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# Child abuse profiles in a Soweto abuse centre

**Mwanda, Nobulembu Babalwa**

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# CHILD ABUSE PROFILES IN A SOWETO ABUSE CENTRE

Nobulembu Babalwa M • ıda

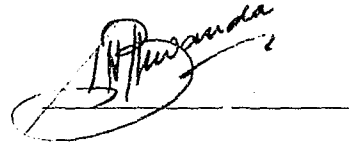
A research report submitted to the Faculty of Medicine, University of the Witwatersrand, in partial fulfilment of the requirements for the degree of Master of Science in Medicine, Community Paediatrics

Johannesburg, 1999

**Supervisor: Prof. J. Pettifor**

**DECLARATION**

I, Nobulembu Babalwa Mwanda declare that this research report is my own work. It is being submitted for the degree of Master of Science in Medicine in the University of the Witwatersrand, Johannesburg. It has not been submitted before for any degree or examination at this or any other University.



## DEDICATION

In loving memory of my father

Barrington Phumelele Mwanda

1928-1990.

## PUBLICATIONS AND PRESENTATIONS ARISING FROM THE THESIS

1. "Should genital examination be routine for all children presenting to a general practitioner ?" – a poster presentation at the 12th International Congress on Child Abuse & Neglect, Auckland, New Zealand, September 6-9, 1998.

2. "Should genital examination be routine for all children presenting to a general practitioner?" – an oral paper presentation at the 13th annual San Diego Conference on responding to child maltreatment, 25-29 January 1999.

## ABSTRACT

The aim of this study was to examine the profiles of child abuse in Zamokuhle Child Centre, a child abuse referral Centre serving black children in Soweto. It was hypothesised that these profiles are different from those described in the Western communities.

A retrospective analysis of all 1995 patient records was done. The data was extracted by the way of a data collection form. A total of 372 children were seen over a ten-month period in which the Centre was operational. Of these records all but four could be traced.

Of the 368 records, 357 were related to sexually abuse. There were very few cases of other forms of abuse. The average age of these children was 8.1 ± 3.6 years and 97% were females. Only in about a third of these children was abuse purposefully disclosed, either to mother (29.7%) or teacher (17.8%). Most of the children (61.3%) were incidentally found to be abused by either a clinician (57.1%) or a parent (27.9%). Most children presented with signs and symptoms that raised enough suspicion of sexual abuse.

An overwhelming majority (278 out of 357) had physical signs highly suggestive of penetration beyond the hymen, on examination. Only in about a third of the cases was the abuse intra-familial, in the majority it was extra-familial. STDs were diagnosed in about 12% of the children.

In conclusion it is apparent from the above that the patterns abuse as seen in Zamokuhle are different from those described in the Western communities. Because this study was facility-based, it is however, difficult to generalise to the general population.

## ACKNOWLEDGEMENTS

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A word of thanks to the following: Soweto Community Health Centres for allowing me to view such confidential and sensitive records for the purposes of this research; the staff at Zamokuhle, for keeping such comprehensive and meticulous records, making it easy to do the research; the mothers and children of Soweto for sharing their stories with us at the Centre; to all those people who spurred me on as it became increasingly difficult to finish this task, the more I delayed, Jonathan Levine and Shireen Mothi from MRC for helping me with the statistics and Professor Lucy Wagstaff for her support.

Many thanks to my husband Trevor for his continued support and constructive criticism; my children who seem to 'understand' when *Mommy* said she was busy and my colleague, Dr Ama Ilunga for being such a friend.

Lastly, and certainly not least to The Almighty, for the strength He gave me.

## PREFACE

South Africa has just recently emerged from an unremitting and unprecedented political strife, which saw the youth and children at the helm. The townships were the hotbed of this violence, while the suburbs were protected and safe.

With the change of the political climate and the realisation of a new democracy, the focus of violence seems to have shifted to the two most vulnerable groups in any society, children and women. There seems to be a rapid spread of this violence beyond the borders of the townships as attested to by the daily news, leaving no safe havens for the children in our country.

This research not only wants to highlight the problem of child abuse in Soweto, but also seeks to draw attention to the tremendous amount of violence that seems to underpin it. Even more ominous is the threat of HIV/AIDS death sentence that these children are likely to get as HIV infection reaches epidemic levels in our country.

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# 1. INTRODUCTION

Hardly a day passes without a detailed and gruesome child abuse story in both the print and electronic media, in South Africa. This public interest can be attributed to many varying factors such as: the change in the socio-political climate and legislation pertaining to child abuse, greater identification of abused children and of even greater concern, the actual increase of the incidence of child abuse in our society.

While the true incidence and magnitude of child abuse remains an enigma world-over (Hobbs et al., 1993), most authorities seem to agree that it is on the rise (Jacklin, 1989; Hobbs et al., 1993). This increase probably reflects the socio-economic stresses (Jacklin, 1989; Howard et al., 1991); breakdown of family systems, militant feminism –which may threaten the male, who then turns to the children (Cohen, 1985) and increasing levels of violence in most communities.

According to the Council on Scientific Affairs (1985), more than one million children in the United States are seriously abused by their parents, guardians or others every year. In South Africa it is difficult to estimate the magnitude of child abuse because of such factors like: the lack of a national register and national surveys; fragmentation of health services; poor notification; paucity of published epidemiological studies and racial and cultural diversities. There is also a lack of a clear definition of child abuse as the focus has for many years been on political problems.

The majority of the reported crimes committed against children in South Africa are of a sexual nature (Mwanda & Kekana, 1996). Reported sexual crimes increased by 108% between 1993 and 1996 in our country (South African Police Service, 1998). This is of course a "tip of the iceberg" as it is estimated that underreporting of crime could be as high as 50%; sexual assaults against children are less likely to be reported than similar crimes against adults and the statistics of the former TBVC (Transkei, Bophutatswana, Venda & Ciskei – independent homelands) states were not included in some of the South African Police (SAP) and Child Protection Unit (CPU) figures (The Nedcor Project, 1996). It is against this backdrop that the Nedcor Project (1996) declared that "there is nothing less than a reign of sexual terror against children in South Africa today."

Most South African townships, of which Soweto is one, are marred by violence of various kinds. They were created during the apartheid era as urban reserves for cheap labour, by forcefully putting people who were not necessarily from the same communities, together. Hence they lack the social cohesiveness and glue that develops when people choose to stay together.

There is also gross overcrowding in these townships, which is due to such factors like the prohibition of self help housing expansion; the escalating poverty-driven rural-urban migration; the 1992 removal of the restrictive laws and lack of provision of structured housing and recreational facilities (Wagstaff et al., 1997). Also, with the new democracy, there has been an unprecedented illegal immigration of aliens mainly from the poverty-stricken neighbouring countries. These factors have resulted in the further saturation of

the already over-stretched resources in the townships and the mushrooming of informal settlements. The latter are notorious for their high crime levels. In a community-based survey done in one of the sub-districts of Soweto, Wagstaff and colleagues (1997) found that the informal settlement households were even more overcrowded than the formal houses.

In South Africa, Soweto is renowned for violence, hijackings and murders. Recently, school children -mainly girls, have been victims of organised crimes like "jack-rollings" (abduction in public, at gun-point, of a female with the purpose of gang-raping) and gang-rapes. Unfortunately, not only did the young people become the heroes of the liberation struggle, but they themselves became perpetrators of violent acts. In fact, the "victim and perpetrator often co-existed within one person" (Government of national unity, South Africa, 1997).

It is against this background that child abuse occurs in Soweto and similar townships. It is my conviction that these social dynamics lend another dimension to child abuse and hence different child abuse profiles than those reported from the mainly white suburbs and from developed countries.

## 1.1 Background about Zamokuhle Child Centre

Zamokuhle is a community-based child abuse Centre at Zola Clinic, Soweto. It is the first and only such Centre in this sprawling Black township of about three million inhabitants. It is run by a multi-disciplinary team comprising of medical doctors, nurses (who also have basic counselling skills training), social workers and psychologists. The latter two professional groups render voluntary services and are from both non-governmental and governmental organisations. It started functioning on the 6th of March, 1995.

Patients that are seen at this Centre are mainly those that are booked. Despite the limitations set out by the booking system which has a finite number of appointments, we are seeing increasing numbers of suspected child abuse cases. In 1995 we saw 372 patients (10 months period); 685 in 1996 and 730 in 1997. Because of the long waiting period for appointments, a large number of appointments are not kept. In 1995, 120 children did not honour their appointments; in 1996 and 1997 the figures almost doubled (210 and 194 respectively).

We receive referrals mainly from 12 clinics that were previously called Soweto Community Health Centres, now under Central Wits Region. All but one of these clinics (Stretford Clinic in the Vaal) are in Soweto.

We see mainly those patients in whom 72 hours has elapsed since their abuse, because we do not have the CPU or the SAP on site for the collection of forensic specimens. We assist all children up to the age of 16 years.

The Medico-legal clinic situated at Chris Hani Baragwanath (Baragwanath) hospital also sees some child abuse clients, particularly those who wish to lay charges and are within the first 72 hours of the assault. They are seen by a district surgeon. This clinic is not a specialised child abuse clinic as is Zamokuhle. A small number of cases are also seen at the Paediatric Department at Baragwanath hospital. As I write, a specialised child abuse follow-up clinic is being set at this hospital.

The evaluations children receive at Zamokuhle include a detailed history (usually taken by a trained nurse counsellor using a standard history form), a medical examination and the necessary laboratory tests. The medical examination is usually done by two doctors (who have received some training in the examination of abused children), independently but at the same time. They confer with each other at the end of the examination. The findings are then documented on a standard medical form. All documented physical findings are then classified as either normal, non-specific, suspicious or inconclusive and strongly or highly suggestive of sexual abuse.

## 1.2 Objectives

- To describe the demographic characteristics of the children seen at Zamokuhle in 1995.
- To describe the profile of child abuse as seen at this Centre during the study period.
- To compare and contrast the emerging patterns with those described in Western societies.
- To formulate treatment policies and protocols for the Centre.

## 1.3 Hypothesis

The child abuse pattern at Zamokuhle is different from that described typically in Western societies.

## 1.4 Limitations

Zamokuhle is a referral Centre for child abuse for all the community health centres in Soweto. Because of its 'specialised' nature there may be a definite bias of the types of child abuse seen there. Most child abuse is not reported and not all the referred patients honour their appointments and hence the patterns we see at the clinic may not necessarily be a true reflection of what is happening in the community. Follow-up and prevalence studies will be necessary to confirm these patterns.

## 1.5 Literature review

".....there is nothing new about child abuse. What is new is the recent willingness to address its existence and to look for ways of preventing its occurrence," observed Hobbs and colleagues (1993). Most authors seem to agree that child abuse has long remained "a blind spot" in both society and medicine. (Hobbs et al, 1993; Wissow1995; Ludwig, 1992).

This is certainly true for South Africa. For instance Robertson (1989) quips, "child sexual abuse used to happen in other countries, not on our shores, or so we thought". Although individuals were recognising and treating child abuse in the early 1980's, according to Robertson (1989) the implication of several prominent South African personalities in child prostitution by the South African Police finally woke up South Africans to the realities and horrors of child abuse.

The current surge in interest in child abuse as attested by the daily reports on the heinous acts committed to children in our country, is probably a further reflection of the willingness now to address its existence by both the professionals and the general public. Also, South Africa ratified the UN Convention on the Rights of the Child in 1995 and has recently (1996) adopted its first Constitution, making it imperative for these issues to be topical (Government of national unity, South Africa, 1997). For a very long time child abuse remained a blind spot in our country, hence a paucity of empirical studies.

### 1.5.1 Definition of child abuse

The definition of child abuse remains both elusive and non-universal. For instance Ludwig (1992) states that "child abuse is a social concept that continues to evolve as children's rights are recognised by society." He further contends that there are three levels of definition at any time, viz. – the legal, the institutional and personal. Consequently, child abuse may be perceived differently by different countries, because it is "what the law says it is."

Because of the evolution of Children's rights, the child abuse definition also varies with time and cultures. What may have been acceptable parent-child interaction decades ago, may be viewed as abusive behaviour today. However, the variation of definitions by different individuals should not be a "reason to shrink from our duty, to protect children", warns Ludwig (1992).

Definitions like "intentional inflicted injury" and "a symptom of family dysfunction in which a child sustains injury" (Monteleone et al., 1998), demonstrate the inadequacy of some of the definitions. For instance the latter definition presupposes that child abuse occurs only within family institutions. Also, Monteleone and colleagues (1998) concede that 'intent is not considered in reporting abuse, protection of the child is paramount.'

Broader definitions though rather imprecise, like child abuse covers 'any acts that impair the developmental potential of a child' (Monteleone & et al., 1998) underscore the

nebulous nature of the term child abuse. Perhaps, Gelles (1978) cited in Besharov (1981) sums up the dilemma faced by researchers when confronted with the definitional problem of such a term like child abuse, when he asserts: "The term "child abuse" is a political concept which is designed to attract attention to a phenomenon which is considered undesirable or deviant.

As a political term, "child abuse" defies logical and precise scientific definition. Malnourishment, sexual abuse, failure to feed and clothe a child, torturing a child, withholding medical care from a child, allowing a child to live in a "deprived or depraved" environment, and helping a child stay out of school have all been defined at various times and in various laws as "child abuse". Thus the definition of child abuse varies over time, across cultures, and between different social and cultural groups."

Finkelhor & Korbin (1988) cited in Korbin (1991) define child abuse as "the portion of harm to children that results from human action that is proscribed, proximate and preventable". Their definition allows for cultural, social and economic differences. They even suggest that failing to allow for these cultural differences when defining child abuse "promotes an ethnocentric position in which one's own set of cultural beliefs and practices are presumed". It is against this background that we shall look at the various categories of child abuse separately although they often co-exist.

### 1.5.2 Sexual Abuse

Often one hears of such comments like 'what is this world coming to', 'the end is nigh' or 'a reptilian mind – where adults devour their young, is evolving among humans', when people are confronted with grisly and sensational child abuse stories. These and similar statements would seem to suggest that sexual abuse is a new phenomenon among the human species. Perhaps also, the appearance of the classic literature on child sexual abuse only in the 1970s, compared to, for instance, physical abuse (which appeared in the 1940s and 1950s), further entrenches this belief.

There is however, overwhelming evidence to suggest that sexual abuse has its roots deeply entrenched in societies. The boy brothels and rent-a-boy services in ancient Greece attest to its age. De Mause (1980) cited in Hobbs et al., (1993) once wrote "the child in antiquity lived his earlier years in an atmosphere of sexual abuse".

#### 1.5.2.1 Definition

Despite the efforts to promote uniform criteria for defining child sexual abuse, there are still variations in the definitions adopted by individual researchers (Wyatt & Peters, 1986). The differences contribute to the discrepancies in estimated prevalence of abuse. Just as there are many definitions of child abuse, there are also many definitions of sexual abuse, with no single one that is entirely satisfactory.

The following are just two example of the definition of sexual abuse:; 'the involvement of dependent, developmentally immature children and adolescents in sexual activities that they do not fully comprehend, are unable to give informed consent to and that violate the social taboos of family roles' and 'the exploitation of a child for sexual gratification of an adult', (Schechter & Roberge (1976); Fraser (1981) respectively cited in Hobbs et al (1993)). Baker & Duncan (1985) also cited in Hobbs et al., (1993) write 'A child (anyone under 16 years) is sexually abused when another person who is sexually mature involves the child in any activity which the other person expects to lead to their sexual arousal.' These definitions preclude those acts that are committed by eleven years old on two- year old children for instance, underscoring the inadequacy of any one definition.

The American Academy of Pediatrics (1991) differentiates between sexual abuse and "sexual play". They suggest that one should look at the frequency and coercive nature, and determine whether there is a developmental asymmetry among the participants. However, they regard those acts where there is "intrusion of the body" even among developmentally symmetrical children of any age, as abnormal. Wyatt & Peters (1989) refer to non-contact and contact abuse in their study. This of course does not take into consideration the psychological effects these acts, whether they are intrusive or non-intrusive, have on the child.

Other researchers adopt a more liberal approach to the definition. Finkelhor (1979), Russell (1983) and Wyatt (1985) all cited in Wyatt & Peters (1986), regard 'consensual sexual activity between children' as part of a normal development and not sexual abuse.

Wyatt & Peters (1986) however, warn, that threats, intimidation or physical force are not limited to adult perpetrators.

Some authors make a distinction between sexual abuse and sexual assault according to the relationship between the aggressor and the victim (Paradise 1990, Monteleone et al., 1998) They regard those sexual acts committed by a person who has an "obligation to provide for the child's well-being", such as a parent, babysitter, a teacher etc, as sexual abuse. According to Monteleone and colleagues (1998) the babysitter or caretaker may be an older child. They regard those sexual contacts made by a person who is not a caretaker of the child, as sexual assault. Paradise (1990) however, concedes that all sexual abuse constitutes sexual assault because of the criminal implications.

Other authors are rather non-committal and prefer the now widely used classification of intra-familial and extra-familial abuse. Monteleone and colleagues(1998) classify the sexual abuse acts into three categories: assault, incest and exploitation. Finkel (1994) comments that incest can be described to reflect legal, psychosocial, and genetic definitions. He defines it as "sexual exploitation of a child younger than 16 years in a sexual manner by a person closely related or functioning in the family as a parent surrogate, for example, a stepfather or common-law partner". Monteleone and colleaugues (1998) define incest as 'sexual intercourse between persons so closely related that they are forbidden by law to marry'. This definition has been broadened to include those offenders that are not necessarily blood relatives of the child, for example the step-father/mother or a paramour.

There is also a disagreement among various authors about the upper age limit of the victim, for the offence to be regarded as child sexual abuse. The Convention (Convention on the Rights of the Child) defines a child as any human being less than the age of 18 years unless, "under the law applicable to the child, majority is attained earlier" (Convention on the Rights of the Child, 1990). Because laws vary from country to country there is a variation of the age limit where majority can be attained. Even among authors from the same countries there are variations, with some authors using age 16 years (Finkelhor 1979, 1984 ) and others using 17 years (Russell, 1983 & Wyatt, 1985) as the upper age limit, all cited in Wyatt & Peters, 1986.

Despite these seemingly varying definitions of child sexual abuse, there seems to be a general consensus that developmental inappropriateness of the act and the power and/or age differential are the key factors in the definition. However, this lack of consensus on what constitutes child sexual abuse has a direct bearing on the accuracy of incidence and prevalence rates of this scourge.

### 1.5.2.2 Epidemiology – Western society

The epidemiology of child sexual abuse in Western societies seems to have undergone a process of evolutionary change. Studies in the early eighties (De Jong et al., 1982, De Jong et al., 1983, Tilelli, 1980 all cited in Huston Parra, Prihoda & Foulds, 1995) reported on a high percentage of stranger perpetrators, in contrast to the later studies. Huston and colleagues (1995) suggest that this could be attributed to the "recent increase in reporting of child sexual abuse".

#### 1.5.2.2.1 Incidence

According to Wissow (1995) the incidence of child sexual abuse is relatively consistent among income groups, compared to neglect and physical abuse which increase with poverty. It is estimated that between 100,000 and 500,000 children in the USA are sexually abused every year {Ricci, 1986; Fuller (1989) cited in Gibbons & Vincent, (1994)}. According to Ricci (1986) sexual abuse accounts for 10-20% of all confirmed child abuse cases and has shown the greatest increase in reported cases relative to all other types of abuse and neglect in children.

According to Finkel (1994) the reported incidence of incest varies widely depending on the source of the report. He observes that there are relatively low figures of incest quoted in articles dealing with medical evaluation of the victims (range 26-31%, citing Tilleli, 1980 & Grant, 1980), when compared to sexual abuse hotline reports (62%, citing

Pierce & Pierce, 1985). Of note is that Finkel (1994) when citing Pierce & Pierce (1985) has only included figures for natural father and step-father for incest, despite the fact that in his definition of incest he includes common-law partners and other close relatives. If one uses his wider definition of incest, which includes siblings, mother's/father's paramour, uncle and other relatives, the correct figure would be 83% (Pierce & Pierce, 1985) instead of 62%, further strengthening his assertion.

Of great interest the natural fathers are implicated in more incestuous abuse cases (39%) than the step-fathers (23%) and mother/father's paramour (5%), in this hotline report (Pierce & Pierce, 1985). This is contrast to the view of Woodling & Kossoris (1981), cited by Cohen (1985), who suggest that the majority (80%) of the father-daughter incestuous abuse involves a step-father or father-substitute like a live-in boyfriend. This discrepancy is probably explained by the anonymity of the hotline, and thus might accurately reflect the true pattern.

A typical child sexual abuse picture is that of a female child who is abused by either a biologic parent, usually a father or other family members (Cohen, 1985; Council on Scientific Affairs, 1985; De Villiers et al., 1990; Hobbs & Wynne, 1993; Huston et al., 1995). Frequently the abuse continues over a prolonged period, and is usually progressively invasive. (Cohen, 1985; Council on Scientific Affairs, 1985; Ricci, 1986; Wissow, 1995; Montelcone et al., 1998;). Even though use of physical force is unusual, the victim is usually coerced into remaining silent.

Consequently, most incest victims present without the signs of acute genital trauma and disclosures are delayed, (Cohen, 1985; Council on Scientific Affairs, 1985; Wissow, 1995; Monteleone et al., 1998). Also, the incidence of sexually transmitted diseases (STDs) in sexually abused children in the Western World is low (Gibbons & Vincent, 1994). In contrast the psychological trauma and self-blame is greater in these children (Cohen, 1985; Huston et al., 1995).

In contrast, Leventhal (1998) notes that although the vast majority of the perpetrators are known by the victim, only a minority are family members. He gives an example of a "rigorous study" that was done by Russell (1986), who found that only in 29% were family members implicated as offenders compared to 60% in which friends and acquaintances were implicated. In this study the step-fathers were more likely to be offenders (17%) than the biological fathers (2,3%).

Huston and colleagues (1995) in the USA challenge this stereotype in their series. They suggest that the relationship of the perpetrator varies with the child's race and ethnicity. For instance they found that Mexican-American children were more likely than Anglo or Black children to be abused by an extended family member. Black children were more likely to be abused by an acquaintance or stranger. They also found that the majority (57%) of those cases where the frequency of abuse was known (78%), involved single episodes.

#### 1.5.2.3.2 Age Distribution

There seems to be no agreement among various researchers as to the peak age of vulnerability to child sexual abuse in children. For example Matson & Gutman (1999) state that the peak age for sexual abuse for both boys and girls is "thought to be 7-13 years", but in their study done at their clinic they found the mean age of confirmed cases to be 4 years. Ricci (1986) reported that the mean age of victims is between 9 and 11 years, with a range of 1-18 years. According to Gibbons & Vincent (1994) citing (Rogers & Thomas, 1984 and Rimsza & Niggemann, 1982), approximately one half of the children are sexually abused between 6 and 12 years – (thus fairly evenly distributed throughout the childhood period).

Central to these differences are perhaps the different definitions different researchers use (e.g. different age range); and the different sexual abuse subcategories. For example, De Jong and colleagues (1982) cited in Ricci (1986) observed that the median age in classic sexual abuse (chronic, acquaintance molestation) was 6 years and in a typical sexual assault (single episode, stranger molestation) was 13 years. In contrast, according to Woodling and Kosoris (1981) cited by Cohen (1985) incestuous relations begin in first-born females when they are between 8 and 10 years.

In a multi-cultural study, Mennen (1995) found the average age of onset of abuse to be similar for the different multi-racial groups (White, Latina, African-American) and about 9 years. The average age at the time of evaluation was 13.4 years ± 2.9. Of interest was

#### 1.5.2.3.2 Age Distribution

There seems to be no agreement among various researchers as to the peak age of vulnerability to child sexual abuse in children. For example Matson & Gutman (1999) state that the peak age for sexual abuse for both boys and girls is "thought to be 7-13 years", but in their study done at their clinic they found the mean age of confirmed cases to be 4 years. Ricci (1986) reported that the mean age of victims is between 9 and 11 years, with a range of 1-18 years. According to Gibbons & Vincent (1994) citing (Rogers & Thomas, 1984 and Rimsza & Niggemann, 1982), approximately one half of the children are sexually abused between 6 and 12 years – (thus fairly evenly distributed throughout the childhood period).

Central to these differences are perhaps the different definitions different researchers use (e.g. different age range); and the different sexual abuse subcategories. For example, De Jong and colleagues (1982) cited in Ricci (1986) observed that the median age in classic sexual abuse (chronic, acquaintance molestation) was 6 years and in a typical sexual assault (single episode, stranger molestation) was 13 years. In contrast, according to Woodling and Kosoris (1981) cited by Cohen (1985) incestuous relations begin in first-born females when they are between 8 and 10 years.

In a multi-cultural study, Mennen (1995) found the average age of onset of abuse to be similar for the different multi-racial groups (White, Latina, African-American) and about 9 years. The average age at the time of evaluation was 13.4 years ± 2.9. Of interest was

that in their series whites tended to be abused longer than African American or Latina girls. Although Huston and colleagues (1995) also did a multi-cultural study, they did not report on age distribution according to race. They however, found that the girls were significantly older than boys (mean ages 9.4 and 7.3, respectively). Unfortunately there is no clarification as to whether the age given is age of onset or of evaluation. They also found a bimodal distribution for girls (the first peak at about 3 years and the second peak at about 14 years), but not for boys.

### 1.5.2.3 Developing Countries

According to Ladikos (1991) there are no "broadly conceived epidemiological" child abuse studies that have been conducted in South Africa, but there are a number of small surveys mainly at hospitals and child welfare agencies. Consequently, the trends that emerge from individual studies probably do not reflect the true patterns of abuse in this country.

Studies done in the culturally diverse South Africa seem to suggest that there are cultural differences in the pattern of abuse in this country (Robertson & Hayward, 1976; Hyslop et al., 1990; Howard et al., 1991; Chapman & Winship, 1993). For instance Hyslop and colleagues (1990) observed in their study that the profile of child abuse at Transvaal Memorial Institute (TMI) in Johannesburg (which up until very recently saw predominantly white children) approximated that seen in Western societies. In contrast, in Alexandra clinic, also in Johannesburg (a community-based clinic that sees mostly black children) the perpetrators were mostly strangers (51%) and schoolboys made up another 17%.

Compared to sexual abuse making up 10-20% of all abuse cases reported in Ricci's series (1986), most of the units in Johannesburg report a higher percentage of sexual abuse with a 54 – 90% range (Hyslop et al., 1990; Howard et al., 1991). TMI had the highest percentage (90%) and the authors attribute this to a "definite bias in the selection of patients at this unit" (Hyslop et al., 1990).

In contrast to the above studies, Berrington et al., (1986) and Chapman & Winship (1993) reported a low percentage of child sexual abuse in their series (both studies were retrospective descriptive hospital-based studies done in Coronation, Johannesburg and rural Eshowe, respectively). It is to be noted however, that the sample size of the study conducted by Berrington and colleagues was very small (n=23), hence it would be improper to compare the results to those of Hyslop and colleagues (1990), (of the 123 cases 54,5% were sexually abused) who also studied the same population.

In a trans-cultural analysis of 54 child abuse cases seen at a psychiatric clinic at Red Cross War Memorial Children's Hospital, Cape Town, over thirty months, there was a low prevalence of abuse among Asiatics (1 case) and Blacks (2 cases), compared to the Cape Coloureds (24 cases) and Whites (27 cases). The authors attributed these differences to the population distribution in Cape Town at the time of the study; the mistrust of Western doctors; differing child-rearing practices and inadequate child welfare services among Blacks (Robertson & Hayward, 1975).

#### 1.5.2.3.1 Perpetrator

There is no clear pattern that emerges in the South African studies probably due to the different population groups that are studied. In a study done by Hyslop and colleagues (1990) in four different units, they found that the biologic family accounted for 37,6% and 21% of offenders at TMI and Coronation, respectively. There were no figures given for Alexandra and Baragwanath, but the authors noted that reported incest was low in

both these communities. At Alexandra the perpetrator is often unknown (unknown is not clearly defined, could mean either undisclosed therefore unknown to the interviewer or a stranger to the child), in about half of the cases (Howard et al., 1991; Hyslop et al., 1990). Howard and colleagues (1991) found in their study that reported incest accounted for only 7% of the offenders.

Chapman & Winship (1993) also found similar results in their study done in a rural area (most probably in a Black population). They found that in about a half of the cases where the perpetrator was known (10 out of 21 cases) it was someone outside the family – often an older boy from a neighbour's home or a scholar. However, it should be noted that their sample size was small (30 sexual abuse out 253 total abuse cases). Notably in the series by both Chapman & Winship (1993) and Howard and colleagues (1991), the perpetrator was unidentified/ undisclosed in a large number of instances (about 30% and 52% respectively). This raises questions about the validity of the observed low incest incidence among Blacks.

A striking finding from a cross-sectional, door-to-door survey of 83 abused women, done by Barthauer and colleague (1996) in a rural community in El Salvador, was that no offenders were parents. The majority (57%) of the perpetrators were friends or neighbours. The median age for abuse was 14 years.

Ladikos (1991) reviewed six studies that were conducted in South African hospitals and Child welfare agencies (mainly in Cape Town and Durban). One of the studies was done

in an Indian population but unfortunately there is no ethnic information about the other five. She noted that there were two trends that emerged, namely: the vast majority of the children who are sexually abused are female, a finding well supported by other studies (Hyslop et al., 1990; Howard et al., 1991; Ladikos, 1991), and the perpetrator is known to the child in about 2/3 of the cases. This is in contra‹ ɔ her ow.. retrospective study (Ladikos, 1991). The perpetrator was known in only about 44% of the cases (23% biologic parent; 18.3% a stepparent and 2.7% known but not related to the child).

Obot (1986) (cited in Mejuini (1991)) observed that intra-familial sexual abuse was grossly underreported in Nigeria, because in most cultures the extended family tends to cover up such cases so that "the family name cannot be spoilt". Out of the 19 cases (seen between 1980 and 1985) of sexual abuse this author reported on, only two assailants were related to the victims. In nine of the cases the victims and the assailants were not related, while in eight cases the perpetrator could no be identified.

Rubagiza (1993) echoes Obot's sentiment. She gives an example of an incestuous case withdrawal by a mother because of threats and blame for "causing shame to her family". She observes that the Ugandan cultural practices are more prejudicial to the girl child. Girls are regarded to be more inferior to boys, hence they are not given the same opportunities as their brothers. She further notes that girls are victims of forced child marriages; child labour and female circumcision, "all in the name of culture and tradition".

#### 1.5.2.3.2 Age distribution

Very few studies report on the age distribution of child sexual abuse in South Africa with great precision. For instance Hyslop and colleagues reported that "the occurrence of (sexual abuse) in the Black population served by Alexandra clinic, decreases in the older child while at Coronation and TMI, this group has the highest incidence". They however, noted that in all groups, there was a moderate peak in the 3-6 year age group. Figures for Baragwanath were not available.

Howard and colleagues (1991) found a peak in the 6-8 year group with a moderate peak at 3-5 year group, concurring with the above results. In a facility based study done by Ladikos (1991) at Weskoppies hospital between July 1986 and June 1989, she found that the average age was 10 years.

### 1.5.2.4 Sexually transmitted diseases

Drew (1994) comments in a letter that their case of sexual abuse in a rural Zimbabwe hospital would not have been diagnosed had the child not developed gonorrhoea as sexual abuse is widely thought to be very rare in rural Africa. He however, concedes that there is gross underreporting of cases.

STDs are one of the few objective measures of sexual abuse in preadolescents, asserts McIntyre (1986), cited by Friedman in Monteleone & Brodeur (1998). Their presence in a child should raise a high index of suspicion for the possibility of sexual abuse (Ricci, 1986; Jenny, 1990; Bays & Chadwick, 1993; Wissow, 1995). The failure to suspect sexual abuse when an STD is diagnosed is pervasive (Hyslop et al., 1990). In fact Ricci (1986) quips "Bedsheets, toilet seats and bathtubs are never suspected of transmitting syphilis and gonorrhoea in adults yet they are often blamed as the source of paediatric infections, more from a lack of willingness to confront the possibility of sexual abuse than from scientific evidence".

The reluctance to have child sexual abuse high in the differential diagnosis list when a child has an STD, is probably due to the vertical (particularly in infancy) and non-sexual transmission of some of the organisms that are known to cause STDs. Also there is usually no history of sexual abuse that can be obtained from the child (Paradise, 1990). Paradise (1990) suggests that the difficulty in obtaining a collaborating history from a child may partly be due to the fact that an STD may be an inadvertent disclosure in a child who is not ready to disclose.

#### 1.5.2.4.1 Prevalence of STDs

The prevalence of STDs varies from series to series and from country to country. For instance in a series which had 1100 cases of STDs in children less than 16 years of age, in England, Chlamydia and first episode genital warts were the commonest conditions diagnosed (Forster, 1994).

According to Glaser and colleagues (1989) (cited in Gibbons & Vincent, 1994) STDs are infrequently encountered in childhood victims of sexual abuse, with only 5-12% routine cultures being positive. He attributes this to the relatively alkaline pH of the prepubertal vagina which inhibits the growth of many sexually transmitted organisms. This is in conflict with Jenny (1990) who states that the high pH " may also increase a child's susceptibility to infection."

In sharp contrast, Howard and colleagues (1991), reported quite a high prevalence (52%) of STDs in their series containing 140 subjects of whom 114 (about 82%) were sexually abused. *Neisseria gonorrhoeae* was the most frequently isolated (24%) followed by *Trichomonas vaginalis* (16%). This high prevalence of STDs should be seen through the backdrop that is painted by Frame and colleagues (1991) (cited in Howard et al., 1991), of a community that has a high incidence of STDs and is riddled with violence and alcoholism in Alexandra.

Hyslop and colleagues (1990) in their series found that Alexandra had the highest prevalence of STDs (55%) despite its rather inferior laboratory techniques (their laboratory only provided gram staining and microscopy), when compared to TMI (9%), Baragwanath (6%) and Coronation (26%) (all of which had an access to the 'state of the

art' laboratory techniques). The authors feel that the figures for Baragwanath are inaccurately low and are rather a reflection of poor notification and identification. Gonococcus was the most frequently identified organism in all four units, followed by Trichomonas and Gardnerella. Although no positive HIV patients were identified in all four units, it is difficult to comment as no information was available about the frequency of testing and the studies were done before the advent of the HIV epidemic in South Africa.

The prevalence of STDs in the studies from developed countries quoted in Jenny (1990) varied from 0.2-45 1%. The author attributed this wide variation to factors like: the microbiological tests used for diagnosis, the age range of the cohort and the underlying prevalence of disease in the community where the children were studied. It should be noted that the report with a high prevalence of STD (45,4%) had a total of only 16 subjects of whom 11 were tested for Gonococcus (GC). If one excludes this series then the upper limit is 26.7%.

According to Forster (1994) there are few studies that have been published in the UK. In a study done by Hobbs & Wynne (1987), cited in Forster (1994), only in 3% of the children who were suspected of being victims of sexual abuse, was an STD diagnosed. She however, points out an important issue, viz.: the lack of standardisation of the microbiological investigations. Only those children who were symptomatic were routinely screened for STDs. This of course may result in underdiagnosis especially in those cases that are infected with chlamydia (which is known to remain asymptomatic) (Hobbs et al., 1993; Forster, 1994).

Loseva & Ibragimov (1996) reported a sharp rise in the occurrence of syphilis among teenagers in Moscow. Their report was based on the archival case studies of the venereological hospital. In 1991 there were 86 children between age 15 and 17 years and 2 between 11 and 14 years that were infected with syphilis compared to 1213 and 71 respectively, in 1995. The common occurrence of syphilis in Moscow is in contrast to other studies (Jenny (1990); Hobbs et al., 1993). However, Friedman (1998) reports that there is a recent rise in syphilis in the adult population and hence the above findings may be a reflection of this.

According to Friedman (1998) very few cases of AIDS have been attributable to sexual abuse. In a study done by Gutman and colleagues (1991), 14 children of the 96 who tested positive for HIV, were confirmed to have been sexually abused. However, only in 4 of these 14 was sexual abuse proven to be the mode of transmission. In 6 children child sexual abuse was a possible mode of transmission (i.e. the perpetrator was either HIV positive or unknown, and no other risk factor was proven), and in the remaining 4 the mode of transmission was unknown. Shamelessly, at least three of the assailants who were implicated knew of the HIV status at the time they assaulted the children. Van Niekerk (1996) in KwaZulu-Natal, South Africa paints a different picture. She reports on an increasing number of sexually abused children, aged 2 to 14 years, who are presenting as HIV + / AIDS as a result of sexual abuse.

McKerrow (1997) did a study in Edendale Hospital (also in Kwa-Zulu-Natal), looking at the prevalence of HIV in sexually abused children. Out of the 47 children who were

tested from a random sample of 135 of suspected sexually abused children, 4 children tested HIV positive. Eighty eight children were not tested because of various reasons such as unobtainability of consent for testing; refusal of consent by the parent and poor compliance with the protocol by the medical staff. One child was less than five years of age and the rest were more than age 9 years. Also, repeat testing was not done because of poor compliance.

Both McKerrow (1997) and van Niekerk (1995) attribute this increase to "the cleansing myth" (which she explains as a belief among young men that one can cleanse oneself of HIV/AIDS by having intercourse with a young female child); "the prevention theory" (which is a belief that to prevent acquisition of HIV one should have intercourse with a young girl who is unlikely to be infected), obviously ignoring vertical transmission of HIV and "the retribution theory" (which is a belief prevalent among the youth, that HIV has been introduced to control black population growth and thus they will not go down alone). These myths have been reported in other sources (City Press, 1995)

#### 1.5.2.4.2 Modes of transmission of STDs and their significance

Nonsexual transmission of STDs is "an infrequent occurrence" and when these infections "affect the prepubertal child, sexual abuse must be highly suspected", assert Neinstein and colleagues (1984). The greatest dilemma that faces most clinicians when confronted with a child who has an STD, is that some of the infections can be acquired before or during birth and some through inoculation with infected formites.

The following table adapted from Neinstein et al., (1984) summarises the current view on the modes of nonsexual transmission of STDs.

Table 1. Modes of Nonsexual Transmission of Sexually Transmitted Diseases

| **Disease** | **Maternal Transmission** | **Nonsexual Human Transmission**** | **Transmission by Fomites *** |
|---|---|---|---|
| Gonorrhoea | Well documented | Not documented | Not documented |
| Chlamydia | Well documented | Not documented | Not documented |
| HSV | Well documented | Documented HSV1 | Not documented |
| *T. vaginalis* | Well documented | Not documented | Not documented |
| *C. acuminata* | Well documented | Not documented | Not documented |
| Syphilis | Well documented | Well documented | Not documented |

**Includes skin-skin or skin-mucous membrane and autoinoculation

*Excludes laboratory accidents;

*T vaginalis* = *Trichomomonas vaginalis*

HSV = Herpes simplex virus

*C. acuminata* = *Condylomata acuminata*

It is widely agreed in the literature that when perinatal transmission and infection via blood transfusion in the case of HIV have been excluded, gonorrhoea, syphilis and HIV in childhood are diagnostic of child sexual abuse (Neinstein et al., 1984; Bays & Chadwick, 1993; Hobbs et al., 1993). Herpes type 2; Chlamydia, Trichomonas and

Condylomata acuminata are extremely likely to be due to abuse, particularly in children out of infancy (Bays & Chadwick, 1993 ).

Not only is the mode of transmission of these infections a confounding factor, but also their incubation periods. Perinatally acquired trichomoniasis is known to persist for several months, if untreated (Paradise,1990) Neonatally acquired chlamydia can last for years – (according to Bays & Chadwick (1993) for 2-3 years and according to Hobbs et al., (1993) up to 2 years). HIV infection may remain clinically silent for more than a year (Paradise,1990; Bays & Chadwick, 1993).

According to Hobbs and colleagues (1993), Trichomonas is a less common infection in child sexual abuse, but is found in older girls. Because it does not survive for a long time in the pre-pubertal vagina, its presence suggests a recent infection (Hobbs et al, 1993; Royal College of Physicians of London, 1991). There was a controversy as to whether *Ureaplasma urealyticum* is pathognomonic of sexual abuse in children (Matson & Gutman, 1999). In adults it is closely correlated with a sexual experience, but it has been found in substantial numbers both in abused children and nonabused controls (Paradise, 1990).

The current recommendation is that *Ureaplasma urealyticum, Gardnella vaginalis, Mycoplasma hominis* and bacterial vaginosis although they may represent "results of traumatic genital injury resulting from sexual abuse", "they are not considered to be reportable paediatric STDs" ( Matson & Gutman, 1999).

#### 1.5.2.4.3 Guidelines for screening of STDs

Policies on screening for STDs in children are currently not standardised world-wide. The cost constraints; symptomatology; prevalence of the STDs in the general community; the discomfort and difficulty of obtaining vaginal specimens from children; and abuse by unknown or multiple assailants are just some of the factors that are used to inform these protocols (American Academy of Pediatrics, 1991; Forster, 1994; Matson & Gutman, 1999). There is however, a consensus in the literature that the result of the assessments for STDs is not only critical to the welfare of the child but can also provide much needed evidence that the child has indeed been abused (American Academy of Pediatrics, 1991; The Royal College of Physicians of London, 1991; Forster, 1994; Matson & Gutman, 1999).

According to some authors routine testing for STDs in asymptomatic children is not recommended unless the history or examination suggests genital, oral, or anal contact (American Academy of Pediatrics, 1991; Bourne et al., 1993). They explain that this is because of the low yield of positive cultures in most geographic locales. Contrary to the latter recommendation, The Royal College of Physicians of London (1991), recommend that "in cases of suspected child sexual abuse it is advisable to screen for STD even in the absence of symptoms." In a study where only symptomatic patients were screened for STDs, the researchers conceded that they might have underdiagnosed STDs (Hobbs & Wynne (1987) cited in Forster, 1994), further strengthening the latter recommendation.

The cost of laboratory investigations is perhaps one of the strong deterrents to routine testing especially when compared to routine prophylactic antibiotic treatment which is practised in some Centres e.g. Baragwanath Medico-legal Centre. The following table is the current government institutions' rates for the various laboratory investigations and for the antibiotics that are used in the prophylactic treatment in suspected sexual abuse cases (Figures supplied telephonically by The South African Institute for Medical Research on 17 Feb 1999 and The Chief Pharmacist at Lillian Ngoyi, Mr Desai, respectively).

**Table 2. Current Government rates for the various laboratory tests and antibiotics.**

| Laboratory investigation | | Antibiotic | |
|---|---|---|---|
| Test | Cost | Antibiotic course | Cost |
| GC culture | R24.96 | Erythromycin 250mg x qid x 7 days | R7.44 |
| Ureaplasma | R13.44 | Flagyl 200mg x tds x 7 days | R1.42 |
| Trichomonas | R13.44 | Canesten | R16.68 |
| Herpes | R59.52 | Rocephin 125mgx imi x stat | R24.57 |
| HIV elisa | R24.96 | | |
| HIV confirmation | R24.96 | | |
| WR | R21.12 | | |
| WR confirmation | R23.21 | | |
| Urine LCR for Chlamydia | R13.44 | | |
| Total | R219.05 | Total | R50.11 |

Confirmation = repeat test if the initial test is positive; imi = intramascularly; tds = three times daily, qid = four times daily: LCR = Ligase Chain Reaction

Using the above figures and the current recommendations (i.e. exclusion of Ureaplasma test), testing for STDs in a child can cost anything between R97.92 to R219.05 if the basic tests are negative and if all the tests are positive and Herpes is included. When this

is compared to the R25.54 (if Flagyl , Canesten and Erythromycin are given) – R50.11 for antibiotics and the fact that there is high non-compliance rates especially in this study population, one cannot help but appreciate the preference of prophylactic treatment to laboratory investigations.

However, the dangers of emergence of resistant strains with the blind treatment and high non-compliance rates should also be considered. In a personal conversation with an STD expert (Prof. Ballard), he supports testing and treatment of proven infections, particularly because STDs in children are not a completely understood phenomenon.

According to De Jong and Finkel (1990) cited in Gibbons & Vincent (1994) the use of prophylactic antibiotics in preadolescents is controversial. Other authors cited in the same reference suggest that prophylactic antibiotic treatment for gonorrhoea and chlamydia is often indicated in adolescents. Friedman (1998) suggests that therapy should not be begun in symptomatic children before obtaining all appropriate samples.

But if one considers that for instance only just over half the infected children with gonococcus are likely to have symptoms; those with pharyngeal infections are likely to be asymptomatic (DeJong, 1986 cited in Hobbs et al., 1993) and the high asymptomatic carriage of chlamydia in the (South African) black male population (Pham-Kanter et al, 1996), one wonders whether children who are suspected to be abused should not be routinely tested for STDs.

### 1.5.2.5 Clinical findings

A normal physical examination is common in child sexual abuse, even in those cases where an offender has confessed to penetration (Muram, 1989, Bays & Chadwick, 1993, Adams et al., 1994). Some studies (cited in Bays & Chadwick, 1993) have reported as high as 73% of normal findings in girls who were allegedly sexually abused. Factors such as delay in seeking medical examination; rapid healing of the hymenal injuries; ejaculatory and erectile dysfunction of the offender and elasticity of the hymenal tissue have been cited as some of the reasons for the normal physical findings (Bays & Chadwick, 1993). It is indeed a question of who did it; what was done; when it was done and to whom it was done.

### 1.5.2.6 Reporting of the abuse

In the USA, according to Goldner and colleagues (1998), there are four agencies which serve as potential recipients for child abuse reports, the social service agencies, police departments, health departments and juvenile courts. Although practice varies from state-to-state, with some states designating only one agency to receive reports and others 2 or more, most states have designated the Department of Social Services. With a very few exceptions, those states with more than one agency use the Social Services as the ultimate co-ordinator of the reports.

Consequently, not all child abuse cases lend up with the police, although "child sexual victimization is by definition a criminal violation" (Sauzier, 1989). In fact, Cohen (1985) reported that some North American clinicians "have successfully suggested in certain jurisdictions that therapy rather than imprisonment for perpetrators be mandated by court order." This author argues that "legally enforced therapy provides external controls for the family and the fear of imprisonment which often inhibits reporting of incidents is minimised."

In Sauzier's study (1989), only 60 out of the 156 cases (38.5%) involved the police. Of these only 37 (61.7%) were prosecuted and only 16 resulted in incarceration of the offender. Of the families who had made use of the criminal justice system, nearly half (48%) felt that their experience was harmful. Common complaints were that the police were insensitive and the conviction rates were not reassuring for many families.

In South Africa the Child Care Amendment Act No. 86, (1991) and the Prevention of Family Violence Act No 133, (1993) provide the guidelines for the reporting of cases of suspected ill-treatment of children. Section 42 of The Child Care Act (1991) specifies that the Regional Director of Health and Welfare of the district in which the child happens to be, or the Director-General or any officer designated by him for the purposes of this section should be notified of any suspected child abuse. The Prevention of Family Violence Act, (1993) broadens the recipients of the report to police officials, commissioners of child welfare or registered State or prescribed welfare organisation social workers.

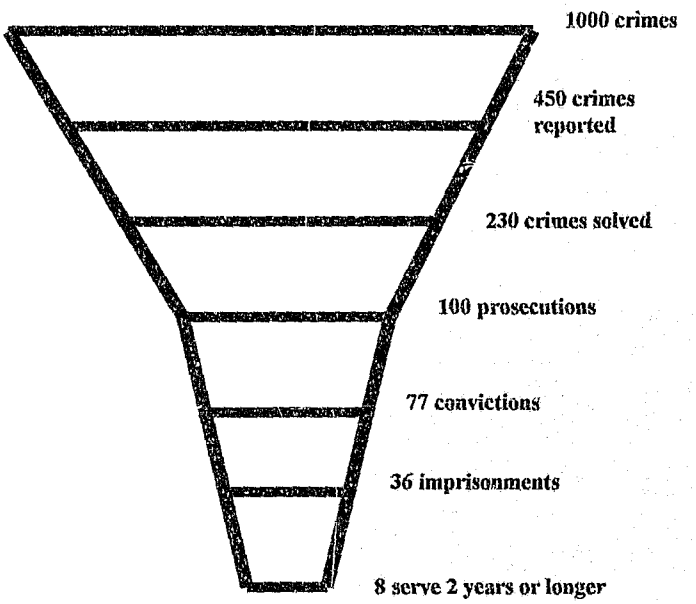
The National Committee on Child Abuse and Neglect (NCCAN) (cited in South African Law Commission issue paper 13, 1998), have criticised the compulsion to report child abuse. They argue that "reporting serves no useful purpose in its own right, and in the absence of prompt and skilfully managed protective services it may even increase the vulnerability of the child". They advocate for the establishment of a centralised child protection register and database, and a thorough investigation of the international experiences on mandatory reporting.

According to Goldner and colleagues (1998) there is a shift from the rehabilitative approach, which up until recently has been a favoured approach to the management of physical and sexual abuse. "Frustrations with the courts' ability to effectively intervene in many cases where such intervention seems necessary" and "the inability of professionals working in the area of mental health and child protection to change deviant behavior, particularly in a cost effective way" have been cited by critics as some of the reasons for a need to change the approach.

Accurate statistics on the reporting patterns and convictions rates are not available in South Africa, but there is a consensus among various researchers that reporting and conviction rates of child sexual are low (Nedcor Report, 1996; Wagstaff et al., 1989; Westcott, 1984). This can perhaps be gleaned from the "criminal justice funnel" diagram (Nedcor Report, 1996), which includes all types of crimes including child abuse.

Of every 450 crimes reported, only 77(17%) are convicted. The conviction rates for child sexual abuse cases would be expected to be even lower than the above figures, given that additional cautionary rules apply when prosecuting such criminal cases (Olivier, 1993).

**Figure 1. "The Criminal Justice Funnel"**




Taken from "Nedcor Report", 1996

According to the above diagram more than half of the cases were not reported. Wagstaff and colleagues (1989) in their paper on a Black urban perspective on child abuse, state that rape is often not reported to the parents or the police because of intimidation of the

victims. In a small study done in a children's hospital in Cape Town, Westcott (1984) reported that very few cases were reported to the police. He attributed this to the lack of abnormal findings on examination and the fear in Black parents of going to the police of because of not have passes (permission) to be in Cape Town. (This study was done at the time of presence of statutes governing the movement of blacks into white areas).

### 1.5.3 Physical Abuse

Contrary to the popular belief that Henry Kempe was the first person to describe child physical abuse in 1961, when he gave his popular lecture on 'Battered Baby Syndrome', there is evidence to suggest that a treatise existed as early as the year 900 (Hobbs et al., 1993). Maybe he should be rightly credited for popularising the diagnosis which focused the necessary attention on the suffering of the usually voiceless in any communities, the children. However, 37 years after Kempe's historic paper we are no closer to reaching a consensus as to what child physical abuse is, in the same way that we have not reached a uniform diagnosis for the other types of abuse.

#### 1.5.3.1 Definition

Physical abuse, battering and non-accidental injury are terms that are used interchangeably to describe physical violence that is directed towards children. Hobbs and colleagues (1993) define a physically abused child as 'any child who receives physical injury (or injuries) as a result of acts (or omissions) on the part of his parents or guardians'. They further explain that the definition includes actual or likely physical injury or failure to prevent physical injury or suffering. For the diagnosis of child physical abuse it is not necessary to prove the nature of the intent (Johnson, 1990; Bourne et al., 1993).

A Children's Hospital in Columbus, Ohio, has defined physical abuse as 'an injury to a child caused by a caretaker – for any reason, including injury resulting from a caretaker's reaction to an unwanted behavior' (Johnson, 1990). According to this hospital, injury includes tissue damage (such as bruises, burns, tears, punctures, fractures, ruptures of organs and disruption of function) beyond erythema or redness from a slap to any area other than the hand or buttocks. They prohibit the use of 'physical discipline' for children under one year of age. The use of an instrument on any part of the body is also considered to be abuse. In contrast, Wissow & Roter (1994) consider 'legally permissible corporal punishment' to include hitting the buttocks with a hand, belt, or a stick as long as not more than an evanescent physical injury is produced.

It is evident from the above definitions that physical abuse can only be diagnosed if there is demonstrable physical injury. Thus the inclusion of the likely injury (instead of only demonstrable injury) as physical abuse by Hobbs and colleagues is a contradiction of their own definition. It however, raises important questions, such as: should we wait for physical evidence before we can make a diagnosis of physical abuse (especially when it is now accepted that physical evidence can be absent in at least 50% of sexually abused children (Bays & Chadwick, 1993); is it not too late for the child by the time there are physical manifestations of the caretaker's behaviour; where can one draw a line between corporal punishment and physical abuse?

These and similar questions have been asked before but clear-cut answers have not been forthcoming. Hay & Stein (1998) for instance ask the question: 'can we hope for a better

world where violence towards children through physical punishment will no longer be socially acceptable – (in much the same way as cigarette smoking has become socially unacceptable)?' Perhaps an appropriate question would be; can children hope for violence free disciplinary measures when Governments and Physicians (who are the advocates for children) have not sorted out their own ambivalence about corporal punishment (Johnson, 1990; Wissow & Rotter, 1994). The difficulty in getting precise answers lies again with the fact that social science definitions are imprecise, cultural and religious practices vary and abusive behaviour is a continuum of normal behaviour.

Perhaps, Johnson (1990) sums up the frustration that many clinicians have, when he declares that terms such as ***substantial, unjustified, and allowable*** leave considerable leeway for reporting and result in various interpretations by professionals who are mandated by law to protect children.

### 1.5.3.2 Culture/religion or abuse

On one hand, one has authors who have a rather sympathetic and cautious view (Johnson. 1990; Monteleone & Brodeur, 1998), when it comes to cultural and religious practices that are sometimes construed as abuse in some quarters. For example, Johnson (1990) states that "physicians should become familiar with folk medicine that is practised in their own communities and develop approaches and policies, in co-ordination with organizations that sponsor immigrants, to educate and provide sensitive medical care for

the children of immigrants". Monteleone & Brodeur (1998) refer to folk medicine practices as "conditions that have been confused with abuse."

On the other hand, there are authors who have an unequivocal view about these practices when it comes to children (Huskisson & Dali, 1993; Swan, 1998). For example Swan (1998) points out the double standards the US Government has. She says that while they require states in the grant programme to include failure to provide medical care in their definitions of child neglect, they allow them to promulgate laws allowing parents to withhold medical care from children on religious ground.

Huskisson & Dali (1993) argue that while we need to acknowledge and accept culturally normal behaviour, we also need to confront norms when the rights of children are undermined. Fortunately, there seems to be a growing general consensus among people working in the child abuse field for a 'first call for children' and the use of the Convention to provide the guidelines (Huskisson & Dali, 1993; Hay & Stein, 1998; Onyango, 1998; Swan, 1998).

Cultural practices such as "Cao Gio" (a form of folk medicine practised by Southeast Asians – where they rub a coin or a spoon heated in oil on an ill child's neck, spine and ribs) and Moxibustion (also practised by Southeast Asians – a form of acupuncture where lighted sticks of incense are used to make small circular burns on the skin at therapeutic points) (Johnson, 1990; Monteleone & Brodeur, 1998), are the practices in question. Swan (1998) reviewed 175 deaths of children during a 20 year period between 1975 and

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1995, where medical care was withheld on religious grounds. She found that more than 80% (140) of the deaths were from conditions for which survival rates with medical care would have exceeded 90%.

### 1.5.3.3 Corporal punishment or abuse?

"Corporal punishment is widely practiced despite evidence of its harm to children", asserted Wissow and Roter (1994). Hobbs and colleagues (1993) note that although it has been outlawed in most other settings such as the prisons and military establishments, it persists with regard to the children. According to these authors many parents who end up battering their children start out by disciplining them and injuries result when things get out of hand.

Meijuni (1991) suggests that child abuse and neglect in Nigerian society is a result of a need for conformity in the adult-child relationship because of societal demands. Failure to conform on the part of the child is met with coercive and punitive measures. In fact, he suggests that, parents who fail to mete out "adequate" punishment to erring children are often seen as permissive. These highly punitive disciplinary measures are not unique to Nigerian society. Onyango (1998) states that disciplining of children in traditional Africa has always been punishment through beating.

Not only are children "disciplined" by their immediate families, but extended family and the general community members may discipline a child in Africa if they so deem fit. To use Onyango's words (1998), children belong to the community in Africa. Meijuni (1991) gives an example of an uncle who severely beat his 14 – year old nephew, bound his hands and feet with copper wire so tightly that it cut into his flesh and locked him in

room for over a day. His response to enquiries about the severe punishment was: "the boy was rather good at stealing, generally delinquent, and downright uncontrollable."

Corporal punishment is not confined to traditional Africa. Rakitzis (1987) (cited by Holdstock, 1990) found that Black pupils reported much lower physical punishment (8.4%) at home compared to the Afrikaans-speaking (30.4%) and English-speaking (41.2%) pupils. Robertson & Hayward (1976) attributed the low prevalence of child abuse (all the 54 cases in their series were physical abused) among Blacks, to such factors like differing child-rearing practices, mistrust of Western doctors, difficulty in assessments of cases due to language barriers and incomplete reporting due to inadequate child welfare services for this population group.

In the USA corporal punishment is illegal in juvenile correction facilities and in the school systems of about half of the 50 states, but not in the home, notes Wissow & Roter (1994). The UK has a similar picture. Corporal punishment is banned in state schools and the code of conduct prohibits it in nurseries, by childminders, in children's homes and foster homes, but it is still widely practised by most parents in all social classes, according to Newson & Newson (1986) cited in Hobbs et al., (1993).

In South Africa, up until very recently, corporal punishment was legal at schools, albeit being practised differently in different racial school systems. The non-uniform regulations for the different education systems (Holdstock, 1990) was probably a reflection of the apartheid era we have just emerged from. For example in a survey of

University students done by Rakitzis (1987), cited by Holdstock (1990), Black students reported a higher incidence of corporal punishment (99.0%) compared to the Afrikaans-speaking students (97.0%) and English-speaking students (71.0%). Thirty percent of the Black students reported daily beatings.

From the above discussions it is obvious that there is a world-wide ambivalence when it comes to corporal punishment and a controversy when interpreting the notion of harm. Of great concern are the lengths to which some of these countries are prepared to go to promulgate and legalise some of the double standard laws pertaining to children. The following statements by Holdstock (1990) and Bourne and colleagues (1993), respectively, succinctly sum up these double standards: "we can call corporal punishment by a thousand names and find a thousand justifications for its use, but it nevertheless remains child abuse" and inclusion of corporal punishment would "arguably make the concept so broad as to be meaningless, given that a majority of American parents use at least mild forms of physical punishment (a slap, a spanking) on occasion".

#### 1.5.3.4 Incidence and prevalence

There is a general consensus among authors from both developed and developing countries, that the officially reported physical abuse cases are a tip of the iceberg (Robertson & Hayward, 1976; Johnson, 1990; Hobbs et al., 1993). Reporting is directly linked to the awareness levels in particular among professionals who deal with children

and the public, and to the correct identification of the abused children (Johnson, 1990 & Hobbs et al., 1993).

It is estimated that 125 000 cases of physical abuse occur annually in the USA. Between 200 and 230 non-accidental deaths occur each year in Britain and about 2% of all children have been physically abused by the age of 17 years (Creighton & Noyes (1989) cited in Hobbs et al., 1993). There are no collated national figures in South Africa, but incidence and prevalence can be gleaned or inferred from the individual studies.

The problem with most of these individual studies (Irwin, 1974; Berrington et al., 1986; Hyslop et al., 1990; Howard et al., 1991) is that they tend to have small samples, are retrospective, and are not fully representative of the general population. For example, Berrington and colleagues (1986) did a retrospective descriptive study in a hospital serving mainly a coloured population. They found that the incidence of child abuse was about 2.5/1000 hospital admissions. The majority of these children was physically abused, a finding similar to Hyslop and colleagues' (1991) study based on the same population group. However, these authors concede that there could be gross underreporting and identification of child abuse by the practitioners in this hospital. This is based on the high incidence (302/1000) of deprivation (defined as both admission weight for age below the 3$^{rd}$ percentile and admission height for age below the 3$^{rd}$ percentile) and the low scores (average 58%) obtained by casualty officers and housemen on a self-administered questionnaire assessing their child abuse diagnostic and management skills.

In another hospital-based case review study done at Red Cross War Memorial Hospital, Cape Town, they found a preponderance of white and coloured abused children (Robertson & Hayward, 1976). The authors attributed this finding to the greater use of child welfare and the Hospital services by these two race groups, when compared to Blacks and Asians. They however, had two interesting findings worth noting: a higher percentage of abused coloured children were conceived out of wedlock and white children less than a year tended to have severe injuries when compared to coloured children.

According to Hobbs & Wynne (1990) physical abuse rarely exists alone. One in six physically abused children have also been sexually abused and others have been neglected or are failing to thrive. Emotional abuse coexists in most cases.

#### 1.5.3.5 Age and sex distribution

Most studies, both in the developed and developing countries report on a high incidence and prevalence of physical abuse among pre-school children (Irwin, 1975; Berrington et al., 1986; Hobbs et al., 1993). In contrast, Howard and colleagues found an age peak of 6-8 years in their retrospective study in a black township of Alexandra (their results to be treated with caution because of the very small sample size). Severe and even fatal head injuries seem to occur most commonly among children less that one year of age (Creighton & Noyes, 1989 cited in Hobbs et al., 1993; Ricci & Botash, 1997), while fatal abdominal trauma is common among toddlers (Ricci & Botash, 1997).

Unlike sexual abuse where females outnumber males for reported cases, there is no clear picture that emerges from the studies for physical abuse. Some studies report a predominance of males (Irwin, 1975; Creighton & Noyes, 1989 cited in Hobbs et al., 1993) while others find no gender preponderance (Howard et al., 1991; Ricci & Botash, 1997).

### 1.5.3.5 Risk factors

Unlike sexual abuse which seems to occur uniformly across all socio-economic strata, physical abuse tends to occur more frequently in conditions of social deprivation and poverty (Robertson & Hayward, 1976; Council on Scientific Matters, 1985; Berrington et al., 1986; Hobbs et al., 1993). Factors such as marital disharmony, especially where partners resort to violence on one another (Irwin, 1975; Council on Scientific Matters, 1985; Hobbs et al., 1993); unplanned pregnancies (Irwin, 1975); substance abuse (Council on Scientific Matters, 1985); socially isolated families with poor support (Council on Scientific Matters, 1985); overcrowding (Robertson & Hayward) and handicapped children (Council on Scientific Matters, 1985 & Hobbs et al., 1993), are just some of the risk factors that are widely referred to in the literature.

### 1.5.3.7 Perpetrators

Most children are physically abused by their parents, either natural parents or parent figures (Irwin, 1975; Council on Scientific Matters, 1985; Howard et al., 1991; Hobbs et

al., 1993). Again, there appears to be no general concensus as to whether mothers physically abuse their children more than the fathers. In Howard et al., (1991) and Berrington and colleagues' (1986) studies, fathers were implicated more than mothers in contrast to Hobbs et al., 1993.

According to Hobbs and colleagues (1993) mother substitutes were less implicated than father substitutes, with step-fathers outnumbering cohabiting boyfriends. They also found that less than half of physically abused children come from families with both natural parents present, but marital difficulties are common when both parents are present.

### 1.5.4 Physical Neglect

Physical neglect is the commonest form of abuse (Council on Scientific Matters, 1985; Loening, 1991; Bourne et al., 1993; Wissow, 1995), very insidious (Hobbs et al., 1993) and probably the most life-threatening (Wissow, 1995). Despite this it is one of the least researched types of abuse (Munkel, 1998). This author also notes that neglect is not reported as an entity in most studies, but is usually noted as a component of other forms of abuse in most studies.

### 1.5.4.1 Definition

The National Study of the Incidence and Severity of Child Abuse and Neglect (NIS-1, 1981) defined neglect "as a situation in which it could be shown that, as a result of caretaker inattention to the child's basic needs for care, protection, or control, the child experienced predictable injury or impairment of serious or greater severity," (Munkel, 1998). This definition requires that there be demonstrable harm for a diagnosis of neglect to be made. In 1986 (NIS-2), the definition was expanded to include those cases where it was "reasonable to suspect there was the risk of injury as a result of neglect".

Loening (1991) defined neglect as "the persistent failure to provide adequate physical and emotional care of the child where the **means are available**", (emphasis is mine). This definition not only raises the obvious questions like when is adequate, adequate; whose judgement matters most – the parent's or the mandated reporter's, but also raises the thorny issue of poverty and neglect. Where does one draw the line between neglect and poverty? Can child welfare services cope with reports of malnourishment as neglect, particularly in developing countries, where these services are few and already fully stretched?

The Council on Scientific Affairs (1985) suggests that while physicians should be sensitive to the socio-economic and cultural realities of their patients, they should report physical neglect, whether or not it results from poverty. Of course there is a great danger

of 'overreporting', which has been defined as "reported cases that are investigated and closed without services being provided (Berger et al., 1989 cited by Munkel, 1998).

### 1.5.4.2 Incidence and prevalence

The true incidence of physical neglect is unknown (Hobbs et al., 1993). It goes mostly undetected and unreported. "It takes death or shocking evidence before many cases of neglect are brought to light", wrote Munkel (1998). Also it is obvious from these definitions that the true incidence is very hard to determine as there is a gross overlap between neglect, physical abuse and emotional abuse.

According to the NIS-1, reported neglect accounted for 48% of all child maltreatment reports in 1980. When the definition was expanded to include the "risk to harm" cases the percentage increased to 63% in 1986 (NIS-2). In the UK, a survey of Child Protection Register in 1988 revealed that neglect alone accounted for 13% of the registrations while neglect in combination with other forms of abuse accounted for about 4% (Hobbs et al., 1993). In South Africa there is no comprehensive statistics available, but some of the common challenges most physicians are usually faced with are malnutrition especially among Blacks.

The working group of the document 'Working Together' defined emotional abuse as "actual or likely severe adverse effects on the emotional and behavioural development of the child caused by persistent or severe emotional ill treatment or rejection" (Hobbs et al., 1993). Pearl (1998) has a rather simpler description of what constitutes emotional/ psychological abuse: acts of omission or commission that are psychologically damaging; the presence of hostile behaviours as well as the absence of positive parenting and a concerted attack on a child's development of self and social competence.

Fortin and Reed (1984), quoted by Straker (1990) define emotional abuse as any parental acts which 'can kill a child's spirit, his ability to feel deeply and to make emotional contact with others.' The Council on Scientific Affairs (1985) noted that emotional maltreatment may include excessive or unreasonable parental demands on children. They give examples of such acts as constant or persistent teasing, belittling and verbal attacks. It is not necessary to demonstrate intent on the part of the parent for one to diagnose emotional abuse (Pearl, 1998).

The above definitions, although essentially the same differ in their emphasis on the effects of the acts on the child and the acts of the parents. Definitions that rely on the effect rather than the act, are not only subjective but also have a problem because of the different coping mechanisms of the different people and genetic constitution. Despite the lack of a precise definition of emotional abuse, Pearl (1998) warns that it is the most damaging of all the types of abuse.

Loening (1991) refers to secondary emotional abuse in his chapter on child abuse. He states that this form of abuse is often inflicted when the child is accused of provoking the perpetrator just at a time when the victim needs love and security.

Other authors have classified emotional abuse according to the nature of abuse committed. Garbarino et al., (1988) cited in Hobbs et al., (1993) classified emotional abuse as rejecting; isolating; terrorising; ignoring; and corrupting. Pearl (1998) also has a similar classification but also adds two more type: verbally assaulting and overpressuring.

### 1.5.5.2 Incidence and prevalence

Despite the agreement by all authors that this type of abuse is present in all forms of abuse, quoted statistics point to a low incidence and prevalence. According to Loening (1995) emotional abuse is far more common in impoverished communities although it is prevalent in all communities and all levels of society. He further suggests that the ubiquity of this type of abuse is due to the "ignorance of the elementary needs of the developing child, particularly when the caregivers themselves are victims of inadequate parenting." In contrast, Ney and colleagues (1993) cited by Pearl (1998) suggest that it is probably more prevalent in wealthier countries.

### 1.5.5.3 Clinical presentation

A child who is emotionally abused may present with physical signs such as delays in physical development and failure to thrive or with behavioural signs like deteriorating conduct, increased anxiety, apathy and developmental lags (Council on Scientific Affairs, 1985). Munchausen by proxy (defined as a form of child abuse in which a parent fabricates or produces illness in a child) (Bryk & Siegel, 1997) also results in psychologically impaired development (Pearl, 1998). It is important to note that these signs are not specific to this type of abuse, but like all types of abuse its recognition is highly dependent on the awareness of its existence on the part of the clinician.

Thus all forms of abuse may vary in their incidence and manifestations in different societies. The present study describes the presentation of abuse at a community abuse Centre in Soweto, and comparisons will be made with findings in other countries and to other parts of South Africa.

## 2. MATERIALS AND METHODS

A retrospective review of all the records of the children seen in 1995 between March and December, was done. Of the 372 records of the patients seen over this ten months period, all but four could be traced, (N=368).

Data obtained using a data sheet (see appendix 1), included demographic information about the child and their parents, characteristics of the alleged perpetrator, types of abuse, physical findings, results of the laboratory investigations, frequency and duration of the abuse. In cases where there were multiple offenders, information was gathered for each offender.

In the prepubertal female children genital examination entailed only inspection with the naked eye. Digital examination was only done in the adolescent girls if pregnancy was suspected. Diagnostic findings highly suggestive of penetration beyond the hymen included: a markedly enlarged hymenal opening for age with associated findings of hymen disruption, including absent hymen, hymenal remnants, healed transections or scars, in the absence of an adequate accidental or surgical explanation.

Non-specific or inconclusive findings included redness of the external genitalia, increased vascular pattern of the vestibular and labial mucosa, presence of a discharge without abnormal hymenal findings.

A calgi-swab was used to collect the specimens from the genitalia and these were dipped in the various culture media for Trichomonas, Gonococcus, Ureaplasma. Herpes was only tested for if there were vesicles in the genitalia. For chlamydia ligase chain reaction (LCR) test the first part of the urine was collected in a urine specimen bottle. All the samples were collected by a regular transport to the laboratory at Chris Hani-Baragwanath hospital.

The information in the records was routinely collected at the time of the initial consultation, and was recorded by a number of different members of the child abuse team. This team consisted of primary health care nurses, social workers, medical practitioners and psychologists. Not all the information was available for each client.

## 2.1 Statistics

The study is mainly a descriptive study. Frequencies and means were calculated where appropriate. The data was analysed using Epi Info 5.

## 3. RESULTS

A total of 372 children were referred to Zamokuhle Child Centre for assessment and management of suspected and alleged child abuse and neglect, over a 10 month period in 1995 (from 06 March 1995 to 31 December 1995). All but four files could be traced. Of these 368 available records, 357 (97.0%) were related to sexual abuse either in combination with other abuse or as an isolated form of abuse (table 3). It is this group that will be analysed further.

**Table 3. Type of Abuse**

| Type of abuse | Frequency | Percent (%) |
|---|---|---|
| Sexual | 350 | 95.1 |
| Physical | 5 | 1.4 |
| Emotional | 1 | 0.3 |
| Combined | 12 | 3.2 |

"Combined" = more than one type of abuse

### 3.1 Sexual Abuse

#### 3.1.1 Demographics

The total number of children with suspected sexual abuse was 357. About 97% (347) of these children were females. The average age of the children was 8.1 ± 3.6 years, with a

peak age between 5 and 10 years and about two-thirds (233) were school-going (table 4). The majority (70.5%) of these school-going children were in grade 4 and lower classes.

**Table 4 . Summary of Demographic Characteristics**

| | | Frequency | Percent (%) |
|---|---|---|---|
| Sex | Females | 347 | 97.2 |
| | Males | 10 | 2.8 |
| Age Distribution | < 5 years | 95 | 26.6 |
| | 5 - 10 years | 154 | 43.1 |
| | > 10 years | 108 | 30.3 |
| Schooling | Not schooling | 46 | 12.9 |
| | Creche/ Preschool | 71 | 19.8 |
| | School | 233 | 65.3 |
| | Left School | 5 | 1.4 |
| | Unknown | 2 | 0.6 |

### 3.1.2 Background information

At least three-quarters (78.2%) of these children were referred to Zamokuhle by Soweto clinics, with Zola Clinic responsible for almost half (46.2%) of these clinic referrals (Figure 2). Only one child was referred by the private general practitioners in Soweto. There was a fairly even representation of all the Soweto townships, with a slight preponderance of those closer to Zamokuhle (figure 3).

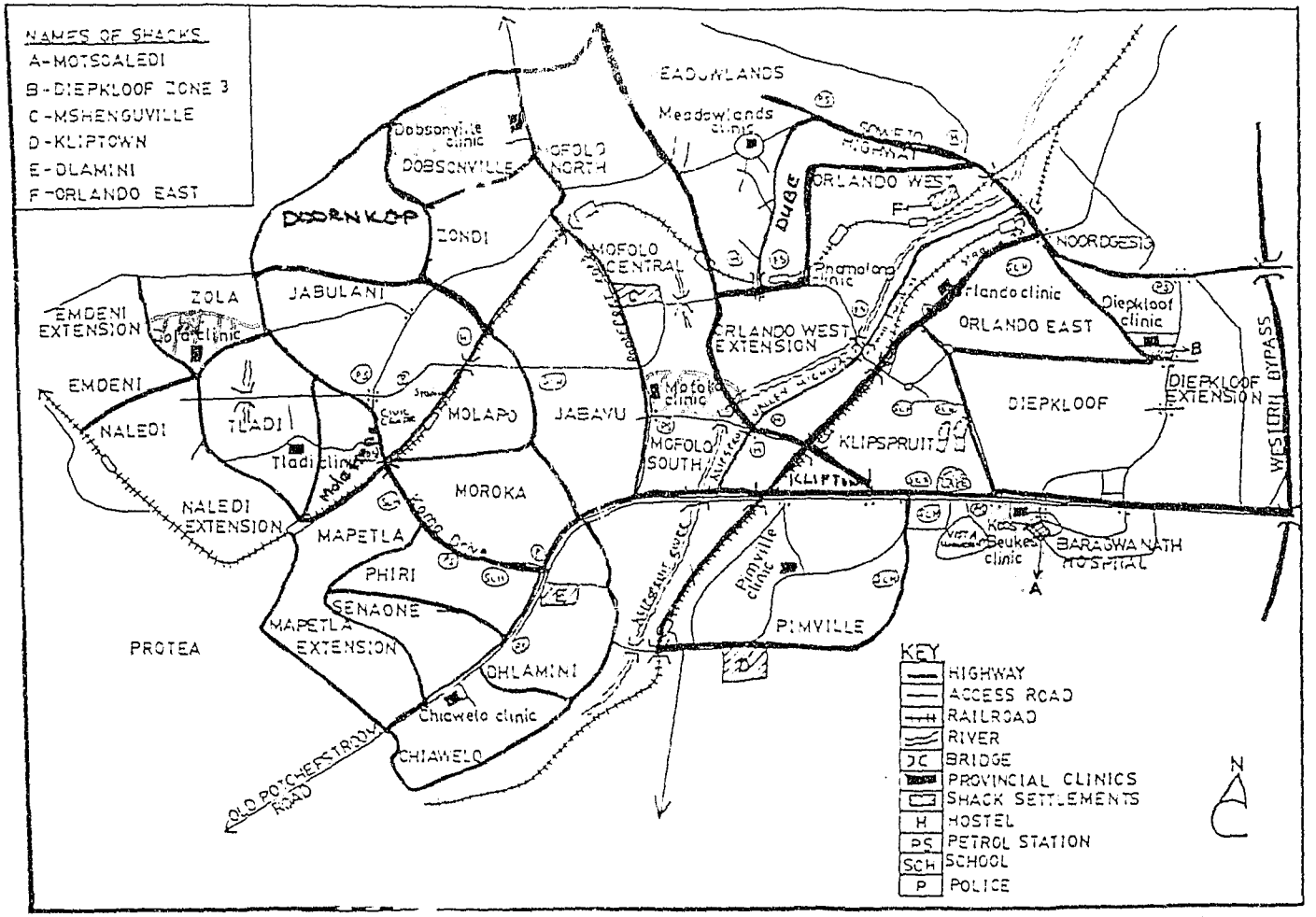



Figure 2. Referrals from the clinics

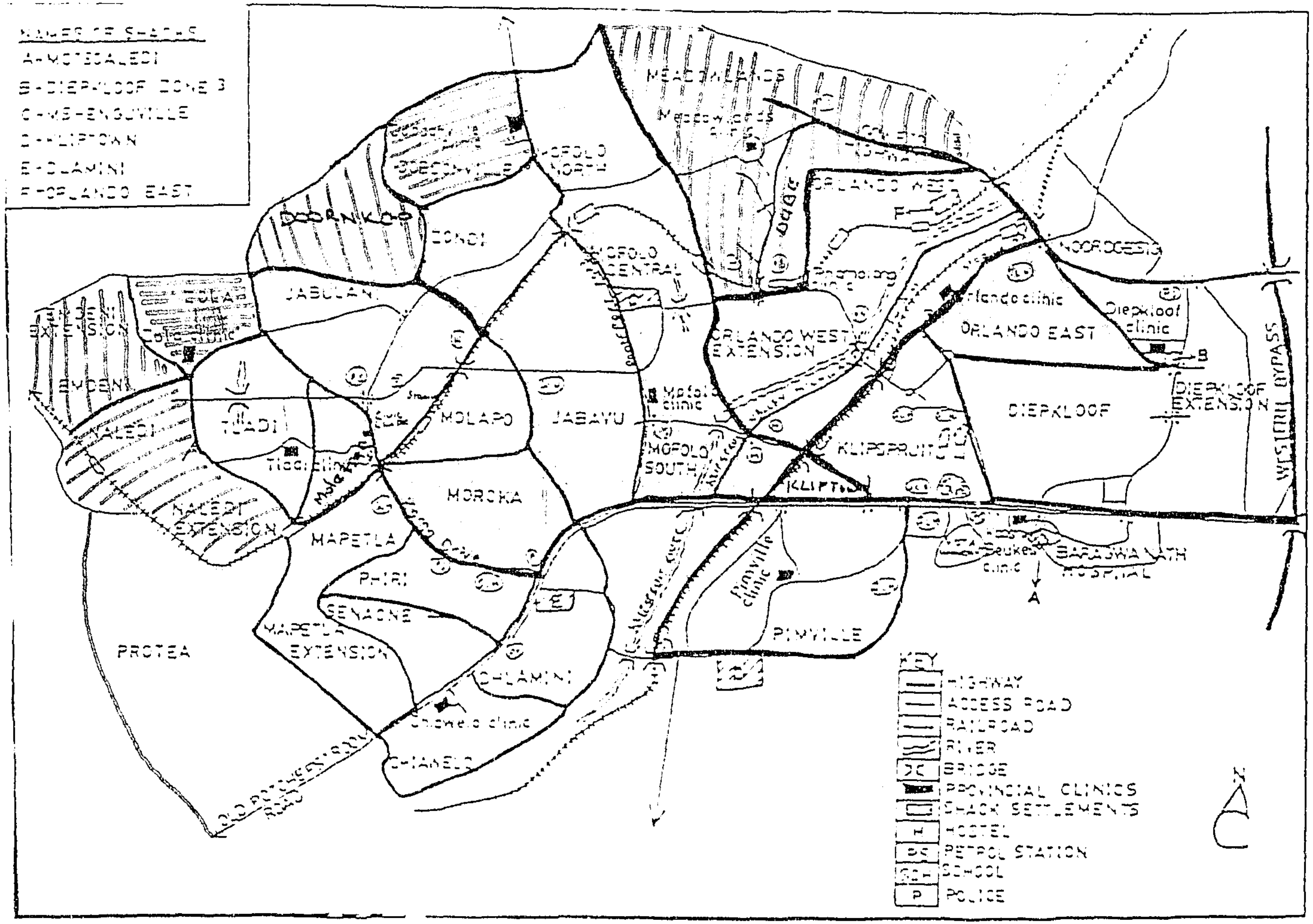
19

• - 71.5%

• - 8-15%

• - 8-3.2%

* Zamokuhle Child Centre




Zamokuhle Child Centre ≥ 78%

= 6-8%

Figure 3. Address of the victim

About three out four (76.2%) children were accompanied by a parent – mother only in 70.6%; father only in 1.7% and father and mother in 3.9% of the cases. A similar number (76.5%) were staying with at least one parent- (41.2% with mother only; 3.4% with father only; 31.9% with both mother and father), at the time of the abuse. Sixteen percent were staying with their grandparents and 4.5% were staying with the other relatives.

Although less than a third (111) of the mothers were married –[94 (84.7%) to the biological father and 17 (15.3%) to another man], there was a father-figure at home in 48.1% (172) of the total number of cases –[131(76.2%) the biological father and in 41(23.8%) another man].

In those families where there were more than one child, 50.5% (139) were from the same biologic parents; 43.3% (119) had different biologic parents and in 6.2% (17) the information was not available. In 8.4% (30) of the cases the biologic father was deceased while in 0.8% (3) the biologic mother had died. Fifteen percent (54) of the mothers reported at least one incidence of abuse in their own lives, - 46.3% (25) in their childhood and 53.7% (29) in their adulthood. In half the cases (27) the abuse was sexual. Similar information for the fathers was not available because most women did not know whether their partners had been abused.

### 3.1.3 Educational status of the parents

The majority of the mothers (65%) had secondary education (defined as an education level from standard six and upwards) (table 5). The education level was not known in 10.9% (39) of the mothers and 42.3% (151) of the fathers.

**Table 5. Education Status of the Parents**

| | Mother | | Father | |
|---|---|---|---|---|
| | Number | Percent (%) | Number | Percent (%) |
| No formal education | 9 | 2.5 | 6 | 1.7 |
| Primary | 77 | 21.6 | 51 | 14.3 |
| Secondary | 223 | 62.5 | 143 | 40.1 |
| Tertiary | 9 | 2.5 | 6 | 1.7 |
| Unknown | 39 | 10.9 | 151 | 42.3 |

### 3.1.4 Housing

Sixty four percent (230) of the abused children lived in stand alone brick houses; of these 42.6% (98) also had backrooms occupied by tenants not necessarily related to the landlord. A further 12.6% (45) lived in backrooms (which were made either of bricks or tin) as tenants and another 15.4% (55) lived in shacks in an informal settlement area.

### 3.1.5 Disclosure of abuse

Only in just over a third of the cases (36.7%) was there a purposeful disclosure of the sexual abuse, either by the child in 101/131 of the cases or by a third party in 30/131. The commonest confidantes were the mother, the teacher and other extended family members. The majority (61.3%) of the cases was incidentally found, mostly (57.1%) by the attending clinician (table 6). Most of these children presented with signs and symptoms which raised suspicion of sexual abuse (table 7).

**Table 6. How Abuse was Discovered and by Whom**

| Disclosed by | Frequency | Percent |
|---|---|---|
| Child | 101 | 28.3% |
| 3rd party | 30 | 8.4% |
| Other | 7 | 2.0% |
| Incidental | 219 | 61.3% |

| Disclosed to | Frequency | Percent |
|---|---|---|
| Mother | 30 | 29.7% |
| Father | 4 | 4.0% |
| Sibling | 3 | 3.0% |
| Friend | 4 | 4.0% |
| Teacher | 18 | 17.8% |
| Neighbour | 3 | 3.0% |
| Cousin | 6 | 5.9% |
| Granny | 13 | 12.9% |
| Aunt | 12 | 11.9% |
| Other | 8 | 7.9% |

| Suspected by | Frequency | Percent |
|---|---|---|
| Clinician | 125 | 57.1% |
| Nurse | 63 | 28.8% |
| Granny | 16 | 7.3% |
| Other Caretaker | 4 | 1.8% |
| Teacher | 10 | 4.6% |
| Other | 1 | 0.5% |

### 3.1.6 Signs and symptoms in those children who were found to be incidentally abused

Table 7 documents the signs and symptoms of the 61.3% of children in whom abuse was discovered incidentally. The majority of the symptoms was related to the genito-urinary tract.

**Table 7. Signs and symptoms in those children who were incidentally found to be abused.**

| | | | STD | | No STD | | Test not done | |
|---|---|---|---|---|---|---|---|---|
| | Frequency | Percent | Frequency | Percent | Frequency | Percent | Frequency | Percent |
| Vaginal discharge | 85 | 38.8% | 5 | 5.9% | 79 | 92.9% | 1 | 1.2% |
| Vaginal bleeding | 28 | 12.8% | 4 | 14.3% | 24 | 85.7% | 0 | 0.0% |
| Genital sores | 24 | 11.0% | 5 | 20.8% | 19 | 79.2% | 0 | 0.0% |
| UTI signs & symptoms | 31 | 14.2% | 2 | 6.5% | 28 | 90.3% | 1 | 3.2% |
| Lower abdominal pains | 19 | 8.7% | 2 | 10.5% | 16 | 84.2% | 1 | 5.3% |
| Learning difficulty | 15 | 6.8% | 2 | 13.3% | 13 | 66.7% | 0 | 0.0% |
| Sexualised behaviour | 12 | 5.5% | 2 | 16.7% | 9 | 75.0% | 1 | 8.3% |
| Broad-based gait | 19 | 8.7% | | | | | | |
| Genital pain & itch | 24 | 11.0% | | | | | | |
| Other 'related' symptoms | 34 | 15.5% | | | | | | |
| Other 'unrelated' symptoms | 19 | 8.7% | | | | | | |

'related' symptoms included torn underwear, generalised body rash, unexplained expensive gifts and money, disturbed sleep, amenorrhoea, etc.

'unrelated' symptoms included fever, chicken pox, respiratory symptoms, painful eyes

Of the children who were incidentally found to be abused, 67.1% (147) disclosed the abuse on further interview (76.1% (112) on the first interview either at the initial clinic or at Zamokuhle and 23.9% (35) on subsequent visits to Zamokuhle). On examination 77.6% of these children were found to have physical evidence which was highly suggestive or compatible with abuse; 21.0% had non-specific signs and only 1.4% had normal genital findings.

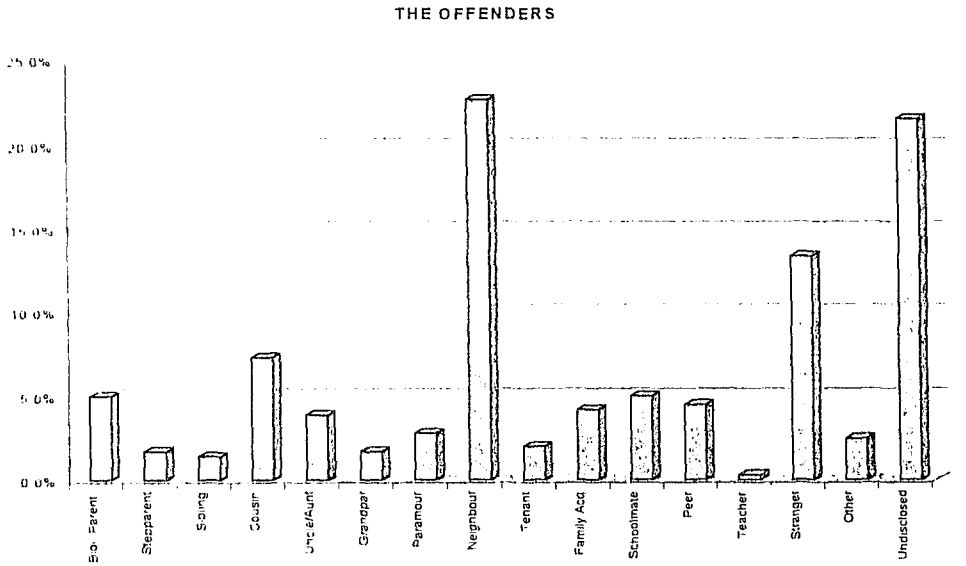
### 3.1.7 The abuse and the alleged offender

About a third of the abuse incidents occurred in an environment which could be considered as safe for the child, (7.0% in victim's home, 20.2% in the home shared by the victim and offender and 4.8% in school) and another 20.2% occurred in the offender's home. The majority (62.5%) of the abuse was perpetrated by someone who had access to the child (a relative in 23,8% and an acquaintance in 38.7%) (figure 4). About 13% (48) of the children were abused by strangers. The offender was not disclosed (unknown) in 21.6% (77) of the cases. The age of the offender was known in about half the cases and the majority (60%) of the abusers was young people.

Almost half (164) the children were abused once only. About a quarter (94) had two or more abuse incidents and in another quarter the number of incidents were unknown. Gang-rape was reported in 19 (5.3%) cases and about 10% (34) gave a history of previous abuse by a different perpetrator. Less than 25% (82) of the children presented to

a Health Centre within a week of the abuse incident while 105 presented at least a month after the incident.

## Figure 4. The offenders



### 3.1.8 Physical findings and laboratory results

An overwhelming majority of the children (278) were found to have physical signs of the genitalia highly suggestive of sexual abuse; 72 had non-specific signs of abuse and 6 had no abnormal genital findings.

The prevalence of sexually transmitted diseases (STDs) was 11.1% (39 children out of 350 tested had at least one STD, with some children having more than one STD) (table 7). The frequency of the STDs was evenly distributed across the age range (12 in < 5 years; 11 in 5-10 years and 16 in > 10 years). *Chlamydia trachomatis* was the most frequently isolated organism (12 out of 172) followed by *Ureaplasma urealyticum* (11 out of 326), HIV (8 out of 344), and ***Trichomonas vaginalis*** (5 out of 331). There were 3 children each with positive syphilis (332 tests done) and gonococcal tests (337 test done) and 2 with Herpes (310 tests done).

Table 8 gives some demographic characteristics of the children who tested positive for HIV and the HIV status of the mother, where it was done.

**Table 8. Demographic Characteristics of the HIV Positive Children**

| Age (yrs) & Sex | Repeat Test Result | Other +ve STDs | HIV status of mother |
|---|---|---|---|
| 2, F | Positive | Nil | Positive |
| 8, F | Not done | Nil | Not done |
| 10, F | Positive | Nil | Not done |
| 11, M | Positive | Nil | Not done |
| 12, F | Not done | Gonococcus, Herpes | Not done |
| 13, F | Positive | Genital warts | Not done, younger sibling negative |

The HIV test was not repeated in some children because they defaulted and could not be traced. The 12 year old was suspected to be a child prostitute on the initial visit and efforts to get hold of the "good Samaritan", whom we later suspected to be a pimp, were not successful.

In approximately half (19) the children with STDs there was a purposeful disclosure and in the other half (18) the abuse was discovered incidentally. The majority (22) of the children with STDs had been abused once only and by an unrelated offender (22). Only 2 of the 19 gang-raped children had STDs. Of the 16 children abused by their peers one had an STD. Twenty eight (71.8%) of the children with STDs were found on examination to have physical findings highly suggestive of sexual abuse; 1 (2.6%) had no abnormal findings and 10 (25.6%) had non-specific signs and symptoms of sexual abuse.

Out of the 210 children who had received prophylactic antibiotic treatment on suspicion or diagnosis of sexual abuse, 17 (8.1%) tested positive for STD. Although the majority (247 =69.2%) of the children came back for follow-up visits spontaneously, most (137 = 55.5%) came back once only. Of the 110 children who defaulted 10 (9.1%) had an STD.

### 3.1.9 Reporting of the abuse to the police

Only 151 (42.3%) of the parent/s laid charges with the police. Forty (11.2%) were undecided and 166 (46.5%) had not laid any charges at the time of the data collection. The outcome of the prosecution was only known in 28 (18.5%) cases. There were 11(39.3%) convictions and 17(60.7%) acquittals.

The mothers who had primary school education or no formal education (47/88) were more likely to lay a charge than those who had at least a secondary education (90/236), and this tendency was statistically significant (p= 0.026). Although there was a tendency for mothers who had a previous history of abuse (either in childhood or/and adulthood) (29/55) to lay a charge with the police than those who had no previous history, (92/242), this was not statistically significant (p=0.078). The relation of the offender to the victim was not a determining factor for reporting to the police, (p=0.647).

## 3.2 Physical Abuse

### 3.2.1 Demographic characteristics

Thirteen children were referred to our Centre for physical abuse, either in isolation or in combination with other abuse forms. Six of these children were also sexually abused; 7 were also emotionally abused and 3 were also neglected. About two-thirds (10) of these children were female and most (11) were attending school. The majority of the children (72.7%) was in fourth grade or lower. One (7.7%) child was less than 5 years of age; 4 (30.8%) were between 5 and 10 years and 8 (61.5%) were older than 10 years.

### 3.2.2 Circumstances around the abuse and the nature of the alleged offender

About 77% (10) of the physical abuse incidences occurred in the victim's home and in 90.0% of these incidences the alleged offender was staying with the victim. Only one child was allegedly physically abused by the teacher at school. Nine of these children (69.2%) spontaneously reported the abuse and in most cases to the mother (44.4%). Only one child was incidentally found to be physically abused, by a teacher.

Most (76.9%) of the alleged offenders were males and were 'relatives' (92.3%) to the child, (biological parent – 46.2%; step-parent – 15.4%; cousin – 15.4%; paramour – 15.4%). The majority of the offenders were adults (table 9).

**Table 9. Summary of the Demographic Characteristics of the Alleged Physical Abuse Offender**

| | | Number | Percent (%) |
|---|---|---|---|
| Sex of offenders | Females | 3 | 23.1 |
| | Males | 10 | 76.9 |
| Age of offender | 15 – 24 years | 2 | 15.4 |
| | 25 – 39 years | 4 | 30.8 |
| | 40 – 59 years | 4 | 30.8 |
| | Unknown | 3 | 23.1 |
| Relation to child | Biological Parent | 6 | 46.2 |
| | Step-parent | 2 | 15.4 |
| | Cousin | 2 | 15.4 |
| | Paramour | 2 | 15.4 |
| | Teacher | 1 | 7.7 |

In 84.6% (11) there was a purposeful disclosure of the abuse, either by the child (9) or by a third party (2). The child disclosed to the non-offending parent in the majority (5) of the disclosed cases and to a sibling in one case.

### 3.2.3 Physical findings and reporting of the abuse

There were no severe physical abuse cases reported to the Centre - all the cases with conclusive evidence (4) of physical abuse had only superficial soft tissue injuries. Only

2 victims had histories warranting a skeletal survey and in both cases there were no abnormalities detected.

Charges were laid in 9 (69.2%) cases, but the outcomes of these are not known. The compliance rate was very low, with only 2 victims coming back for counselling.

## 3.3 Emotional Abuse

### 3.3.1 Demographic characteristics

Of the 11 children who were diagnosed as emotionally abused all were suffering from other forms of abuse. Nine (81.8%) were females. Seven children (63.6%) were also physically abused; 6 (54.5%) were sexually abused and 5 (45.5%) were neglected. Two children (18.2%) were less than 5 years of age; 4 (36.4%) were between 5 and 10 years and 5 were older than 10 years. Of the 7 (63.6%) who were attending school, 5 (71.4%) were in grade 3 or lower.

### 3.3.2 The Abuse

There was a purposeful disclosure in the majority (81.9%) of the cases – 5 (55.6%) by the child and 4 (44.4%) by a third party. Only one emotional abuse case was incidentally found. Most (8) of the alleged offenders were adult males and were related to the child

(table 10). The biological parent was implicated in 45.5% (5) of the total cases; the step-parent and cousin in 18.2% (2) each; the paramour and the neighbour in 9.1% (1) each.

**Table 10. Summary of the Demographic Characteristics of the Offender**

| | | Number | Percent (%) |
|---|---|---|---|
| **Sex of offenders** | **Females** | **3** | **27.3** |
| | **Males** | **8** | **72.7** |
| **Age of offender** | **15 – 24 years** | **3** | **27.3** |
| | **25 – 39 years** | **3** | **27.3** |
| | **40 – 59 years** | **3** | **27.3** |
| | **Unknown** | **2** | **18.2** |
| **Relation to child** | **Biological Parent** | **5** | **45.5** |
| | **Stepparent** | **2** | **18.2** |
| | **Cousin** | **2** | **18.2** |
| | **Paramour** | **1** | **9.1** |
| | **Neighbour** | **1** | **9.1** |

### 3.3.3 Reporting of the abuse

Of the 8 (72.7%) charges that were laid, there were 2 convictions. The outcome of the other 6 charges was not known.

## 3.4 Neglect

There are no children who presented primarily with neglect. All the five children who were neglected had other forms of abuse. Three (60%) were physically abused; 2 (40%) were sexually abused and all 5 were also emotionally abused. In all 5 cases a parent or a parent figure was implicated (3 children were neglected by the parent; 1 by a stepparent and 1 by a paramour). In all 5 cases there was a primary disclosure of the neglect.

# 4. DISCUSSION

## 4.1 Sexual Abuse

### 4.1.1 Epidemiology

#### 4.1.1.1 Prevalence

About 95% of all the child abuse cases seen at Zamokuhle in 1995 were sexual abuse cases. This figure is much higher than the 10-20% of all confirmed child abuse cases reported from developed countries (Ricci, 1986, Matson & Gutman, 1999), but comparable to some facility-based studies done in Johannesburg (range 54-90%) (Hyslop et al, 1990; Howard et al.,1991). Wider consensus is that neglect is the commonest form of abuse (Council on Scientific Matters, 1985; Ricci, 1986; Loening, 1991; Bourne et al., 1993; Wissow, 1995; Matson & Gutman, 1999).

There were however, some South African studies that reported low levels of sexual abuse in their series (Berrington et al., 1986; Chapman & Winship, 1993). The small sample size in Berrington and colleagues' study (1986), (n = 23) makes it difficult to compare the results to for instance Hyslop and colleagues' study (1991), which was also conducted in the same facility.

The high numbers of sexually abused children in our study probably reflect:

- The specialist nature of our clinic.
- The discomfort clinicians have in dealing with sexual abuse given the wider implications such a diagnosis has both to the relationship between the clinician and the family and further management of the victims and their families.
- The heightened awareness of child sexual abuse both in the community and among health-worker.
- The intolerance most communities have towards child sexual abuse.
- The probable underdiagnosis of other forms of abuse.

It is quite inconceivable that in a community such as ours, (which is plagued by high levels of both societal and domestic violence and poverty), physical abuse and neglect can affect only a handful of children, as suggested by the results. The imprecise terms such as "substantial", "unjustified" and "allowable" that are used in the definition of physical abuse (Johnson, 1990) and delineation of poverty and neglect, are just some of the challenges that are faced by most clinicians, when presented with possible physical abuse and neglect. Also, South Africa is probably in an era comparable to the late 70's – early 80's in the developed world, when sexual abuse was highly topical and hence the relatively increased identification.

#### 4.1.1.2 Age and Sex distribution

The average age of the children (including both girls and boys) was 8.1 ± 3.6 years. This compares with some studies done in both the developed and developing countries (Kempe, 1978 & Woodling & Kossoris, 1981, both cited in Cohen, 1985; Ladikos, 1991; Ricci, 1986; Matson & Gutman, 1999). Notably, because different authors have used different criteria for the definition of abuse, there seems to be no consensus on the "peak age of vulnerability" for sexual abuse. For example, according to some researchers the average age for typical rape cases (single episode; stranger molestation) is higher (13 years - 14 years) (De Jong and colleagues (1982) cited in Ricci (1986); Barthauer et al., 1996). Because of the relatively high prevalence of abuse by strangers (13%) in this series one would have thus expected a slightly higher average age.

The vast majority (97%) of the cases seen at Zamokuhle were females. Although this gender preponderance has been reported in a large number of studies, from both the developed and developing countries (Westcott, 1984; Ricci, 1986; Hobbs & Wynne, 1987; Hyslop et al., 1990; Howard et al., 1991), the female to male ratio in this series (32:1) is much higher than those reported in the U.K. (2-3:1-2) [Hobbs & Wynne, 1987; Baker & Duncan, 1985 cited in Hobbs et al 1993], the U.S (3-4:1) Matson & Gutman, 1999 and at TMI (in Johannesburg, at the time of the study serving predominantly white children); about 4:1) (Hyslop et al., 1991). They however compare with the ratios at Baragwanath hospital (34:1) (Hyslop et al., 1990) and Alexandra (about 23:1) (Hyslop et al., 1990; Howard et al, 1991), both facilities serving Black children.

One significant factor that could explain the very low numbers of males in this series is the way child abuse was diagnosed. Most abuse cases were incidentally discovered by clinicians (see results) and boys have fewer physical signs of sexual abuse (Huston et al., 1995), thus making suspicion less likely. It is also possible that abuse among black boys is much lower than among white boys, given the consistency of the findings in these different studies. On the contrary, some authors believe that boys may be sexually abused to the same extent as girls (Hobbs & Wynne 1987; Rogers & Terry (1984 cited in Hobbs et al., 1993). They argue that boys are likely to underreport because they are less likely to be believed or suspected.

#### 4.1.1.3 Family background

Only a third of the children were staying with both biological parents, although there was a father-figure in almost half the cases. Also, in those families where there was more than one child, it is noteworthy that at least 40% of these children had mixed parentage, (colloquially known as "mixed assorteds", derived from mixed assorted biscuits). These probably reflect the breaking of family values and systems in this community, which are a legacy of apartheid. Of great interest would be to establish whether the children in these situations are in any greater risk of abuse intra-familiarly, either by half-sibling or by paramours.

### 4.1.2 Perpetrators

Less than a quarter (23.8%) of the offences were incest (including abuse by paramours). A further 38.7% were perpetrated by non-relatives who had easy access to the child, with neighbours accounting for the majority (81 of ) of these cases. Strangers accounted for 13.4% of the cases and 21.6% was undisclosed.

In developed countries and the western community, it is generally accepted that incest accounts for most sexual abuse incidents (Cohen, 1985; Council on Scientific Affairs, 1985; Pierce & Pierce, 1985; Ricci, 1986; De Villiers et al., 1990; Hyslop et al., 1990; Hobbs & Wynne, 1993; Huston et al., 1995). However, it should be noted that the actual proportion of incest varies according to the source of the report. For instance Finkel (1994) noted that incest was lower in articles dealing with medical evaluation of the victims than in the hotline reports and hence the wide range of 26% (Tilleli, 1980 cited in Finkel, 1994) and 83% (Pierce & Pierce, 1985). The point being made by Finkel (1994) is that incest is shrouded in a veil of secrecy even in the developed countries.

In South Africa, Hyslop and colleagues (1990) reported on higher levels of "abuse by the biological parents (37.6%)" when compared to acquaintances (25.4%) at TMI. It would seem that the opposite is true for Coronation – where 34% of the perpetrators were family acquaintances and 21% the father. They further note that in Alexandra the perpetrator is often unknown (51%), findings which were confirmed in Howard and colleagues' study (1991). The difficulty with Hyslop and colleagues' study (1990) is that it would seem

that apples are not being compared with apples as mentioned earlier and there is poor definition of ter. poor clarity as whether "unknown" as used by Hyslop et al., (1990) and Howard (1991) when applied to perpetrators, means strangers or undisclosed).

However, Hyslop and colleagues (1990) note that the profiles of child abuse found at TMI approximate those found in the Western world. But contrary to their belief that the low levels of reported incest among Black families are due to the acceptability and tolerance of this practice in this culture, our experiences at Zamokuhle are different. We feel that most women have become silent partners in the incest crime largely because of their financial dependence on their male partners (Mwanda & Ilunga, 1998). Hence there is a great possibility that the undisclosed abuse (26%) may well be family members.

Another anecdotal finding in this series is the relatively high percentage of strangers (13%), a finding which has been reported in comparative studies here in South Africa (Howard, et al., 1991) and in the USA (Huston et al., 1995). In this community this is a legacy of apartheid - the lack of school transport for most Black children and "staying-in" maids; long commuting distances between home and the workplace and lack of proper recreational facilities. Consequently most children have to walk unaccompanied long distances to school, are left in care of other older siblings or worse still unsupervised and become easy prey to child stalkers while playing in the open veld.

Cousins were the commonest perpetrators (26 out of 85) among the incest perpetrators, followed by the biological parent (18 out of 85). Father substitutes accounted for 16 out

of 85 (step-father – 6 and paramour 10). According to Williams (1998) although abusive sexual activity among siblings, cousins, and non-related children who are age-mates is considered to be common, it is infrequently documented. Becker (1990) cited in Matson & Gutman (1999) also supports the fact that substantial numbers of offenders are juveniles (age range 5-19years). According to Finkelhor (1979,1984), cited in Williams (1998) cousin incest accounted up for 28% of incest, a finding similar to this study.

There is a controversy as to whether biological fathers account for more than father-figures in father-daughter incestuous relations. Some studies suggest that biologic fathers are implicated in more incestuous abuse (Ladikos, 1991; Pierce & Pierce, 1985), while others implicate father-figures more (Woodling & Kossoris, 1981 cited by Cohen, 1985). In this study although there were more natural fathers than surrogate fathers, concerns are that the latter may be disproportionately more.

The greater majority of the cases reported a 'once only' sexual abuse incident and were reported within a month of the actual incident (45.9% & 36.4% of the total abuse, respectively). These were expected findings given that most of the abuse was extra-familial (Huston et al., 1995). About 5% of the children were abused by more than one person at the same time (gang-raped) and approximately 10% gave a history of abuse by another offender. Gang-raping is an emerging phenomenon in South Africa. Although it was confined to the townships initially, with the increase in violence it has now spread to the previously predominantly white suburbs. Because of the high degree of violence involved and intimidation, it is felt that this figure is a tip of the iceberg. I could not find

any quantitative data on this phenomenon, but Wagstaff and colleagues (1989) concede that it is an increasing phenomenon in Soweto.

### 4.1.2 Disclosures

In less than a third of the cases was there a spontaneous disclosure. In 8.4% of the cases a third party disclosed the abuse. In 3 out of every 5 children, the sexual abuse was suspected by either the attending clinician (57.1%) or a caretaker (40.5%). Most of the children presented to the clinician with medical evidence suggestive of sexual abuse (see table 5).

The rates of purposeful disclosures seem to be far less than described in other studies (55% -Sauzier, 1989; 40%- Frothingham et al., 1991 cited in Hobbs et al., 1993; 53%- Howard et al., 1991; 49% - Keary & Fitzpatrick, 1994). The disclosure rates in Howard and colleagues' study (1991), (a comparative study to this series) need to be treated with caution as they have classified those cases suspected by the parent as purposeful disclosures. The latter contradicts the generally accepted definition of 'disclosure' i.e. the verbal information by the child about their sexual experiences (Jones, 1988 cited in Hobbs et al., 1993; Keary & Fitzpatrick, 1994).

The above findings raise more questions about disclosures: which children are likely to tell?; why do some children tell and others do not?; should genitalia be routinely examined during all paediatric visits to a primary health care facility?; what are the

consequences of "accidental disclosures"? and are clinicians competent with genital examinations?

This study was not designed to answer any of these questions, but these anecdotal findings raise a question of routine genital examinations in this community, where "children are not heard but seen". The advantages of routine examination would be:

- It would help to desensitise the examination of the genitalia,
- It would demystify the open discussion of sexually related issues, and
- It would help familiarise health-workers with normative variations of the genital anatomy and the procedures of examining children's genitalia.

The dangers of such a practise are:

- Repeated genital examinations could be traumatic and potentially abusive to the child.
- Suspicious findings could inadvertently lead to mistrusts and break-ups of families.

There was positive feedback from two international child abuse conferences, where this notion of routine genital examination, was presented. In fact from personal discussions with some of the child abuse experts in the USA it would seem that this is standard practice in many of the counties. When children are seen for routine developmental assessments, physical and sexual abuse is routinely screened for.

The advocacy for routine examination of the genitalia should not be seen to discount the importance of the history from the child and the encouragement of children to talk. Bays

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& Chadwick (1993) in fact declared: "the child's history is essential in the accurate diagnosis of most cases of sexual abuse", particularly because " a normal physical exam is common in sexual abuse victims".

It is noteworthy that 147 of the 219 children who were incidentally found to be abused, disclosed the abuse once suspicion about their abuse was raised. About 76% of these disclosed on the first interview either at the referring clinic or at Zamokuhle. 23.9% disclosed on subsequent visits to Zamokuhle. This contrasts sharply with Keary & Fitzpatrick's findings (1994), : low disclosure rates (14%) in those who were referred because of suspicion of abuse.

One of the greatest concerns is whether our "witch-hunt" and the resultant accidental disclosures do not create "victims" and thus did more harm than good. Again it is difficult to answer this question with any degree of certainty as this study was not designed to do so.

There is evidence to suggest the opposite. My undocumented experiences at Zamokuhle with some of the mothers who were revealing their own sexual abuse as a child for the first time at the clinic, is that they wish someone had noticed their plight and come to their rescue. In Sauzier's study (1989) the children who had accidentally disclosed showed fewer signs of anxiety and hostility on standardised tests than the children who had disclosed spontaneously. She however, points out that "the way in which the sexual

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abuse revelation is handled has an important impact upon the child's eventual adjustment".

### 4.1.4 Physical findings

About 72% of the children referred to Zamokuhle were found to have physical signs highly suggestive of sexual abuse. This is in contrast to many studies from the developed countries (Ricci, 1988; Muram, 1989; Sauzier, 1989, Bays & Chadwick, 1993; Adams et al., 1994), where normal physical findings in sexually abused children are common. Factors such as : the relatively high levels of incest (Cohen, 1995; Council on Scientific Affairs,1985; Hobbs & Wynne, 1993; Huston et al., 1995); "high frequency of dry intercourse" (Ricci, 1988); delayed disclosures with the resultant retrospective interpretation of genital trauma (Cohen, 1985; Council on Scientific Affairs, 1985; Wissow, 1995; Monteleone & Brodeur, 1998), are just some of the reasons that have been put forward for the observed low incidence of abnormal physical findings.

It is difficult to comment on the South African pattern as some studies either did not have this kind of information (Hyslop., et al, 1990; Ladikos, 1991) or the series were too small to comment on (Westcott, 1984). But in a study done by Huston and colleagues (1995) in the USA among Blacks, Whites and Hispanics, they reported higher genital findings indicative of penetration among blacks.

It is thought that the high incidence of abnormal findings in this series could be attributed to the selection criteria of most of the patients seen at Zamokuhle, (most children were suspected to be abused because of the suggestive medical evidence, see results). Also, the relatively high abuse by strangers (a factor which has been directly (Huston et al., 1995) or indirectly (Cohen, 1985; Council on Scientific Affairs, 1985; DeVilliers et al, 1990; Hobbs & Wynne, 1993) implicated as the cause of higher incidence of abnormal genital findings in sexually abused children), may explain our findings. Also, Huston and colleagues (1995) found in their study that Black children reported more penetration than Anglos and Mexican American and that abuse by strangers often had higher rates of multiple perpetrators.

It is noteworthy that according to Bays & Chadwick, (1993), there were higher rates of physical findings in the earlier studies, due to the fact that only most severe cases came to light. They further state that the increased public awareness of child abuse has resulted in "more children being brought for examination early in the course of abuse or when no abuse has occurred", thus resulting in the low frequency of positive findings. Certainly South Africa is experiencing sexual abuse as a relatively new problem.

### 4.1.5 Sexually transmitted diseases

Thirty- nine out of 350 tested children (about 11%) had at least one STD. This compares very well with the 5-12% routine positive cultures quoted from developed countries (Glaser and colleagues, 1989 cited in Gibbons & Vincent, 1994). However, most authors

have reported very low incidences of STDs (Hobbs & Wynne, 1987 cited in Forster, 1994; Ricci, 1988; Siegel et al., 1995), but it should be noted that in most of these series only symptomatic children were tested.

The prevalence of STDs in the South African studies varied from 6% (at Baragwanath) to 55% (Alexandra), (Hyslop et al., 1990; Howard et al., 1991). The lack of standardisation of the microbiological tests (Alexandra relying on very basic tests viz. Gram stain and microscopy when compared to the other Johannesburg units, Baragwanath, Coronation and TMI – which use 'state-of-the-art' laboratory techniques), (Hyslop et al., 1990) and the unavailability of the criteria for testing in the study, calls for circumspection when comparing these results to those in this series.

It is felt that the prevalence of STDs in the series is artificially low because at least 210 children had received prophylactic antibiotic treatment prior to testing. This assertion is probably true because according to Pham-Kanter and colleagues (1996) STDs are endemic in South Africa and because of the socio-economic disparities between Blacks and Whites, the former are affected to a larger degree by STDs.

Contrary to the other studies in Johannesburg where gonococcus was frequently isolated, (Hyslop et al., 1990; Howard et al., 1991), Chlamydia was the most frequently isolated organism in this study. Chlamydia was also found to be the commonest organism in a study done in the UK (Forster, 1994). Four studies done in developed countries (cited in

Matson & Gutman, 1999) have reported on gonococcus as the commonest organism isolated in sexually abused children.

The relatively high incidence of Chlamydia in this study can be attributed to two factors: the high sensitivity of the urine LCR test (Stamm, 1999), (about 90-96% for the detection of chlamydial urethritis in males and 69-96% in females studies cited in Stamm, 1999) used in this series and the high asymptomatic carriage of chlamydia in the South African black male population (Pham-Khanter et al., 1996).

Up until very recently most researchers have been using cell culture methods which are known to be technically difficult for detection of C. trachomatis (Stamm, 1999). There are no studies published yet for LCR methods in child abuse (discussion from the 1999 San Diego Conference), but Stamm (1999) reports that LCR ... rally detects 15 to 40% more infected persons when compared to cell culture. Thus the incidence of chlamydia in infected children will be expected to increase as researchers use LCR.

Six of the 344 children tested for HIV, tested positive. Five of the six HIV positive children are likely to have been infected through sexual abuse. Although the overall prevalence of HIV is low in this series, the rate of sexual abuse as a mode of transmission of HIV is higher than in Gutman and colleagues study (1991) (4 out of 96 HIV positive were confirmed to have acquired their HIV through sexual abuse). However, Gutman & Matson (1999) concede that there is limited data of how much sexual abuse contribute to the pool of paediatric HIV infection.

Despite the claims from various sources in this country, that HIV positive men are raping young girls to rid themselves of HIV (City Press, 1995; van Niekerk, 1996; McKerrow, 1997), the rates of HIV positive children as a result of sexual abuse remain low (McKerrow, 1997). It is noteworthy that the latter study was done in Kwa-Zulu-Natal which is the region worst affected by the HIV epidemic (Pham-Kanter et al., 1996). However, if the failure to obtain repeat assays for HIV at 12 weeks after the assault is taken into consideration, then the observed rates are probably artificially low.

The expense of STD testing is cited as one of the limiting factors to routine testing (Siegel et al., 1995). In their series these authors report that they could have saved at least $22 000 if they had done selective testing. In our institution it may cost a child up to R220,00 for STD testing if the tests are positive. On average it costs about R97,00 if the basic tests are done (Gonococcus, Urine LCR, HIV, WR, Trichomonas). Herpes is done very rarely and only if there are blisters. Up until very recently, Ureaplasma was done routinely, but because of the latest recommendations (Matson & Gutman, 1999), it has been dropped.

Although it makes economical sense to treat all children who are suspected to be abused (cost between R14.21 and R63.35),rather than investigate first, this practice is not considered good medical practice. Not only will this practice rob us of the epidemiological patterns of STDs in our community, but also rob us of a powerful corroborative evidence which is vital in child abuse cases (Bays & Chadwick, 1993; Friedman 1998). Also, there is a danger of the emergence of resistant strains given the

high non-compliance rates to long courses of antibiotics, which may cost m in the long-run. According to Pham-Kanter and colleagues (1996) up to 13% gonococcal isolates were resistant to penicillin antibiotics, in 1996.

### 4.1.6 Reporting of the abuse

Less than half of the cases (42.3%) were reported to the police. There were no figures in Hyslop and colleagues' study (1991) although they reported that a minority of cases reached the judicial system, partly due to failure to lay charges. In a small series in Cape Town (n = 20) about 45% reported the cases to the police. The figures from the developed countries vary widely (6% - Fuller (1989) cited in Matson & Gutman, 1999 to 38.5% - Sauzier, 1989), despite the mandatory reporting.

One of the big reasons for the low reporting to the police is that there are multiple recipients of the reports, with the Social Services playing a major role in the US for instance (Goldner et al., 1998). In fact suggestions are that the rehabilitative approach is the preferred approach to the criminal one (Cohen, 1989). The compulsion to report has been criticised in South Africa by NCCAN particularly in the absence of 'prompt and skilfully managed protective services" (cited in South African Law Commission issue paper 13, 1998).

Various authors have cited varying reasons for the strong aversion of reporting sexual abuse to the police. For example Howard and colleagues (1991) cite the low conviction

rates as a major reason (see "criminal justice funnel" diagram). Hyslop and colleagues (1990) attributed this aversion among Black communities to the intimidation of the victims and their families and the preference of 'family "indaba"' as a method of the dispute resolution.

In our experience the lack of confidence in the legal system; the gross and real intimidation of victims and their families, (the epitome being the famous Mamokgeti case), the preference of "community justice system" and family "indabas", (these being characterised by retribution and reparation (Mwanda & Kekana, 1996)) largely account for the low reporting and hence low conviction rates. The finding that the less educated mothers were more likely to report the abuse was very interesting and unexpected. Also, one would have expected that the children who were abused by non-family members would report to the police more readily than those abused by family members. More studies are needed to confirm these trends.

In this series the outcome of the prosecution was known in only 28 of the 151 reported cases. There were 11 out of 28 convictions and 17 acquittals. Because no extra efforts were made to get this information if the CPU member responsible for the case or the parent did not report back, these results should be treated with caution. Suffice to say that incarceration rates are low world-over (26.7% in Sauzier's series (1989)). In South Africa these figures can be gleaned from the general crime figures in the "The Criminal Justice Funnel" (Nedcor report, 1996).

## 4.2 Physical Abuse

There was a very low incidence of physical abuse in our Centre – (13 out of 368 children), hence generalisation to the wider population is difficult. This finding is similar to that of Howard and colleagues (1991) but in contrast to other South African studies (Berrington et al, 1986). Of note is that Howard and colleague's study was conducted in Alexandra township, which has similar socio-economic, cultural and political dynamics as our community.

However, this finding defies any logical expectations as the study population has most risk factors for physical abuse {viz. Social deprivation and poverty, (Robertson et al., 1976; Council on Scientific Matters, 1985; Berrington et al., 1986; Hobbs et al., 1993); overcrowding, (Robertson et al., 1976); substance abuse, (Council on Scientific Matters, 1985); unplanned pregnancies, (Irwin, 1975) and marital disharmony, especially where partners resort to violence on one another, (Irwin, 1975; Council on Scientific Matters, 1985; Hobbs et al., 1993). Also, according to some authors Africans tend to be very punitive when disciplining their children (Meijuni, 1991; Onyango, 1998).

This raises important questions – are health-workers in these communities underreporting physical abuse or is this finding a true reflection of the status quo? According to Johnson (1990) and Hobbs and colleagues (1993), reporting is directly linked to the awareness levels among professionals and to the correct identification of the abused children. Also, the definition of physical abuse requires the presence of demonstrable physical injuries

for the diagnosis to be made. The ambivalence of health-workers to corporal punishment (which is due to their own "punitive" upbringing), is probably one of the most important contributory factors to the poor identification of physical abuse, in this community.

Contrary to those studies which reported on a high incidence and prevalence of physical abuse among pre-school children (Irwin, 1975; Berrington et al., 1986; Hobbs et al., 1993), we found a peak in age greater than 10 years. In Howard and colleagues' study (1991) the age peak was 6-8 years, an age close to that in this study. According to most authors (Creighton & Noyes, 1989 cited in Hobbs et al., 1993; Ricci & Botash, 1997), severe and even fatal injuries occur most commonly among children less than one year of age, which probably explains the absence of serious injuries among the children we saw.

The preponderance of female victims, (in contrast to those studies where there is no gender preponderance (Howard et al., 1991; Ricci & Botash, 1997) and those with a predominance of male victims (Irwin, 1975; Creighton & Noyes, 1989 cited in Hobbs et al., 1993)) and of the male offenders (similarly to Howard et al., 1991 and Berrington et al (1986) and in contrast to Hobbs et al., (1993)) probably reflects the patriarchal nature of this community. A majority of our children were abused by their parents (either natural parents or parent), a finding similar to other studies (Irwin, 1975; Council on Scientific Matters, 1985; Howard et al., 1991; Hobbs et al., 1993).

Five children were diagnosed as have signs and symptoms of physical abuse only, the rest also had other forms of abuse. According to Hobbs & Wynne (1990) physical abuse

rarely exists alone. The other types of abuse were diagnosed in a very small number of cases, making any discussion on them to be meaningless. It however, suffices to say that we are definitely underdiagnosing them.

## 5.0 CONCLUSION

The profiles of abuse at Zamokuhle are indeed different from those described in the developed countries and Western communities. This conclusion is based on the following factors:

- The patterns of reported abuse – more sexual abuse than neglect and physical abuse.
- The alleged offenders of sexual abuse are mostly extra-familial.
- The physical findings in most sexually abused children are abnormal.
- STD prevalence – it is felt that although the STD levels fell within the 'normal limits', that in fact they were artificially low due to the prophylactic treatment prior to treatment.

## 6.0 RECOMMENDATONS

- From the South African literature review and this study it is apparent that there is an acute need for a knowledge base of the pattern of abuse in this country. Facility-based studies only provide a snap-shot of child abuse problem. A national study would not only provide the much needed knowledge about the patterns of abuse among the different cultural groups, but also inform prevention and rehabilitative strategies.
- Primary prevention has been hailed as the most efficacious and effective management of most medical problems. Until recently, the rehabilitative approach to child abuse was the mainstay of management of abuse in the USA. There is a shift to primary

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prevention, as the inefficiency of the former mode of management is being realised (Goldner et al., 1998). More awareness campaigns could assist in this regard and may even impact on the disclosure rates.

- Awareness should not only be raised in communities but also among Health Workers. The disturbingly low levels of referrals from the private general practitioners and the low incidence of other forms of abuse other than sexual abuse may be reflective of poor identification of abuse and the poor knowledge of what to do about the abuse after it has been identified.
- Urgent studies on the incidence and prevalence of STDs in abused children are needed, given the infection burden some communities have. The information gathered on such studies will inform treatment and management protocols. The developing countries will have to spear-head this kind of research as they are the most affected.
- Routine testing for *Ureaplasma urealyticum and* Herpes should be stopped in the light of the new evidence that Ureaplasma is not exclusively an STD (Gutman & Matson, 1999) and the very low yield of Herpes when there are no visible blisters.
- Follow-up studies are necessary to check whether the patterns identified in this study do not evolve and to establish risk factors which will in turn inform preventive programmes.

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## APPENDIX 1

## CHILD ABUSE PROFILES IN A SOWETO ABUSE CENTRE - DATA SHEET

IDENTIFYING INFORMATION

1. RECORD NUMBER

2. CONSULTATION DATE AT ZAMOKUHLE

3. REFERRED TO ZAMOKUHLE TO ZAMOKUHLE BY:

| | | |
|---|---|---|
| 1. Soweto clinics-78.3% | 2. Teacher – 3.0% | 3. GP - 0.3% |
| 4. CPU - 6.8% | 5. Neighbour/friend –0.5% | 6. Self-3.8% |
| 7. Bara medico-legal-1.6% | 8. Other- 5.7% | 9. Unknown - |

4. IF REFERRED BY SOWETO CLINIC, WHICH ONE?

| | | |
|---|---|---|
| 1. Zola – 46.2% | 2. Meadowlands – 4.9% | 3. Orlando – 3.8% |
| 4. Dobsonville – 5.2?% | 5. Mofolo – 3.5% | 6. Tladi 4.5% |
| 7. Phomolong – 1.4% | 8. Chiawelo – 2.1% | 9. Stretford – 4.5% |
| 10. Pimville – 1.7% | 11. Koos Beukus - 7.6% | 12. Diepkloof 1.7% |
| 13. Local Authority Clinics – 2.1% | | |

5. ACCOMPANIED TO THE CLINIC BY:

| | | |
|---|---|---|
| 1. Mother - 69.3% | 2. Father - 1.6% | 3. Both parents - 3.8% |
| 4. Neighbour/s - 1.6% | 5. Aunts 8.4% | 6. Teacher/s 0.8% |
| 7. Strangers – 0.3% | 8. Siblings – 2.2% | 9. Friend/s - 0% |
| 10. Granny/s - 8.7% | 11. CPU- 0% | 12. Alone 0.8% |
| 13. Other - 2.4% | | |

6. ADDRESS WHERE CHILD STAYS

| | | |
|---|---|---|
| 1.Zola - 10.6% | 2. Jabulani – 4.6% | 3. Emdeni - 12.2% |
| 4. Naledi – 6.0% | 5. Tladi - 1.1% | 6. Moletsane - 3.5% |
| 7. Mapetla – 1.4% | 8. Senoane – 0.5% | 9. Dlamini – 0.3% |
| 10 Chiawelo – 1.4% | 11 Zondi – 3.3% | 12 Moroka – 2.4% |
| 13 Phomolong –0% | 14 Phiri – 0.5% | 15 Molapo - 1.4% |
| 16 Jabavu –5.4% | 17 Mofolo – 4.6% | 18 Dube – 1.1% |
| 19 Orlando West –1.9% | 20 Orlando East – 3.3% | 21 Diepkloof – 1.6% |
| 22 Meadowlands –6.5% | 23 Dobsonville – 6.5% | 24 Protea 1.1% |
| 25 Pimville – 1.4% | 26 Mzimhlophe - 0.3% | 27 Motsoaledi - 0.3% |
| 28 Silvertown – 0.8% | 29 Doornkop - 7.6% | 30 Orange Farm – 5.2% |
| 31 Klipspruit – 0.3% | 31 Kliptown 0.5% | 32 Other 2.4% |
| 33 Unknown – 0% | | |

## BACKGROUND INFORMATION ABOUT THE CHILD

7. DATE OF BIRTH

8. SEX
   1. Female - **96.2%** 2. Male - **3.8%**

9. SCHOOLING
   1. Not schooling yet – **13%** 2. Preschool/nursery **19.0** 3. School **66.0%**
   4. Left school – **1.4%** 5. Tertiary – **0%** 6. Unknown - **0.5%**

10 IF SCHOOLING, WHICH STANDARD ?
   1. Sub A - **22.1%** 2. Sub B - **17.6%** 3. Std 1 **17.6%**
   4. Std 2 - **13.5%** 5. Std 3 **8.2%** 6. Std 4 **7.8%**
   7. Std 5 - **4.9%** 8. Std 6 – **4.5%** 9. Std 7 – **0.8%**
   10 d 8 – **1.6%** 11 Std 9 – **0%** 12 Std 10 – **0.4%**
   99 - **0.8%**

11 MENTAL DEVELOMENT, GROSS ASSESSMENT
   1. **Normal** - **94.0%** 2. Sub-normal - **4.9%** 9. Unknown **1.1%**

12 ANY PHYSICAL DISABILITY ?
   1. Yes - **2.2%** 2. No - **96.7%** 9. Unknown **1.1%**

13 IF YES, WHAT DISABILITY?
   1. Cerebral Palsy – **11.1%** 2. Deaf - **33.3%** 3. Limb abnormality **0%**
   4. Blind – **11.1%** 5. Other - **44.4%**

## FAMILY STRUCTURE

14 FAMILY WITH WHOM CHILD IS STAYING
   1. Mother - **41.6%** 2. Father - **3.5%** 3. Both parents – **31.0%**
   4. Grandparents – **16.6%** 5. Other relatives **4.3%**
   6. Foster family – **0.3%** 7. Foster home – **0.5%**
   8. Other – **1.4%** 9. Unknown **0.8%**

15 MARITAL STATUS OF THE MOTHER
   1. Married to biological father – **25.5%** 2. Married to another man **3.8%**
   3. Divorced/separated - **9.5%** 4. Widowed **3.3%**
   5. Remarried – **0.8%**
   6. Single, cohabiting with biological father **10.1%**
   7. Single, cohabiting with another man – **7.1%**
   8. Single, not cohabiting, good relation with biological father **7.3%**
   9. Single, not cohabiting, relation with another man – **13.9%**
   10. Single, no stable relationship – **14.1%**
   11. Other – **1.9%** 12. Unknown **2.7%**

16 IS MOTHER ALIVE ?
   1. Yes – **96.7%** 2. No **0.8%** 3. Unknown **2.4%**

17 IS FATHER ALIVE?

1. Yes - **83.2%** 2. No - **8.7%** 3. Unknown **8.2%**

18 NUMBER OF SIBLINGS

19 ARE THE SIBLINGS ALL FROM THE SAME PARENTS?

1. Yes - **50.0%** 2. No - **43.7%** 3. Unknown **6.3%**

20 HAS MOTHER EVER BEEN ABUSED?

1. Yes – **14.7%** 2. No **66.0%** 3. Unknown **19.3%**

21 IF YES, WHEN?

21.1 CHILDHOOD

1. Yes - **44.6%** 2. No - **53.6%** 3. Unknown - **1.8%**

22.2 ADULTHOOD

1. Yes – **54.5%** 2. No – **43.6%** 3. Unknown – **1.8%**

22 IF YES, WHAT TYPE?

22.1 SEXUAL

1. Yes - **50.9%** 2. No - **49.1%**

22.2 PHYSICAL

1. Yes – **41.8%** 2. No – **58.2%**

22.3 EMOTIONAL

1. Yes - **41.8%** 2. No – **58.2%**

22.4 NEGLECT

1. Yes - **1.8%** 2. No - **98.2%**

23 HAS FATHER EVER BEEN ABUSED?

1. Yes - **0%** 2. No - **9.2%** 3. Unknown **90.8%**

24 MOTHER'S HIGHEST EDUCATIONAL LEVEL

1. No formal education – **2.4%** 2. Primary school - **21.5%**
3. Secondary school – **61.7%** 4. Tertiary **2.4%**
5. Unknown- **12.0%**

25 FATHER'S HIGHEST EDUCATIONAL LEVEL

1. No formal education - **1.6%** 2. Primary school - **14.1%**
3. Secondary school - **39.7%** 4. Tertiary level - **1.6%**
5. Unknown - **42.9%**

26 TYPE OF HOUSING WHERE CHILD STAYS

1. Stand-alone brick house - **37.0%** 2. Stand-alone shack **15.8%**
3. House with rented backrooms – **27.2%** 4. Tenant, backroom - **12.2%**
5. Other – **1.6%** 6. Unknown - **6.3%**

17 IS FATHER ALIVE?

1. Yes - **83.2%** 2. No - **8.7%** 3. Unknown **8.2%**

18 NUMBER OF SIBLINGS

19 ARE THE SIBLINGS ALL FROM THE SAME PARENTS?

1. Yes - **50.0%** 2. No - **43.7%** 3. Unknown **6.3%**

20 HAS MOTHER EVER BEEN ABUSED?

1. Yes - **14.7%** 2. No - **66.0%** 3. Unknown **19.3%**

21 IF YES, WHEN?

21.1 CHILDHOOD

1. Yes - **44.6%** 2. No - **53.6%** **3.** Unknown **1.8%**

22.2 ADULTHOOD

1. Yes – **54.5%** 2. No – **43.6%** 3. Unknown **1.8%**

22 IF YES, WHAT TYPE?

22.1 SEXUAL

1. Yes - **50.9%** 2. No - **49.1%**

22.2 PHYSICAL

1. Yes – **41.8%** 2. No – **58.2%**

22.3 EMOTIONAL

1. Yes - **41.8%** 2. No – **58.2%**

22.4 NEGLECT

1. Yes - **1.8%** 2. No - **98.2%**

23 HAS FATHER EVER BEEN ABUSED?

1. Yes - **0%** 2. No - **9.2%** 3. Unknown **90.8%**

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1. No formal education – **2.4%** 2. Primary school - **21.5%**
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1. No formal education - **1.6%** 2. Primary school - **14.1%**
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26 TYPE OF HOUSING WHERE CHILD STAYS

1. Stand-alone brick house - **37.0%** 2. Stand-alone shack **15.8%**
3. House with rented backrooms – **27.2%** 4. Tenant, backroom - **12.2%**
5. Other – **1.6%** 6. Unknown - **6.3%**

**ABUSE**

27 TYPE OF ABUSE

27.1 PHYSICAL ABUSE

1. Yes - **3.5%** 2. No - **96.5%**

27.2 SEXUAL ABUSE

1. Yes - **97.0%** 2. No - **3.0%**

27.3 EMOTIONAL ABUSE

1. Yes - **3.0%** 2. No - **97.0%**

27.4 NEGLECT

1. Yes - **1.4%** 2. No - **98.6%**

28 WHERE DID THE ABUSE OCCUR?

1. Victim's home - **7.1%** 2. Offender's home - **21.7%**
3. Veld - **7.9%** 4. Public, closed space - **1.1%**
5. School premises – **4.9%** 6. To/from school - **3.5%**
7. Other **3.3%** 8. Home shared by victim & offender - **21.7%**
9. Unknown – **28.8%**

29 HOW WAS THE ABUSE DISCOVERED?

1. Child disclosed - **29.1%** 2. Incidental finding **59.8%**
3. Third party disclosed – **9.2%** 4. Other – **1.9%**

30 IF CHILD DISCLOSED, WHO DID HE/SHE TELL?

1. Mom - **29.9%** 2. Dad - **4.7%** 3. Sibling **3.7%**
4. Friend - **3.7%** 5. Teacher - **16.8%** 6. Neighbour **2.8%**
7. Other - **38.3%**

31 IF INCIDENTAL FINDING WHO SUSPECTED IT?

1. Clinician – **56.8%** 2. Parent/s - **27.7%** 3. Teacher - **5.5%**
4. Granny - **5.9%** 5. Other caretaker - **1.8%** 6. Other **2.3%**

32 IF INCIDENTAL FINDING, WHAT WAS THE PRESENTING COMPLAINT?

32.1 VAGINAL DISCHARGE

1. Yes - **38.6%** 2. No - **61.4%**

32.2 VAGINAL BLEEDING

1. Yes - **12.7%** 2. No - **87.3%**

32.3 VAGINAL SORES/ ITCH

1. Yes - **10.9%** 2. No - **89.1%**

32.4 UTI SYMPTOMS

1. Yes - **14.1%** 2. No - **85.9%**

32.5 LOWER ABDOMINAL PAINS

1. Yes - **8.6%** 2. No - **91.4%**

32.6 LEARNING DIFFICULTIES

1. Yes **6.8%** 2. No - **93.2%**

32.7 SEXUALLY PROVOCATIVE BEHAVIOUR

1. Yes - **5.5%** 2. No - **94.5%**

32.8 OTHER

1. Yes - **44.1%** **2.** No - **55.9%**

33 IF INCIDENTAL FINDING, CHILD DISCLOSED ON:

1. First interview - **51.4%** 2. Subsequently - **15.9%** **3.** Never - **32.7%**

34 NUMBER OF ABUSE INCIDENTS

1. Once only - **44.8%** 2. 2-5 times - **13.0%** 3. >5 times - **0.8%**
4. Many times - **14.4%** 5. Unknown **26.9%**

35 AGE AT WHICH PRESENTING OFFENCE OCCURRED

36 TIME LAPSE BETWEEN ABUSE AND INTERVENTION

1. Same day - **3.0%** 2. Within same week - **19.3%**
3. > 1 week, < 1 month - **13.6%** 4. 1-6 months - **13.6%**
5. 6-12 months - **6.8%** 6. > 1 year - **10.6%**
7. Unknown - **33.2%**

37 TYPE OF INTERACTION BETWEEN ASSAILANT AND VICTIM

37.1 PHYSICAL ASSAULT

1. Yes - **15.8%** 2. No - **25.3%** 3. Unknown **59.0%**

37.2 SEDUCTION WIT GIFTS/MONEY

1. Yes - **14.1%** 2. No - **26.6%** 3. Unknown **59.2%**

37.3 VERBAL THREATS

1. Yes - **23.9%** 2. No **16.8%** 3. Unknown **59.2%**

37.4 OTHER

1. Yes - **5.4%** 2. No **35.3%** 3. Unknown **59.2%**

38 VICTIM ABUSED BY MORE THAN ONE OFFENDER AT THE SAME TIME

1. Yes - **5.2%** 2. No – **73.9%** 3. Unknown - **20.9%**

39 HISTORY OF ABUSE, BY A DIFFERENT OFFENDER

1. Yes - **9.5%** 2. No - **69.8%** 3. Unknown - **20.7%**

40 PLACE WHERE PRESENTING ABUSE OCCURRED

1. Soweto -**68.8%** 2. Outside Soweto but in Gauteng - **8.4%**
3. Outside Gauteng - **1.4%** 4. Unknown **21.5%**

**OFFENDER**

41 SEX OF OFFENDER

1. Male - **76.9%** 2. Female - **2.4%** 3. Unknown **20.7%**

42 APPROXIMATE AGE OF OFFENDER (years)

1. 0-9 - **4.9%** 2. 10-14 - **6.5%** 3. 15-24 **17.9%**
4. 25-39 - **13.3%** 5. 40-59 **5.7%** 6. 60-70 **1.1%**
7. > 70 - **0.8%** 8. Unknown - **49.7%**

43 RELATION TO THE VICTIM

1. Natural parent - **6.3%** 2. Step-parent **1.6%** 3. Sibling **1.4%**
4. Cousin **7.9%** 5. Uncle/aunt **-3.8%** 6. Paramour-**3.3%**
7. Half brother/sister - **0%** 8. Grandparent - **1.6%**
9. Neighbour - **22.0%** 10. Tenant – **1.9%**
11. Family acquaintance - **4.1%** 12. Schoolmate - **4.9%**
13. Peer - **4.3%** 14. Teacher - **0.5%** 15 Stranger –**13.0%**
16. Other - **2.4%** 17. Unknown - **20.9%**

44 CHILD ONLY VICTIM

1. Yes - **75.6%** **2.** No - **19.8%** 3. Unknown **4.6%**

## OUTCOME OF THE ABUSE

45 PHYSICAL FINDINGS IN PHYSICALLY ABUSED:
1. Appears normal - **36.4%** 2. Conclusive evidence - **36.4%**
3. Inconclusive - **27.3%**

46 PHYSICAL FINDINGS IN SEXUALLY ABUSED:
1. Appears normal **3.3%** 2. Conclusive evidence **76.5%**
3. Inconclusive **20.2%**

47 VAGINAL SWABS & URINE RESULTS

47.1 UREAPLASMA
1. Positive - **3.0%** 2. Negative - **86.7%** 3. Not done - **10.3%**

47.2 TRICHOMONAS
1. Positive - **1.4%** 2. Negative - **89.7%** 3. Not done **9.0%**

47.3 HERPES
1. Positive - **0.5%** 2. Negative - **84.8%** 3. Not done **14.7%**

47.4 GONOCOCCUS
1. Positive - **0.8%** 2. Negative **91.8%** 3. Not done **7.3%**

47.5 CHLAMYDIA
1. Positive - **3.3%** 2. Negative - **44.6%** 3. Not done **52.2%**

47.6 BHCG
1. Positive - **0.8%** 2. Negative – **9,5%** 3. Not done - **89.7%**

47.7 RPR
1. Positive - **0.8%** 2. Negative – **90.5%** 3. Not done **8.7%**

47.8 HIV
1. Positive - **2.2%** 2. Negative – **92.4%** 3. Not done **5.4%**

48 PROPHYLACTIC TREATMENT GIVEN BEFORE TESTING
1. Yes - **57.6%** 2. No - **28.0%** 3. Unknown **14.4%**

49 CHARGES AGAINST THE OFFENDER LAID
1. Yes - **42.7%** 2. No - **46.5%** 3. Unknown - **10.9%**

50 IF LAID, A CONVICTION SECURED
1. Yes - **7.0%** 2. No - **10.8%** 3. Unknown - **82.2%**

51 CHILD CAME BACK FOR FOLLOW-UP TREATMENT
1. Yes - **68.8%** 2. No **31.3%**

52 IF YES, HOW MANY TIMES
1. Once - **54.9%** 2. Twice - **22.1%** 3. Thrice - **10.3%**
4. > 3 times - **12.6%**

53 IF YES, CAME BACK SPONTANEOUSLY
1. Yes - **95.7%** 2. No - **4.3%**

**PLEASE NOTE: THE ABOVE FIGURES ARE FOR ALL 368 PATIENTS, i.e. BEFORE THEY WERE CLASSIFIED ACCORDING TO THE TYPE OF ABUSE.**

# RESEARCH PROTOCOL FOR MSc (Med.) IN CHILD HEALTH

## PAED 804

**CANDIDATE** :Nobulembu Babalwa **Mwanda**

**STUDENT NUMBER** :83 1227 9

**DEPARTMENT** :Paediatrics and Child Health

**DEGREE** :MSc (Med.) in the field of Child Health: Community Paediatrics.

**SUPERVISOR** : Professor J Pettifor

**TITLE** :CHILD ABUSE PROFILES IN A SOWETO ABUSE CENTRE.

**POSTAL ADDRESS** :P.O. Box 1705, Southdale, 2135

**TELEPHONE NUMBER** :(011) 682 1820 (h)
(011) 934 9415 (w)

**ETHICS COMMITTEE APPROVAL** :Ref: R14/49 , Protocol number M 960232

## THE RESEARCH PROBLEM

Child abuse is neither new nor unique to South Africa. It is a scourge world over and has its roots deeply entrenched in society. It can be historically traced to as early as the 4rth century AD.[1] It has no respect for racial bounds, cultural divides, religious subsets and social classes.[2]

While the true incidence and magnitude of child abuse remains an enigma world-over1,most authorities seem to agree that it is on the rise.[1,2] This apparent increase has been attributed to various factors like, increased public awareness [2,3,4] greater identification, change in social climate and legislation, and even of greater concern, the actual increase of child abuse which may reflect socio-economic stresses[2], and increasing levels of violence in the communities.[3]

*It is estimated that more than 1 million children in the United States are seriously abused by* their parents, guardians or others every year,[5] and between 100 000 and 500 000 children are sexually abused every year.[6] Some prevalence studies have estimated that as high as 1 in 4 girls and 1 in 6 boys were sexually abused as children.[6]

In South Africa the magnitude of child abuse is unknown, probably due to the lack of a national register, national surveys, fragmentation of health services, poor and fragmented notification , racial and cultural diversities, and a relative paucity of published South African studies on research on child abuse.[7] There is also a lack of clear definition of child abuse and the focus has for many years been on political problems.

Soweto is marred by violence of various natures. It has the highest number of 'hijackings' and murders in the whole of South Africa. It would thus be very naive to imagine that the children - probably the most vulnerable group in any society, - would be left unscathed. Recently, school children - mainly girls, have been victims of 'jack-rollings' and gang-rapes.

During the apartheid era, children were at the fore-front of the struggle. They assumed leadership roles thus forcing them into premature adulthood. They also assumed adult roles in issues like sex, thus becoming sexually active at a rather early age.
In our centre we have had numerous reports of young boys, - who coincidentally cannot be charged for rape because of their age, using the existing statutes for rape, -forcefully having intercourse with young children, sometimes at gun-point.
This pattern of abuse is probably unique to certain sectors of the South African population.

While some regional studies suggest that the profile of child abuse in South Africa resembles that described in Western Societies,[2,4,8,10] some suggest that there may be variations with cultural and racial connotations.[7,9,11] Some of the latter studies have reported for instance a high incidence of sexually transmitted diseases (STDs) in sexually abused children and abuse of children mostly by strangers. This differs from the typical Western society picture, where children are sexually abused mostly by people who are known to the child and hence a consequent low incidence of STDs.

Zamokuhle Child Centre (Zamokuhle) is a child abuse centre that is run by a multi-disciplinary team, comprised of medical practitioners, social workers, psychologists, nurse-counsellors. It enjoys a good working relationship with the child protection unit branch of the South African Police,(SAP). It was recently established - 06 March 1995- at Zola, Soweto and sees predominantly black patients under the age of 16 years. It is a referral centre for all the 13 clinics under the Soweto Community Health Centres, but also accepts self-referrals and referrals from teachers, civic organisations and the SAP.

This study hopes to add more weight to the call for a national survey for child abuse and analysis of child abuse amongst groups of different cultural and racial backgrounds. It is hoped that when this is done, we will have an understanding of child abuse in South Africa and hence more informed and efficacious primary preventive measures.

## OBJECTIVE.

1. To describe the demographic characteristics of children seen at Zamokuhle in 1995.

2. To describe the profile of child abuse as seen at this centre, during this period.

3. To compare and contrast the emerging patterns to those described in the Western society.

4. To formulate treatment policies and protocols, based on the findings in the study.

## HYPOTHESIS.

The child abuse pattern in Zamokuhle is different from that described in the Western Society.

## METHODS.

Records of all the patients seen at Zamokuhle since its inception, 06 March 1995 to 31 December 1995, will be examined and the relevant data will be extracted - see attached data sheet. There were three hundred and seventy two patients that were seen during this period.

Every child that comes to Zamokuhle is seen either by a trained nurse counsellor - called a family friend - or a social worker. History is taken from the escort, who is usually a relative and from the child, using a standardised form. The child is then seen by a medical practitioner, who verifies the history and does a medical examination. The clinical findings are also entered in standardised forms. Most children are examined by one of the two doctors who work at this centre, and then the second doctor verifies the first doctor's findings independently, during the same consultation. The two doctors then discuss their findings and try to reach a consensus.

At the end of each day, there is a case conference where each patient is discussed in detail and the information collected by the different persons is further verified. An impression of the child's problem and the management thereof is discussed during these case conferences. The children who are not brought by their immediate relatives or have some information missing, are asked to bring the latter on subsequent visits when they come for counselling.

Vaginal or penile swabs are done on patients who are suspected to be sexually abuse, by the doctors and are sent in specific culture media to the South African Institute for Medical Research (SAIMR) laboratory at Baragwanath Hospital or Hillbrow. Blood specimens are collected after obtaining an informed consent - see attached consent form, and sent to the same laboratory. SAIMR sends written reports back to the centre, which are then filed accordingly for each child.

## CONSENT AND ETHICAL CLEARANCE.

All the legal guardians who bring their children to the clinic are requested to sign a consent form after the contents of the form have been discussed with them by the attending nurse counsellor or the social worker. The consent form used in this clinic is attached to this protocol.
The anonymity of the patient will always be maintained during this study as I will be using only the file numbers for identification.

Consent will also be asked from the Director of SCHC, under which Zamokuhle falls, to use the clinical data in the patient's records.

Ethical clearance for review of the patient records has been sought from the University of Witwatersrand Ethical Committee. I am still awaiting for it.

## SAMPLE SIZE.

All the records of the patients seen during the first year,- 06 March 1995 to 31 December 1995,- of the centre's operation will be reviewed. There were 372 patients seen during this period.

## PILOT STUDY.

A pilot study will be done to check whether the information in the data sheet is indeed available from the records. Ten records, randomly selected, will be used for this purpose. These 10 records will also be used for the study. Amendments to the data sheet will be made accordingly.

## STATISTICAL ANALYSIS.

Descriptive information will be obtained and analysed. Frequency tables and graphs will be constructed and where appropriate comparisons may be made. Chi squared test will be used.

## BUDGET.

Perhaps the greatest expenditure for this research is going to be the time in collecting and analysing the data. Although this is a hidden cost ,thus making it more difficult to put a price on it, it is more expensive than the actual costs. Since there is no experimental work I am doing , the only actual costs will be for the binding of the research report as I am doing the typing myself, and these should not exceed R300.00. Also, the expertise and advise from a statistician may be sought, and I have approached the medical research council for this purpose.

## TIME SCHEDULE.

The whole research project and the compilation of the report should take ten months at most. Three months will be spent on data collection and entry in the computer, 2 months on the analysis of results and 5 months on the writing of the report.

**MOTIVATION.**

Zamokuhle Child Centre is the first and the only child abuse centre, run by a multi-disciplinary team in Soweto. It serves as a referral centre for all the 13 clinics under the SCHC. We also see referrals from other agencies like SAP, Teachers, Bara Crisis Centre, General practitioners etc. We see children who are under the age of 16 years.

The treatment protocols that are used at this centre were adopted from the Transvaal Memorial Institute, which has a similar clinic but saw up until very recently, predominantly, white patients. These treatment protocols may however, be inappropriate for our population as we have seen a substantial number of children with STDs. Also, a fair number of the children that present at our clinic are sexually abused by strangers. This differs from what has been described in the Western society, where most reported cases are incest.

There was a worrying article in one of the newspapers, where it was claimed that there is a myth going around in Soweto, that HIV positive men rape young children between the ages of six months and ten years, to cure themselves of the disease. Although this may be an urban legend, it would be foolhardy to dismiss it, especially that there are rising numbers of reported sexual abuse cases and an increasing HIV incidence. If however there is some truth in this news, we shall expect to see an increasing incidence of HIV in sexually abused children

Lastly, there is very little published material in child abuse for African children. Most child care workers jut assume that the profiles are the same as defined in Western society. My hypothesis is that we may be looking at a different set of problems completely, as the social dynamics are different in different cultural and racial settings. If indeed the profiles are different, we will need different primary and secondary measures, and these can only be informed by scientific research such as this one.

G.G.S. 541

APPENDIX 3

CHILD ABUSE CLINIC - SOWETO

## CONSENT FORM

CHILD'S NAME: ----------

I hereby consent to a complete medical examination and to the recording of findings for legal purposes.

I authorise the collection of all necessary specimens for laboratory tests, and for the taking of necessary photographs of injuries related to the reason for this examination, including tests for all sexually transmitted diseases.

As AIDS is a sexually transmitted disease, I understand that I am giving consent for an HIV blood test to be done, with pre- and post test counselling.

I authorise the use of the medical records, including any necessary photographs and relevant laboratory reports as requested by the Child Abuse Clinic, SCHC, for medico-legal purposes, and also research.

I further give my consent for reports to be obtained from and/or sent to :-

School- _____

General Practitioner: _____

Psychiatrist: _____

Psychologist: _____

Welfare Agency: _____

Child Protection Unit: _____

Other: _____

SIGNED: _____ DATE: _____

NAME : _____

RELATIONSHIP TO CHILD: _____

WITNESSED BY: _____ DATE: _____

NAME: _____

POLICE OFFICER/ SOCIAL WORKER / MEDICAL PRACTITIONER / NURSE

ALL CASES ARE REGISTERED BY LAW WITH THE DEPARTMENT OF NATIONAL HEALTH.

**Author** Mwanda N B
**Name of thesis** Child Abuse Profiles In A Soweto Abuse Centre Mwanda N B 1999

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