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CHILD ABUSE AND NEGLECT: SOCIAL WORK EXPERIENCE AT TYGERBERG HOSPITAL

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ABSTRACT

Since the proclamation of the Child Care Act 74 of 1983 suspected cases of child abuse and neglect have been notifiable by medical personnel. This obligation to notify has recently been extended to include social workers and several other categories of people taking care of children. The objective of this study is to share the social work experience in a tertiary care hospital in response to the greater awareness of child abuse and the importance of a central register for every institution or district managing cases of child abuse. A comprehensive register of all suspected cases of abuse in children below 18 years of age and cases of severe malnutrition has been kept at the Social Work Department at Tygerberg Hospital (TBH) in the Western Cape Province since 1987. This register was surveyed for the period 1 April 1994 - 31 March 1995. Five hundred and eighty six children with suspected child abuse were referred to the Social Work Department during this time. Of these, 246 (42%) were evaluated for child sexual abuse, 213 (36%) for physical abuse and 127 (22%) for severe malnutrition and neglect. Social workers from TBH were involved for a median duration of 1-2 months for physically abused and malnourished children, and 2-3 months for sexual abuse cases. A total of 5545 hours were spent on interviews, arrangements of children's safety, completing notification and referral reports, and preparing evidence for court and preparing children for court proceedings during this period. The magnitude of serious child abuse is extensive and more than the present infrastructure can handle. More social workers functioning within well-trained and supervised teams and placed suitably in the service network, notably in the outlying areas, are urgently needed.

1. INTRODUCTION

Child abuse in South Africa has reached shocking proportions. At the National Conference on Crimes against Children held in Cape Town in March 1999 the South African Police Service reported that 33 827 cases of child abuse were dealt with during the period January to November 1998.

In the Child Care Amendment Act (96/96) proclaimed during August 1998 the obligation to report suspected cases of child abuse has been extended to teachers and people employed by or in charge of shelters, places of safety and children's homes. It also makes provision for the implementation of a National Register which should contain information about the victims of child abuse and neglect.

The Western Cape Protocol for the Multi-disciplinary Management of Child Abuse and Neglect, which was compiled by the Institute for Child and Family Development with the Western Cape Child Abuse and Neglect Forum, was presented to the Western Cape Government and accepted

by Mr Ebrahim Rasool, then Western Cape Minister for Health and Social Services, on 6 December 1996 (Institute for Child Health 1996). This protocol was aimed at all government and non-government departments, agencies, organisations and institutions involved in care of children and they are by virtue of their role and commitment to children bound by the protocol. According to this protocol the doctor and social worker dealing with child abuse should report incidents of child abuse to the Provincial Register.

2. OBJECTIVE

The objective of this article is to share the social work experience in a tertiary care hospital with social workers working in primary health care settings and welfare agencies and to highlight the importance of a central register for the hospital, community health centre or clinic.

3. METHODS AND STUDY POPULATION

Tygerberg Hospital (TBH) is an academic referral hospital situated in the Western Cape Province of South Africa. It is a tertiary care facility for both adults and children. There are, however, some secondary care facilities for serving mainly the surrounding communities. The Dental Faculty of the University is adjacent to the Hospital and cross-referral is normal practice.

A comprehensive register of all suspected cases of abuse in children under 18 years of age and cases of severe malnutrition has been kept at the Social Work Department at TBH since 1987. These patients are mainly referred to the social workers by the medical staff of other departments inside the hospital when child abuse is suspected. A limited number of suspected child abuse cases were referred directly to social workers from outside the hospital.

The register contains a copy of the notification form for each patient filed in alphabetical order. The notification form contains the following information:

- Personal details of the allegedly abused child (full names, date of birth, address, also admission and discharge date and folder number);
- The medical and general condition of the child (diagnosis/injuries sustained, the explanation for the injuries, which sometimes differs from the injuries themselves and reveals suspicion of abuse, date and time of injuries, information on the suspected perpetrators, relationship with the child, previous incidents, police involvement, referring person);
- Family composition (which includes information on the parents' age and education level, the number of children in the family, their ages and school standards, and whether the parents practice family planning. This is specifically important in cases of neglect and malnourishment);
- Family relationships (marital status of the parents, relationship between parents, relationship between parents and children);
- Housing and environment (type of housing, number of inhabitants, facilities, e.g. electricity, water and sanitation);
- Work and financial circumstances;
- Social contacts (includes information on alcohol and drug abuse by parents and criminal history);
- Care of the patient (who cares for the patient, will the child be safe at home and, if not, the reason why);

- Evaluation (should include positive and negative aspects);
- Services rendered (actions taken by the social worker to safeguard the child, referrals, is the family already known to a welfare agency?);
- Conclusion and recommendation (especially important when referred to other welfare agencies);
- Name of the social worker involved.

The Social Work Department uses the same standardised form for every patient referred to the Department. The form was designed by the Social Work Department in TBH in co-operation with the local Department of Social Services, Provincial Administration of the Western Cape (PAWC) and regularly revised since 1987 according to developing needs. The notification form has been designed to be used as a referral report to other welfare agencies as well as a summary report for the Social Work Department. This was done to limit the amount of administration involved in child abuse cases.

A concise daily register is also kept, which implies that information is available either on presenting the patient's name or by presenting the date of referral.

The register is cross-checked monthly by the Chief Social Worker to determine the number of patients referred and to make sure that no patients had been missed or services duplicated by social workers. Duplication can easily happen in a large hospital where social workers are scattered across different departments.

The figures in this article are based on the information obtained in a survey that was carried out on cases dating from 01 April 1994 to 31 March 1995. The information from the register and the medical information obtained from the hospital files were combined on a data capture sheet for each incident of child abuse notified to the Social Work Department during this period.

Children who had a clear history of abuse or obvious medical evidence of abuse, or both, were classified as having definite evidence of abuse. Children who sustained accidental injuries as a result of domestic violence were also classified as having been abused. Where a child was documented to have a sexually transmitted disease, it was classified as definite sexual abuse. In patients where both sexual and physical abuse occurred, it was classified as sexual abuse. When the possibility of child abuse was raised and was still suspected after full investigation even though no confirmatory evidence could be found, the case was classified as probable child abuse. In some cases where abuse was highly unlikely after investigation, children were classified as not abused. All children with severe malnutrition (mainly marasmus and kwashiorkor) were investigated for child abuse or neglect, according to the Child Care Act of 1983, but the main goal was to ensure that parents and guardians received the necessary socio-economic assistance.

Information on the patient data sheet was checked by a paediatrician and then entered into a computer database (Paradox 4.0).

4. MANAGEMENT OF CASES

Although children are seen at the Surgical and Gynaecological Departments, none of the medical staff of these departments is involved in the Child Abuse Management Team (CAMT). All children with suspected child abuse are referred to the Social Work Department.

The CAMT consists of 2 paediatricians (1 for physical and 1 for sexual abuse), 3 social workers, 1 child psychiatrist and a number of rotating clinical psychologists. The team meets weekly for

case studies and service planning. The Social Work Department keeps minutes of the meetings. Photos, slides and a register of suspected child abuse cases are also kept by the Department of Social Work. The workload for all these participants is in addition to the social workers' normal daily workload. Not all children are seen by the paediatricians, psychiatrist or psychologists, but every case of suspected child abuse is investigated by a social worker. These social workers have no jurisdiction outside the hospital and have limited statutory power, so that most cases are referred to community social workers for community investigations, children's court proceedings and follow-up services. The hospital social worker also does the screening of children for referral to a psychologist or psychiatrist. From time to time outside social workers/teachers are invited to meet with the team to discuss difficult cases.

No notification of suspected child abuse was received from the Dental School during the study.

Acute cases of sexual abuse (less than 72 hours after the incident occurred) were mostly seen by the District Surgeon (DS) of the local authority involved at a designated room in the Trauma Unit. These were usually female patients in the age group between 13 and 18 years of age. Although the DS was not on the CAMT and seldom contributed to the clinical notes in the hospital file of the patients, all these patients were still referred to the social workers of TBH.

5. RESULTS

Five hundred and eighty six children below 18 years of age were referred to the Social Work Department as suspected cases of child abuse or severe malnutrition during the survey period. **Table 1** shows an analysis of the type of abuse, gender and median age.

TABLE 1

TYPE OF ABUSE, NUMBER, SEX AND MEDIAN AGE (RANGE)

Type of abuse and number (%)		Sex		Median age in months (range)
		Male (%)	Female (%)	
Sexual	246 (	24 (10)	222 (90)	126 (5,6-216)
Physical	213 (	96 (45)	117 (55)	32,4 (0-213)
Malnutrition neglect	127 (	78 (61)	49 (39)	12,6 (1-38)

Sexual abuse was confirmed or probable in 224/246 (91%), physical abuse in 185/213 (87%) of cases and neglect in malnourished children in 23/127 (18%) of total cases investigated for the various types of abuse. Twenty of the children with sexual abuse had a history of physical abuse and 4 of the physically abused children were examined for sexual abuse that was not confirmed. Physical abuse mostly affected younger children: 60 (28%) were evaluated for physical abuse before 1 year of age, while only 2 (2%) of sexual abuse cases were less than 1 year of age. Sixty-four percent of physically abused and 19% of sexually abused children were below 5 years of age. The Department of Paediatrics and Child Health is responsible for children up to 13 years of age and 89% of physical abuse and 63% of sexual abuse patients were below that age. The older children were seen by the District Surgeon or at adult facilities in the hospital.

The majority of children surveyed were from the Coloured ethnic group (87%), which reflects the main population served by TBH. A relatively low percentage (6%) was from the Black ethnic group. The rest of the cases were from the white population group. The male:female ratio for sexual abuse patients was 1:9 in all three ethnic groups. Ninety percent of patients were from within a radius of 50 km from TBH and only 10% were referred from rural areas, but 16% of malnourished patients came from rural areas.

Patients with suspected abuse or severe malnutrition were referred to TBH by other organisations or doctors in 39% of cases. This is summarised in **Table 2.**

TABLE 2

WHO REFERRED CASES TO TBH?

Referred by:	Physical no. (%) (n=213)	Sexual no. (%) (n=246)	Malnutrition no. (%) (n=127)
GP/Day Hospital or Clinic	42 (20)	38 (15)	60 (47)
CPU/SAPS	19 (9)	39 (16)	-
School	2 (1)	11 (4)	-
Welfare organisation	4 (2)	7 (3)	6 (5)
Self/Neighbours/Family	29 (13)	25 (10)	4 (3)
Parent/Guardian	107 (50)	95 (39)	43 (34)
Unknown	10 (5)	31 (13)	14 (11)

GP = General Practitioner
CPU = Child Protection Unit
SAPS = South African Police Service

Perpetrators were only identified in cases where abuse was confirmed or probable; the likely perpetrators are shown in **Table 3.**

TABLE 3

PERPETRATORS IN CONFIRMED AND PROBABLE ABUSE

Perpetrators	Physical n=185	Sexual n=224
Within Family	136 (74%)	57 (25%)
Father figure	76	44
Mother	46	1
Parents	10	-
Grandfather	1	3
Brother	2	6
Other	1	3
Outside Family (Known)	39 (21%)	125 (56%)
Parent's friend	4	22
Patient's friend	1	25
Uncle	5	16
Neighbour	6	19
Caregiver	6	6
Other Family	7	12
Gang	3	10
Boarder	-	5
School boys	-	2
Other known	7	8
Unidentified	15 (8%)	44 (20%)
>1 Perpetrator	5 (3%)	2 (1%)

Risk factors for abuse were identified by social workers during interviews. Three categories of risk factors were identified. These are parental risk factors, risk factors involving the child and risk factors involving the community or the perpetrator.

The role of alcohol and drug abuse by parents whose children were physically abused was striking. Sometimes drunk and abused parents abused their children themselves or were too drunk to protect the children against abuse by others. Information on whether parents were abused as children was only documented where relevant and therefore the figures do not present a complete picture. Prematurity as a risk factor was often not documented. Violence in the home or community poses a risk for physical abuse and often resulted in the child being an accidental victim. Behavioural problems were often difficult to identify as being a cause or the result of the abuse. The high percentage of sexual abuse cases where intimidation was documented was also noticeable. Intimidation of the victim by perpetrators or the family who do not want the child to reveal sexual abuse is often the reason why sexual abuse is not detected. On the other hand, it is important to note that in spite of intimidation a large number of children eventually revealed sexual abuse. It is not known whether the support and reassurance that they received through the intervention of social workers played a part. Patients were mainly from the lower socio-economic group. Identified risk factors are summarised in **Table 4.**

TABLE 4

RISK FACTORS IDENTIFIED

Risk factors	Physical n=185	Sexual n=224
Parental		
Personal problems	63	31
Relationship problems/Divorce	75	60
Alcohol/Substance abuse	129	72
Unemployed/Financial problems	73	49
Abused as child	7	5
Total	*158 (85%)*	*127 (57%)*
Child		
Physical/Mental Retardation	9	15
Prematurity	6	0
Behavioural problems	19	62
Street children	3	0
Alcohol/Substance abuse	5	10
Total	*35 (19%)*	*76 (34%)*
Community/Perpetrator		
Crowding	49	18
Alcohol/Substance abuse	43	21
Violence	77	70
Intimidation	34	92
Total	*113 (61%)*	*158 (71%)*

Social workers from TBH were involved for a median duration of 1-2 months for physical abuse and malnourished children and 2-3 months for sexual abuse cases. The exact time spent on each case was noted and entered into the central computer at TBH. During the study 2 171 hours were spent on physical abuse, 1 638 hours on sexual abuse and 1 736 hours on malnutrition cases. Time was spent on interviews (average of 1,6 persons interviewed per case), arrangements for children's safety (161 cases), completing section 42A(1) notification reports (563 cases), referral reports and contact with community-based welfare agencies (390 cases), preparing evidence for court and preparing children for court proceedings (68 cases). Only one case required a social worker to give evidence in court during this period.

6. PATIENT PROFILE

Presenting symptoms and/or complaints of children with confirmed or probable abuse are summarised in **Table 5.** Malnourished children were either referred as severe malnutrition cases or were brought in by a parent for coincidental medical conditions such as diarrhoea, oedema or respiratory tract infection.

TABLE 5

PRESENTING SYMPTOMS/COMPLAINTS

Presenting symptom or complaint	Physical n=185 (%)	Sexual n=224 (%)
Trauma	77 (42)	7 (3)
History of trauma	43 (23)	6 (3)
Medical condition unrelated to abuse	44 (24)	21 (9)
Overdose (drugs)	11 (6)	13 (6)
School referral	2 (1)	10 (4)
Abandoned child	12 (6)	1 (<1)
Neglect	30 (16)	1 (<1)
Poisoning	14 (8)	-
Enuresis/Encopresis	2 (1)	7 (3)
Behavioural problems	4 (2)	43 (19)
Anal trauma/warts	-	6 (3)
Vaginal trauma/bleeding	-	30 (13)
Vaginal discharge	-	36 (16)
Sexually Transmitted Diseases (STD's)	-	3 (1)
Pregnancy	-	3 (1)
Alleged sexual abuse	4 (2)	111 (50)
Alleged physical abuse	95 (51)	1 (<1)

PS: Some patients presented with >1 symptom/complaint

Two hundred and fifty patients (24 boys) were examined for suspected sexual abuse, 4 of whom were eventually diagnosed as physical abuse only. Recent or acute sexual abuse (less than 72 hours since last abuse) was present in 81 (32%), while 169 (68%) presented either with alleged chronic abuse (more than 72 hours since last incident) or with other symptoms or history indicating sexual abuse. Of the 250 cases, 108 (43%) were examined by doctors of the Department of Paediatrics and Child Health (70% of all patients below 13 years of age), 65 (26%) were seen by the DS of which 56 (86%) were "acute" rape cases. The department of Gynaecology handled 47 (19%) cases, 36 (15%) were seen by the Department of Child Psychiatry, without any genital examination and 22 (9%) were either seen at other Departments or no clinical examination was done. Twenty-eight patients were seen by more than one medical department, of whom 24 were referred to the Department of Gynaecology. Ninety-five (38%) patients in total were referred to Child Psychiatry for evaluation and/or treatment.

Only 16 (6%) gynaecological examinations were done under general anaesthesia, of which 10 involved suturing of lacerations. One hundred and two cases were investigated for sexually transmitted diseases.

Of all the children seen for suspected abuse or severe malnutrition, 390 (67%) were admitted to TBH for 1 to 108 days. Thirty-two (8%) of these admissions were for social/safety reasons, 44

(11%) for both medical and social reasons and 314 (81%) were for medical reasons only or psychological reasons. Duration of admissions is given in **Table 6.**

TABLE 6

DURATION OF HOSPITAL STAY

Type of abuse	Number of cases	Number admitted (%)	Mean (days)	Median (range) (days)
Sexual	n=246	80 (32)	8,86	5 (1-56)
Physical	n=213	185 (87)	9,86	4 (1-108)
Malnutrition	n=127	125 (98)	22,16	20 (1-101)

The known outcomes in terms of legal action, final placement and medical outcome are summarised in **Table 7.**

TABLE 7

OUTCOME OF CHILD ABUSE CASES

Outcome	Physical n=185 (%)	Sexual n=224 (%)	Malnutrition n=23 (%)	Total n=432 (%)
Legal Action				
Criminal court	43 (23)	104 (46)	1 (4)	148 (34)
Children's court	22 (12)	12 (5)	2 (9)	36 (8)
Unknown	55 (30)	49 (22)	5 (22)	109 (25)
Placement				
Foster care	31 (17)	17 (8)	2 (9)	50 (12)
Institutional care	5 (3)	8 (4)	0	13 (3)
Perpetrator removed	5 (3)	15 (7)	0	20 (5)
Returned to family	135 (73)	180 (80)	16 (69)	331 (76)
Died	5 (3)	-	2 (9)	7 (2)
Unknown	4 (2)	4 (2)	3 (13)	11 (2)
Previous abuse	17 (9)	18 (8)	1 (4)	36 (8)
Medical Outcome				
Permanent physical damage	18 (10)	4 (2)	2 (9)	24 (6)
Recovered	161 (87)	200 (90)	19 (82)	380 (88)
Died	5 (3)	1 (other cause)	2 (9)	8 (2)
Unknown	1 (<1)	18 (8)	0	19 (4)

* Unknown = Further management by other hospital/welfare organisation

As mentioned earlier, it was not possible to do the follow-up work which should have revealed the outcome of every case, because in many cases the follow-up work and intervention takes months and they have not presented a clear outcome by the end of the study period. Due to

limited staff it is also impossible for welfare agencies to present feedback reports to referring hospitals, with the result that the eventual outcome of the cases is unknown.

More sexual abuse cases than physical abuse cases are taken to court, because in cases of physical abuse children are more easily protected by the intervention of social workers. Three hundred and thirty one patients (76%) were returned home after being abused. In cases of intrafamilial sexual abuse social workers prefer to remove the perpetrator rather than the victim, whereas in extrafamilial abuse the child is mostly safe at home. Where children are abused by fathers, the mother often decides to leave her husband to protect the children and such children also need not be removed by court order.

The 7 children who died from abuse were below 2,5 years of age and 3 (43%) were younger than 1 year. Eighteen physically abused children had permanent physical damage, of whom 13 (72%) were below 3 years of age and 7 (39%) were less than one year old. Five of the children younger than a year had depressed skull fractures with or without intracranial bleeds.

7. DISCUSSION

"Even a minor event in the life of a child is an event of that child's world and thus a world event" Gaston Bachelard (1884-1962), French scientist, philosopher, literary theorist (quoted in Bachelard G & Bachelard S 1988). For each child discussed here as "data", their experience was a world event.

Services for abused children are fragmented in South Africa and until recently no national register for such cases existed. A child abuse register was initiated at TBH Social Work Department in 1987. Initial numbers were low. However, as public and professional awareness increased, notifications escalated and with that the demand for provision of services. As in other developing countries, serious financial constraints are limiting the allocation of additional staff to deal with this problem.

Although the number of physical and sexual abuse cases are quite similar, it is probable that some physical abuse cases are missed in the hectic Trauma Unit and patients discharged without referral to the Social Work Department.

The majority of physically abused children were younger than 5 years of age. This figure agrees with the findings of the Red Cross Children's Hospital, which serves a different area in the Cape Metropole (Argent *et al.* 1995).

Sexually abused children were slightly older and the majority are at junior school age. According to the Child Care Act, a child is defined as anyone younger than 18 years and it is in the 13-18 year group that girls were often sexually abused by peers. A study conducted in Switzerland also found that 35% of the abusers came from the victim's peer group (Halpérin *et al.* 1996).

The male to female ratio of 1:9 for sexual abuse cases was consistent in all three ethnic groups. This finding is also consistent with the data from the Red Cross Children's Hospital, where it was found that only 10-14% of sexual abuse victims were male (Argent *et at.* 1995; Jaffe *et al*, 1988).

Perpetrators were identified mainly in the case of older children. Twenty-five percent of sexual abuse perpetrators were direct family members of the victims, which is not dissimilar to findings (Jaffe *et al.* 1988; Howard *et al.* 1991; De Villiers *et al.* 1996; Larsen *et al.* 1996). Of the

perpetrators identified, 172 (77%) were known to the child. In physical abuse cases the perpetrator was often a direct family member (74%).

In the Cape Metropolitan area there are two tertiary medical centres where abused children are seen, although 10% of TBH's referrals come from areas less than 50 km away. It is essential that dedicated Child Abuse management teams, with doctors and social workers equipped to address these problems, are established in the rural regions. This was confirmed by an editorial in the South African Medical Journal in 1992 (Winship *et al.* 1992). District Surgeons in some regions were of the opinion that the clinical examination of pre-pubertal children for evidence of sexual abuse could be more appropriately performed by paediatricians, gynaecologists or general practitioners with appropriate experience of working with children. The CAMT at TBH found from experience that District Surgeons do not routinely screen children for sexually transmitted diseases, as was also confirmed in the editorial.

With this workload at TBH it was impossible to do the follow-up work which should be done to determine whether the child received the necessary attention by the welfare agencies that they were referred to. Most cases were referred to the Department of Social Services of the PAWC, which was responsible for channelling of cases to the appropriate welfare agencies, keeping a provincial register and obtaining feedback reports from welfare agencies.

CONCLUSION

This study found that the magnitude of serious child abuse is not only extensive, but that it is also more than the present infrastructure can handle. This unfortunately results in sub-optimal rendering of service to victims because essential follow-up cannot be done adequately. More social workers, placed suitably in the service network and notably in the outlying areas, are urgently needed. All persons dealing with cases of potential child abuse, including the police and district surgeons, need more training to handle such children with proper professional skills and compassion. Supervision of persons handling cases of child abuse is essential. Such supervision is best carried out in a team, where knowledge and experience can be shared. It is a matter of national urgency that the formation of such teams, especially in the rural areas, receives top-level attention.

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