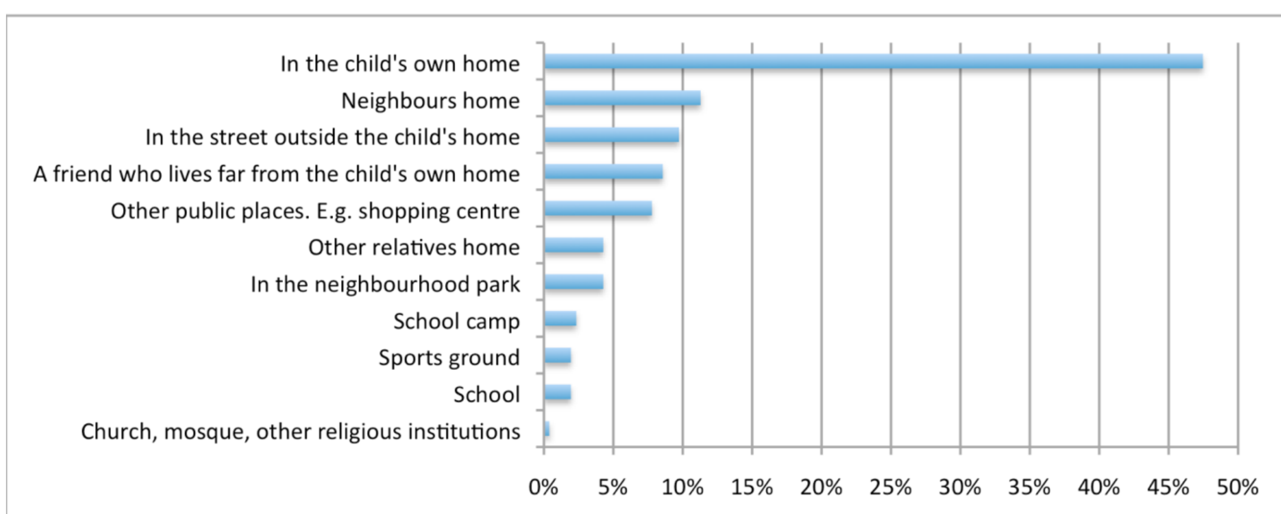
On assessing perception of places in which child abuse could occur, most respondents (40%) correctly indicated that child physical and sexual abuse could occur anywhere. 60% of those respondents failing to realize that abuse could occur anywhere, the least respondents recognized the possibility of abuse occurring in religious institutions (57%) and public places (69%).

Figure 12: Perceptions of child abuse locations



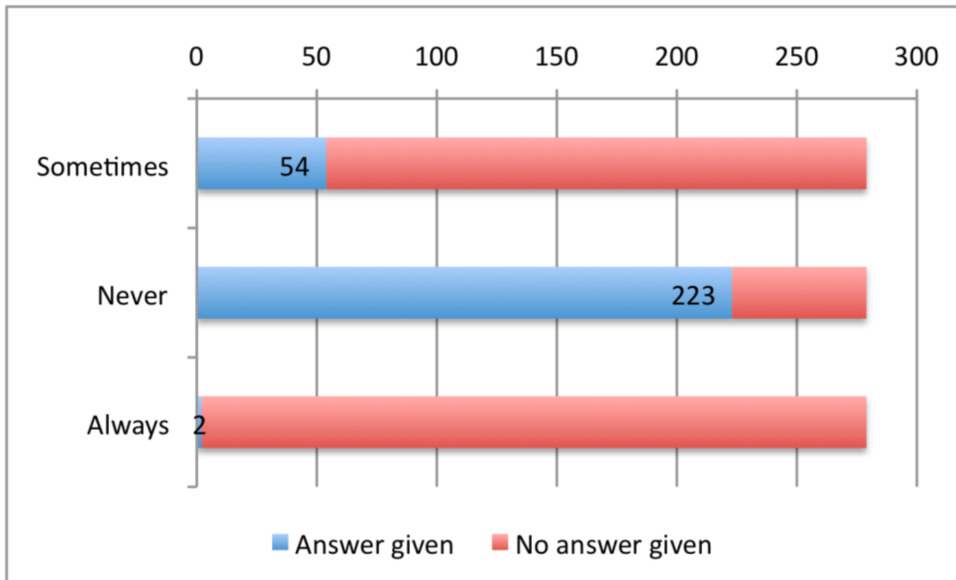
When asked about thoughts on where child physical and sexual abuse is most likely to occur, most respondents (70%) correctly indicated that child abuse most likely occurs in the child's own home (47%) or in close proximity (33%) to the child's own home.

Figure 13: Perceptions of most likely location of child abuse



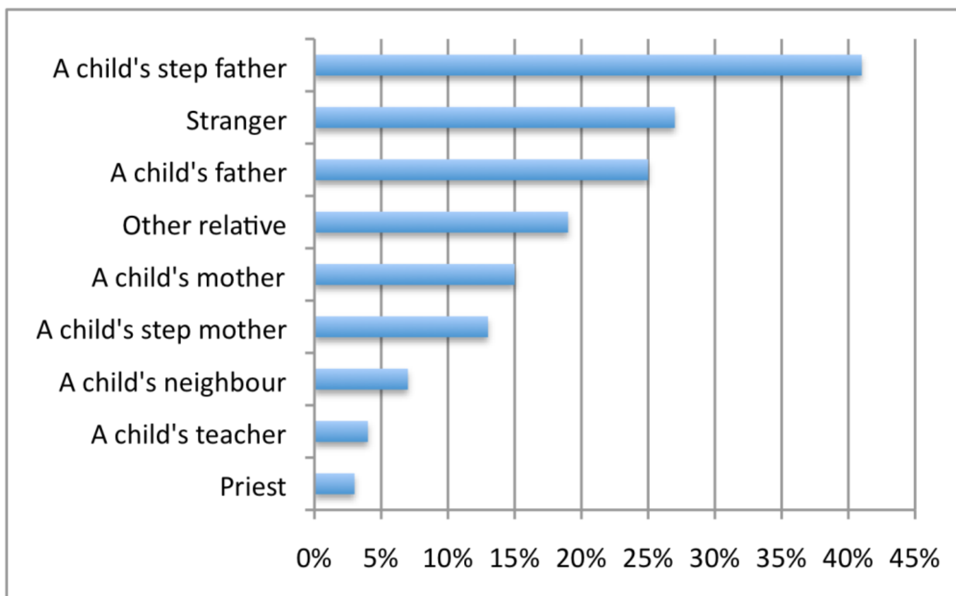
A total of 80% of respondents thought the abused child victim was never to blame for the abuse. 19% thought that children were sometimes to blame for the abuse and 1% thought that children were always to blame for the abuse. It is interesting that a significant difference was noted in the respondents over the age of 60 with regard to this matter (Appendix 9). Respondents over the age of 60 were more likely to say that children are always (4%) or sometimes (38%) to blame for the abuse than respondents in other age categories.

Figure 14: Responses to Question: Is it the child's fault for being abused?



Perceptions relating to perpetrator profiles were also assessed. Most respondents correctly indicated that anyone could be found guilty of child abuse. This perception was replicated in both the open question relating to perceptions and closed questions. When asked who they thought the most likely perpetrator would be, 47% of respondents indicated that the child's step father is most likely to be found guilty of child abuse. Respondents viewed male persons more threatening than their female counterparts.

Figure 15: Perception of potential perpetrator of child abuse



Regarding injuries suffered by victims of abuse, most respondents (58% and 60% respectively) correctly indicated that both victims of physical and sexual abuse sometimes suffer visible injuries. However 35% and 30% of respondents indicated their belief that victims of child physical and sexual abuse would always suffer visible injuries. The minority of respondents (10% and 6% respectively) thought that victims of physical and sexual abuse would never suffer visible injuries.

Table I: Respondents' attitude to reporting child abuse

Responses	No		Yes	
	No.	Percentage	No.	Percentage
Report it (to Police, Child Welfare or other social services)	50	18%	229	82%
Keep it to yourself as it is none of your business	270	97%	9	3%
Offer friendship & support to the child	192	69%	87	31%
Confront the abuser	217	78%	62	22%
Tell the child's parents	142	51%	137	49%
Tell the child's parents Other	5	2%	274	98%

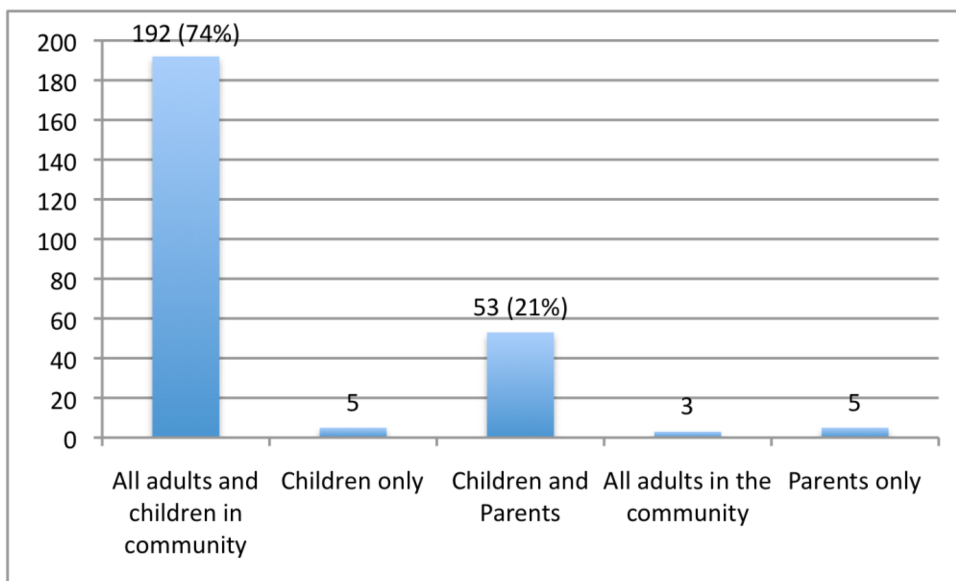
In assessing attitudes to reporting child abuse, most respondents (82%) indicated that they would contact the police or social services in the area should they know of a child that is being abused. A total of 49% of respondents also indicated that they would inform the child's parents of the abuse. Whereas 22% of respondents said that they would confront the abuser and 31% said that they would offer friendship and support to the child. Only 3% indicated that they would keep it to themselves feeling that it was not their business to become involved.

In assessing help seeking behaviour, most respondents indicated that they would report child abuse to the local police station (70%). In addition 47% indicated that they would contact a welfare organization. Only 20%, 14%, and 15% of respondents indicated that they would report the abuse to

the doctor, religious institutions or the child's school teacher/principle respectively. Most respondents (56%) indicated that they would go directly and in person to report the abuse, 33% said that they would report it telephonically. Only 9% of respondents were able to name a local welfare organization to which they could report child abuse.

Regarding attitudes to education, all respondents indicated that children should be taught what child abuse is and where to find help. Most respondents thought that children should receive information regarding child sexual and physical abuse at home from their parents. Educating children at school and through community awareness programmes were also viewed as acceptable by 68% and 46% of respondents respectively. Most respondents (74%) indicated that child abuse awareness programmes should be aimed at all adults and children in the community. Only 3% indicated child abuse awareness education should only be aimed at adults and not at children.

Figure 16: Targeted audience for child abuse education

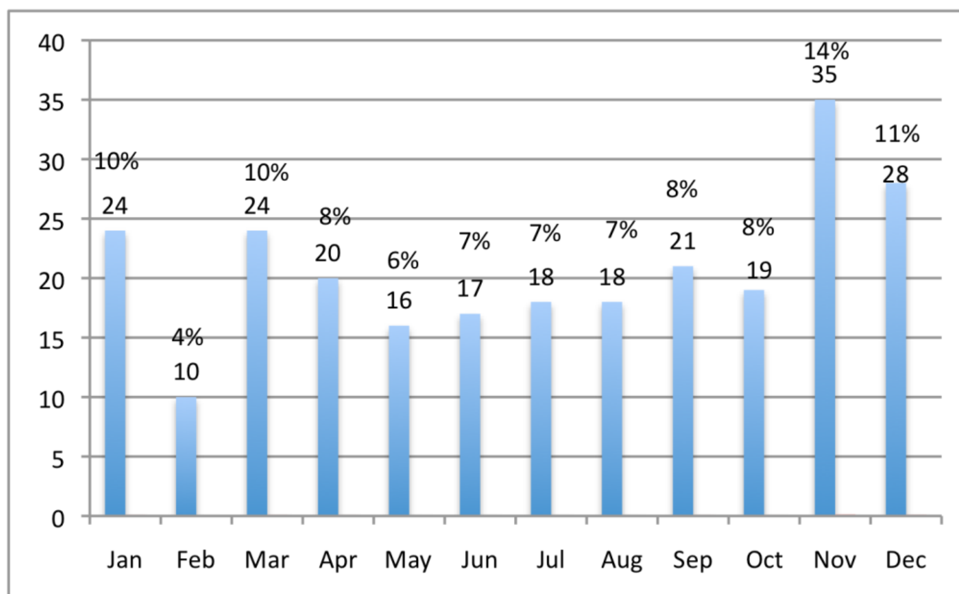


Case Record Review Patterns of Physical and Sexual Abuse

A total of 250 case records were reviewed. Although 291 case records were initially selected for inclusion in the study, 41 of these had to be excluded as they were unobtainable from the hospital records department. The cases excluded from the study were similar to those included with regards to age and gender profile and month of presentation.

The number of cases of child physical and sexual abuse presenting over a one-year period to the M5 Rape Crises Centre at Karl Bremer hospital was equally distributed over the twelve-month period with a slight peak over the November to January period (36% of cases over these 3 months).

Figure 17: Calendar distribution of frequency of reported cases



The majority of child victims presenting over the one-year period were victims of child sexual abuse (96%). Only 2% of victims were physically abused, 1% physically and sexually abused and the remaining 1% either had findings (history and examination) that were not consistent with child abuse or failed to document the type of abuse reported.

Table II: Type of child abuse present in case records

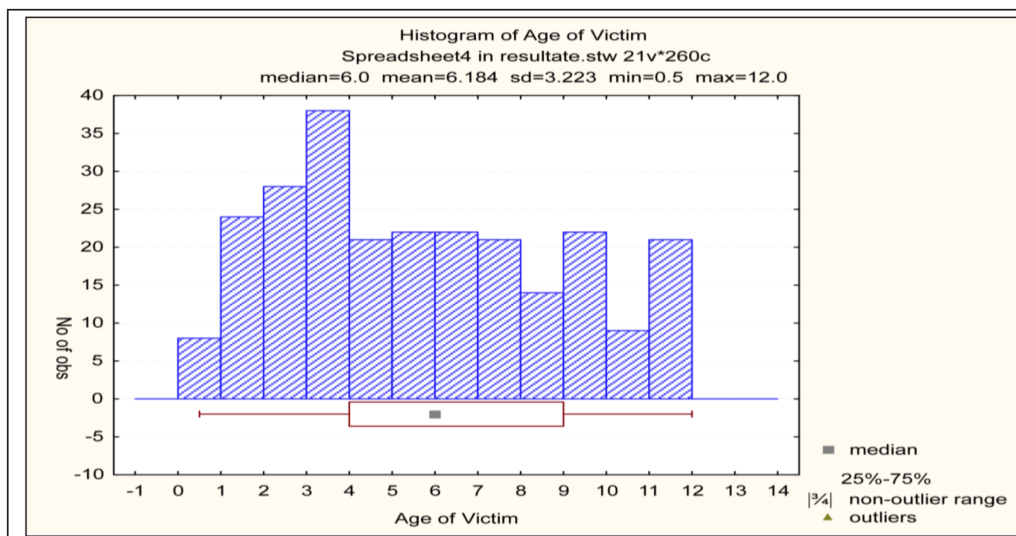
	No.	Percentage
Sexual	241	96%
Other	1	0%
Physical	4	2%
Sexual and Physical	3	1%
Not specified	1	0%
Total	250	

Table III: Age distribution of victims in case records

	No.	Percentage
1month - 1 yr	4	2%
1 -4 yrs	93	37%
5 - 8 yrs	87	35%
9-12 yrs	65	26%

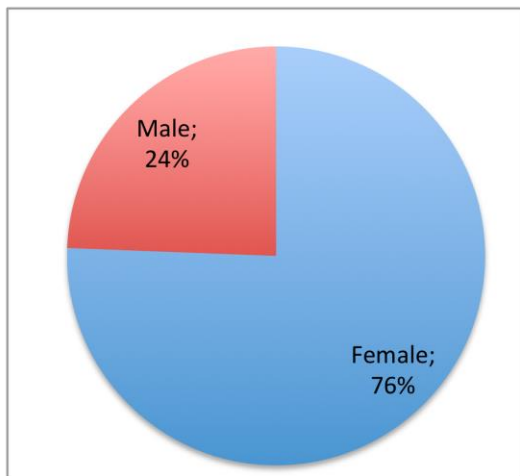
The mean age of victims of physical and sexual child abuse presenting was 6.18yrs (SD 3.223).

Figure 18: Age distribution of child victims in case records



In addition, 76% (189) of the total number of victims presenting were female and 24% (61) were male.

Figure 19: Gender split of case records



Only two of the four victims of child physical abuse were female. A total of 92% of victims presenting had no chronic or acute medical illnesses, 2% had a mental disability and 4% had other chronic illnesses.

Table IV: Case records' victims' medical history

	No.	Percentage
Healthy	229	92%
Speech/hearing impediment	1	0%
Other	15	6%
Mental disability	5	2%

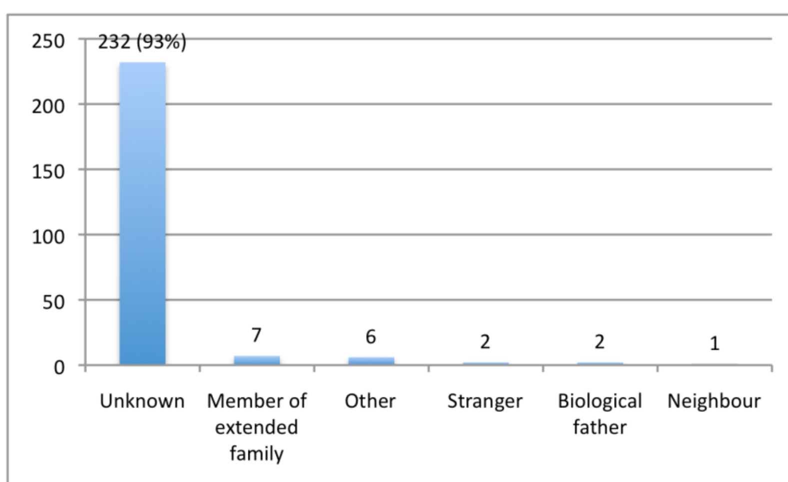
Information regarding family structure of victims of abuse was not well documented and in 57% of cases no information regarding family structure could be obtained from the case records. 31% of the victims presenting belonged to single parent families, 4% traditional families and 6% of victims had other family structure (e.g. communal home, extended families living in the home, foster home, divorced parents).

Table V: Case Records' victim' family structure

	No.	Percentage
Not specified	142	57%
Extended family living together	2	1%
Other	16	6%
Traditional family	11	4%
Single parent	76	31%
Communal home	1	0%
Step parent family	1	0%

Information regarding perpetrator profile was scant and incomplete. In 82% of cases it was not specified whether or not the perpetrator was known to the victim. In 12% of case records it was documented that perpetrator was known to the victim. Only in 7% of cases was the relationship of the perpetrator to the victim specified.

Figure 20: Relationship of suspect to victim



The gender of the perpetrator was not specified in 85% of cases. But in 14% of records the perpetrators was documented as being male and in 1% as being female.

Table VI: Gender of suspect

	No.	Percentage
Not specified	212	85%
Male	36	14%
Female	2	1%

Respondents were also asked whether they thought victims of child sexual and physical abuse suffer visible injuries. A total of 30% of respondents were of the opinion that child victims of sexual abuse always suffered visible injury, 60% thought they sometimes suffered visible injury and 10% thought they never suffered visible injuries.

Results of In-Depth Interviews

Themes were structured according to the original questions posed by the semi-structured questionnaire. The 17 emerging themes relate to various aspects of child abuse and are listed below:

Home Environment and Victim Profile:

- Strained relationships within the home
- Complex family structures
- Lack of a strong male parent figure
- Threatening immediate environment
- Quiet obedient character of the victim.

Circumstances under which Child Abuse occurs and Perpetrator Profiles:

- Unsuspecting circumstances under which child abuse occurs
- Perpetrators known to the victim and the victim's family
- Fear of disclosing the abuse.
- Communication barrier between parents and child victims of abuse
- General lack of accountability within communities

Parental Reactions to the Abuse:

- Paralyzing pain
- Extreme and uncontrolled anger
- Fear of ongoing effects of the abuse

Help-seeking Behaviour of Families of Abused Victims:

- Fear of reporting child abuse to the police
- Indirectly reporting to the police

Sources of Support for Victims of Child Abuse and Their Families:

- Paucity of professional help
- Comfort from personal sources of support

Table IX: Summary of the Victim and Perpetrator profiles.

	VICTIM			*PERPETRATOR*			
CASE	**AGE**	**GENDER**	**RESIDENCE**	**AGE**	**GENDER**	**RELATIONSHIP TO ABUSED**	**INTERVIEWEE**
1	10 YRS	FEMALE	KUILSRIVER	14 YRS	MALE	NEIGHBOURHOOD FRIEND, WELL KNOW TO VICTIM AND HER FAMILY, FAMILIES WELL AQUINTED	PARENTS OF VICTIM
2	9 YRS	MALE	SCOTTSDENE	14 & 15 YRS, 9 & 11 YRS		NEIGHBOURHOOD FRIEND/ SCHOOL FRIENDS, WELL KNOWN TO VICTIM & FAMILY	MOTHER OF VICTIM
3	10 YRS	FEMALE	WESBANK - DELFT	21 YRS	MALE	NEIGHBOURHOOD AQUINTANCE, FAMILIES WELL AQUINTED, WELL KNOWN TO VICTIM AND FAMILY (KNOW HIM FOR 11 YRS)	LEGAL GUARDIAN OF VICTIM
4	10 YRS	FEMALE	WALLACEDENE - KRAAIFONTEIN	34 YRS	MALE	MEMBER OF HOUSEHOLD FOR 19 YRS, RAISED AS OWN CHILD, ORPHANED AT AGE 15 WHEN GRANDMOHTER DIED	MOTHER OF VICTIM
5	8 YRS	FEMALE	EERSTE RIVIER	40 + YRS	MALE	GRANDMOTHER'S BOYFRIEND – MEMBER OF PREVIOUS HOUSEHOLD	GUARDIAN OF VICTIM
6	11 YRS	FEMALE	PAROW VALLEY	60 + YRS	MALE	MATERNAL GRANDFATHER	MOTHER OF VICTIM
7	11 YRS	FEMALE	TOWNSHIP	30 + YRS	MALE	NEIGHBOUR	MOTHER OF VICTIM
8	4 YRS	FEMALE	KUILSRIVER	Child	MALE	SCHOOL MATE	GRANDMOTHER/ GUARDIAN
9	12 YRS	MALE	RUYTERWAGCHT	30 YRS	MALE	NEIGHBOUR	PARENTS OF VICTIM
10	8 YRS	FEMALE		30 YRS	MALE	DISTANT RELATIVE	MOTHER OF VICTIM

The researcher has chosen a predominantly quantitative approach. The qualitative data serves as triangulation to provide convergent validity and serves to enhance the credibility of the results. It is used here to strengthen the information gained from and conclusions drawn from the quantitative aspects of the research. The most relevant themes in this regard are expanded on below:

Home Circumstances

Lack of a strong male parent figure

It seemed evident from the interviews that several of the households of the candidates interviewed lacked a strong male role model or parent figure. This absence of a strong male presence was absolute in many cases:

"*Ons is 'n huisgesin wat bestaan net van vroumense in 'n huis." (Our home family consists only of females); "my husband is working in Jo'burg, and he isn't came back for about four years"; "Her daddy isn't even in the picture." ; "I have been divorced for 21 years now, I have got two daughters out of the marriage, and now "M" (victim); So it is only the four of us in the house. Her father is somewhere around in Elsies River. I used to get hold of him in last year. I asked him if he wanted to take the child in with him or what? He said no, because the child doesn't actually have a bond with him."*

In other cases, although physically present, a lack of active participation in caring for, poor role modeling or a perceived absence seemed evident:

"*When she told me I was so shocked, I phoned my husband first and but he doesn't care, he didn't bother to pick up the phone and I sent him a sms about what happened". "Because then he (child's father) had two houses. He was staying with us and he was staying on his own also, weekends and stuff like that."*

In one case the child's parents were informed of the abuse while it was taking place by a witness to the abuse but failed to act. The mother in this case also failed to act but was disempowered by the father's disinterest.

"*En net toe wat sy pa nou kom, en toe sê ek sy pa. Maar sy pa het hom nie gesteur daarop nie.*" (When his father came, I told his father. But his father did not bother himself with it.)

Threatening community or home environment

Another interesting theme that emerged from the research is that of an unsafe home or community environment. Safety is a relative term and never guaranteed in any community or home. However, in several of the interviews, parents/guardians expressed their opinions or feelings that the community or even the home environment posed a threat to the child.

"*Want ek weet van baie kinders wat aangerand en gerape was en waar daar moord was en sulke goed in ons gebied.*"
(Because I know of many children that were assaulted and raped and where there was murder and such things in our area).
"*Because we got the shebeen next door and I did not trust these guys ,when they came from school they must try to stay in the house and watch dvds.";*
"*Valhalla Park waar hulle (ex-wife and children) uit kom, is nie n regte environment nie, en die environment is nie vir my, want ek kom daar deur, dit is nie 'n goeie environment nie. Dit is totally nie 'n goeie environment nie.*"
(Valhalla Park where they come from, is not a good environment, and the environment is not ..to me... because I came through it, it is not a good environment. It is totally not a good environment")
"*Want sulke dinge (referring to the sexual abuse that happened to her daughter) gebeur elke dag in squatter kampe*"
(Because things such as this (sexual abuse of daughter) happens every day in the squatter camps).
In this case the abuse took place in the child's own home and the mother also identified her perceived threat of the home environment:
"There is too much men in my house. To be honest, ek het gesê doc, ek wil nie kla nie (I do not want to complain) , ek is tevrede met die huis, maar hy is te klein.(I am happy with my house, but it is too small) Ons lê daar op 'n hoop (we lie there on top of each other.). And to be honest, I only have two daughters. With me we are three women in that house, a house full of men."

Circumstances under which Abuse occurred/Perpetrator Profiles

Unsuspecting circumstances

Many of the parents/guardians interviewed expressed their surprise at the circumstances under which the abuse occurred. In all the cases interviewed the abuse took place in very close proximity to or inside the child's own home. None of the incidents of abuse occurred under exceptional circumstances. They all happened in places the child often visits or while the child was doing things they often do. In most instances the parents were in very close proximity while the abuse was occurring. In several cases the abuse was perpetrated by a person the parents would never have suspected. This theme is revealed in the following quotes:
"*Sy het toe gesê: 'Mammie, ek gaan gou 'n cartoon movie gaan haal'." (So she said, "Mommy I am quickly going to fetch a cartoon movie.") "Ek het gesê: 'Dit is ok sussie, jy kan maar gaan'."(I said: "It is okay girl, you can go.") "Ek voel,... sy het my gesê waarnatoe sy gaan, want dit is wat*

my kinders doen." (I feel,... she told me where she was going because that is what my children do)
"Maar ek het gedink, as so iets gebeur, sal dit miskien iemand wees wat groot is, wat dwelms gebruik, 'n vreemdeling by die skool, want hulle sê altyd by die skool dat hulle nie in vreemde karre moet klim nie. Ek het nooit gedink dat 'n seun van 14 jaar oud dit aan my kind sou doen nie. (But I thought should something like this happen, it would be somebody that is adult, that uses drugs, a stranger at the school, because they always tell them at school not to climb into the cars of strangers.)
"Die kerk het mos daar netbal gespeel,dit is 'n klub, en dan gaan hy altyd soontoe, ek het nog nooit gedink dit sou daar gebeur nie." (The church played netball there, it is a club, and then he always goes there, I never thought that this would happen there.)

"Ek stuur haar gewoonlik nooit sonder iemand na die huis toe. So stuur ek vir hom toe saam met die sleutel, gaan haal hulle skateboards uit. Ons huis is 100m daarvandaan af. Toe hulle daar kom en goed, toe gee hy geld vir die ander kinders om winkel toe te gaan, toe is hy besig met haar."
(I normally don't send her home alone. That's why I sent him with the key for them to take out the skateboards. Our house is 100m away. When they arrived there and so, he gave the other children money to go to the shop, while he was busy with her.)

"ek meen, jy verwag dit mos nie van jou eie familie – en dan hoor jy op die nuus dat 'n oupa het sy eie kleindogter verkrag, of 'n oom verkrag sy niggie of nefie – jy dink nooit dit gaan met jou eie familie gebeur nie."
(I mean, you don't even expect this from your own family – and then you hear it over the news that a grandpa raped his own granddaughter, or an uncle rapes his niece or nephew – you never think it will happen to your own family)

"Ek het nog nooit gedink hy kon so iets doen nie."(I never thought he could do something like this)
"How could I be so....., my baby needed my help. In my house... yo... my baby get hurt very nearby me, I didn't even hear, I didn't even know."

<u>Perpetrator known to victim/victim's family</u>

In all of the cases interviewed the abuse was perpetrated by somebody known to the victim and the victim's family. The relationship of victim to perpetrator varied from being a relative or an unrelated member of the household to being a community friend or neighbour.

"Hy is nie iemand wat jy baie hassels mee het nie en hy groet altyd ...... En sy ma het altyd daar na haar ma toe gekom en gesels met haar ma, en gaan hy daar by WK-hulle in die kamer in en gesels."(He isn't somebody with whom you would have many hassles and he always greets... And his mother always came there to her mom and chatted with her mom, and then he would go in by WK-them into the room and chat.)
"Hy het voor hulle ouers groot geraak, ek en die kinders se ma raak saam groot in die blokke. So hulle is ouer as hy en hy was maar gebruik gewees al die pad."(He grew up in front of her parents, the children's mother and I grew up together in the blocks. So they are older than him and he was even used all the way)
"Die ding wat nou vir haar gemolesteer het, ken ek nou al van destyds. Hy bly vyf huis van ons af." (This thing that now has molested her, I know from way back then. He stays five houses away from us)
"jou kind sê....Boeta het haar verkrag."(Your child says..... Boeta raped her)
"her grandmother's boyfriend, sort of like molested her."
"Toe sê sy maar sy wil nie gaan nie, toe huil sy, toe sê ek maar wat is fout? Toe sê sy 'Oupa touch me down there.'."(Then she said but she doesn't want to go, then she cried, so I said but what's wrong? Then she said "Oupa touched me down there".)
"Want die seuntjie kom altyd daar speel, hy is verlangs familie van ons"(Because the boy always comes to play there – he is distantly related)
"Yes,I know him. he just came from Malawi ,he is there about 3 weeks but I never spoken to him but I know him and I have seen him."
"He knows the guy for a long time previously, the guy invited him to his house, but he never went before."

Fear of disclosing the abuse

In several of the interviews, it was evident that the abuse was not disclosed by the victims themselves. In cases where it was disclosed by the victims and even in cases where it was disclosed by community members, there always was a delay in disclosing the abuse to the parents. In one case the delay was only one day but in all the other cases it ranged from a week to months to years of delayed disclosure. A common theme seemed to be fear of disclosure. Fear for various reasons. Several were afraid of the threatened violence by the perpetrator:
"Nee, daar gaan nie moeilikheid wees nie, want WK gaan in elk geval nie sê nie. As enige een van julle gaan praat gaan ek vir julle doodmaak." (as relayed to parents by a child witness to the abuse.)

(No, there's not going to be any trouble because WK is in any case not going to tell. If any of you are going to talk then I will kill you.)

"Sê jy jou pa, dan maak ek jou dood".(You tell your father then I will kill you)

"He took her to his house and took the knife and he shows her the knife and said if you tell anyone I gonna kill your mother that is why she didn't tell me immediately"

Another fear that victims had was that of being blamed for the abuse:

"Sê gou vir Mammie, hoe voel jy Sissie?". Toe sê sy, "Bang mammie". Toe vra ek vir haar, "Hoekom het jy nie vir my gesê nie?". Toe sê sy, "Ek was bang mammie sal sê dit was my skuld". Toe sê ek vir haar, "Nooit nie......""

(Quickly tell Mommy, how do you feel Sissie? So she says: "Afraid, Mommy". So I ask her:"Why didn't you tell me?" So she says: "I was afraid Mommy will say it was my fault.")

In cases where a close family member perpetrated the abuse, there seemed to be a fear of betraying or harming that person.

""hoekom het jy nou nie vir mamma gesê nie" Sy was bang. Nou vra ek "vir wat?" Toe sien ek waarvoor sy bang was... want die die tyd wat my boeta hom jaag met die byl, toe skree sy, en sy is nou mal want sy is nou gewoont dis haar boeta, sy vat dit as haar boeta. Hy moenie vir hom doodmaak nie....."

("Why did you not tell Mamma?" She was afraid. Now I ask: "What for?" Then I saw why she was afraid….because at the time my boeta chased him with the axe, then she shouted, and she is now mad because she is now accustomed to it being her boeta, she takes it as her boeta. He must not kill him…")

Fears described by those to whom the victim first disclosed the abuse included fear of betraying a family member, in this case, the child's maternal grandfather:

"(Dit was) moeilik om te praat daaroor ....weet nie hoe om te sê en vir wie aan te sê nie.....want, em, ...dis my pa wat dit aan haar gedoen het. Verstaan jy, ek weet nie, dit is like, jy weet nie hoe om te voel nie. Um, ek het still gebly, ek moes nou seker nie stilbly, ek moes seker onmiddellik iets gedoen, maar so ek gesê het, ek was bang om vorentoe te kom."

"(It was) difficult to talk about it...don't know how to tell and whom to tell..because, ..um..it's my father who did it to her. Do you understand, I don't know, it is like ... you don't know how to feel. Um, I kept quiet, I probably should not have, I should probably have done something immediately, but as I said , I was afraid to come forward ..."

Some feared involving themselves in something that was not really their business. Others feared further traumatization of the victim by putting them through the process of various medical tests,

interrogation and court appearances.

"I know this process because I worked in the child and Family unit where we prepare children who have been sexually assaulted or abused, to go to court and I know how stressful it is on the whole family. I did not want to unsettle her because she already has all these behavioural problems"

<u>A general lack of accountability within communities</u>

This was one of the most striking themes produced by the research. By this the researcher finds that no one seems to take ownership or responsibility in matters concerning child abuse. There is a general tendency within communities to "sweep things under the rug", pretend they are not happening or denying the seriousness of that which has occurred whether subconsciously to themselves or openly to others as often is the case with the family (parents and spouses) of the perpetrators. Even the police seem to relinquish their responsibility to prosecute offenders, especially when offenders are under the age of 18 years. Community members (family of victim and perpetrators) and police express empathy towards such perpetrators fearing how imprisonment might impact their future. The following quotes illustrate this lack of accountability.

Here the father of one of the victims expresses his wish that children be taught to stand up for each other and this way be accountable for each other's safety:

"*Ek wil net hê hulle moet weet as iets met iemand gebeur moet hulle huis toe kom en kom sê daar gaan iets aan. Ek bedoel, dit het nie ver van die huis af gebeur nie. En as iemand net wil op staan en sê hulle gaan sê dan sal hierdie dinge miskien nie gebeur nie. As iemand net gesê het "ek gaan my ma hulle nou sê" dan het dit miskien nie gebeur nie. Ek bedoel dit is wat ek verlang van hulle is om te dink om almal se veiligheid te beskerm......"*

(I just want to say they must know if something happens to someone they must come home and come and tell something is going on. I mean, it did not happen far from the house. And if only someone stood up and said they are going to tell, then these things will maybe not happen. If someone just said: "I am going to tell my mom now", then it will maybe not have happened. I mean this is what I expect of them…to think so that everybody's safety is protected…"

Here a father expresses his feeling that although child abuse commonly occurs in the community; no action is taken to do anything about it. In many cases it is covered up and not reported.

"umm...al die dinge weet ons van, maar omdat ons nie 'n Polisie Stasie het nie, ons het nie die regte umm, plekke waar mense na toe kan gaan nie, word baie van hierdie goeters toe gesmeer."

(...umm...all these things we know about, but because we do not have a police station, we don't have

the right umm... places where people can go to, many of these things are covered up.)

In this case a grandmother (guardian) relays how a crèche teacher who witnessed something happening to the victim on the school premises failed to tell her about what she had witnessed:
"She said she didn't want to tell me anything, she first wanted to see if I picked up anything or what. I looked at this woman, and I didn't know what to think or what to say."

In this case a repeat offender of child sexual grooming is thought to have targeted several young boys in the community over a period of several years. A father of a victim relays how another victim currently about 17yrs of age was targeted in a similar manner a few years prior but did not want to get involved with reporting this to the police:
"Gister toe die een laaitie vir my sê– die een wat oor die pad bly – toe sê hy, ek moet asseblief nie vir die polisie sê van hom nie. Want so iets het gebeur met hom, hy's bang, hy wil nie involved raak daarmee nie. Dit was net 'n persoonlike oomblik, toe vra ek vir hom ken hy die man, toe sê hy net ek moet 'K' weg hou van die man af. Want om die draai, een, twee, drie mense van wat ek weet, en niemand praat daaroor nie. Dit gebeur oor 'n lank tyd want niemand wil daaroor praat nie.
En daai community is so stil né, almal lewe vir hulself. Niemand sal eintlik sulke dinge oplet nie. Hulle is almal so negligent man. Die kinders, sal nie weet watter kinders seer kry nie. Tot as die kinders weet, die kinders gaan nie daar oor praat nie.
(Yesterday when the one younster told me – the one living across the road – he said I must please not tell the police about him. Because something like that happened to him, he's afraid, he does not want to get involved with it. This was just a personal moment, so I asked him do you know the man, so he just said I must keep "K" away from the man. Because around the corner, one, two three people I know of and no one talks about it. It is happening for a long time because no one wants to talk about it)
"And that community is so quiet hey, everyone lives for himself. Nobody will actually notice such things. They are all so negligent man. These children will not know which children do get hurt. Even if the children know, the children are not going to talk about it.")

The following cases illustrate reluctance on behalf of the police and family members to hold child and teenage offenders of child sexual abuse accountable for their actions:
In this case the child was a victim of sodomy (clinically evident), the suspect a14-year- old boy:
"*Ons het vanoggend polisiestasie toe gegaan en 'n klag gelê. Die Inspekteur het vanoggend gesê ons moet maar besluit na die dokter se verslag."*
'Ons weet ook nou nie regtig wat ons moet doen nie, nou vra ons vir haar, omdat hy nou so jonk is,

hy is standard 6, moet ons nou voortgaan met die saak? Of moet ons vir hom 'n waarskuwing gee. Nou sê sy (victim) "mammie, ek kan nie sê nie, jy moet sê was ons moet doen." Sê sy…, sy wil hom net nie weer sien nie."
(We went to the police station this morning and laid a charge. The inspector said this morning we have to make a decision after the report of the doctor. We do not really know what we should do, now we ask her, because he is still so young, he is in standard 6, must we proceed with this case? Or should we give him a warning. Now she (victim) says: "Mommy I can't say, you must say what we must do." Says she…, she just does not want to see him again.)

Parental Reactions

Uncontrolled anger

This theme highlights the magnitude of the emotional response to the abuse. Anger is mainly directed at the perpetrators but also at themselves, their circumstances and community:
…dan gaan ons hom grab. (…then we will grab him.) Want ons gaan hom seer maak, definitief voor die boere hom vat, gaan ons hom pyn laat voel. ('Cause we are going to hurt him, definitely before the cops take him, we are going to let him feel pain.) 'Cause I will make sure, I will buy myself acid. I will make sure that I harm him in any way. Cause he did hurt me very badly.
Hy het my seer gemaak. Hy het my…, mevrou, hy het my diep seer…, hy het my seer gemaak…, hy het my seer gemaak (sobbing).
So at that point in time I was very angry with my sisters, for allowing this and not doing anything. I was also angry with this guy. I did not want to confront him because I knew I would do something to him. "I always said if anything like this happens in my family, I will take the law into my own hands and the law can then do with me what has to be done."

In some instances anger is even directed at the child for 'allowing" the abuse to happen and not saying anything or for going to the place where it occurred, although innocently so.
En ek kan nie explain hoe ek gevoel het nie, is net ek het histeries geraak. Ek het net geskree dis al. (And I can't explain how I felt, it's just that I became hysterical. I just screamed, that's all.)
En...toe het ek op sy ma ook geskree... ek het net baie mal geraak. Seker omdat ek so kwaad geraak het Vrydag met haar. (Was jy kwaad met haar?). Geskel...want net voordat dit gebeur het ek nog vir haar gesê sy moet saam my gaan, en toe sê sy sy gaan met my suster bly. En toe speel sy nou met die meisiekind, maar toe kom hy mos nou met haar speel.

(And… then I screamed at his mother also... I just became so mad. Probably because I became so angry Friday at her. (Were you angry at her?) . Scolded… because just before it happened, I still told her she must go with me and then she said she is going to stay by my sister. And then she played now with this girl, but just then he came to play with her.)
Ek het my kind gewurg, voor die polisie, ek het hom gewurg.
(I strangled my child, in front of the police, I strangled him.)

Help-seeking Behaviour

<u>Fear of reporting abuse to police authorities</u>

It was evident from the interviews that in most cases the parents of the victims showed initial reluctance in reporting the abuse to the police authorities. Many of them sought advice from acquaintances or family who were employed by police or welfare services. Others required prompting by neighbours, family, the school or social services to report the abuse. The reason for this reluctance was explained by various underlying fears held by the parents. Some feared that police-reporting was not warranted, uncertain about the magnitude of the crime:
I also thought it was less serious because I thought he had just penetrated her with the finger I thought that ...ag.. it's not so... not, not serious. And I was just thinking… Ag, it's not really happening. You know you just blank out, you just tell yourself, it's not happening. But when I sit still and think of the little things that she said, the infection and stuff like that then I tell myself, no, this is serious.
Others feared being scorned by community members:
"Ek wou dit nie gedoen het nie, ek wil nie..., maar toe het 'n ander vrou my gesê 'Jy moet dit nie daar los nie, want hier raak ons kinders ook groot." "Ek het nie baie vriende in die lewe nie en ek lewe mos nie elke dag nie. My kinders bly agter eendag en ek wil nie hê hulle moet verwyte kry by ander mense nie, ek kan dit mos nie sien en hoor nie."
(I did not want to do it, I did not..., but then another woman told me: 'You must not leave there, because these children also grow up.' ... I do not have many friends in life and I won't live forever. My children will remain behind one day and I don't want them to be blamed by others... I will not be able to see or hear it.)
Fear of the hostility of the process of reporting and the court caused others to be reluctant to report the abuse:
"Om die waarheid te sê, is ek nie ene wat hou om in die hof te staan nie. Want die prokereur draai so baie dinge, dat dit lyk jy as ouer agterna die verkeerde ene is. Ek wil nie hê dat aan die einde van

die dag, dat dit moet lyk asof ek onbevoeg is, en my man onbevoeg is om na ons kinders te kyk."
(To tell the truth..., I am not one who likes to be in court. Because the lawyer twists so many things, that it seems afterwards that you as parent is the one in the wrong. I do not want it to seem, at the end of the day, that it would look like I am incompetent, and that my husband is incompetent, to look after our children.)

As already illustrated, concern about the well-being of child perpetrators was another reason for hesitation before reporting to the police.

Some interviewees expressed doubt in the competency of the police system stating that they would rather take matters into their own hands as nothing would be done about it:

"*My vrou se ma, het my geforce om hulle te bel. Ek het gese ek wil hulle nie bel nie. Ek het niks saak met die polisie nie. Hulle moet kom wanneer ek klaar is. Want as jy nie 'n persoon wys, kyk hier, jy maak nie a fool van my nie, dan kom hulle uit die tronk en doen hulle net dieselfde ding. Daar is nie prupose daarin nie. Maar hulle gaan, dan doen hulle die verkeerder dinge, dan kom hulle uit, dan doen hulle die selfde dinge weer., dan gaan hulle net weer tronk toe."*
(My wife's mother forced me to phone them. I said I do not want to phone them. I do not have a case with the police. They must come when I have finished. Because if you don't show a person, look here, you don't make a fool of me, then they come out of jail and just do the same thing. There is no purpose to it. But they go, then they do the wrong things, then they come out then they do the same things again..., then they go to jail again.)

Sources of Support for Victims of Child Abuse and Their Families

<u>Relying on personal sources of support</u>

It seemed evident that the minority of those interviewed had received professional help or counseling. This is due to a lack of resources within the state hospitals. Although counseling services are offered at the Centre, it is insufficient to allow everyone the opportunity to make use of the service even if only for an initial assessment. Only those cases thought to be in need of counseling are referred. Thus many victims of child abuse and their families rely on personal sources of support within their own communities. This again highlights the importance of community education and involvement, to take ownership of the problem and to help those suffering from within the community.

"Sy het baie ondersteuning en meer liefde nodig, goeie ouerskap en bemoedinging om dinge in haar kop te probeer regkry."She needs lots of support and more love, good parenting and encouragement to try to rectify things in her head.)

Discussion

Discussion of Sample

Although an original sample of 320 respondents were approached, 41 had to be excluded either due to inaccessibility of property or respondent refusal to partake in the study resulting in a sample size of 279 respondents (87% of target). A general attitude of interest was expressed by most community members approached with several of those refusing to participate stating that they simply did not have the time, this could be understood as it was not possible to pre-arrange appointments. A few felt unaffected by the study as they did not have children or because their children had already left the home, others felt that it was something that nothing could be done about and thus that there was no point in taking part in the research. The later two reasons given were however in the minority.

This attitude of interest is probably a reflection of the scale of the problem within the community, the broader Western Cape and throughout South Africa. According to the SAPS 2006/2007 annual report[6] more than 16 068 cases of child rape, 3 517 cases of indecent assault, 19 687 cases of assault to do grievous bodily harm and 21 736 cases of common assault were reported during this period. This represents only a third of the actual problem.

The Ravensmead community is an impoverished community in the Western Cape. A large proportion of the population are poorly educated with >30% having only a primary education. Less than 4% of residents have any form of tertiary education. This is according to census data from 2006. (Appendix 8).

The sample reflects a slightly higher level of education. This could be because Census data was generated 4 years ago. Greater opportunities for and recognition of the importance of education by the youth means that a higher proportion of young people strive to obtain a higher education. More recent Census data may reflect this trend but is currently not available. This could also be because people agreeing to conduct the survey were more educated and thus had a greater appreciation of the importance of the subject. However this is unlikely to have had a huge effect as very few people refused to partake and a high proportion of respondents had only a primary and secondary level of education. The greater discrepancy was in the secondary and tertiary level of education.

In the Case Record reviews, 250 cases were included in the study. The results obtained from all these case records were included in the data analysis of this research project. Data was recorded as it was documented in the case records. Only clearly documented data could be recorded and included in the study. It was unfortunate certain areas especially with regard to home circumstances, and perpetrator profiles, contained incomplete information. This limited the conclusions that could be drawn from this section of the research.

The Qualitative In-depth Interviews were conducted at the Karl Bremer Rape Crises Centre. The parents/guardian of the victim was interviewed on presentation or at a pre-arranged follow up. All parents/guardians approached to participate were willing to partake in the research study. Several of them indicated gratitude for the opportunity to talk about what had happened, their feelings and concerns. In most instances, the abuse had just occurred or been reported and interviewees were still processing the magnitude of what they had been through. Sensitivity was required so as to reduce the risk of secondary traumatization. Interviews were conducted in a private room at the Rape Crises Center. Sufficient time was available to conduct the interviews calmly and thoroughly. The fact that the incident of abuse had occurred so recently was advantageous in that occurrences, actions taken and feelings were fresh and could thus be accurately relayed. However, consideration must be given to the fact that interviewees may have had more clarity and may perhaps have had different perspectives if they had more time to recover from the initial shock of what had happened.

Discussion of Research Findings

A number of interesting findings regarding the Ravensmead community's knowledge and perceptions of child sexual and physical abuse are presented in this data.

Discussion of definitions of child sexual and physical abuse

Only 44 out of the 279 respondents to the questionnaire demonstrated a good understanding of what constitutes both sexual and physical abuse. This means that only 44 respondents recognized all or most aspects of physical and sexual abuse as described above. Respondents were more likely to recognize rape and sexual assault as acts of child sexual abuse, with fewer respondents recognizing acts of sexual grooming and sexual exposure as being abusive. This was particularly noticeable when respondents were expected to explain what they meant by Child Sexual Abuse in an open-ended question. This could be due to literacy problems within the community and reflect difficulty with self expression rather than an actual lack of understanding. The presence of a research assistant

meant that poor understanding of the question or difficulty writing was unlikely to be reasons for poor performance on this question. Only 147 respondents demonstrated a good understanding of sexual abuse based on the open-ended question(F*igure 7).* Further more Vignettes were used in a closed ended approach to assess situations that respondents perceived as sexual abuse. Here respondents were expected to recognize all aspects of sexual abuse in order to be assessed as having a good understanding. Respondents performed better in this question with 213 demonstrating a good understanding of sexual abuse in this question. A limitation of the vignettes however is that because of the broad definition of sexual abuse, all scenarios depicted could be viewed as abusive and thus actual and depth of understanding could not be assessed in instances where all vignettes, although correct, were selected as depicting abusive situations.

Understanding of the definitions of physical abuse was also assessed with the use of an open-ended question and the use of vignettes depicting scenarios that could be viewed as physical abuse. The open-ended questions presented the same challenges as the question on sexual abuse. As physical abuse is defined as any act of intentional injury inflicted on a child, loose definitions such as 'hitting/ beating a child' were accepted as demonstrating a good understanding in the open ended questions. Thus 155 respondents demonstrated a reasonably good understanding of physical abuse based on the open-ended questions(F*igure 8*). Only 144 respondents demonstrated a good understanding of physical abuse based on the vignettes, this could be because less 'serious acts' of physical abuse are in fact not recognized as being abusive.

Thus it can be seen that greater proportion of respondents demonstrated a good understanding of sexual abuse than did physical abuse. This could be because while a general attitude of disgust and unacceptability of any acts of sexual exposure of children exists among community members, many aspects of physical abuse may be accepted as the norm. P. Lachman[1] in his study conducted in the early 90’s on the child abuse reporting system in the Western Cape highlighted that more than half of all reported cases of child abuse were for child sexual abuse. He offers a possible explanation for these high percentages of reported child sexual abuse cases being due to underreporting of physical abuse due to acceptance of violence against children as being the norm.

A study conducted by L. Pierce et al[3] in 2003 examined the definitions of child abuse and neglect in South Africa exploring and comparing the view points of lay persons and those working with victims of child abuse. The researcher found that all respondents ranked child sexual abuse as most serious. Physical abuse was ranked as the eleventh most severe category of child abuse, she concluded that this reflected that several forms of physical abuse were acceptable to many South

Africans, even those working with child abuse.

Perceptions of Victim Profiles

Community members' perceptions of the victims of child physical and sexual abuse were assessed with relation to four aspects. These were perceived age of victims, perceived gender of victims, perceptions of circumstances predisposing to abuse and perceptions of places where abuse may occur.

Age

Respondents to the questionnaire survey were asked to select an age category, which they perceived as being the age range in which most cases of child physical and sexual abuse occurred. Six age categories were listed ranging from 0-12yrs with one "all ages" category. 30 % of respondents indicated a perceived age bias amongst victims of child sexual and physical abuse. In the proportion of respondents who indicted a perceived age bias amongst victims of child abuse most respondents (60%) perceived child victims to be under the age of 6yrs. As many as 70% of respondents indicated their perception that sexual and physical abuse of children occurred in all ages equally i.e.: no age bias with respect to victim profile existed (*Figure 21*). This could be viewed as partially true as children of all ages are at risk of sexual and physical abuse and abuse does occur in children of all ages. However studies seem to suggest that certain age groups are more at risk. A descriptive study conducted by P. Howard[2] on child abuse in Alexandra look at cases of child sexual, physical abuse and neglect presenting at the Alexandra health centre. This study demonstrated that 63% of child victims were older than 6years. A study conducted by S.Andronikou et al[7] at the Red Cross War Memorial Children's Hospital in Cape Town showed the mean age of child victims of violence (including victims of sexual violence) to be 6yrs and 9 months but that risk peaks occurred at the age of 3-4 yrs and again after the age of 10 yrs.

The case record review conducted, looked at the profiles of victims presenting at the Karl Bremer Hospital, Cape Town from January 2009 to December 2009 and demonstrated the mean age of victims to be 6.18yrs (SD3,22), with peaks at the age of 3-4yrs and again at 10 and 12 years. The majority, 60% of victims were above the age of 6 years.(F*igure 18*)
This seems to suggest that in our population children above the age of 6yrs are more at risk of being abused particularly those over the age of 10 yrs. This could be due to anatomical changes that occur in children after the age of 10 years. Confusion and sensitivity regarding sexual identity at this age may also allow for easy victimization. Another interesting peak seems to occur between the ages of

3-4yrs. This could be due to children at this age becoming more social and broadening their preferred sphere of interaction beyond that of their primary caregiver. Further research regarding age category risk and reasons thereof may be useful in strategizing prevention campaigns.
Six out of ten victims included in the in-depth interviews were aged 10-12.*(Table IX*)

Gender

Perceptions of gender bias relating to victims of child sexual and physical abuse were explored. Respondents were asked whether they perceived girls or boys to more often be victimized or whether both were victimized equally. Child sexual and physical abuse was explored separately. 63% of respondents indicated that child sexual abuse happens equally to both boys and girls. 35% indicated that females were more often sexually abused than males.(F*igure 11*)
A study conducted in Alexandra (1991) found that 96% of sexually abused children were female. In a study conducted by S.Andronikou et al[7] at RXH in 2001 looking at the case records of 200 victims of child sexual abuse over a nine year period it was found that 87% of victims were female. A literature review by K.Lalor[5] in 2004 reviewed six clinical studies of child sexual abuse and found that 80-95% of victims were female. The case record review conducted at Karl Bremer hospital found that 76% of victims of child sexual abuse were female, while 24% were male.(F*igure 19*)
P.D. Carey[18] in 2008 explored risk indicators and psychopathology in traumatized children with a background of sexual abuse and found female gender ($P = 0.002$) to be a predictor for child sexual abuse. Thus research illustrate that females are still more often victims of sexual abuse than are males. However based on these studies there seems to be a trend that increasing numbers of males are falling victim to sexual abuse. This trend could be due to a greater number of sexual abuses of boys being reported or due to an actual increase in the number of boys being sexually assaulted. It is interesting that definitions of rape and sexual abuse have changed as it becomes increasingly recognized that sexual abuse happens to both males and females. The Criminal law (sexual offences and related matters) act no32 of 2007[17] saw a change in definition of rape to include acts of anal and oral penetration, which were previously classified as sexual assault rather than rape. However insufficient studies have been reviewed here to accurately comment about this possible trend. Further research regarding this is required.

In this research, 70% of respondents to the questionnaire indicated their belief that child physical abuse happens equally to both males and females, while 22% thought that physical abuse happens more commonly to females.*(*F*igure 10)* S. Andronikou et al[7] in the study conducted at RXH, looking at incidents of violence against children found that 56% of victims of violence were male.

In the case record review conducted at Karl Bremer Hospital only 4 cases of physical abuse and 3 cases of combined physical and sexual abuse presented. Of the 7 cases, three victims were female. Research studies conducted on child physical abuse are few. The above cases record reviews seem to suggest that victims of child physical abuse are more often male.

Home circumstances predisposing to Child Abuse

Community members were asked to indicate which home circumstances or environments may predispose to child physical and sexual abuse. Most (90%) of respondents thought that alcohol abused by adults in the home and lack of parental supervision were risk factors for child abuse. A.M. Mathoma et al[14]. conducted a study in Botswana regarding the knowledge and perceptions of parents regarding child physical and sexual abuse also illustrated the perception that alcohol abuse rendered parents negligent and more likely to commit sexual abuse. Negligent parents were also thought to be a predisposing risk for child abuse. Several studies support the view that lack of parental supervision predisposes to child abuse. K.lalor[5] highlights the fact that risk factors for child sexual abuse identified in more than one study include absent parents, high numbers of step fathers, unaccompanied or street children, being raised without one's father and poverty as being risk factors for abuse. A study conducted at the university of the North in South Africa by S.N.Madu[19] explored the relationship between absent parental physical availability and child sexual, physical and emotional abuse and found that child sexual abuse was predicted by prolonged periods of not living with the biological mother and by having ever had a step father or adoptive father. A total of 58% of the Ravensmead sample identified step parent families as a risk factor for child abuse. Single parent families have also been identified as posing significant risk for child abuse. P.D.Carey[18] in 2008 explored risk indicators and psychopathology in traumatized children with a background of sexual abuse. In this study the author used multinomial regression analysis and found having a single parent to be a predictor of child sexual abuse (P = 0.01). Only 39% of respondents in the Ravensmead sample identified single parent families as being a risk for child sexual and physical abuse. There was no significant influence of parental status or marital status on respondent's choice of answer. Single parents were not found to be significantly more likely to say that single parent families were not at risk (P value 0.07) than the rest of the sample. This could be as a result of large numbers of single parent families in Ravensmead and respondents not being aware of abuse occurring in these families. In answering questions such as this one tends to draw on ones own experience and on what is portrayed in the media.

It is interesting that in the case record review of this study, conducted at the Karl Bremer Hospital Rape Crises centre, that although family structure was not clearly documented in most case records, at least 31% of victims were clearly documented as belonging to single parent families.*(Table V*) This data was drawn from information given to reception staff on admission of these cases thus might be inaccurate depending on the vigilance of the person entering the data. However it does concur with the findings of other research.

The qualitative aspect of this research also found the lack of a strong male parent figure to be a dominant theme emerging from the interviews. At least 4 out of the ten parents/guardians interviewed were single mothers, a further 4 although married had either separated from their partners at the time of the abuse, or had an absent father or mother (in one case) in terms of caring responsibilities.

Places where abuse occurs

When asked where child abuse may occur 106 (40%) respondents recognized that abuse could occur anywhere. Places that the least respondents recognized as places in which abuse could occur are public places and religious institutions.(Figure 12) A national youth victimization survey (accessed from Fact Sheet Violence Against Children 2008), conducted in 2005 by Leoschut[20] found that 32% of victims of sexual assault were assaulted in public entertainment areas. The high rate of sexual assault occurring in public places is probably as a result of youth between the ages of 13 and 18 being included in the study but highlights an important misconception that child abuse does not occur in public places.

When asked to indicate which place was considered most likely for child abuse to occur, 47% of respondents indicated that abuse was most likely to occur in the child's own home. Cumulatively, a further 25 % of respondents indicated their opinion that child abuse was most likely to occur in a neighbours home, the street outside the child's home or in the neighbourhood park.*(Figure* 13*)*
A retrospective record review conducted by A.G Feiggen et al[8] at RXH in 2004 looked at victims of non-accidental head injury presenting to the trauma unit. In this study 85% of assaults occurred in the child's own home. Another study conducted at the same hospital in 2001[7] looked at several forms of violence against children, also found that most cases of injuries occurred in and around the child's own home. It also notes that child abuse is more likely to occur in homes where violence occurs. The youth victimization survey conducted by Leshout[20] showed that 16.2% of sexual assault

occurred in the child's own home, 18.6% occurred in the street outside the child's home and 22.4% occurred at school, and 6.6 % at homes other than the child's own home. In the Ravensmead survey, 82% of respondents recognized that abuse may occur at school and 89% of respondents recognized that abuse also occurs in homes other than the child's own home.(*Figure 12*). In Total 70% of respondents correctly identified the home and place close to the home as being the most likely places in which child abuse would occur.

In the qualitative aspect of this research, it was also found that in all the cases interviewed, the abuse occurred either in or in close proximity to the child's home. In addition, at the time that the abuse was perpetrated the parents were physically nearby in many instances but were unaware that the abuse was taking place. Parents in these case interviews were unsuspecting of the circumstances under which the abuse occurred (this was one of the themes identified)meaning that they thought the places their children had gone to were safe or that the supervision they had was adequately protective, but in all instances they were wrong. This is perhaps because although respondents are aware that child abuse happens in or around the child's home one never expects it to occur in or near to one's own home. Thus knowing predictive circumstances may not equate to recognizing predictive circumstances in ones own environment. This highlights the need to teach communities to own the problem and accept it as something that could happen in their own homes and thus be more personally involved ensuring adequate protection measures are in place.

Guilt of Victim

One of the questions in the survey explored whether or not child victims of physical and sexual abuse were ever to blame for the occurrence of the abuse. Although 80% of respondents thought that children were never to blame for the abuse, 19% thought that they were sometimes to blame and 1% thought that they were always to blame. It is however interesting that respondents over the age of sixty were significantly more likely to think that children may be to blame for the abuse.(*Appendix 9*) This could be because recognition of the rights of children has only been highlighted in recent years, with younger generations showing greater respect for and recognition of the rights of children. Older generations may be of the opinion that the current generation of children mature too early and thus display adult like behaviour early on and thus should assume responsibility in an adult manner. A study conducted in Botswana and Swaziland (A.M.Mathoma et al[14]) explored the knowledge and perceptions of parents regarding child sexual abuse. This study also found that respondents thought that children were partially to blame for being sexually abused

at times arguing that children's manner of dressing, watching television programs on sex and desire for material possessions puts them at risk of being sexually abused. This however is a serious misconception that needs to be addressed as any form of sexual or physical abuse even if directed at an adult should never be blamed on the victim.

In two of the in-depth interviews, the mother interviewed directed anger towards the victim after finding out about the abuse, indicating partial blame attributed to the victim.
This would be an important point of education as blaming child victims even partially for the abuse that they have been subjected to has several implications. Many victims of abuse already often feel guilt and this will enhance the burden of guilt unfairly born by victims of abuse. It also may decrease the guilt of the perpetrator, making it a more acceptable offence. It may also increase complacency within communities to combat a problem which is perceived as self induced by the victim.

Perpetrator Profile

Respondents to the questionnaire survey were asked to indicate their perceptions regarding possible perpetrators of abuse. 143 respondents realized that anyone may be found guilty of child sexual and physical abuse. More than 90% of respondents believed that the child's father and step father were potential perpetrators of child abuse. Fewer respondents believed the child's mother (76%) and step mother (84%) to be potential perpetrators. 47% of respondents perceived the child's step father to be one of the most likely perpetrators of abuse. 25% of respondents perceived the child's biological father to be one of the most likely perpetrator of abuse. Only 13% and 15% of respondents respectively perceived the child's step mother and biological mother to be one of the most likely perpetrators of child abuse.(*Figure 15*) This demonstrates the perception that male gender is seen as a key characteristic of perpetrators of child physical and sexual abuse. Several studies have shown that most perpetrators of sexual and physical abuse are in fact male. A study conducted by A. Fieggan et al[8] at RXH looking at incidents of violence against children under the age of 13yrs found that 70 assaults, 81% of the perpetrators were male usually the child's father (41%) or another family member (20%). A clinic based study in Alexandra looking at cases of child sexual abuse found the child's father to be the perpetrator in 38% of cases. Another study conducted at RXH in 2001[9] examined the case records of 200 victims of child sexual abuse and found that 99% of perpetrators were male. All perpetrators of sexual abuse in the qualitative aspect of this research were male.

An important finding revealed by the literature is that in most cases of child abuse perpetrators are known to the child. The SAPS[6] report that in 70% of cases of rape the perpetrator is in fact known to the victim. The youth victimization survey conducted in Cape Town in 2005[20] found that in 16% of cases the perpetrators were relatives or members of the child's household. A further 29.8% were known community members and 9.8% were friends or acquaintances of the victim. The study conducted at RXH examining 200 cases of child sexual abuse found that in 70% of cases the perpetrators were known to the victim. 26% of assailants were neighbours, 18% family friends or acquaintances and in 6% the biological father.

In the Ravensmead survey 47% of respondents identified the step father to be the most likely perpetrator of child abuse. This is likely to be a reflection of media statements and reports. It was found that 27% of respondents to the current study perceived strangers to be the most likely perpetrators of abuse.(*Figure 15*) This may indicate a need for education regarding perpetrator profiles.

In the in-depth interview all suspected perpetrators were either close relatives, household members or neighbours. In three of the cases the suspected perpetrators were children under the age of 18yrs. What is also of interest is that only in one case where the assailant was well known to the family was the parent suspicious of his behaviour prior to the abuse occurring. In all other cases, the parents expressed surprise that the perpetrator was capable of such an act and said that it was seemingly out of character.

Injuries Sustained

Respondents were also asked whether they thought victims of child sexual and physical abuse suffer visible injuries. A total of 30% of respondents were of the opinion that child victims of sexual abuse always suffered visible injury, 60% thought they sometimes suffered visible injury and 10% thought they never suffered visible injuries. It is important to note that absence of injury cannot exclude sexual abuse and that victims of sexual abuse do not always suffer visible injuries. This is evident if one looks at the definitions of child sexual abuse and the fact that even non physical sexual violation (e.g. sexual grooming) also constitutes abuse and is considered a criminal offence. Further reasons for absence of injury includes the perpetration of sexual acts during which no injury was inflicted upon the child (e.g.: touching or kissing the child inappropriately, coercing a child into performing sexual acts on the perpetrator and time elapse between abuse occurring and being

reported allowing time for healing to occur and victims hiding injuries due to embarrassment.

Visible injury could also have been interpreted by some respondents as visible emotional injury for example, noticing behavioural changes in child. Even in this interpretation not all children will display noticeable behavioural or emotional responses to having been abused. Some clinical studies have also supported the view that the absence of an injury cannot exclude child sexual abuse. P.A. Howard[2] in the study conducted in Alexandra included all children with a positive history of child abuse even in the absence of any clinical findings to support this diagnosis. A.B. Van As et al[9]. In his study conducted at RXH looking at the patterns of injury, management and outcome of child rape victims also noted that absence of injury could not exclude child sexual abuse.

The parents of victims in the In-depth interviews failed to recognize any emotional or physical signs that sexual abuse had occurred. In retrospect one parent noted that she had noticed blue rings around her daughters eyes (only afterwards realizing it was due to excessive crying) and that she stayed in her room a bit more than usual but not enough so to raise any suspicion.
With regard to physical abuse, 35% of respondents thought that victims of physical abuse would always suffer visible injuries, 58% thought sometimes and 6% thought victims of child physical abuse would never suffer visible injuries. By definition physical abuse involves some act of physical harm being inflicted upon the child but even so injuries may not always be outwardly visible. Certain acts of physical violence may not leave visible injuries (especially less violent acts) but may be equally emotionally scarring to the child (e.g. frequently slapping the child in the face or pulling the child by the ears may not leave visible injuries but are very emotionally and potentially damaging acts). Again, even when visible injury has been inflicted, time elapsed between abuse and reporting may result in healing of previously visible wounds and 'covering up' of injuries by children may prevent abuse from being outwardly obvious.

Respondents responses to victims of child abuse

When respondents were asked what they would do if they became aware of a case where a child was being sexually or physically abused, 82% indicated that they would report the abuse to the relevant authority. Only 18% indicated that they would not report the abuse to police or social services indicating that they would either tell the child's parents, confront the abuser, befriend the child, not tell anyone or something other (e.g.: confide in a community member or acquaintance knowledgeable about the law or social services*).(Table I)* This is an important finding as reporting

cases of child abuse to the authorities is in fact mandatory for all persons according South African Law (Sexual offences (and related matters) Act no32 of 2007 and Children's Act 38 of 2005)[17]. The sexual offences act referred to above stipulates that any person having knowledge of a sexual offence against a child must report the offence to the police. The childcare act referred to above stipulates that certain professionals with reasonable belief that a child has been sexually or physically abused must report the abuse to the department of social development, a child protection agency or to the police. It can thus be seen that according to the Sexual Offences and related matter act 32 of 2007 it is a criminal offence for anyone not to report child sexual abuse to the police. Although most community members indicated that they would report the abuse, this number could be falsely high, as people may have indicated what they feel they should do rather than what they actually would do. Only three respondents indicated that they would not report the abuse at all, as they felt it was not their concern. The above findings may illustrate a falsely high level of accountability amongst respondents. A study conducted in the USA by L.Bensley et al[21.] compared hypothetical responses to victims of child abuse to actual responses and found that although only 1% of individuals hypothetically reported that they would not report the abuse, of the respondents who knew of an actual case of abuse 16% admitted to doing nothing. It is however highly probable that accountability in this regard differs from community to community and thus a better indication of the Ravensmead communities actual level of accountability in terms of reporting child abuse would be to look at the action taken by people in the community who are aware of children being abused. In the questionnaire survey 49% of respondents indicated that they would tell the child's parents.(*Table I*) It is interesting to note that in the in-depth interviews several of the parents were informed of the abuse by concerned members of the community who had come to know of the abuse. Thus in these cases the courage shown by these community members in speaking out gave a voice to the victim and caused the abuse to be recognized.

When asked where respondents would report the abuse, 70% of respondents indicated that they would report it to the police or local welfare agency. When asked to name facilities within the community to which they could report abuse 67% of respondents mentioned the police station. 15% of respondents said they would report it to the local welfare but were unable to state the name or location of such a welfare, 22% said they did not know where to report abuse. Only 9% of respondents were able to name a local welfare agency. Reporting abuse to the police is the preferred response according to the Sexual offences act but the child care act highlights the reporting of abuse to any welfare agency or accountable professional.

The in-depth interviews however revealed that several fears relating to reporting of abuse to the

authorities exist. Even the parents of the abused victims express some reluctance and fears in approaching the police. Many of these parents relied on friends and acquaintances that were involved with or employed by the police or social services to help them contact the police. Some went to the local clinics that referred them to the police. This suggests a need for a community based organization viewed as less threatening than the police services to act as a go between (role played by community based welfare organizations) and highlights the importance of community members being aware of which organizations exist in the community and how to contact them.

Education programs

All but one respondent were of the opinion that children should be taught about child abuse and where to find help. The majority of respondents thought they should receive the information at home (74%) or at school (68%). It is good to note that 49% also thought community awareness programmes would be useful in educating children on the subject of child abuse. This information is important as understanding whether and what kinds of education programs are acceptable to specific communities helps in structuring education programs that are suited to the community. A total of 74% of respondents indicated that education programs should be aimed at all adults and children in the community reflecting a general attitude of interest within the community. Only 21% indicated that education should be aimed primarily at parents and children.(*Figure 16*)

RECOMMENDATIONS

Feedback to Involved parties

An important step to initiating change would be to give feedback into the community from which the information was drawn. Thus Local NGO's, social services and Police services should receive feedback regarding the findings and recommendations of the research. Feedback should also be given to those parties directly involved in and who have shown an interest in the research project. This would include The Staff at the Rape Crises Centre at Karl Bremer Hospital, community participants in the questionnaire survey and interviewee's who partook in the in-depth interviews. Feeding information back directly to the Ravensmead community will help to empower individuals who have already expressed an interest within the community. Although this would be a small start it might foster a sense of ownership having been part of the process from the outset and encourage them to take up their role in speaking out and taking action against child abuse in their direct environment.

Improving Knowledge of Laws and Definitions

A key finding of the research is that only 44/279 (15%) respondents had a good overall understanding of what child physical and sexual abuse is. It is impossible to combat a problem without understanding what it constitutes. Thus knowledge of the definitions of child sexual and physical abuse as defined by South African law should be relayed to the Ravensmead community. A practical way of doing this would be to involve the SAPS and the Western Cape Department of Education in organizing age appropriate programmes at schools creating awareness of the laws relating to child physical and sexual abuse (rights and responsibilities awareness). This will not only create an awareness of rights but knowledge about the criminal nature of their actions may also discourage teenage offenders. It is however not the understanding of the children but that of the adults that was shown to be lacking by the research. Adults within the community also need to be reached. It is thus recommended that community based N.G.O's and social services community based awareness programs aiming to teach adults in the community specifically about the new laws and definitions of child physical and sexual abuse. This will provide community members with a sense of what the law supports as constituting child abuse and strengthen individuals’ stance against child abuse knowing that they are backed by the law.

Education regarding victims and perpetrators profiles

An important finding highlighted by this research is that child abuse often occurs under the least expected circumstances and in places considered safest and by people considered to be trusted by the victims and their families. Community awareness programmes should aim to increase community vigilance with regard to the children, creating awareness that abuse happens under the most unsuspecting circumstances and that no one is exempt from it occurring. A child abuse awareness programmes should be organized to run at strategic places where several community members can be reached. Involving schools in assisting with running programs to educated parents will be useful in reaching parents. Other members of the community should be reached through awareness campaigns organized at churches/ other religious institutions and workshops run within the community by social and health services to which all members of the community are invited. These workshops should be well advertised using the findings of this research project as evidence of the need for education within the community and to focus the content of these workshops in areas where knowledge is lacking and perceptions are skewed.

Increasing community accountability

A sense of community responsibility needs to be embedded into the community whereby each community member takes responsibility not only for their own well being but also for the well being of every other community member. This is best done by involving community members from the outset in combating child abuse. Interested community members who partook in the survey should be identified and approached to actively involve themselves in educating the community regarding child abuse. In addition to giving feedback to all participants regarding the finding, all participants should be invited to attend a workshop on child abuse education. This workshop should be run in conjunction with local welfare/ social services and police services in the area. In this workshop ideas should be drawn from the community members on targeting other community members. Key community members with a keen interest in alleviating child abuse should be identified to spearhead ongoing education programmes and eventually targeting prevention programs at people most in need.

Greater Visibility of NGO's and Social services in the area

It is evident from the research that community based NGO's and social services geared to help

victims of child physical and sexual abuse importantly bridge the gap between community members and the police when it come to help seeking and reporting of abuse. Community members however are largely unaware of which organizations and social services they can approach in their area. Thus these services need to make themselves, their mission statements and function better known to community members. This can be done through clearly sign posting premises within the community, sending out pamphlets to households informing community members of their function, location and contact numbers. Also strategic positioning of representatives within the community for example linking specific representatives to schools or making use of interested volunteers from several sections of the community and educating them regarding all aspects of child sexual and physical abuse. These individual should make their presence known to community members providing an accessible and unthreatening avenue for help.

Destigmatising fears relating to police reporting of the abuse

It is ironic that the police service being the most visible and well-known avenue for help within the community is also evidently a much feared avenue for help. This detracts from its accessibility to those in need of help. It is recommended that the police services actively involve themselves in alleviating these fears through their active participation in educating the community regarding their rights, the rights of their children and the role the police plays in ensuring these rights are upheld specifically relating to child abuse.

Strengthening implementation of Police Protocols relating to child abuse.

This bears particular reference to protocol relating to prosecution of child offenders. Clear guidelines should be in place for prosecuting child offenders of sexual assault. Community members reporting abuse perpetrated by child offenders should not be made to feel responsible for considering the well being of such offenders.

LIMITATIONS OF STUDY

1. Paucity of published studies conducted in South Africa regarding community perceptions on child physical and sexual abuse, meant that it was not possible for the researcher to build on prior studies relating to community perceptions to obtain deeper and more complete information. The study thus takes a broad look at community perceptions on child physical and sexual abuse and identifies areas of concern regarding knowledge and perceptions. Further studies are needed to take a more in-depth look at specific areas of concern identified by the research. For example, the research identifies a perception amongst community members that the abused child is sometimes to blame for the abuse. More in-depth research would reveal the reasons and circumstances under which such blame is attributed to the child victims.
2. Incomplete recording of information in case records limited information that could be drawn from this section of the research. Information was especially limited regarding family circumstances of victims, places where abuse occurred and perpetrator profiles, making it difficult to accurately describe these aspects of cases presenting to Karl Bremer Hospital Rape Crisis Center.

CONCLUSION

Knowledge gaps exist in the understanding of child physical and sexual abuse within the Ravensmead community. Most cases of child abuse occur under unsuspicious circumstances, and are perpetrated by somebody known to the victim. Female gender still seems to pose a significant risk for sexual abuse. The mean age victims of physical and sexual abuse presenting at the Karl Bremer Hospital Rape Crises Centre, was 6.18 years. Unperceived barriers exist to accessing avenues for help. Community accountability and knowledge needs to be increased through community specific prevention programmes.

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Appendix 1

Questionnaire Survey – Child Physical and Sexual Abuse

Thank you for taking the time to complete this questionnaire. Your participation is needed in order to complete this research, which aims to benefit your community. This research project will also allow me to complete my degree, and your assistance with this is greatly appreciated. Please ensure that you have read, understood and signed the attached consent form.

Please complete all questions fully.
Completion of demographic details will greatly help with analyzing results. Please note that your name is not requested as this questionnaire in anonymous.

Thanking you.
Dr. L.C. Foster

Demographic Information:

Age:

18-25 ☐ 25-35 ☐ 35-50 ☐ 50-60 ☐ > 60 ☐

Gender:

Male ☐ Female ☐

Marital Status:

Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐

Parental Status:

Biological parent ☐ Step parent ☐ Legal guardian ☐ No children ☐

Level of Education:

< Grade 7 ☐ Grade 8 - 12 ☐ Tertiary Education ☐

Your Perceptions of Child Physical and Sexual Abuse

1. What is Child Sexual Abuse? Please explain in your own words.

____

____

____.

2. What is Child Physical Abuse? Please explain in your own words.

____

____

____.

3. Do you think a child is being **Sexually Abused** when:

	Yes	No	Unsure
a. Child's neighbour shows him movies/ pictures of people having sex.			
b. Child's father touches her breasts before tucking her in at night.			
c. Child's uncle kisses her on the lips, she kisses him back willingly.			
d. A stranger exposes himself (his private parts) to a child.			
e. Parents engage in sexual intercourse in front of their child.			

4. Do you think a child is being **Physically Abused** when:

	Yes	No	Unsure
a. A parent hits a child with a shoe for misbehaving.			
b. A father purposefully burns his child's hand with a cigarette butt.			
c. A mother shakes her baby vigorously because he won't stop crying.			
d. A mother falls asleep with her child on her lap, he falls and injures his head.			
e. A father under the influence of alcohol, pushes his child against the wall, banging the child's head.			

5. Child Abuse occurs most commonly in which age group? Choose one.

< 1month ☐ 1 month - 1 yr. ☐ 2 - 5 yrs. ☐ 6 - 8yrs. ☐ 9 - 12 yrs. ☐ All ages ☐

6. Child **Physical** Abuse happens most commonly to: Choose one.

Boys ☐ Girls ☐ Both equally ☐

7. Child **Sexual** Abuse happens most commonly to: Choose one.

Boys ☐ Girls ☐ Both equally ☐

8. Do you think that Child Sexual/ Physical abuse is more likely to occur in homes where:

		Yes	No	Unsure
a.	Alcohol is abused by adults in the home.			
b.	Parents are not always aware of their child's whereabouts.			
c.	A single parent cares for the children.			
d.	Extended families (aunts, uncles, cousins) live together.			
e.	Step parents care for the children.			
f.	Traditional family units (mother, father, children only) live in the home.			
g.	Parents are well educated and employed.			

9. Where may Child Abuse occur?

		Yes	No	Unsure
a.	In the child's own home.			
b.	Neighbour's home.			
c.	School.			
d.	Church, mosque, other religious institutions.			
e.	In the street outside the child's home.			
f.	In the neighbourhood park.			
g.	Sports grounds.			
h	Other relatives' home			
i.	Shopping centres.			

10. Where do you think **most** cases of Child Abuse occur? Choose one (√ appropriate box).

a.	In the child's own home.	
b.	Neighbour’s home.	
c.	School.	
d.	Church, mosque, other religious institutions.	
e.	In the neighbourhood park.	
f.	Other relative’s home	
g.	Shopping centres.	
h.	Unsure.	

11. Who of the following persons may be found guilty of Child Abuse?

		Yes	N	Unsure
a.	A child's mother.			
b.	A child's father.			
c.	A child's step mother.			
d.	A child's step father.			
e.	A child's teacher.			
f.	A child's neighbour.			
g.	Priest or religious leader.			
h.	Stranger.			
i.	Other Family member			

12. Who are the following persons are **most likely** to be perpetrators of Child Abuse? (Please √ a maximum of two).

a.	A child's mother.	
b.	A child's father.	
c.	A child's step mother.	
d.	A child's step father.	
e.	A child's teacher.	
f.	A child's neighbour.	
g.	Priest or religious leader.	

h. Stranger.

i. Other Family member

j. Unsure.

13. If a child has been Physically or Sexually abused, is it the child's fault? (Choose one).

Always ☐ Never ☐ Sometimes ☐

14. Children who have been Physically Abused suffer visible injuries: (Choose one).

Always ☐ Never ☐ Sometimes ☐

15. Children who have been Sexually Abused suffer visible injuries: (Choose one).

Always ☐ Never ☐ Sometimes ☐

16. What would you do if you knew a child was being Physically Abused?

a. Report it (to Police, Child Welfare or other social services) ☐
b. Keep it to yourself as it is none of your business. ☐
c. Offer friendship and support to the child. ☐
d. Confront the abuser. ☐
e. Tell the child's parents. ☐
f. Other: Explain ☐

____

____.

17. To whom will you report Child Physical/Sexual Abuse?

a. Doctor. ☐
b. Police. ☐
c. Child Welfare. ☐
d. Priest or religious leader. ☐
e. School teacher or principal. ☐
f. Other. ☐

18. How will you contact such persons/ institutions?

Telephonically ☐ In person ☐ Book an appointment ☐ Not sure ☐

19. What facilities are available in your neighbourhood to which you could report cases of Child Abuse? If you do not know of any, please say so.

____

____

____.

20. Do you think that children should be taught what child abuse is and where to seek help?

Yes ☐ No ☐

21. Where do you think they should receive such information?

a. School. ☐
b. Home, from their parents. ☐
c. At church or religious institutions. ☐
d. Community programmes eg. Workshops or awareness days in the community. ☐

22. Who do you think Child Abuse awareness programmes should be aimed at? (Choose one).

a. Children only. ☐
b. Children and parents together. ☐
c. Parents only. ☐
d. All adults in the community. ☐
e. All adults and children in the community. ☐

Appendix 2

Patterns of Child Physical and Sexual Abuse. Perceptions of the Community.

Interview Template

Details of victim:

Age: ____________

Gender: [M] [F]

Type of Abuse: [Physical] [Sexual]

Relationship to perpetrator: ____

Relationship to interviewee: ____

Relationship to person reporting abuse: ________________________________

____

Interview Questions:

- Family structure
- Alcohol/ drug abuse
- Violence in the home
- Issues of neglect

1. Please describe (…victims…) family and home environments with regard to family structure, alcohol/drug abuse, violence in the home, and issues of neglect
2. When did the abuse start, and how did you realize that (….victim….) was being abused.
3. What was your initial reaction to the abuse?
4. When did you report the abuse? How did you report the abuse?
5. What were your fears about reporting the abuse?
6. What happened when/ after you reported the abuse?
7. What has been done to help you and (….victim….) cope with this terrible ordeal?

APPENDIX 3

Data Capture Sheets – Quantitative analysis

1. Month of Presentation:

1.1. ___ □ January
1.2. ___ □ February
1.3. ___ □ March
1.4. ___ □ April
1.5. ___ □ May
1.6. ___ □ June
1.7. ___ □ July
1.8. ___ □ August
1.9. ___ □ September
1.10.___ □ October
1.11.___ □ November
1.12.___ □ December

2. Age Of Victim:

Actual Age: ___________

2.1___ □ 0 -1mnth
2.2___ □ 1mnth-1yr
2.3___ □ 1yr – 5yrs
2.4___ □ 5yrs-8yrs
2.5___ □ 8yrs -12yrs

3. Type of Abuse:

3.1___ □ Physical
3.2___ □ Sexual

4. Family structure of victims of Abuse:

4.1___ □ Traditional family structure
4.2___ □ Extended family living in home
4.3___ □ Single parent family
4.4___ □ Step parent family
4.5___ □ Communal home/living space
4.6___ □ Other
4.7___ □ Not specified

5. Identity of perpetrator:

5.1___ □ Known

5.2___ □ Unknown

6. Gender of perpetrator:

6.1___ □ Male
6.2___ □ Female
6.3___ □ Unknown

7. Relationship of perpetrator to Victim:

7.1 ___ □ Biological mother
7.2 ___ □ Biological father
7.3 ___ □ Stepmother
7.4 ___ □ Stepfather
7.5 ___ □ Guardian/ Adoptive parent
7.6 ___ □ Family friend
7.7 ___ □ Other member of household
7.8 ___ □ Member of extended family
7.9 ___ □ Neighbour
7.10___ □ School teacher/principle
7.11___ □ Priest/religious leader
7.12___ □ Stranger
7.13___ □ Other _____________________________
7.14___ □ Unknown

8. Place where abuse occurred:

8.1___ □ inside child's own home
8.2___ □ inside child's neighbours home
8.3___ □ outside child's own home
8.4___ □ outside child's neighbours home
8.5___ □ Veldt/Bush
8.6___ □ Public place
8.7___ □ School
8.8___ □ Other ___________________________

9. Injuries sustained (sexual abuse):

9.1___ □ Minor bruising/ abrasion
9.2___ □ Tears of hymen or perineum
9.3___ □ No visible Injury
9.4___ □ Severe injury requiring minor surgical intervention
9.5___ □ Severe injury requiring referral to tertiary institution for further management.

10. Injuries sustained (physical abuse):

10.1___ □ Shaken Baby syndrome
10.2___ □ Cigarette burns
10.3___ □ Burns (open flame or hot water)
10.4___ □ Penetrating injuries (other than head)
10.5___ □ Blunt Injuries (other than head)
10.6___ □ Head injury

11. Documented referral to social worker/Social services:

11.1___ □ Yes
11.2___ □ No

12. Child taken to place of safety:

12.1___ □ Yes
12.2___ □ No
12.3___ □ Not documented

13. Child returned home:

13.1___ □ Yes
13.2___ □ No
13.3___ □ Not documented

14. Planned further intervention:

14.1___ □ Yes
14.2___ □ No
14.3___ □ Not documented

APPENDIX 4

Letter of Informed Consent – Questionnaire Survey

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

Child Abuse: Patterns of Physical and Sexual Abuse in the Northern suburbs of Cape Town and a communities perceptions and knowledge on the subject.

REFERENCE NUMBER: N09/03/087

PRINCIPAL INVESTIGATOR: DR L.C.Wicomb

ADDRESS: Karl Bremer Hospital, Bellville

CONTACT NUMBER: 0843064576

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- *The study has three parts to it. The first part is a questionnaire survey that will be conducted in Ravensmead. Participants have been randomly selected and all adult members of the community are eligible to participate. The researcher requires at least 300 participants in order to ensure that the community is adequately represented. The second section involves collecting information from the records of all child victims of abuse presenting to a local hospital in order to describe the patterns of child sexual and physical abuse that occurs in some communities of the Northern suburbs of Cape Town. All records will be kept anonymous. The third component involves in depth interviews with the families of victims of abuse. This will take place at Karl Bremer hospital or another convenient location if so agreed upon.*
- *The study aims to describe the patterns of child physical and sexual abuse occurring in the communities of the Northern suburbs of Cape Town and to gain an understanding of the knowledge and perceptions of the community regarding child abuse. The researcher would also like to identify whether community members would know how and where to*

report abuse and whether you consider education and prevention programmes on the subject to be necessary. The researcher hopes to identify what knowledge and resources are lacking in this community that would help in the prevention of child abuse.

- *Participants in the questionnaire survey have been randomly selected based on street and house number in order to ensure that everyone has an equal chance of being selected to participate. Case records of all cases of child abuse presenting to the hospital over a one year period will be extracted and the patterns of abuse as recorded in these case notes described. Ten families of abused children will also be randomly selected to participate in an in depth interview.*

Why have you been invited to participate?

You have been randomly selected to participate in the study. This means that you qualify as an adult member of the Ravensmead community to participate in the questionnaire survey. Your input into the research project will be greatly valued and will enable the researchers to achieve our aims. Your participation is imperative to the success of the research.

What will your responsibilities be?

You are required to complete the questionnaire survey presented to you. Your name and address will be kept anonymous. All other information should be completed in full. You reserve the right not to answer all the questions however this may mean that we may not be able to include your questionnaire in some of the results of the study.

Will you benefit from taking part in this research?

This questionnaire survey affords you the opportunity of voicing what you feel is lacking with regard to services and education on the subject of child physical and sexual abuse in your community. It further will allow us as researchers to make recommendations as to how this problem should be addressed in terms of education and prevention with particular reference to your community. Thus it aims to benefit the community and particularly those children suffering as victims of child physical and sexual abuse.

Are there any risks involved in your taking part in this research?

There are no foreseeable risks involved in your taking part in this research.

Will you be paid to take part in this study and are there any costs involved?

No you will not be paid to take part in the study but there will be no costs involved

for you, if you do take part.

Is there any thing else that you should know or do?

- *You can contact Dr ...L.C. Wicomb…………at tel: 084 3064576……if you have any further queries or encounter any problems.*
- *You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.*
- *You will receive a copy of this information and consent form for your own records.*

Declaration by participant

By signing below, I ……………………………….…………. agree to take part in a research study entitled *(insert title of study).*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…......…………….. on (*date*) …………..………. 2010.

....

Signature of participant Signature of witness

Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....…......…………….. on (*date*) …………..………. 2010.

....

Signature of investigator Signature of witness

Declaration by interpreter

I *(name)* ………………………………………….……… declare that:

- I assisted the investigator (*name*) ………………………………………. to explain the information in this document to (*name of participant*) ……………..…………………………….. using the language medium of Afrikaans/Xhosa.

- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ....…........…………….. on (*date*) …………...………..2010.

....

Signature of interpreter Signature of witness

APPENDIX 5

Letter of Informed consent – In –depth Interview:

PARTICIPANT INFORMATION LEAFLET AND CONSENT FORM

TITLE OF THE RESEARCH PROJECT:

Child Abuse: Patterns of Physical and Sexual Abuse in the Northern suburbs of Cape Town AND A communities perceptions and knowledge on the subject.

REFERENCE NUMBER: N09/03/087

PRINCIPAL INVESTIGATOR: DR L.C.Wicomb

ADDRESS: Karl Bremer Hospital, Bellville

CONTACT NUMBER: 0843064576

You are being invited to take part in a research project. Please take some time to read the information presented here, which will explain the details of this project. Please ask the study staff any questions about any part of this project that you do not fully understand. It is very important that you are fully satisfied that you clearly understand what this research entails and how you could be involved. Also, your participation is **entirely voluntary** and you are free to decline to participate. If you say no, this will not affect you negatively in any way whatsoever. You are also free to withdraw from the study at any point, even if you do agree to take part.

This study has been approved by the Committee for Human Research at Stellenbosch University and will be conducted according to the ethical guidelines and principles of the international Declaration of Helsinki, South African Guidelines for Good Clinical Practice and the Medical Research Council (MRC) Ethical Guidelines for Research.

What is this research study all about?

- *The study has three parts to it. The first part is a questionnaire survey that will be conducted in Ravensmead. Participants have been randomly selected and all adult members of the community are eligible to participate. The researcher requires at least 300 participants in order to ensure that the community is adequately represented. The second section involves collecting information from the records of all child victims of abuse presenting to a local hospital in order to describe the patterns of child sexual and physical abuse that occurs in some communities of the Northern suburbs of Cape Town. All records will be kept anonymous. The third component involves in depth interviews with the families of victims of abuse. This will take place at Karl Bremer hospital or another convenient location if so agreed upon.*
- *The study aims to describe the patterns of child physical and sexual abuse occurring in the communities of the Northern suburbs of Cape Town and to gain an understanding of the knowledge and perceptions of the community regarding child abuse. The researcher*

would also like to identify whether community members would know how and where to report abuse and whether you consider education and prevention programmes on the subject to be necessary. The researcher hopes to identify knowledge and resources lacking in this community that would help in the prevention of child abuse.

- *Participants in the questionnaire survey have been randomly selected based on street and house number in order to ensure that everyone has an equal chance of being selected to participate. Case records of all cases of child abuse presenting to the hospital over a one year period will be extracted and the patterns of abuse as recorded in these case notes described. Ten families of abused children will also be randomly selected to participate in an in depth interview.*

Why have you been invited to participate?

You have been randomly selected to participate in the in-depth interview. Because you have had a personal experience of child abuse occurring within your family, you are able to provide us with information that those who have not been through this experience cannot. We would like to understand the challenges facing you at home as well as the challenges you are currently facing regarding the abuse of your loved one. Your in-put will provide us with very valuable information and may serve to help you and others who have found themselves in similar situations should recommendations made as a result of this research be put into practice. We will further assist you by referring you to a social worker or psychiatrist should you require such services and have as yet not received it.

What will your responsibilities be?

You will be required to participate in an in-depth interview. This should not take more than an hour of your time. We require you to answer the questions posed to you as fully as possible. You reserve the right not to answer all the questions and to discontinue the interview at any point should you so wish.

Will you benefit from taking part in this research?

This interview affords you the opportunity of voicing what you feel is lacking with regard to services and education on the subject of child physical and sexual abuse in your community. It further will allow us as researchers to make recommendations as to how this problem should be addressed in terms of education and prevention with particular reference to your community. Thus it aims to benefit the community and particularly those children suffering as victims of child physical and sexual abuse.

Are there any risks involved in your taking part in this research?

There are no foreseeable risks involved in your taking part in this research.

Will you be paid to take part in this study and are there any costs involved?

No, you will not be paid to take part in the study but there will be no costs involved for you, if you do take part. We will cover any transport or meal costs that you have incurred in order to be available to partake in the interview.

Is there any thing else that you should know or do?

- *You can contact Dr ...L.C. Wicomb…………at tel: 084 3064576……if you have any further queries or encounter any problems.*
- *You can contact the Committee for Human Research at 021-938 9207 if you have any concerns or complaints that have not been adequately addressed by your study doctor.*
- *You will receive a copy of this information and consent form for your own records.*

Declaration by participant

By signing below, I ………………………………..…………. agree to take part in a research study entitled *(insert title of study).*

I declare that:

- I have read or had read to me this information and consent form and it is written in a language with which I am fluent and comfortable.
- I have had a chance to ask questions and all my questions have been adequately answered.
- I understand that taking part in this study is **voluntary** and I have not been pressurized to take part.
- I may choose to leave the study at any time and will not be penalized or prejudiced in any way.
- I may be asked to leave the study before it has finished, if the study doctor or researcher feels it is in my best interests, or if I do not follow the study plan, as agreed to.

Signed at (*place*) ....…........…………….. on (*date*) …………...……….. 2010.

....

Signature of participant Signature of witness

Declaration by investigator

I *(name)* ……………………………………………..……… declare that:

- I explained the information in this document to …………………………………..
- I encouraged him/her to ask questions and took adequate time to answer them.
- I am satisfied that he/she adequately understands all aspects of the research, as discussed above
- I did/did not use a interpreter. (*If a interpreter is used then the interpreter must sign the declaration below.*

Signed at (*place*) ....…........…………….. on (*date*) …………...……….. 2010.

....

Signature of investigator Signature of witness

Declaration by interpreter

I *(name)* …………………………………………..……… declare that:

- I assisted the investigator (*name*) ………………………………………. to explain the information in this document to (*name of participant*) ……………..…………………………….. using the language medium of Afrikaans/Xhosa.
- We encouraged him/her to ask questions and took adequate time to answer them.
- I conveyed a factually correct version of what was related to me.
- I am satisfied that the participant fully understands the content of this informed consent document and has had all his/her question satisfactorily answered.

Signed at (*place*) ....…......…………….. on (*date*) …………...……….. 2010.

....

Signature of interpreter Signature of witness

APPENDIX 6

HEALTH RESEARCH ETHICS COMMITTEES
Faculty of Health Sciences, Stellenbosch University

CHECKLIST-GENERAL

To be completed by Applicant and checked by Ethics Admin Office

PROTOCOL TITLE:

Child Abuse: Patterns of Physical and Sexual Child Abuse presenting at Karl Bremer Hospital and the knowledge and perceptions of the Ravensmead Community on child abuse.

PROTOCOL NUMBER	PROTOCOL VERSION	PROTOCOL DATE

	CV (max 2 pages)	Investigator Declaration	Conflict of Interest statement signed.	Admin Office Comments
PRINCIPAL INVESTIGATOR:	yes	yes	yes	

SUB-INVESTIGATORS

1.
2.
3.
4.
5.
6.

OTHER STAFF

	Applicant	Comments	Admin Office
	Y /N / NA		
Applicant Signature	**Y**		
Supervisor Signature	**Y**		
HODiv Signature	**N**		
Protocol synopsis	**Y**		
Full protocol	**Y**		
Page numbers on protocol?	**Y**		
Budget	**Y**		
Informed Consent Form	**Y**		
Questionnaires	**Y**		
Other measuring tools/instruments.	**Y**		
Recruitment material/ Advertisement(s)	**N**		
DoH or other letters of approval to conduct research	**N**		
Material Transfer Agreement	**N**		

A. Section B: ***To Be completed by Applicant***

INFORMED CONSENT FOR RESEARCH CHECKLIST.

Element	Yes (PI)	Yes/No (Reviewer)
1. That consent is being sought from the participant to participate in research.	Yes	
2. The purpose of the research and where it will be conducted.	Yes	
3. The expected duration of the participant's involvement in the research.	Yes	
4. The total number of participants that will be involved at this site and/or South Africa and worldwide.	Yes	
5. A description of **all** the processes and procedures to which	Yes	

the participant will be subjected, emphasizing any experimental procedures that are innovative and have not been used in medical practice.

6.	The principal investigator's name and contact details.	Yes
7.	Explanation of participants responsibilities.	Yes
8.	Explanation of any randomization process if applicable).	Yes
9.	Circumstances that may result in the project being terminated or the participant being withdrawn.	Yes
10.	A description of foreseeable risks and discomforts.	Yes
11.	A description of benefits to the participant or others both during and after the research. If there are no expected benefits, the participant must specifically be made aware of this.	Yes
12.	Disclosure of alternative procedures and course of treatments available if applicable	N/A
13.	Description of extent to which confidentiality will be maintained and protected.	Yes
14.	Statement that sponsors of the study, study monitors or auditors or REC members may need to inspect research records.	N/A
15.	Statement that the Health Research Ethics Committee has approved the research.	Yes
16.	Contact details of the committee.	Yes
17.	Explanation of how research related injury will be managed and details of insurance if applicable.	N/A
18.	Explanation as to whom to contact in the event of research related injury.	N/A
19.	Participation in the study is entirely voluntary	Yes
20.	Participants are free to withdraw at any point without explanation or any negative consequences. Their routine health care will not be adversely affected.	
21.	Participants must be informed of their rights to be told any new relevant information that arises during the course of the trial and the ICF should be revised, where appropriate to incorporate this information.	N/A
22.	That the study will be conducted according to the International Declaration of Helsinki and other applicable international ethical codes for research on human subject.	Yes
23.	Any expense to which the participant may be liable.	Yes
24.	Explanation regarding payment for participation or out of pocket expenses	Yes
25.	Identity of the funder , where applicable and any potential conflict of interests.	Yes
26.	Where appropriate, the participant should also be requested/advised to inform his general practitioner and life insurance company or medical aid of his/her participation. ☐ Not considered appropriate/necessary	N/A
27.	Simple, clear language has been used (Maximum Grade 8 reading level) and all medical and technical terms have been explained.	Yes

Section C. To be completed by Applicant

	Yes(PI)	Yes/No (Reviewer)
1. Does the study have relevance and scientific or clinical value and applicability to the proposed research population?	Yes	
2. Does the protocol include an adequate literature review?	Yes	
3. Is the selection of subjects equitable and appropriate; adequate consideration and protection of vulnerable research populations.	Yes	
4. Is the design and methodology appropriate to answer the research question?	Yes	
5. Is the methodology clearly described, in sufficient detail?	Yes	
6. Is the statistical analysis plan, including sample size calculations, clearly outlined and justified?	Yes	
7. Are the inclusion and exclusion criteria clearly defined and appropriate?	Yes	
8. Have risks been minimized and is there an acceptable balance between potential risks and benefits?	Yes	
9. Does the PI have the necessary qualifications, expertise, facilities, and time and support staff, to carry out the proposed research?	Yes	
10. Has a section on 'Ethical Considerations' been included in the protocol?	Yes	
11. Has the informed consent process been clearly explained in the protocol?	Yes	
12. Are issues relating to protection of privacy and confidentiality of data adequately addressed, especially if the study involves a retrospective review of clinical records?	Yes	
13. Has a waiver of informed consent been requested if the study involves a retrospective review of clinical records?	Yes	
14. Does the study involve collection of DNA/RNA and, if so, has consent been adequately sought for this?	N/A	

APPENDIX 7

APPROVAL LETTER TO CONDUCT THE RESEARCH STUDY AT KBH

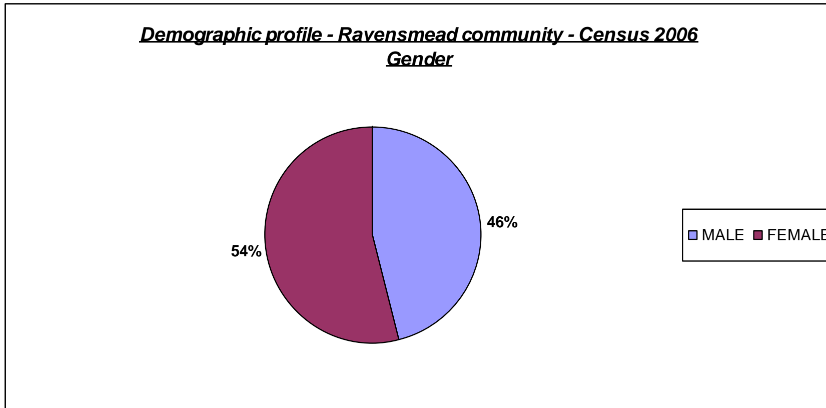
Dear Dr Forster

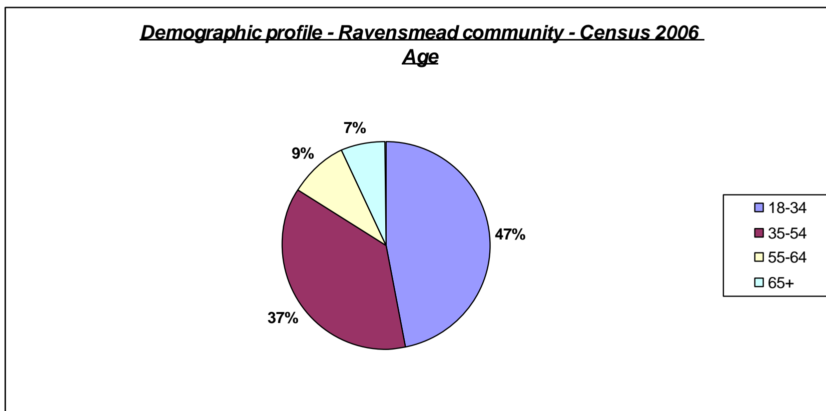
I hereby give permission to start with your research, provisionally that you will provide us with the approval of the Ethics Committee as soon as you received it.

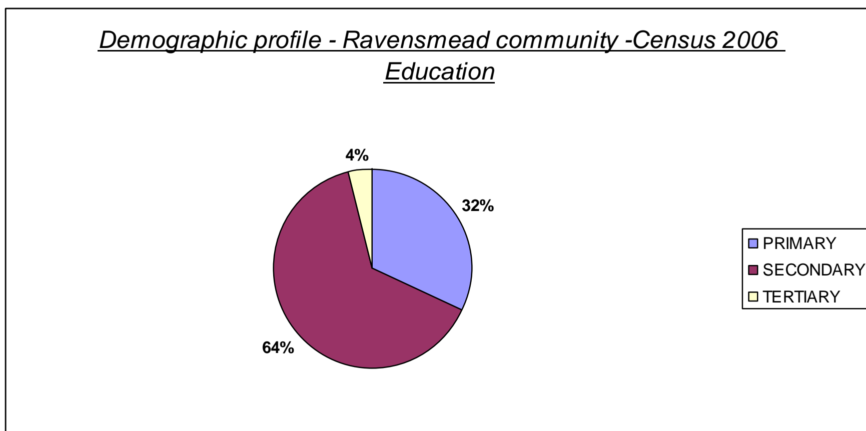
Kind regards
Dr L Naudé
Senior Medical Superintendent

KARL BREMER HOSPITAL

APPENDIX 8







APPENDIX 9

Categorized Histogram: If a child has been Physically or Sexually abused, is it the child's fault?