Reported child abuse and neglect in Cape Town

Peter Lachman
June 1996
Revised March 1997

Reported Child Abuse and Neglect in Cape Town

A thesis
completed in fulfilment of the requirements
for the degree of Doctor of Medicine
in the Faculty of Medicine
University of Cape Town,
Cape Town, South Africa

Peter Irwin Lachman
18th June 1996
Revised March 1997

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Declaration

*I, **Peter Irwin Lachman**, hereby declare that the work on which this thesis is based is original (except where acknowledged otherwise), and that neither the whole work or any part of it has been, is being, or is to be submitted for another degree in this or any other University.*

I empower the University of Cape Town to reproduce this thesis for the purpose of research, either the whole or any portion of the contents, in any manner whatsoever.

Signed Signed by candidate

PETER IRWIN LACHMAN

DATE: 20th June 1996

REVISED: 20th March 1997

Acknowledgements

This study was undertaken with the aid of many practitioners in the field. I thank colleagues and friends who helped with the conception of the research and the completion of the study.

Academic support

The *Child Health Unit* was my home for many years. *Professor Marian Jacobs* and *Professor Maurice Kibel* have, through the years, provided guidance, inspiration and careful direction for which I am always grateful. *Jan Hollingshead* has provided constant advice and help, and *Annamarie Krauss-Mars* has assisted in many ways to ensure the thesis was completed.

Shifra Jacobson and all the staff at RAPCAN, and *Annette Cockburn* of the Homestead provided vital critical support. Professor *Moncef Marzouki* (Sousse, Tunisia) has been a model for all those in the child protection field, and has influenced my thinking especially on child protection policy. Professor *Barbara Korsch* (Los Angeles) has encouraged me, provided counter arguments to some of the ideas expressed, and facilitated the completion of the thesis during a visit to Santa Monica.

Project design

The report form was designed with *John Pledger, Rose September* and *Loraine Doran,* and was rendered computer compatible by *Andrew Argent.*

Data Collection

The collection of the data was undertaken by all the practitioners in the field working at various agencies. *Zanetta Airey* of the Department of Health collected the completed forms

and performed essential role of co-ordinating the Reporting Centre. This was facilitated by *Peter Vugarellis.* Most of the forms were entered onto the computer by *Mary Green.*

Literature review

The search for the latest articles and research on child abuse was completed with the assistance of by *Doreen Keogh* of the Health Sciences Library, Children's Hospital, Los Angeles.

Statistical analysis

Statistical input in the analysis of the data was provided by *Ian Leich* (London).

Proof reading

I am indebted to *Hilda Klein, Geoffrey Bracken* and *Annette Cockburn* for proof reading the thesis.

Funding

The research was funded by the *Nellie Atkinson Research Fund* which is administered by the University of Cape Town, and by a *Medical Research Council* short term grant.

Dedication

This thesis is dedicated

to my mother, Sybil.

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Abstract

The problem

The study of child abuse in South Africa has concentrated on management issues, and the epidemiology of child abuse and neglect has yet to be determined. Child abuse intervention programmes are based on data from studies conducted in the United States and Europe. Over the past few years practitioners in the field have expressed the need for local information to be available in order to plan future child protection programmes. A review of the literature reveals that the medico-legal model developed in the United States and the United Kingdom, based on investigation, is under strain due to the large number of reported cases of child abuse.

Aims

The study aims to compare the data collected with that reported in the literature. The specific research questions include:

- Can the characteristics of abused children in Cape Town be determined?
- Do the characteristics of child abuse and neglect in Cape Town differ from those reported in the literature?
- Should and can a child abuse reporting system be developed and implemented?
- Can prevention and intervention strategies be developed based on the epidemiological data that has been collected?

- Can the study in Cape Town provide an impetus for further research in the field of child abuse and neglect?
- Can the results provide the basis for a National Plan of Action on child abuse and neglect?

Methodology

Following extensive consultation in with professionals and practitioners in the field, a child abuse reporting system was established in Cape Town, South Africa. Clear definitions of child abuse and neglect were agreed upon, and for the period October 1993 to May 1995 practitioners in the field reported all cases of child abuse and neglect to a central reporting centre. The data was entered on to a computer and analysed by the researcher.

Results

- *The overall picture of child protection in Cape Town:*
  - Child abuse and neglect primarily affects females in the Cape Town area;
  - younger children are more likely to be physically abused or neglected;
  - older children are more likely to be sexually abused.
- *Characteristics of the children abused, in particular, the differences between male and female children:*
  - Females are at a high risk of child sexual abuse,
  - Males are more prone to physical abuse.
  - There is an absence of reported fatal child abuse.
- *Profile of the alleged perpetrator:*
  - most of the abuse is either intra-familial, or inflicted by a person known to the child.

- *The geographical distribution of child abuse:*
  - the distribution of abuse is influenced by the reporting agencies. In this study the incidence of reported child abuse and neglect is predominantly from the Cape Flats areas, though this does not reflect the rate of reported child abuse and neglect.
- *Action is taken by child protection agencies:*
  - the majority of reported child abuse and neglect is managed by social service agencies;
  - the police do not investigate child reported child abuse and neglect in the majority of cases.
- *Comparison with the literature:*
  - The characteristics of reported child abuse differ from that in the literature.
  - Child physical abuse is under-reported in comparison to other countries.
  - Rates of reported child sexual abuse are higher than those reported in the literature.

Conclusions and recommendations

Child abuse is an important problem in Cape Town, and in South Africa as a whole. The required response to this phenomenon is the development of an appropriate Child Protection Service, based on the concept of the prevention of child abuse and neglect, rather than on a reaction to abuse already present. This involves consideration of the data in this study and other studies, as well as examination of the philosophy behind the Child Protection Service to be set up. This approach can be adapted in other countries.

Chapter 1 The problem of child abuse and neglect

Introduction

Over the past few decades, children in South African have been victims of the violence that has enveloped the society. Practitioners in child welfare agencies and the health sector, the general public, and the media have recognised that children in South Africa are exposed to a high level of child abuse. The extent of the problem of child abuse and neglect remains unknown. Despite this, there has been a growth in programmes aimed at the management of the abused child. These have focussed on investigation of the abuse and, where possible, on the protection of the child. The issue of prevention of child abuse and neglect has only recently been considered in the literature. Research on prevalence or incidence of child abuse and neglect in South Africa has been mainly hospital based.

This study aims to provide data that will aid in the development of a relevant and appropriate Child Protection Service in South Africa. This thesis will report on a study undertaken in Cape Town in 1994 which attempts to determine the profile of child abuse and neglect in metropolitan Cape Town. The thesis documents the first unified reporting system for child abuse and neglect in the city. The data presented will provide insight into the characteristics of some of the children who are abused in this area of South Africa. From this information inference will be made as to the possible strategies that can be undertaken to counteract child abuse and its ramifications.

The central tenet of this paper is that there must be a continuum from research to practice, from epidemiology to prevention. To plan prevention and intervention programmes, it is

necessary to document the incidence and if possible the prevalence of the problem and develop agreed methods of collating data. This data can then be used to develop intervention programmes aimed at preventing child abuse and neglect. It will be argued that the implications of the societal causes of abuse must be taken into account when developing a national strategy and plan of action. Finally, it will be argued that the mere adoption of management and prevention strategies from the developed world is insufficient and inappropriate in addressing the problem. The investigative approach to child abuse will be challenged, and an argument for a post investigative approach based, on a partnership with parents and families, will be made.

To support the above argument, the thesis will discuss some theoretical models of child abuse. It will consider aspects of the response to child abuse in the developed world, in Africa, and in South Africa, and then present the data collected. This will form the basis for a discussion on a new approach to child abuse and neglect that can be adopted in South Africa.

The "discovery" of child abuse and neglect

Although child abuse as an entity has been present in all societies in the past, the formal study of child abuse and neglect in the fields of study in paediatrics and social work is recent, and there has been an exponential growth of interest in the topic since the early articles. In the paediatric and child health literature child abuse was first documented by Henry Kempe and his associates in 1962. Prior to this, child abuse was not an area of research in the medical literature. There had been papers by paediatric radiologists (Caffey, 1946; Woolley and Evans, 1955) on the phenomenon of unexplained injuries, but as Lynch (1985) notes, before Kempe there was little if any serious recognition of child abuse by child health professionals, and by

society at large. The initial professional response had been by social workers who were the first professionals to respond to the problem. This is despite the presence of evidence of abuse in historical tracts as far back as Ancient Greece, and in literature, e.g. the works of Charles Dickens. A comprehensive review of child abuse in history is given by De Mause (1980).

In their seminal paper Kempe et al. (1962) conclude that ... *"The battered baby syndrome, a clinical condition in young children who have received serious physical abuse is a frequent cause of permanent injury or death ..... Psychiatric factors are probably of prime importance in the pathogenesis of the disorder, but our knowledge of these factors is limited."*

The literature on child abuse and neglect is now extensive, but as Gough (1996) points out, there is a lack of uniformity in the literature as to the conceptual framework for research. This has resulted in the lack of agreement among professionals and among researchers as to what constitutes child abuse and neglect. Definitions of abuse change over time, differ between cultures, professionals and within society. The lack agreement on *what actually constitutes child abuse* influences the discussion on *what causes child abuse.*[1]

Although our understanding of the phenomenon has increased, we are still in the position of not being certain of the factors that lead to abuse. Parton (1986) traces the gradual recognition of child abuse by Social Services and Child Welfare Departments in the United States in the 1950's in an attempt to determine why child abuse warranted a "discovery". The initiative was taken by Kempe, who defined child abuse as a "medical" problem, a syndrome or an illness. The early view was that child abuse was not necessarily linked with poverty; rather with immature, aggressive and impulsive parents. The "battered baby syndrome" became the new

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[1] The definitions of child abuse and neglect used in this study are given in Chapter 5.

childhood illness of the 1960's, as more cases were described. Parton (1986), supported by the analyses of Pfohl (1977) and Antler (1981), argues that possibly there was need for paediatricians to discover a new horizon to conquer.

A similar process of "discovery" followed in the United Kingdom and other countries, where paediatricians took the lead in the diagnosis of the new "disease". The development of the field was almost identical in South Africa, where two paediatricians, Winship and Loening, were in the forefront of the early research. The process in most countries was similar. First, "discovery" in the medical literature that legitimised discussion on child abuse, then a response from the media, highlighting the issue. Finally, the legislative response took place as state organisations reacted.

A theoretical basis to the "discovery" of child abuse and neglect

A possible explanation of the way child protection has evolved can be developed from Michel Foucault's[2] analysis of the different discourses and rules that society creates to govern the way we act. Parton's (1991) interpretation of Foucault's theories helps to explain the evolution of the theories on child abuse. A discourse is a method of deciding whether a statement is true or false. This allows the development of a field of knowledge, in this case, child protection. In order to control the response to a situation, a discipline is created which involves training and body of knowledge. This involves analysis of the cause and effect of the phenomenon and the development of a solution or response. The new discipline possesses the insight into the problem, and determines acceptable knowledge which will in turn influence society's response to the problem. If one considers the development of the field of child abuse and neglect following the "discovery " of child abuse by Kempe (1962), it is evident that a new science has

[2] The discussion of Foucault's theories is derived from a number of his books as listed in the references.

developed with academic journals, conferences and "experts" who determine the development of social policy and child protection systems.

The aim of a new science is to determine what is normal (Parton, 1991). This opposes the old juridical order in which the rule of law maintains the social order, and each individual is responsible for his or her actions. The individual who transgresses a law is not seen as being "ill" and can return to society once a sentence has been served. In the new scientific order a different form of social control is in operation. Foucault provides a critique of the controls that society develops over its members in terms of various disciplines. Knowledge is legitimised in each of the disciplines, viz. psychology, psychiatry, medicine etc., and each discipline helps to determine the new power of knowledge in the society. The new fields of knowledge, both scientific and social sciences, determine what is normal, and how we in society should respond to the norm. In child protection the issue of what is abuse became medicalised and taken over by the new sciences. These new sciences are able to diagnose when events or conditions are not normal, and can therefore "treat and cure". Research into what is essentially a social problem has become a scientific area of concern: i.e. research is shrouded in the mystique of a science.

Discipline or adherence to the norms and rules of society in Foucault's analysis depends on *hierarchical surveillance* which is continued control of the body of knowledge (e.g. peer review), *normalising judgment* which provides for floating standards and discretionary judgment (e.g. defining the values governing the discipline), and *examination* which allows for surveillance of the system to ensure compliance. The new sciences become the instruments of power, as power and knowledge are interwoven. Foucault contends that this led to a change in the concept of punishment, the emergence of imprisonment for transgressors, and the mixing

of welfare and social control. Social controls become public in that what was once private and within the family, is now in the public domain. This is regarded to be an essential element of child protection (Garbarino, 1996). The new disciplines become more and more classified, and experts now regulate how society responds and should respond to social problems, such as child abuse and neglect.

Foucault analysed different disciplines, for example, in *"The Birth of the Clinic"* (1973) he discusses the emergence of medicine. He states that the clinic did not exist before it was invented by modern medicine. Similarly, the field of child abuse and child protection did not exist as a paediatric problem before Kempe "created" it in the medical literature. Over the years it has been developed and refined, for example child sexual abuse did not exist in the literature prior to the early 1970's. In light of this, Parton (1991) asks how these questions about child abuse were placed on the medical agenda, how they were developed, and why they followed this route. The importance of asking these questions is that it helps to explain the response to the problem and the type of protective system proposed. Parton (1991) concentrates on the development of child protection policy in England, but an analogy can be drawn to the development of child protection policy in South Africa.

This process is a further development of medicine as an agent of social control. Foucault discusses the emergence of medicine as an "instance of social control" in the eighteenth century. The inclusion of child protection within the discipline of medicine is part of a process that commenced in the 18th century when *" the medical politics outlined in the eighteenth century had its first effect on the organisation of the family, or rather the family-children complex, as the first and most important instance for the medicalisation of individuals"* (*The Birth of the Clinic,* 1976). Medicine assumes an importance beyond healing, and adopts an

administrative role in the application of power. In the development of legislation on child protection in the United States, Kempe and his colleagues provided the "scientific" knowledge and the moral backing to the political campaign to pass appropriate legislation such as mandatory reporting. This was, in part, to address ethical dilemmas faced by doctors when confronted by child abuse. Legislation to protect children from abuse has followed that which was developed in the United States and in England, and it provides the models for child protection systems. An understanding of the reasons for the development of these models is essential in the planning of a new model for South Africa.

This approach can help one understand the emergence of the discipline of child abuse, with competing theories of causation and differing strategies for prevention and management. It is clear that no one theory can explain the phenomenon. The development of a theoretical discourse on child protection, mainly the medical (or public health[3]) model of child abuse, supplemented by a legal framework, has influenced the research undertaken, its methodology, the strategies developed to deal with the problem, and the policy developed by the State to address the issue. As one critically reads the literature and the policy that is developed, the need for a fresh approach to child abuse and child protection becomes apparent.

Research in the field of child abuse

Whilst research into the incidence and prevalence of child abuse has mainly taken place in Europe and the United States, most countries have experienced a growth in the research into child abuse. Concurrent to this there has been an increase in the provision of services to abused children.

[3] The use of terminology can be confusing. The reporting of child abuse has adopted a "public health" approach. Authors commonly refer to the "medical" model of child abuse as noted in the text. The difference is that the "medical" model refers to how child abuse is viewed and the "public health" response relates to the approach adopted in the development of the reporting system.

The past 35 years have witnessed a dramatic change in our approach to child welfare. Child abuse has become a major phenomenon in both the practical and the academic fields. Numerous journals are published, social service agencies spend much of their time on the management of child abuse and neglect, and a sub-speciality has developed in the medical field.

A small, though increasing number of academic studies on child abuse in Africa, Asia and South America have been published. Nonetheless, the theories on child abuse and the programmes to protect children and prevent abuse have been based on the western experience. Professionals in developing countries have tended to import models that may not necessarily fit local conditions. This study will consider three areas of research, viz. prevalence and incidence studies (Chapter 2), reporting processes (Chapter 3), and evaluation of prevention programmes (Chapter 4).

Theoretical models on causation of child abuse

The debate over the cause of child abuse and neglect is one which is not resolved. In Table 1.1 a summary of the different ideologies on the causation of child abuse is given. This classification is, by its nature, artificial as the cause of child abuse is multi-factorial.

Table 1.1: Theories on the causation of child abuse (adapted from Parton, 1986)

Theory	Description
Penal approach	The individual has freewill, and child abuse is cruelty to children. The parent has responsibility for the child, which is upheld by a legal system which will punish transgressors.
Medical or Public Health approach	The behaviour of the abuser is predetermined, and child abuse is a disease or syndrome which results from forces beyond the control of the individual e.g. mental illness. The problem is viewed in terms of treatment and cure requiring medical expertise with social work and legal back-up to treat the dysfunction.
Traditional Social Work approach	Child abuse is caused by a family's inability to cope and requires adjustment, counselling, compassion and rehabilitation.
Radical Social Work approach	Child abuse results from social structures and inequalities, and needs to be addressed by social change.
Psychological approach	The temperament of the child may play a part in precipitating an abusive act. (Steele 1987)

The distinction between the theories are not clear cut, and there is overlap. However, the framework provides a paradigm in which one can locate most studies. The initial approach concentrated on the individual makeup of the abuser as opposed to an analysis of societal factors that contribute to providing the setting for child abuse to take place.

Hobbs et al. (1993) note that there is no single psychological theory that explains child abuse. Theories have focused on the parent-child relationship, in particular on the bonding process (Lynch and Roberts, 1977). Whilst stress may be a causative factor, it cannot be the only cause, as many parents who live under conditions of extreme stress do not abuse their children.

Poor attachment to parents may explain why some children are insecure and prone to abuse (Ainsworth et al., 1978). The hypothesis that child abuse may be related to abnormal development of attachment provides a clue to possible intervention, aiming to improve early parent-child relationships, and concentrating on the strengthening of the family unit. The psychological approach attempts to analyse abuse in terms of the failing of human relationships and provides a partial answer. Family violence is a possible underlying factor, as children who live in environments characterised by high levels of violence within the family may be more at risk of child abuse (Gelles and Cornell, 1990). Exposure to intra-familial or extra-familial or societal violence may be an additional factor in the development of abusive tendencies later on in life. As Hobbs et al. (1993) conclude, there is no explanation as to *why* children are abused. The need to define causative factors is apparent in the attempt to develop prevention strategies.

Parton's (1986) analysis in *"The Politics of Child Abuse"* concentrates on the emergence of child abuse in Britain, but the questions he raises have relevance for South Africa. Parton defines the determinants of social problems and the production of conditions incompatible social cohesion in a significant sector of society. He concludes that one should not be concerned merely with the problem of child abuse but also with the origins of the phenomenon as this will determine our response.

The ecological theory of child abuse asserts that areas with socio-economic deprivation could have higher rates of child abuse and neglect. Gil, (1973, 1975) and Garbarino and Kolsteny (1992) are some of the theorists who postulate that child maltreatment rates is related to indicators of socio-economic and demographic well-being of society. High risk areas are characterised by social disorganisation and a lack of social cohesion. Low risk areas are

related to "a strong social fabric". It is important to note that low socio-economic status per se does not imply high rates of child abuse. It is the lack of cohesion and community spirit, and the deficiencies in community support and resources that result in increased stresses and higher rates of child abuse. This is in contrast to the generally held view proposed by Kempe in his writings and further developed by researchers such as Finkelhor[4] who does not support the theory that class, i.e. occupation, income and education, and race are key factors in identifying abuse. He postulates that child sexual abuse crosses all classes.

In South Africa there has been a tendency by opponents of the State in the past years to adopt the *radical social work approach* to child abuse. There is some validity to this approach if one analyses the conditions within the society as a whole. **It would be prudent to assume that a single approach will not explain the complex problem of abuse.**

The influence of the political and economic structures in society is demonstrated in South Africa where the response to child abuse (and other social issues) at first ignored the realities of power relationships and the importance of societal abuse (Patel, 1992). The services that developed reflected the power relationship in the country. This was in essence no different from much of the writing on child abuse in the literature, for as Parton observes *".... it will be important to locate the reaction to child abuse within the shifts in the economy and ideological forces in society."* He continues *"the way child abuse is defined and policies are developed is a product not only of the demands made by moral entrepreneurs who promote the issue, but also the response of different sections of the State apparatus."* (Page 11 and 12) The debate over the role of the state in the care of children has been analysed by Parton (1991) who recognises that in England there has been a shift in the policy aimed at the

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[4] Refer to list of references for articles by Finkelhor.

protection of children. The United Kingdom *Children Act* of 1989 provides a framework for the protection of children, and brings together the separate legislation on children. The *Children Act* draws its inspiration from a number of incidents regarded as failures in the protection of children, (the Maria Caldwell case and Cleveland, to name two). It provides intense debate on the causation of child abuse. The conflicting theories on child abuse as discussed above were in part ignored or compromised, so that a workable approach to child protection could be developed. Yet the *Children Act* concentrates on child protection without addressing the root causes of child abuse. Child care is now seen in terms of the protection of the child from harm.

This is extremely relevant when one examines how the apartheid structures responded to child abuse and child care in general with adequate services for White children and poor or virtual lack of services for Black children (Patel, 1992). The development of the services required to deal with child abuse is dependent on acceptance of the rights and needs of children, a clear definition of what constitutes abuse, and the integration of the concept of prevention as well as a child-centred approach to the problem. The development of child abuse management and prevention programmes was left to the Non-Governmental Organisations (NGOs) in South Africa, while State Departments lagged behind (Patel, 1992). Parton highlights the need to determine whether the problem is *individual,* i.e. the response must be towards the abuser and the abused child, or whether the problem is *collective*, i.e. the society as a whole must be addressed. Much of the early literature and research suggests the former, and profiles of abusing families and parents, and extra-familial abusers have been compiled. The competing ideologies suggested by Parton provide a background to the understanding of our response to child abuse.

It is difficult to define the cause of child abuse and the balance between societal factors and personal or psychological makeup of the abuser. Proponents of the theory of the "*cycle of abuse*" argue that the experience of child abuse increases the potential for an individual to become an abuser. This is dependant on how the experience was managed, and on the societal response to the abuse. Although this theory is supposedly supported by a research on abusers, it does not explain, for example, why many girls who are abused do not become abusers themselves.

The abuser and the child act as individuals, and the radical approach cannot explain all forms of abuse. Parton challenges Kempe's original assertion that child abuse is classless and all children have equal risk, a theory adopted by the mainstream child abuse theory. Yet, as will be discussed in the analysis of the results of this study, there is a perceived higher incidence of child abuse in poorer sections of the community. This could be explained by the assertion that child abuse cannot be hidden as well in the lower classes, as in the middle and upper classes. Parton (1986) argues that child abuse is more prevalent in the deprived classes, as a result of the power differentials in society.

The causation of child abuse is a vexed issue and one which will not be answered by a simple theory. The approach taken in this study is that, the causes of child abuse include numerous personal factors including the psychological make up of both the abuser and the abused child, and the past experiences of the abuser (e.g. whether the abuser was abused), **but the structure of society is a key factor in determining the conditions that allows child abuse to occur.** Societal structure establishes power differentials between the different groups in society - age, race, gender etc. The collective responsibility of society as a whole for child

abuse does not necessarily detract from the individual responsibility for the abuse committed. Child abuse and neglect should be seen in a broad context.

The problem of child abuse in South Africa

Historical perspective

The issue of child abuse and neglect has received increased attention over the years in South Africa. In the colonial era before Union in 1910, the Cape Province, Transvaal and Natal had child protection legislation that was consolidated in 1913 into the *Child Protection Act.* Legislation on adoption was added in 1923, and these were supplemented in 1937 with the *Children Act.* The legislation was replaced by a new *Child Care Act* in 1960 that emphasised the role of the family in child care, but did not mention child abuse. In 1983 the *Child Care Act number 74* was passed and it reflected development in child care with emphasis on the parent's role in child care. This Act covered areas of child care, i.e. adoption, fostering, children homes, etc., but failed to define child abuse. An innovation was *Section 42,* which made it a criminal offence should doctors, nurses and dentists fail to notify the Regional Director of Health and Welfare if they examined a child *"in circumstances giving rise to suspicion that the child has been ill-treated or suffers from injuries, the cause of which might have been deliberate."* The aim was to facilitate discovery of cases of child abuse, but the absence of a protocol of reporting and definitions of abuse made this provision easy to ignore. When the Act was revised in 1991, this was not addressed. However, social workers were added to the list of mandated reporters. This Act is discussed further in Chapter 3.

The reality of life in South Africa meant that the *Child Care Act* could not be realistically applied to the vast majority of South Africa's children. Child labour, for example was not

illegal in terms of labour legislation despite numerous laws such as the *Manpower Training Act (56 of 1981)* or the *Basic Conditions of Employment Act (30 of 1983)*. The legal system was slow to respond to the needs of children, with legislation providing for the needs of the child witness being introduced as recently as 1993. Professionals in the field responded to the needs of children by calling for changes in the legal approach to child abuse, and by many studies reported at the SASPCAN conferences of 1985, 1987, 1989, 1991 and 1993. Review of the proceedings of these conferences reflects the growing concern of professionals with regard to child abuse and the need to develop strategies that could be applied in prevention and management of abuse.

Approaches to child abuse in South Africa follow the example of the Western world, as discussed above, with the response to the abuse of children being seen mainly through the traditional social work approach in the welfare and social services sector. The first medical response occurred in the 1980's in the major centres. The response followed that in the United States and the United Kingdom, where medical recognition of the problem gave some impetus to the recognition of first physical and then sexual abuse as major problems in the country. As will be discussed in the next chapter the first reports on child abuse are found in the literature of the late 1970's and early 1980's.

The first medical service response is evidenced in the setting up of clinics, viz., in Durban at Addington Hospital (1984) and in Cape Town at Red Cross War Memorial Children Hospital (1987), and in Johannesburg at the Johannesburg Hospital (1987).

In South Africa, the years of apartheid had a number of effects on the child protection field (Patel 1992; Loffel 1993; Majodina; 1993; Magwaza, 1993) On the one hand the society

entrenched a legacy of abuse action against children, and on the other there was an effort to take a broad view of the problem by those involved in the children rights movement. The South African response has been documented in a few papers (Chapter 2), and is presently under review as new systems are being formulated.

Current views on child abuse and neglect

With the political changes of the 1990's, the rights of children in South Africa have received increased attention. There has been a focus on the implementation of the *United Nations Convention on the Rights of the Child* of 1989. In this document there are two specific rights related to child abuse and neglect. These are:

- ***Article 19***

  State Parties shall take all appropriate legislative, administrative, social and educational measures to protect the child from all forms of physical or mental violence, injury or abuse, neglect or negligent treatment, maltreatment or exploitation, while in the care of parent(s), legal guardian(s), or any other person who has the care of the child. Such protective measures should, as appropriate, include effective procedures for the establishment of social programmes to provide necessary support for the child and for those who have care of the child, as well as for other forms of prevention and for identification, reporting, referral, investigation, treatment and follow up of instances of child maltreatment described heretofore, and, as appropriate, for judicial involvement.

- ***Article 34***

  State parties undertake to protect the child from all forms of sexual exploitation and sexual abuse. For these purposes State Parties shall in particular take all appropriate national, bilateral and multilateral measures to prevent:

  - *The inducement or coercion of a child to engage in any unlawful sexual activity;*
  - *The exploitative use of children in prostitution or other unlawful sexual practices;*
  - *The exploitative use of children in pornographic performances and materials.*

If one considers a broad interpretation of child abuse and neglect, all the provisions of the Convention should be relevant.

Realistically to approach the implementation of this Convention, and, what is more important, to make an impact on the well being of children living in South Africa, an objective analysis of child abuse in South Africa is required. **It is the tenet of this thesis that the data presented may provide a basis for ongoing research, for service and policy development in the field of child care, and may provide some direction for the prevention and management of all forms of child abuse and neglect.**

Issues in child protection in South Africa

The problems in the field of child protection include the philosophy of child welfare in South Africa, the lack of reliable information and statistics on the extent of the problem, the absence

of an effective reporting mechanism, the lack of a cohesive policy and strategy to deal with the problem, and the inadequacy of services to implement policy once it has been developed.

Philosophy of child welfare in South Africa

The child welfare system in South Africa in the apartheid era is a reflection of underlying political power and the distribution of wealth in the country. Patel (1993) examines the social welfare system in South Africa and concludes that *"in general, social security programmes have tended to punish people for not being able to cope. Through stringent eligibility requirements they have excluded the majority from benefits. These programmes have generally been paternalistic, distinguishing between the worthy and the unworthy poor."* She continues that race is the primary factor in allocation of resources. This is in contrast to the alternative welfare culture which had focussed on poverty, inequality and underdevelopment. In terms of child protection, this welfare structure is reflected in the lack of services, either for prevention or intervention. The discrepancy is not only racial, but is also influenced by urban/rural disparities, disadvantaged education levels, and poverty.

Lack of information and statistics

Statistics and theories regarding child abuse and neglect are regularly quoted, often without basis and foundation. In a review of research in the field of child sexual abuse over the period 1984 to 1990, Levett (1991) noted that a broadly conceived epidemiological study has not yet been carried out in South Africa. A number of surveys have been carried out at institutions that deal with abused children. As there is no uniform methodology, these figures cannot be extrapolated to the community at large, or be compared to each other. Whilst research in South Africa in the child abuse field has been fairly extensive, it has concentrated on the management of sexual abuse. Review of research literature suggests that the majority of

projects took their cue from international research. Recently, prevention has become more prominent, as has the effect of violence on the children in South Africa (Swartz and Levett, 1989; Gibson 1989). There has been a strong history of practical based research as evidenced by the yearly SASPCAN conference proceedings (SASPCAN 1985-1993). To date, though numerous studies on violence and children have been published, major incidence or prevalence studies have not been conducted.

Absence of a reporting mechanism

In terms of *Section 42* of the *Child Care Act* health professionals are required to report all diagnosed or suspected child abuse cases to the Minister of Health. A mechanism for the reporting does not exist, with at least seven different registers for child abuse existing during the period 1985 to 1994, each with its own inclusion and exclusion criteria. As data on child abuse is not validated, the statistics provided cannot be accepted as a reliable basis for planning. A clue to the extent of the problem is shown by the reports to the police Child Protection Units with an increase of 40% over the period 1991 (about 12,000) to 1993 (about 17,000). The official figures given by the various State social service departments for the period 1991-1992 are remarkable for their inaccuracy, i.e. a total of 2000 children for the entire country. This infers either a lack of reporting, a lack of processing the reported data, or a whitewash of a problem, that in the view of professionals on the ground, was reaching epidemic levels.

Whilst there is a temptation on the part of policy makers to follow the lead of the United States and introduce mandatory reporting, the debate on mandatory reporting has yet to be held. This issue will be considered in this thesis, and alternatives will be presented.

Lack of a cohesive policy and strategy on child abuse services

The policy pursued in the 1980's and early 1990's reflected the lack of co-ordination in the States' approach to children. It is clear that there were differing policies for children as determined by race (Patel, 1992). Definitions of child abuse have always been contentious with the State insisting on extremely narrow definitions. The *Child Care Act of 1989* made a provision for the management of child abuse, but prevention is not considered, service needs are ignored and aspects of the Act do not take into account the inequalities of the country. At the other end of the spectrum are Non-Governmental Agencies that take a broad view of child abuse, and often include the State as one of the perpetrators. Child abuse and child protection in South Africa clearly have a political agenda.

In the latter years of apartheid a paralysis existed in the field of policy development. As child abuse policy was controlled centrally, this tended to negate the development of an effective programme. The following positive approaches in this period nevertheless include:

- the formation of child protection units by the South African Police Force, which have had a minimal impact, as they are based in major cities. The units are understaffed, and tend to concentrate on sexual abuse. The majority of child abuse cases reaching the police are seen in regular police stations;

- the development of child abuse awareness programmes by some schools. This was usually restricted to schools in the White Education Departments, and the exposure of children to these programmes was limited;

- the development of programmes by many of the semi-autonomous social service agencies in the country, and by some Non-Governmental Organisations.

Most programmes introduced in the past have been reactive, unco-ordinated and lacking an effective child protection philosophy and policy.

Conclusion

The study of child abuse and neglect has proliferated over the past twenty years. Although child abuse and neglect has been a phenomenon throughout the ages, it has become an issue of the late 20th century for a number of reasons including the growth of the child children's rights movement, changed attitudes within society, and economic development. Numerous theories have been postulated as to the causation of child abuse. These range from those concentrating solely on the characteristics of the individual, to those focusing primarily on societal issues. Causes may vary from society to society, but the fundamental issue is how society regards women and children and the power differentials within the society. This provides the background within which individual factors may operate.

In the following chapters the incidence and prevalence of child abuse as reported in the literature and the ways of preventing child abuse will be discussed. The aim is to provide the background to the results of this study which indicates the rates of reported child abuse for children in Cape Town, and the characteristics of children who have been abused. This forms the basis for the development of a child protection service in South Africa. In addition, the analysis and conclusions can be the basis for a new approach to child abuse and neglect elsewhere.

Chapter 2 The epidemiology of child abuse and neglect

Introduction

The development of a strategy for the prevention and management of child abuse and neglect is dependent upon the understanding of the characteristics, as well as the extent of the problem. The initial reports on child abuse had no epidemiological basis on which to draw conclusions. Before the first reports in the literature, child abuse was not conceived of as a major issue. Once Kempe et al. (1962) drew attention to it, a gradual interest in child abuse developed and an attempt was made to document its prevalence.

In this chapter, some studies that analyse the features of child abuse will be considered. The aim is to answer the following questions:

- *Can lessons be learnt from published studies?*
- *Are the characteristics of child abuse universal?*
- *Is it necessary to carry out further studies in countries where the epidemiology of child abuse is not determined?*
- *If studies are to be conducted, what form should they take?*

Problems in the research of child abuse and neglect

The analysis of studies on child abuse presents problems due to the nature of the subject. Definitions of child abuse vary enormously. Terminology differs in that maltreatment is interchanged with abuse, victimisation, assault, and misuse, to name a few. Each word has different connotations, emotional responses and interpretations. The definition of the child varies from country to country, and across cultures. When one considers the differing forms of

abuse the problem becomes even more complex, particularly with sexual abuse and corporal punishment. The very personal nature of abuse, particularly sexual abuse, results in difficulties when elucidating the incidence or prevalence of the problem.

Child abuse and neglect in the United States and Europe

Most recent research has concentrated on the effects of child abuse and on the analysis of intervention programmes. The first epidemiological reports on child abuse used limited definitions based on the medical model (Newberger and Daniel, 1976; Christoffel et al., 1981). Helfer (1984) reviews the use of epidemiological methodology and concludes that it is important to link this to revised treatment and preventative approaches. The early research comprised incidence studies, prevalence studies and the reviews of fatalities. Helfer criticises the lack of standardisation of definition, and attempts, through the medical model, to determine the causative factors of child abuse. His paper emphasises the view that the breakdown of interpersonal relationships, and stress are causative factors. This approach is limited, as it ignores societal factors and is disease orientated.

The difficulty in determining the prevalence of abuse is clearly stated by Rosenberg and Krugman (1991) who express the view that after the first 16 years of mandatory reporting accurate statistics are still unavailable. They state categorically that child abuse occurs across socio-economic classes. This is the standard interpretation that was first postulated by Kempe et al. (1962). It has been challenged by others such as Parton (1986), and Pelton (1978). Pelton argued that child abuse is stress related, and that, as the poor have more inherent stress than others in society, it was to be expected that abuse levels would be higher than found in other social classes. Child abuse still occurs in all social classes.

To overcome the difficulty in determining the true prevalence of abuse, researchers have employed a number of different techniques. One study cannot determine the actual prevalence, and in most cases it is important to recognise the limitation of the studies.

Incidence studies

Incidence studies, (such as the National Centre for Child Abuse and Neglect Incidence Study in the United States of America, 1981), and that by Mrazek et al. (1983) in the United Kingdom, examine new cases that present to professionals and social services. The methodologies used include specific incidence studies, the analysis of reporting statistics, court records, case studies, analysis of treatment and investigation.

Finkelhor and Hotaling (1984) appraise the 1981 USA National Incidence Study. The study attempts to assess the number of cases known to professionals in a one year period, using a stratified random sample in ten states. Data was collected from reports to agencies and was extrapolated to provide an incidence rate. The limitations are the lack of accounting of cases not known to agencies. Using retrospective studies it is postulated that the Incidence Study underestimated the true incidence by two thirds. Despite these limitations, the study attempts to use standardised definitions and sampling methods. It broadens the source of information to include agencies outside traditional child protection agencies. They make a number of recommendations for future epidemiological studies:

- Prevalence studies on adults, though this may not reflect current abuse unless it concentrates on the most recent cohort of adults (18 year olds);
- Interviews with parents to try to uncover more intra-familial abuse may be possible but can be incomplete;

- Interviews with adults on whether they have knowledge of abuse which may widen the net:
- Interviews with professionals to uncover cases not reported:
- Use of a wider definition of child sexual abuse:
- More detail on the type of abuse that occurred, age at first abuse, and the way in which abuse became known.

The second National Incidence Study in the United States in 1988 is evaluated by Cappelleri et al. (1993) who use five key demographic factors - age at discovery, gender, income, ethnicity, and county-metro status. They also compare the risk of sexual as opposed to physical abuse. Using logistic regression they show that sexual abuse is more likely in Whites, girls and urban children, than in Afro-Americans, boys, and rural children. They confirm that rates of abuse varied with socio-economic status of the families. The study provides a partial view of the profile of abused children and contributes valuable data for intervention. Incidence studies clearly produce an underestimation of the problem, whilst prevalence studies using interviews of differing population groups provide another perspective.

Child Physical abuse

As a baseline incidence rate in the United States, the Second National Incidence Study (Cappelleri et al., 1993) reports rates of 4.95 per 1000 per year for physical abuse.

Review of police records

This approach has been applied by a few researchers. Such reviews are limited as it has been repeatedly demonstrated that a minority of cases are notified to the police. Jaffe et al. (1975),

in an early report, confirm these limitations, and state that their study on review of police department records only provides the profile on a subset of children. In addition, the legal perception of child abuse differs from that of the social one and of that used in many other research studies. This data can provide supplementary information, and at that time was the only source of data.

Interviews with parents

Gelles (1978) interviewed a representative sample of parents to ascertain levels of violence. He reports that 14% of children experienced some form of violence. This figure decreased in a repeat of the study in 1986 (Straus and Gelles). The rate dropped to 10%, and is accompanied by an increase in reported cases. This may be interpreted as the result of publicity on child abuse, and indicates the caution that is required in interpretation of either statistic. Segal (1995) writes about interviews with 319 professional parents in an attempt to determine the extent of child abuse in the Indian middle class. She concludes that almost half of the parents admitted to the use of "abusive" violence against their children. This candour is explained by the cultural acceptance of corporal punishment as a method of discipline in India. This raises concerns on the need for intervention at all levels, and places the severity of the problem in developing countries into perspective. This problem is emphasised by Farinatti et al. (1991) who report on the lack of services in Brazil.

Interviews with children and questionnaires

An attempt to ascertain the level of violence aimed at children, in addition to that reported to professionals, is made by Finkelhor and Dziuba-Leatherman (1984) by means of a national telephone survey of 2000 children aged 10 to 16 years. They find that in the previous year 25% had experienced some form of violence, 12.5% had experienced an injury, and 1%

required medical attention. Only 25% of the incidents were reported. They conclude that levels of child victimisation far exceeded reported statistics with up to three times higher in the case of assault, and five times higher in the case of rape. Crime statistics are discounted, as only 6% of all cases of victimisation were reported to the police. The importance of these findings is that it emphasises the amount of unreported abuse. Limitations of telephone interviews are apparent in that children without telephones are excluded, children in abusive homes may be precluded from speaking openly, and validation of abuse cannot be conducted. A report by Berrien et al. (1995) conducted in Russia and concentrating on physical abuse indicates a high prevalence rates of 28.9%, which may suggest that it is easier to fill in questionnaires about physical rather than to disclose in a direct interview.

Review of childhood fatalities

An alternate method of approach is to examine the extent of child fatalities as a result of child abuse and to use this data to extrapolate on the extent of non-fatal child abuse. Ewigman et al. (1993) review maltreatment fatalities in Missouri, and document drastic under reporting due to inadequate investigations, poor communication between agencies, and a deficient reporting system that allowed such fatalities to be missed. McClain et al. (1993) report on an analysis of the childhood death certificates from all states in the USA, for the period 1979 to 1988. They include deaths from stated child abuse, homicide, undetermined cause, accidents, sudden infant death syndrome, and from natural causes. The major problem with a retrospective analysis such as this, is the reliance on the classification made by the person completing the form. They estimate that up to 85% of child abuse deaths were not recorded as such. The use of this approach would be far more valuable in a prospective study after an educational campaign aimed at the correct filling in of death certificates, and validation of the cause of death by an independent review of case notes. Hobbs et al (1996) review the records of children who have

died from Sudden Infant Death Syndrome and conclude that the possibility of non-accidental fatality should be considered in the differential diagnosis as a matter of course. The problems with identification of infanticide are stressed by Roy and Labbè (1997), who conducted a retrospective study of 29 unexpected deaths of infants in Quebec. Forty-one percent of such deaths over a ten year period were adequately investigated, and official statistics are presumed to be inaccurate. They suggest that a formal investigation of all sudden infant or unexpected deaths be carried out, including skeletal surveys, autopsy's and possibly coroner's inquest and a police investigation.

A recent series of articles in *Child Abuse and Neglect* (1995) highlights the issue of childhood fatalities as a result of child abuse. Subdural haematoma as a result of head trauma is the common theme of the reports. Kasim and Cheah (1995) provide an account of childhood deaths in Malaysia with a review of 30 cases in Kuala Lumpur over a seven year period. The average age of the children is two years five months, though almost two thirds are under two years of age. "Shaken Baby Syndrome" is given as the most common cause of death in which the most frequent abuser is the father. This is explained by "the fathers" inexperience in the practice of child care", an explanation that is difficult to accept as the sole reason for this finding.

Hicks and Gaughan (1995) note that there has been a dramatic increase in childhood fatalities in the United States as reported by McCurdy and Daro (1995). They review post mortem findings over a five year period and find similarly to the Malaysian study, that head injury is the most common form of injury resulting in death. Problems highlighted by the study are that most of the families are already known to child protection agencies, though the child who died is not always the focus of the agency. In 30% of the fatalities criminal procedures were not

instituted due to lack of evidence. In Scotland, Squires and Butussil (1995) report on 168 deaths as a result of house fires over a ten year period. They conclude that neglect or negligent behaviour must be considered as a causative factor. Gellert et al. (1995) report on a multi-disciplinary approach to fatalities in Orange County, California. They propose that the reviews be carried out prospectively rather than retrospectively, and that they become standard practice.

Krugman (1995) comments that the value of these reports is *"to give us the opportunity to develop preventive interventions, which if implemented would presumably reduce the number of children dying in similar situations in the future"*, the problem being the identification of effective programmes. It provides an important perspective on the most extreme consequence of physical abuse.

Child sexual abuse

As a baseline incidence rate for the United States, the Second National Incidence Study (Cappelleri et al., 1993) reports rates of 2.11 per 1000 per year for sexual abuse. Pilkington and Kremer (1995a; 1995b) analyse research undertaken in the field of child sexual abuse using community and college samples to determine its incidence and prevalence. Prevalence studies which have consistently reported higher rates, have concentrated on three population groups, the general population, college students and clinical inpatient and outpatient samples. Research carries ethical dilemmas, as services should be offered to those who reveal past child abuse and request assistance.

In his treatise on the *History of Sexuality* (1979), Foucault discusses the controls society developed with regard to sex. Foucault proposes that up to the seventeenth century sexual practices were not concealed. It was the development of various discourses in the 18th century onwards that resulted in the secrecy of sex. This determined the confinement of sex to the home. The development of the various controls in society contributed to the emergence of child sexual abuse as a problem. The controls influence not only the ability to conduct research but also researchers' and practitioners' ability to define the actual problem. This emphasises the difficulty experienced by researchers in defining child sexual abuse, which was the last of the abuses to be described in the literature, (and the one which has become the most extensively researched). Definitions of sexual abuse have been inconsistent and at times not offered, (Landis, 1956; Russell, 1983; Wyatt, 1985), while the definition of the upper age limit to childhood varies from 16 years (Baker and Duncan, 1985) to 18 years (Russell, 1983). Rates of child sexual abuse vary from 16% (sample size 930 women) in Russell's study (1983), to 15% (sample size 531) in Finkelhor's report (1990), to 62% in a study of 248 women by Wyatt (1985) in Los Angeles.

The major college-based studies were those by Kinsey et al. (1956), Finkelhor (1979) and Priest (1992) who report prevalence rates ranging from 19% to 25% of the sample. Pilkington and Kremer (1995a) conclude that community-based studies do not provide a clear idea on the extent of the problem. This is due to the confusion of definitions, the inclusion or exclusion of non-contact abuse, and the study participants' lack of analysis of the severity of abuse. They stress the importance of face to face interviews as opposed to self administered questionnaires. The major problem of community studies is the inherent bias of the study population. The statistics from both these study methodologies are only part of the answer to the extent of child sexual abuse.

In their analysis of empirical studies on child sexual abuse, Pilkington and Kremer (1995a) stress that the variance in prevalence figures is due to the lack of uniformity in the definition of the child, of what constitutes abuse and the methods used to elicit the information. These studies analysed clinical histories of adults presenting with psychological and psychiatric disorders. Rates vary from 3% to 90% using inpatient samples, outpatient samples and clinical presentations such as multiple personality disorders, eating disorders, and chronic psychosomatic conditions. The major problem with these types of surveys is extrapolating the results to the general population. The conclusion by Pilkington and Kremer is for better study design and uniformity of definitions.

Leventhal (1988), in a comparison of Kinsey (1956) and Russell (1983), concludes that there has been an increase in the prevalence of child sexual abuse despite differences in methodology. In Kinsey's study 24.1% of women report an episode of sexual abuse before adolescence. The sample of 4,441 women is drawn from members of social units, e.g. social clubs who volunteered for the interview after a presentation. Russell (1983) goes further, and matches women and interviewer by ethnicity and race. Russell's study was in San Francisco and possibly is not representative of the USA population. Other differences are that Russell reports a higher prevalence of intra-familial abuse and more serious abuse.

Despite these problems, Finkelhor (1994) notes that studies from Europe have tended to be consistent with the North American experience. He argues that the higher rates noted in the United States could be due to the methodologies used. He calls for a more "rigorous" research methodology outside the USA so that a comparative analysis can be made. The effect of culture and societal values on child abuse should be addressed. In an earlier article, Finkelhor (1993) concludes that, although epidemiological research on child sexual abuse has been

persuasive in documenting the extent of abuse, there has been a lack of orientation to the determination of the characteristics that may be helpful in detecting abuse. He calls for longitudinal studies, rather than cross sectional or retrospective ones, to determine the risk factors for child sexual abuse.

A similar study to the one reported in this thesis, is one conducted in Northern Ireland by MacKenzie et al. (1993). They attempt to determine the incidence of child sexual abuse in the province by analysing all reported cases of child sexual abuse. They use a broad definition of child sexual abuse and note a number of methodological difficulties that beset the research. Verification of abuse is difficult as data is received from secondary sources, child sexual abuse is a sensitive subject, and confidentiality is ever present. The incidence rates are an underestimate of the problem, in that they report a range of 0.9 to 1.87 per 1000 per year. This is lower than the USA National Incidence Study (1988) rate of 2.2 to 2.5 per 1000 per year. They note the difficulty in extrapolating their results to other regions in the United Kingdom.

Sariola and Uutela (1994) attempt to determine the prevalence of child sexual abuse in Finland with a student questionnaire administered in 409 comprehensive schools. They find that 1-3% of the boys and 6-8% of the girls reported episodes that they classify as sexual abuse. This is similar to that reported in the United States (Russell, 1983; Wyatt, 1985; Finkelhor, 1990). As questionnaires may underestimate the true prevalence of child abuse, this study should not be considered in isolation.

Recognising the limitations of retrospective studies relying recollections of childhood experiences and or adult survivor reports, Finkelhor et. al. (1997) explore the possibility of

extending the research tool of asking parents about contemporaneous acts of physical violence against their children to asking about sexual abuse. This is an interesting concept as it theoretically could provide an up-to-date analysis of the state of child abuse, though they note that parents may not reveal the abuse due to shame or fear. Incest may not be revealed. To test the feasibility of such an approach, a telephone survey on the topic of sexual abuse was conducted. The results reveal that 1.9% of the respondents' children were sexually abused over the previous year, and 5.7% of the respondents' children had been sexually abused at some time. The survey indicates that more males had been abused than females. A characteristic is that over 23% of respondents had been sexually abused themselves. The validity of this type of data cannot be tested, and this approach can not replace other forms of epidemiological study. Telephone interviews may be a useful tool for data collection, but they cannot stand alone.

Child Abuse in Africa

The study of child abuse in Africa has been limited in comparison with research in the United States and Europe. Child protection is overshadowed by the massive political and economic problems experienced by the people of Africa. The publication of reports has been restricted to a few articles. Pan African conferences on child abuse as well as a number of seminars have been held. At the *2nd African Conference on Child Abuse and Neglect* a number of papers were presented from eighteen African countries. This does not imply that there has not been research or documentation of the problem, rather that the lack of resources has resulted in the paucity of reporting and the relative absence of research.

In addition, there has been a misconception that child abuse is not a common occurrence in Africa as children are valued and loved as part of African culture and tradition. This is questioned by Okeahialam (1984) who highlights some child rearing problems in the area of disability, female circumcision, the treatment of children of multiple pregnancy and the effects of the breakdown of the extended family. Khama (1993) comments on the difficulty in defining child abuse in the African context in Botswana. She notes that the cultural attitude to abuse is variable and often the distinction between abuse and discipline is blurred. One of the major factors is the belief in the infallibility of the male in the family structure, both in physical and sexual abuse. A problem in determining the incidence of child abuse is the *"private nature of abuse"*. The statistics presented by Khama are limited in their use as they reflect the first reports to the service.

In Tanzania, Omari (1993) provides the alternate socio-political perspective, indicating that poverty, the effect of AIDS and the breakdown in the structure of the family with increasing urbanisation, are the major factors. Ebigbo (1992) conducted a situation analysis on child abuse for UNICEF, but does not provide prevalence figures, but an analysis of the attitudes of Nigerians to differing forms of abuse. Whilst this shows an increasing recognition of the problem, it is not conclusive as the attitudes are mixed. The study, however, tends to support the theories put forward by Omari.

Child physical abuse

Nowrojee (1993) provides an analysis of physical abuse in schools in Kenya and concludes that the culture of acceptable violence should not be a barrier to developing a movement against the corporal punishment of children. She notes the virtual absence of any statistics on

abuse in Kenya, and the difficulties of providing universal definitions despite the approval of the United Nations *Convention on the Rights of the Child.*

Research in Nigeria has been sporadic, though a number of papers have been published. Wilson-Oyelaran (1986) reported on child labour and physical abuse in Nigeria and noted that research is not systematic. The role of poverty as the sole factor is questioned and it is suggested that a multi-dimensional approach must be adopted including culture, social environment, and the family and individual. This approach is supported by Asogwa (1986) in an analysis of child labour and its effects on children.

Child sexual abuse

The theme of male domination as a factor is continued by Orimba (1993) and Anyanzwa (1993) who report on the subservient position of women in Kenya, and the influence this has on child sexual abuse. Unfortunately their reports are anecdotal and there are no accurate figures available. Rubagiza (1993) summarises the problem in Uganda: *"some cultural practices have a negative impact on society, especially where they tend to victimise the girl child, and such practices are practised out of ignorance".* She refers to child marriage, female circumcision, incest and child labour. Kamau (1993) challenges the view that culture does not affect the problem of child sexual abuse and adds weight to the call for rights of women being central to any action against child abuse.

In Zimbabwe Bundy (1993) analyses the court records for child sexual abuse in Harare. This study is limited in that it deals with only a small percentage of abuse cases. She analyses 291 court records over a three year period. All the children were girls, with an average age of 10-13 years. The perpetrators are generally male, and 15 % of the perpetrators are below 18

years old. The response to the abuse is not particularly encouraging, and she calls for change in the legal approach to abuse.

War and child abuse

The few reports from Mozambique have concentrated on the effects of the civil war on family life. The war destroyed the fabric of the society, and the experience of the children of Mozambique is probably replicated in all societies which have undergone prolonged periods of war. The political instability of much of Africa and the ongoing civil wars implies that the research in Mozambique and the programmes that have been analysed could have important lessons for children in other parts of Africa. The war has resulted in research in the area of the rehabilitation of the children forced into the armies of the civil war (Boothby et al., 1992).

Child abuse in South Africa[5]

South Africa has a long history of research in the field of child abuse and neglect. The social service system for the White population was modelled on the English system; thus it inherited the tradition of investigative research. In addition, the network of universities in South Africa provided academics with an interest in child protection issues. Much of this research has not been published. The research has been influenced by the experience in Europe and the United States and therefore is not always relevant to the experience in Africa. Loffell (1992) notes that until 1980 a very narrow concept of child abuse was used in the social service agencies. The medical definitions were used, and only in the early 1980's was non-accidental neglect recognised. Political factors were acknowledged but not accepted as a major causative factor. Loffell links the rise of the human rights and children rights movement as essential in precipitating a changed view on child abuse. Yet the majority of articles published continued

[5] Some specific studies are discussed in Chapter 7.

to ignore this, and it was only towards the end of the decade that political factors were reported in articles on the effect of violence on children. Detention of children and the reporting of this detention (Thomas 1988), and the development of children rights activist groups changed the conception of child abuse. The academic boycott had both positive and negative effects on research in South Africa. It removed contact with peers in Africa and in the developed world, but stimulated a vigorous interest in the effects of State policy on children.

Research was facilitated by the formation of SASPCAN, the *South African Society for the Prevention of Child Abuse and Neglect*, in 1984. At first, research was aimed mainly at management issues, and concentrated on a narrow definition of child abuse. This changed with increasing opposition to apartheid and State policy on children. The injustice of the society and the realisation of the link between government policy and child protection issues was realised early by a number of researchers. This implies that studies have moved to the issues of structural abuse and the effects of political policies on child abuse ahead of many countries in the north.

A key factor in child abuse has been the breakdown of family structure as a result of deliberate State policy and the ongoing civil war. McKendrick and Hoffman (1990) state this succinctly: *" when a nation becomes severely polluted by violence, the corrosive effects perforate all layers of society, damaging national institutions, community life and family living, so that no individual within the society remains untouched by its insidious presence".*

Child physical abuse

Killian (1993) postulates that the irrevocable disintegration of family life in the Natal midlands is due to the violence both "legitimate and illegitimate" that exist in the area, as well as the

heritage of the apartheid system. Thousands of families living within South Africa in the 1980's and 1990's have been exposed to stresses of violence, poverty and oppression. Figures quoted by Killian (1993) are an underestimate. The broadened concept of child abuse implies therefore that the numbers of children exposed to emotional abuse perpetrated by the State, police, armed struggle and crime is incalculable. The social engineering of apartheid restructured the family life of most Black families with the production of single parent families, female-headed households, homeless families. The breakdown of traditional family values resulted in a climate where abuse is prevalent in the more narrow sense. Killian (1993) also notes that children became both activists and victims of the social order. Magwaza et al. (1993) report on post traumatic stress syndrome as a result of violence in Natal and conclude that this is a serious consequence of the violence that pervades the region. Unfortunately, the study highlighted the difficulty in making the diagnosis and the paucity of services available to address the problem.

Child sexual abuse

Jacobs and Loening (1991) conducted numerous studies on children in Natal. They report in a hospital study in Durban that 83% of abused children were sexually abused and 95% of these were girls. The vulnerable age group is three to twelve years of age, and 20% of alleged perpetrators were teenagers. The sample is skewed as it is hospital based; however, similar figures are reported by Chapman and Winship (1993).

In Cape Town Westcott (1984), then Jaffe and Roux (1985) report similar results with sexual abuse being predominant at the Red Cross War Memorial Children Hospital, where the number of children presenting with child abuse increased from 240 in 1984 to 560 in 1989. A study by Argent et al. (1995) reports on 600 children presenting to the hospital. A definite

diagnosis was made in 256 children of whom 40% were physically abused and 60% sexually abused. Virtually no children with neglect were seen. Most of the physically abused children were boys (60%), with 25 % being under one year. Of the sexually abused children, 90% were girls with an average age of 6.8 years. The physically abused children were younger than those sexually abused.

Sexually abused children presenting in hospital is studied in detail by McKerrow (1990) who looked retrospectively at the records of 365 children over a three year period from 1986 to 1988. He reports that the sexual abuse was usually acute, with 13.7% chronic abuse. Over 70% of children had physical signs of abuse and 15.6% had signs of sexually transmitted diseases, a finding confirmed by Argent et al. (1995). McKerrow (1990) notes that only 1% of alleged perpetrators were women.

A paper by Haffejee (1991) discusses the emergence of child sexual abuse as a phenomenon in the Indian community in Natal. He notes that before the study, sexual abuse was thought to be non-existent in this community and concludes that this is the probable explanation. Fontes (1995) postulates that abuse is found in most cultural groups if one looks for it.

Levett (1989) attempts to determine the prevalence of sexual abuse by studying women university students. She studied 94 unsolicited students at the University of Cape Town by means of a structured educational workshop concerning gender socialisation and sexual abuse. She reports that 43.6% of the group had experienced instances of sexual abuse under the age of 18 years, with attempted rape in 17%, and intrusive physical contact in 47.5%. This type of study provides some evidence of the extent of the problem and is a useful supplement to

epidemiological studies. It does not provide accurate data as the women may have pre-selected themselves, and this could skew the figures.

Child Labour

Research on child labour has been limited in South Africa, as it has been in the rest of Africa. Swartz and Levett (1990) estimate that 60000 children were involved in farm labour, with low wages, long hours, no rights or security. These children are denied medical care and education. This is confirmed by Waldman (1993) in her case study on child labour in the Western Cape. Loffell (1993) notes that figures for child labour are inadequate, and that this is to be addressed by research by the forum on child labour.

Conclusion

The review of reports on the epidemiology of child abuse in various societies is aimed at focussing on the present study. The questions posed at the start of the chapter are intend to place this study in perspective.

- *Can lessons can be learnt from published studies?*

  The studies discussed in this chapter have ranged from simple observations to detailed epidemiological studies. What emerges is that research on child abuse has been random, and there has not been any co-ordinated research programme either in South Africa or internationally. This is an issue that should receive urgent attention. While the independence of academic thought is vital, the review of the literature suggests that research should be part of any programme development.

- *Are the characteristics of child abuse universal?*

In this chapter the international perspective on child abuse including child abuse in Africa and South Africa has been discussed. The studies reported are representative of those in the literature and have concentrated on the various types of child abuse. There are conflicting reports, and it is becoming more clear that while child abuse is a universal problem, its presentation varies from society to society and within differing groups in any particular society. A recent book edited by Fontes (1995) emphasises the cultural diversity involved in child abuse in the United States. Fontes (1995) states clearly that *"in much of the early work, the ethnicity of the people discussed is not even mentioned, as all White samples are used"*. She stresses, however, that one must acknowledge that feelings and behaviours may result from experiences of oppression and not culture per se. This is highly relevant for a multi-cultural country such as South Africa. There is a need to conduct research aimed at developing programmes and prevention strategies appropriate to the community involved. This thesis will not report on race which is a contentious issue (see Chapter 5). It is an issue which influences the way results are reported and interventions planned.

- *Is it necessary to carry out further studies in countries where the epidemiology of child abuse is not determined?*

Research on child abuse has not been a priority in developing countries, and, as shown in this chapter there are few reliable studies that provide a comprehensive picture. The need for researchers in developing countries to undertake epidemiological studies is stressed by Finkelhor (1994). Concentrating on child sexual abuse, he concludes that if one looks for abuse one will find it, and he reiterates the need to document it. It is

important that research is undertaken for an expressed purpose, to provide the information required to develop prevention and intervention programmes. State departments should work in collaboration with professionals and academics in the field to design a situation analysis of the state of child protection to develop the appropriate response. One should not rely on the popular media to be the source of statistics.

- *If studies are to be conducted, what form should they take?*

  The study of child abuse from all perspectives has been limited in Africa. Therefore there is a need to initiate focussed research in the area. Research should commence with the development of clear definitions of abuse that can be accepted by practitioners from different disciplines, and, hopefully cross culturally. This may be difficult to achieve. This should be followed by studies to determine both the incidence and prevalence of child abuse together with the characteristics of the children and the abusers. The data can influence intervention procedures and evaluative research on the intervention strategies can be undertaken. The study that is described in the following chapters aims to provide the basis for future research on the issue.

The results of this study, as well as the conclusions drawn from them, will provide the start of the journey to the development of a co-ordinated research programme in South Africa. This could feed into the child protection strategy required to address the problem of child abuse and neglect.

Chapter 3 Reporting of child abuse and neglect

Introduction

The issue of reporting of child abuse remains contentious and unresolved. This was first noted by Kempe et al. (1962) when they ended their report on the "battered baby syndrome" by defining a problem that persists today: *"Physicians, because of their own feelings and their difficulty in playing a role that they find hard to assume, may have great reluctance in believing that parents are guilty of abuse. They may also find it difficult to initiate proper investigation so as to assure adequate management of the case."*

The lack of reporting or at least of documenting the extent of child abuse and neglect may be a contributing factor to the late recognition of the phenomenon. Consequently reporting systems have been developed in numerous countries in order to ensure that children who have been abused are brought to the attention of service providers. Reporting to a central authority, even for statistical purposes only, is not a simple matter as it raises numerous debates. In this chapter a number of key issues will be raised.

- *Should a child abuse be reported, and if so why?*
- *If society adopts a reporting system should it be mandatory?*
- *What are the problems with a mandatory reporting system?*
- *What alternatives exist for monitoring the extent of child abuse?*

The argument in support of reporting of child abuse and neglect

In the United States the issue of reporting of child abuse was first raised by the awareness generated by Kempe et al. (1962). As child abuse became more recognised, pressure was placed on Congress to enact legislation that would form the basis of a child protection system. From the epidemiological perspective one cannot plan an intervention unless the prevalence of the problem is known and the annual incidence is charted. Pressure from the medical fraternity ensured the success of the debate on whether to legislate for mandatory reporting. By 1967 every State in the United States had introduced a law aimed at reporting and investigation. This was followed by a Federal law in 1974 which linked State reporting, investigation and management of child abuse to the receipt of federal funding for child protection programmes.

The development of the reporting system relied heavily on the public health model of reporting infectious diseases. Levine and Doueck (1995) stress that sponsors of the legislation took on the "medical"[6] model of child abuse (where child abuse is viewed as an illness) rather than the societal view (where child abuse is seen as having roots in the structure of society and poverty). They assert that this approach assumed that treatment can be offered to abusers, that abuse is cyclical, and that mandatory reporting would result in the identification of all children who are abused. This is in a similar vein to the reporting of infectious diseases. However, Eckenrode et al. (1988) stress that the failure to increase the funding of child protection programmes in proportion to the number of cases reported has resulted in failure in the delivery of services to reported children.

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[6] See footnote 3 (page 7)

At the ISPCAN Congress on Child Abuse and Neglect (1996), the argument for reporting is given by Furniss and by Toth[7]. Furniss refers to the paradox between mandatory reporting and the needs of therapy, and concludes that societies with mandatory reporting protect children better than those countries without mandatory reporting, as professionals are forced to face up to the reality of child abuse. Toth reports that mandatory reporting increases public awareness of child abuse and neglect, combats the secrecy surrounding child abuse, and allows for the early investigation of the possible abuse. These arguments are the foundation of the mandatory reporting culture.

Types of reporting

Warner and Hanson (1994) provide the "medical" approach to child abuse reporting when they categorically state that *"intervention cannot begin until these families are brought to the attention of the treatment agencies"*. This approach takes the view that the multi-step, multi-behaviour process of identification and reporting is a critical antecedent to treatment of abusive families.

Warner and Hanson (1994) divide reporting of physical abuse into four stages aimed at providing an appropriate response at each level. This model could be adapted for all types of abuse and presumes the acceptance of the "medical" model of abuse.

- *Assessment and evaluation* involves the identification of the injury and questioning its cause. It is a crucial stage in initiating the process of investigation, and, as noted by Badger (1989), Saulsbury and Campbell (1985), and Collings (1996), it is the one area where physicians most often fail.

[7] Referenced under ISPCAN (1996)

- *Identification or diagnosis of abuse* is similar to the medical concept of diagnosis in that it does not require the same degree of certainty (Dubowitz, 1990), but refers to the possibility of abuse being present.

- *Reporting* is the process of informing social services of the need for investigation of a potential episode of child abuse. This requires a service that will take action, and trust in the service on the part of the reporter.

- *Validation* constitutes the process where the possibility of abuse is verified or rejected following investigation. Saulsbury and Hayden (1986) note that reports generated by physicians usually have a high level of validation.

The importance of the above approach is that it allows for identification of problem areas in the reporting process. It assumes that reporting is valuable and worthwhile and does not question whether one should report at all. This is in keeping with the assumption that if one reports and an investigation follows, the welfare of the child in question would be improved.

If one critically examines the issue of reporting, it is clear that the debate over reporting is fundamental to the type of child protection system that one develops. Mandatory reporting, offered as the solution to identification and management of child abuse, is not the sole approach. Crenshaw et al. (1994) summarise the debate on reporting by the use of a combined approach starting from the premise that neither extreme is the answer to the debate. They defines the models of reporting as follows:

1 Mandatory reporting

This is where all cases of child abuse as defined are reported by mental health providers. There is no certainty that provision for any services subsequent to the report being made will be available. The introduction of mandatory reporting has been heralded as a legal response to the issue of child protection. Legislators considered that if child abuse is made reportable, the extent of the problem could be determined. Reaction to the problem could then be mobilised both on an individual and societal level, i.e. there is the premise that child abuse can be eradicated by laws. As Crenshaw et al. (1994) note, the approach is not therapeutically oriented and is carried out in the main by Social Services. Ards and Harrel (1993) state categorically that *"tremendous gains in public awareness of child abuse and neglect have been made in this country (USA) in the past 15 years, stimulated by the passage of mandatory reporting laws in every state."* They base their enthusiastic support for this on the rapid increase in the number of children reported to the child protective services 1,154,000 in 1980 (18.1 per 1000 per year children) to 2,08600 in 1986 (32,8 per 1000 per year children). They attribute the increase to heightened awareness of abuse, and greater efforts to implement the law. Whether this increased reporting rate resulted in a safer environment for children is not discussed. The study notes that younger children are more likely to be reported, whilst gender, race, or income do not affect reporting of child abuse. Type of abuse is an important variable in that sexual abuse is more likely to be reported than that which is physical or emotional.

Ethical problems in mandatory reporting include confidentiality, conflicts on legal responsibilities as opposed to responsibilities to the child, fear of overload of Social Services as a result of false positive reporting, and doubts regarding the value of reporting. (Winefield

and Bradley, 1992). Badger (1989), in a survey of paediatricians and family doctors in Alabama raises concerns expressed by doctors relating to how mandatory reporting impacts on the doctor-patient relationship. Factors that influence reporting are the presence or absence of injury, attitudes towards physical punishment, parental response to the injury, and the physician's knowledge of the parents. He also notes that training in child protection increases reporting rates.

2 Voluntary reporting and conjoint reporting:

Conjoint reporting refers to a joint report by Mental Health Services and the family as active partners. In this type of reporting system the abusive parents report the abuse themselves to the Child Protection Service. If they fail to do so the Mental Health Service will undertake the reporting procedure (Trad and Pfeffer, 1988). The therapeutic approach to reporting is influenced by the individual needs of the child and how the family will be helped to stop abusive practices. (Agatstein, 1989). The argument for this system is that parents become active partners in the process of reporting, which in turn becomes part of the therapeutic process. The problem may be that cases will be under-reported and that this system requires a well developed service that provides good therapeutic intervention.

3 Discretionary reporting

Finkelhor and Zellman (1991) suggest that the calls for training as the solution to the poor reporting rates is too simplistic a response. Zellman (1990a) groups reporters into four categories:

- Consistent reporters who always report;
- Consistent non reporters who never report;

- The uninvolved who never encounter abuse;
- Discretionary reporters who report under differing circumstances. Eighty percent of those who did not report made a rational informed decision not to report.

Finkelhor and Zellman (1991) propose a flexible reporting system using registered trained reporters. Central to this approach is the development of reporting options based on specific criteria. These will concentrate on the benefits of reporting. This would decrease the number of unnecessary reports, allow open discussion on the necessity to report, allow reporters to sort out many cases, and improve data collection. Problems could lead to the development of a class structure within the reporting system and professional over-confidence, as well as the lack of detection of serious abuse. The proposals continue to support the underlying view that mandatory reporting is advisable but should be more efficient.

Arguments against reporting of child abuse and neglect

Crenshaw et al. (1994) report that their research indicates limited support for alternatives to mandated reporting among mental health professionals; however, they remain pessimistic about changing current laws due to lack of support from child protection agencies and the existing child protection culture.

While the reporting of child abuse initially appeared to be an appropriate method of helping to safeguard children, numerous problems that can invalidate the process have been noted by various authors.

Bias

The strongest arguments against reporting are reports about bias in the reporting process. Most studies have shown that reports are more likely from the inner city than from the suburbs. A popular explanation is that reporting is less prevalent in the middle and upper classes. McKittrick (1981) notes the need to come to terms with one's own biases and prejudices in order to be an objective reporter.

Eckenrode et al. (1988) show that reports from professionals are substantiated at a significantly higher rate than those from non-professionals for all types of abuse, particularly neglect. From 1973 to 1984 there was a 17% increase in reports. The percentage of substantiation decreased to only 35% in 1984. The problem of stress on poor families often exposes them to unwarranted investigation. Families in minority groups have higher rates of abuse substantiated, and cases of physical abuse in Afro-Americans tend to go to court. Hampton and Newberger (1985) raise the possibility that factors such as income, mother's role in the family, emotional abuse, maternal employment, race, and unreported sexual abuse influence reporting.

The use of child abuse as a cause of death is also problematic. This is clearly shown by Ewigman et al. (1993) who analyse death certificates in Missouri over a five year period and come to the conclusion that child maltreatment fatalities are drastically underreported in that only 47 % of those which are definitely maltreatment are reported. This finding raises doubt on the validity of death certificates of young children with regard to traumatic fatalities and unexpected deaths.

Failure to report

Badger (1989) notes that fear of the legal process inhibits reporting. These findings are supported by Saulsbury and Campbell (1985), MacDonald and Reece (1979), and Morris et al. (1985). Morris et al. (1985) find that "inappropriate discipline" is often not reported as physical abuse. Other factors are uncertainty, fear of losing patients in private practice, lack of training, lack of confidence in the Social Services, and unsupported belief that abuse is uncommon in private practice settings.

Swoboda et al. (1978) notes that 85% of psychologists, 63% of psychiatrists and 50% of social workers in their sample would not report a case of child abuse. These results are replicated by Attias and Godwin (1985), Haas et al. (1988), and Kalichman and Craig (1991). Concerns about confidentiality and the protection of the therapeutic process are given as reasons for failure to report. Reporters often interpreted the law differently and this influenced compliance.

In a study on 1200 mandated reporters (Zellman, 1990a), up to 40% of respondents admitted that at some stage in their career they had suspected child abuse and had decided not to report it. Reasons given for this decision are: insufficient evidence, the case is not serious enough, the case had already been reported, therapy would be disrupted, belief that no further benefit would be gained for the child, the abuse had been resolved, and lack of trust in the social service agency.

Vignette studies have repeatedly supported this reluctance to report. Attias and Goodwin (1985) show this in a group of psychologists, psychiatrists and counsellors. Zellman (1990a) analyses the patterns that characterise decision making in reporters. Using case vignettes, she

determines that two sets of judgments influence the likelihood of reporting, i.e. seriousness and operational definitions of abuse, and the predicted efficacy of making a report in terms of perceived benefit for the child and for the family. As protective services are swamped with reports, so less is done for the "mild" cases, which can result in reporters deciding whether or not to bother to report. The type of abuse also has an influence, as sexual abuse is more likely to be reported than neglect.

Pollak and Levy (1989) examine the counter transference factor which is the totality of emotional reactions of the reporter to the family and child. They postulate that this is always present and it can be poorly managed or adapted to benefit the child, depending on the circumstances. They stress that reporters are under-trained and lack an understanding of the psycho-dynamics that are inevitable in all cases of child abuse. They call for education, training, and the provision of experts for support and advice. Deisz et al. (1996) attempt to analyse the reporting practice of mandated reporters as opposed to their legal requirements. They show that there is variance between practice of reporting, and the legal need to report. The limitation of the study is that those involved volunteered for the exercise. It will be indicated later in this chapter that one of the most important reasons for not reporting is the role the therapist plays as a therapist as opposed to an investigator, though training and education and perceptions on abuse are important.

Occupation and gender of the witness influence the perception of the incident and the decision to report (Dukes and Kean 1989; Skiffington et al., 1983). Kean and Dukes (1991) go further in trying to determine the characteristics of witnesses in deciding to report. Gender of the victim is a major determinant as females report child abuse more if the victim is a girl, and if

the abuser is a father. They postulate that this is related to the power relationships in society, and raise the possibility that the abuse of boys is under reported in the statistics on child abuse.

Rindfleisch and Bean (1988) show that there is a variance in reporting patterns in institutions. Important factors influencing reporting are type of abuse, staff commitment to the process of child protection and the child (as opposed to the agency), and the reporter's relationship to the outcome.

Ards and Harrel (1993) find that sexual abuse is the most common form of abuse reported to the Child Protection Service in the United States. By analysing the two incidence studies in the USA, they find that age was an important variable in that younger children were more likely to be known to Child Protection Services, and that sex, race and income did not play a significant role. Type of abuse is a significant factor, with sexual abuse being more reported than other forms and neglect the least reported.

In a study in rural Australia, Manning and Cheers (1995) analyse the attitudes to reporting by residents of the town. They note that the fears to reporting include a desire not to interfere in private affairs of other families, and the emotional factors that reporting involved. Not surprisingly, physical and sexual abuse would be reported more frequently than neglect and emotional abuse. They state that the nature of a rural community causes a difference in attitudes to reporting. The feeling is that the child's welfare is a community responsibility, and that outside agencies or professionals should not be involved as there is lack of confidence in them. The strength of traditional values in determining the response to abuse, and the problem of accepting that someone from a close knit community would abuse a child, influence the decision to report abuse. This is important in the South African context where a large

proportion of the population live in rural communities. Manning and Cheers (1995) suggest a number of approaches to address these factors, with education being the major tool to increase trust in child protection services, as well as recognition that rural communities have differing priorities to urban communities.

Neglect has been under reported by all professional groups. It is traditionally seen as a welfare issue and not a medical issue. Neglect was the first of the types of abuse to be recognised, but as it is often interwoven into the social fabric of society, and is difficult to define, there has been little recognition and under reporting. Kempe did not include it in his early writings, and thus, as child abuse was medicalised, the concept of the *"neglect of neglect"* was introduced by Helfer (1990). Johnson (1993) indicates that this is a definite problem amongst physicians, who report other forms of abuse more readily. Factors that influence this lack of recognition and reporting of neglect include minor illnesses, parental characteristics such as background, religion, intellect, and the economic status. He calls for standardised definitions of neglect, and increased training in the recognition of neglect.

Over reporting

Winefield and Bradley (1992) attempt to measure the extent of over reporting as a result of mandated reporting, by analysing the computer records of the child protection services in South Australia. They find a substantiation rate of 56% which compares well to other reports in the USA (Eckenrode et al., 1988; Barone et al., 1981). They raise the question whether the trauma of investigation of unsubstantiated reports is justifiable, or whether it is the price one must pay to detect the positive cases. Alternatively, the criteria for substantiation may be too high. Lack of substantiation may not imply that abuse has not occurred but may simply reflect the workload of the relevant agency.

The argument against mandatory reporting of child abuse and neglect

The argument against mandatory reporting is given by Marneffe and by Belsey[8] in the debate held on mandatory reporting at the ISPCAN Congress on Child Abuse and Neglect held in Dublin in August 1996. Marneffe bases her objections on the philosophical conflict between *"the legal approach to child rescue and the social work approach to protective services"*[9]. She proposes that the adoption of mandatory reporting results in the neglect of the larger social and psychological forces that underlie all forms of human violence. The approach that is advocated is a "therapeutic" response, rather than a "punitive" response to the act of abuse. Belsey argues on a more practical level, viz. he questions the effectiveness of mandatory reporting in protecting the child given the lack uniformity of reporting mechanisms, definitions of child abuse and neglect, and difficulties in evaluation of surveillance systems. Further problems in reporting system are noted by Daro[10] (1996) who notes that reported child abuse provides only a portion of maltreatment, and that the resulting statistics are fragmented.

These arguments highlight the difficulty in deciding whether a reporting system should be mandatory or not, and as noted in the section on the argument for mandatory reporting, stress that there is no uniformity amongst professionals as to whether mandatory reporting is of benefit to the abused child.

Reporting and therapeutic relationships - the threat to confidentiality

The most critical analysis of mandated reporting is made by psychologists who are concerned with the confidentiality of their client-therapist relationship. It has been argued that reporting

8 Referenced under ISPCAN (1996)

9 Marneffe's approach to child abuse and neglect is discussed in Chapters 9 and 11.

10 Daro on the whole supports mandatory reporting.

can become part of the therapeutic process (Zellman and Finkelhor, 1991). Weinstock and Weinstock (1986) reflect the fears of those concerned with confidentiality and the possible negative effects of investigation. Positive effects include increased sensitivity to the prevalence of child abuse, while negative effects include fears of liability on therapists, over-reporting, deterioration of patient confidentiality, and disregard of the effects on the family. The possibility of the intervention process set off by mandated reporting being more harmful than helpful has been ignored. This is more apparent when the goal of conviction of the perpetrator becomes the main aim of intervention. In many countries the success of child abuse intervention is measured in the number of convictions obtained, despite the negative effects this may have on the child involved. Weinstock and Weinstock (1986) conclude that *"...child abuse laws present difficult ethical dilemmas for therapists as well as for patients and society. Not only do the statutes demand rigorous reporting actions that practitioners may find clinically and ethically contra-indicated, but serious criminal and civil penalties are imposed for failure to obey the law."*

Therapists and social workers can find the "policing" nature of child protection in opposition to the helping profession they joined. In the United Kingdom the separation of the roles of the police and the social workers is blurred in joint investigations. This impacts negatively on the social work intervention required. Mandatory reporting may result in the "helping profession" being perceived as biased against the client as a result of the investigative nature of reporting (Drews, 1980). This approach concludes that the punitive and the therapeutic nature of the reporting system are incompatible.

Weinstock and Weinstock (1986) make far reaching suggestions which run counter to the ethos of reporting. This includes limited exemption for "treating" therapists, appropriate

alternatives for children in therapy, removal of criminal sanctions, reporting if ongoing abuse is not addressed, and preparation of the client prior to reporting in order to maintain confidentiality.

Thompson-Cooper et al. (1993) go further in that they suggest that now that society is aware of the issue, the reporting laws can be dispensed with. They consider that the system of the *"confidential doctor"* be introduced (discussed in Chapter 10). This implies that reporting occurs only if the family does not co-operate with intervention. Besharov (1990) asserts that in most cases social work intervention is unnecessary, and an over zealous approach to reporting can result in problems of multi-agency assault such as in Cleveland in the United Kingdom.

Improving the quality of reporting of child abuse and neglect

Dubowitz (1988) reports that training of medical practitioners improved the level and quality of identification and reporting. This is confirmed by Badger (1989) who demonstrates that younger paediatricians who had been exposed to child protection training in their undergraduate years were more likely to recognise child abuse. Reiniger et al. (1995) report on a survey of 1368 mandated reporters in New York State who are legally required to be trained in child abuse detection and management. They note that of all cases of child abuse some 69% are not reported. Schools have the highest number of unreported cases, while the highest number of reports are made by the police, hospitals and mental health services. In their analysis of those attending a compulsory course for mandated reporters, they find that mandated reporters are aware of abuse and its identification, but many are unaware of procedures and protocols, or of the legal implications of the reporting process. They conclude

that failure to report is due to a serious knowledge gap and that in order to maintain an effective reporting system, ongoing training of reporters is essential. This study is significant as it addresses the fundamental problem of mandated reporting, i.e. the lack of knowledge of indicators of child abuse. A flaw in the analysis is the failure to question the value of mandated reporting and to consider the possible alternatives to mandated reporting. Von Burg and Hibbard (1995), in a study on the reporting practices of dentists in Indiana, stress the importance of training of professionals to be mandated reporters. They emphasise that if a reporting system is to operate, dentists are in a unique position to detect abuse, as over 50% of injuries are to the head and the neck. Their study demonstrates the value of training and could apply to other professionals.

Reporting in apartheid South Africa

The debate in the United States, and the success of the medicalisation of a social phenomenon, has influenced the approach to child protection in the rest of the world. Mandatory reporting became the solution and has been adopted in many countries. Services to meet the needs of identified children have been developed, although they have not managed to address the extent of the problem. In South Africa the *Child Care Act of 1983* adopted mandatory reporting but failed to consider the consequences of this action, viz. the provision of services for children who are reported. This was reinforced in the *Child Care Amendment Act number 86 of 1991.* Section 42 of the Act provides for mandatory reporting in a number of clauses.

1 *"Every dentist, medical practitioner, [or] nurse or social worker who examines [or] attends or deals with any child in circumstances giving rise to the suspicion that the child has been ill-treated, or suffers from any injury, single or multiple, the cause of*

which probably might have been deliberate, or [is undernourished] suffers from a nutritional deficiency disease, shall immediately [in the prescribed manner] notify the Director - General or any officer nominated by him [Regional Director of Health and Welfare of the district in which the child happens to be] for the purpose of this section of those circumstances".

This clause does not attempt to define what constitutes child abuse or neglect. It includes a condition that may or may not result from abuse, and does not provide a mechanism for reporting. There is no parameter for the degree of suspicion, and this can lead to false reporting and low substantiation rates.

2 *"On receipt of a notification in terms of subsection (1) the Director-General or the said [Regional Director of Health and Welfare] officer may issue a warrant in the prescribed form and manner for the removal of the child concerned to a place of safety or a hospital".*

This clause assumes that resources are available for intervention. The need to specify only one form of intervention may reflect the coercive philosophy underlying the welfare system in apartheid South Africa.

3 *The Director-General or the said [Regional Director of Health and Welfare] officer shall thereupon arrange that the child and his parents receive [prescribed] treatment as the Director-General or the said [Regional Director] officer may determine.*

The wording of this clause indicates that the Social Services Department considers child abuse to be a treatable condition. This is a direct adoption of the theories postulated by the "medical" model of child abuse. It is an attempt to exclude societal factors as being significant causative factors in child abuse.

4 *"This section shall not exclude any other action against or treatment of the parent and child in terms of this Act".*

5 *"Any dentist, medical practitioner, [or] nurse or social worker who contravenes any provision of this section shall be guilty of an offence".*

6 *"No legal proceedings shall lie against any dentist, medical practitioner, [or] nurse or social worker in respect of any notification given in good faith in accordance with this section".*

The final three clauses are designed to encourage reporting by the mandated reporters. These have not been followed seriously, either by the State or by mandated reporters, as evidenced by the low rate of reporting (refer to Table 7.2).

The Act does not allow the reporter to consider the benefits of reporting or whether the best interests of the child can be served in any other way. This Act clearly follows the United States lead of mandatory reporting using the medical model. The inclusion of nutritional disorders is interesting, as it places child abuse in the disease spectrum, and infers that child abuse is not a societal problem. It may imply that nutritional disorders are the result of parental neglect, and not the consequence of societal issues such as poverty linked to the apartheid system. Despite

this, the *Child Care Act* was welcomed by many children rights campaigners as being a start to addressing the needs of abused children in South Africa.

The mandatory reporting of child abuse was reinforced by the introduction of the *Prevention of Family Violence Act, Act number 133 (4) of 1993* which extends the concept of mandatory reporting.

> *"Any person who examines, treats, instructs, or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from an injury the probable cause of which has been deliberate, shall immediately report such circumstances: -*
>
> *(a) to a police official; or*
>
> *(b) to a Commissioner of Child Welfare or a social worker referred to in section 1 of the Child Care Act , 1983 (Act No. 74 of 1983)".*

This Act expands the concept of mandatory reporting with all citizens becoming mandatory reporters. The police are offered as an alternative to the Social Services departments, thereby emphasising the criminalisation of the concept of child protection. The viability of a reporting system in a developing country, which lacks adequate child protection services, is not addressed in these Acts. The approach is prescriptive and coercive, and reflects the philosophy of the formal welfare sector in South Africa (Patel, 1993), and does not take into account the arguments discussed in this chapter.

Reporting in post apartheid South Africa

There have been few studies on reporting of child abuse in South Africa. Collings (1996) reports on the low level of reporting of child abuse by General Practitioners in the greater Durban area. Of the 137 respondents, 91.2% indicated that they were not trained to carry out their role as mandatory reporters, and only 39.4% indicated that they would definitely report child sexual abuse in the future. The reasons for this reluctance to report are no different from those discussed above. Collings emphasises the lack of training as being a major factor, though he does not question whether reporting should be mandatory, or suggest the type of Child Protection Service that should be in place .

In the protocol for child protection prepared for consideration in the Western Cape (1996)[11], the child abuse reporting system essentially remains unchanged, and is based on the models developed and implemented in the United States and England. In the proposed system child abuse is viewed as a criminal offence. To initiate the investigation and the proposed intervention, mandatory reporting is required. The system is dependent on the establishment of child protection centres and intervention teams, which may not be readily achievable.

Conclusion

Besharov (1987) states the problems with reporting succinctly: "*Although the mandate to report may seem straight forward, definition vagueness and evidential ambiguities combine to make the decision to report (or not report) a difficult and stressful one.*" The issue of reporting child abuse and neglect as a means of defining the problem and initiating the response to it is not as simple as it may seem. The questions posed at the start of the chapter can be addressed.

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[11] The proposal will be discussed in greater detail in Chapter 10.

- *Should a child abuse be reported, and if so why?*

  Reporting of child abuse can serve a purpose if a well established response to the reporting process is available. The reporting of child abuse has been recognised to be a way to delineate the problem, identify children who have been abused or neglected, and deliver services to these children. The approach in most developed countries has been to introduce reporting systems based on the premise that this would lead to investigation, and ultimately greater protection of children. Despite the problems of reporting, and the perception that under-reporting may occur, one of the results of mandatory reporting has been the overwhelming of social services by unsubstantiated reports of child abuse, the initiation of many unnecessary investigations, and the development of a child abuse industry. The advantages for those children detected should be weighed against the disadvantages and problems that have been discussed in this chapter.

- *If society adopts a reporting system should it be mandatory, and what are the problems with a mandatory reporting system?*

  Mandated reporting of child abuse is not the only solution to setting up child protective services. In this chapter the approach to reporting child abuse has been reviewed and numerous problems with the reporting process have been discussed. It has been intimated that the assumption that the reporting of child abuse is a panacea to the problem is not universally accepted. Reporting is one aspect of the solution, if at all.

- *What alternatives exist for monitoring the extent of child abuse?*

  Reporting of child abuse has a function, but must be tailored to the needs of the society and to the resources available. This will be discussed in greater depth in the analysis of the reporting system in Cape Town, which forms the basis of this study (Chapter 10 and 11). Alternative approaches to reporting could be considered. The non-adversarial approach to child abuse will be discussed in Chapter 10. As mandatory reporting does not provide comprehensive statistics, alternative methods of data collection could be considered.

Reporting of child abuse and neglect is fraught with potential problems. As will be demonstrated in the results of this study, reporting can go some way in providing information on child abuse and neglect. However the introduction of mandatory reporting has not necessarily solved the issues facing Child Protection Services as was originally hoped, and should be considered carefully before its adoption.

Chapter 4 The prevention of child abuse and neglect

Introduction

The evaluation of research on the prevention of child abuse is fraught with problems. Implementation and development of programmes tend to be concurrent. The definitions of child abuse differ, and most programmes do not have on-going evaluation components. As the causes of child abuse are so varied, and the conditions in various societies or within societies differ so widely, comparisons are often impossible to make. Double blind studies are rare and the early programmes have methodological flaws, as the lack of accurate baseline statistics and the increased reporting of child abuse makes abuse rates difficult to interpret. Finally, there has been an emphasis on quantitative research as opposed to qualitative research, which may not be entirely appropriate.

This chapter considers research on prevention and it will be contended that, in order to prevent child abuse, a holistic approach is required. Children are part of a broader society and prevention programmes cannot focus on the child and the family alone. Ideally prevention programmes should be evidence based and should be developed form epidemiological research.

There is a considerable body of research on the subject, and practitioners have attempted to develop programmes that achieve some degree of prevention. Wolfe (1993) clearly spells out the pessimism that pervades the field of child abuse and neglect when prevention is considered. *The complexity of what we have come to consider physical abuse of children poses terrific challenges to our understanding of this phenomenon and our choices to intervene and/or*

prevent its occurrence. It stands to reason therefore that, at the present time, little consensus exists as to the formation of policy directions for this problem"

Prevention programmes are often planned without an understanding of the complex requirements inherent in these programmes. Majodina (1993) summarises the prerequisites for prevention programmes:

- There is a need for a conceptual framework that views child abuse as a complex multi-factorial social phenomenon, and not as a simplistic cause and effect event.

- A successful programme combines a number of strategies and aims at providing individual assistance as well as overall environmental adjustment.

- Effective programmes are culture sensitive and take into account the child rearing practices in the area. This does not imply that one accepts abusive practices, but one can ensure that definitions of abuse are not imposed from outside.

- Programmes are not to be started in isolation, and must form a part of an overall policy for child protection.

and

- Prevention cannot occur without advocacy for women and children. Advocacy for children aims at influencing institutions and individuals with power to use that authority in the interests of children. It can be adversarial or, preferably, can be a process of negotiation and confluence of ideas. Outcomes of the advocacy process include the building of networks between different NGOs and State structures. The process

involves empowerment of the dispossessed, and by organising at a local level, the programme has more chance of succeeding.

In addition, the debate on prevention reflects the debate on the causation of child abuse. Is child abuse the responsibility of the individual, or of deficiencies in society as a whole? The first results in programmes aimed at individual children or potential abusers, often in defined high risk populations. The second, and more unexplored area, is the approach that child abuse is a reflection of the structure of the society, and any serious prevention programme must aim to change the fundamental conditions in society that provide the conditions for child abuse. This latter theory, as postulated by theorists such as Gil (1973) and Parton (1985), is difficult to assess on a practical basis, and will be expanded upon in Chapter 9. This chapter will concentrate on the prevention programmes that are focused on the individual.

A review of the prevention of child abuse

The issue of prevention has been analysed by a number of authors (Helfer, 1982; Dubowitz, 1989; Wolfe, 1993; Gough, 1988; MacMillan et al., 1994a; 1994b). They have attempted to ascertain whether there are any meaningful lessons to be learnt about the effectiveness of prevention programmes developed over the past 25 years. It is apparent that the majority of the studies that are reviewed refer to secondary and tertiary prevention - prevention of further abuse once abuse has occurred. Primary prevention studies are not readily available in the literature.

Table 4.1 Analytic reviews of child abuse prevention programmes

Review	Focus of paper	View on child abuse	Conclusions Made
Helfer 1982	Child abuse viewed entirely in the public health model. Brief comment on role of society. Studies reviewed aim at high risk individuals, treatment, education and intervention. Does not critically compare programmes	Any interaction or lack of interaction between a child and his or her caregiver which results in non-accidental harm to the child's physical and/or developmental state.	Suggests a multi-faceted approach to prevention - i.e. no one programme can be successful.
Gough 1988	Medical framework used. Looks at causal pathways for abuse and analyses studies in this light. Does not critically compare programmes	Notes the problem in lack of definition of abuse and prevention	Concludes that the complexity of abuse is not clearly understood. Calls for investment in prevention - recognises that this is political in nature.
Dubowitz 1989	Medical framework used. Reviews wide range of studies on prevention aimed at the individual. Societal factors not emphasised. Does not critically compare programmes.	No clear definitions given besides for medical definitions of prevention..	Primary: limited increase in knowledge for csa programmes. Non-specific results on awareness programme. Secondary: positive report on programmes for high risk groups. Tertiary: problem in being both preventative and investigative.
Wolfe 1993	Discusses programmes aimed at high risk groups. Analysis of the risk factors that should be addressed in prevention programmes	Child maltreatment is the everyday experiences of a child that are unhealthy or inappropriate to normal development	Concentrates on the needs of the family - prevention seen in terms of support for the family in the community.
MacMillan 1994a physical abuse	Most comprehensive review of intervention programmes in perinatal and early childhood periods. (11 studies identified). Critically compares programmes. Studies by Olds have highest methodological scores. (see below)	Prevention is any intervention provided to prevent child maltreatment from occurring.	Studies too diverse for meta-analysis. Difficulty to ascertain measurement of outcome. Home visitation may be of benefit.
MacMillan 1994b sexual abuse (csa)	Critically compares programmes - 19 controlled studies (8 types of interventions), most aimed at general prevention of csa.	As above for physical abuse. Outcome in terms of knowledge, prevention skills, behavioural responses and child disclosure rates.	Unsure whether increasing children's knowledge on prevention of csa makes a difference.

Table 4.1 continued Review	Focus of paper	View on child abuse	Conclusions Made
Gutterman (1997)	Critical review of 18 early intervention programmes aimed at preventing child physical abuse and neglect.	Notes increasing interest in early intervention. Difficulty in comparison due to lack of uniform methodology and outcome measures	Concludes that there a re a number of principles for a successful early intervention programme, including. education and support for parents, parenting skills and acknowledging ecological issues.,

The problems with these papers are not the methods the authors used, but the difficulty in analysing research studies that have different definitions of abuse and of prevention. Helfer's (1982) view on prevention is that it aims at improving the interaction between child and parent/caregiver. Helfer uses the public health model of prevention in terms of primary, secondary and tertiary prevention to analyse prevention research. This approach has been adopted by most reviewers, and the analysis of prevention programmes is seen in this light.

- *Primary prevention* is any intervention aimed at preventing the abuse of an individual from ever happening. The broadest strategy would be to change the conditions in society that provide the setting and circumstances that may result in abuse. Dubowitz (1989) concludes that in the United States very little primary prevention was in place at the time of his paper.

- *Secondary prevention* is the initiation of an intervention aimed at individuals identified as being in a high risk environment in order to prevent abuse. Many studies are in this area, as it is specifically targeted, and the relevant population is defined.

- *Tertiary prevention* is any intervention initiated after abuse has occurred, to ensure that re-abuse or ongoing abuse is prevented. This involves identified children and

families, and is often part of the overall intervention strategy, though in countries such as South Africa it is very limited.

The concept of child abuse prevention, as similar to prevention of disease, is taken to its extreme by Gough (1988) who uses the example of the eradication of malaria by the World Health Organisation as a model for child abuse. He states that *"child abuse is sometimes referred to as a disease in our society and its eradication may be seen in one of two ways. It could be achieved by changing the social conditions in which child abuse occurs ..... **destroying the breeding grounds of abuse**. Alternatively, eradication programmes may involve the control of the individuals committing the abuse by treating them, or by removing them from circulation in society, or in some other limited way removing them from those they may hurt."*

Recognising that changing the social conditions would ultimately involve challenging the structure of society, he concludes that the second option are the ones to be followed.

Table 4.2 Public health model of prevention compared to child abuse prevention

Prevention in public health/medical model	**Prevention in child abuse**
Reduce contact to infectious agent, e.g. to malaria mosquito.	Reduce contact with situations that predispose to abuse e.g. stress.
Prophylaxis against malaria	Home visitation to help improve parent-child bonding
Inoculation against infectious diseases	Inoculation against abuse by means of education.

Gough's analysis of abuse is important as it represents the mainstream thought on the management and prevention of child abuse. He theorises that there are virtually infinite causal pathways to child abuse and that prevention strategies should try to address these. Action could be at a societal level, e.g. campaigns to change values and attitudes, or can be aimed at the individual by specific community programmes.

Wolfe (1993) approaches his analysis of research on child abuse prevention by first assessing the risk factors that must be addressed.

- *Problems related to the family context* which include marital discord or coercive family interactions, socio-economic factors such as poverty, and social isolation.

- *Child treatment needs* which include poor nurturing by caregivers and attention to the child's adaptation to the environment, particularly if abuse has occurred. Intervention therefore addresses relationship development, cognitive and moral development, self control, behaviour problems, and the avoidance of placement out of the home.

- *Problems of the parents* which include parenting skills, reaction to "difficult" children, expectations of children, emotional distress, and negative lifestyles and habits.

Wolfe (1993) takes a psychological approach by defining child maltreatment as unhealthy or inappropriate experiences for psychological growth and development, though unhealthy and inappropriate are not defined. This would by implication include societal causes of abuse.

Wolfe does not consider societal causes in any depth, though he does recognise the need to address child abuse at individual, community, familial, and societal levels. Rather, his approach is to address the growth of the child's self esteem and self-identity by addressing the parent-child relationship, to teach social sensitivity, and to consider the possibilities for older children to develop out of their families' environments. He considers prevention interventions as being more successful than treatment of abused children. He stresses the importance of *"true family support and the encouragement of personal self-efficacy"*, and stresses the need for research on programmes directed at non-parenting teenagers. He concludes that our knowledge of the effects of child maltreatment brings us closer to the realisation that it reflects core problems in our socialisation patterns.

All the reviews concentrate on the most reported intervention, i.e. that of improving the parent-child interaction. There have been programmes aimed at non-parenting adolescents in order to provide them with skills for parenting as well as developing their strengths and self esteem (Burgess, 1985; Wolfe et al., 1988). The outcome of this approach has not been assessed in any meaningful way.

MacMillan et al. (1994a; 1994b) provide the most comprehensive analysis of prevention programmes in both physical and sexual abuse. They had intended to conduct a meta-analysis, but found that there is no uniformity in the programme design, methodology, admission criteria, or evaluation of outcome in the research reviewed. Eleven studies are identified and each is reviewed by a team of reviewers against set criteria, including sample allocation, comparison of experimental and control groups, inclusion and exclusion criteria, follow-up and outcome. Outcome concerned hospitalisations, rates of visitation to emergency rooms and injury rates. They find that most studies concentrate on high risk groups (the definition of

which is not uniform) in the perinatal and early childhood periods. Duration of the intervention varied from a few months to two years. They examine the different outcome measures which are difficult to compare. Outcomes used include visits to hospitals, rates of visits to emergency room, injury rates, child development, parent child relationships, and parenting skills. Garbarino (1986) raises the problem of whether outcomes such as improved parenting skills translate into decreased child abuse in practice, and the issue still remains unresolved.

Home Visitation as an intervention programme

Home visitation as a possible intervention was postulated by Kempe in 1976. There have been numerous studies on home visitation (Siegal, 1980; Larson, 1980; Resnick, 1985; Olds, 1986; Taylor and Beauchamp, 1988; Wolfe, 1988; Hardy and Street, 1989; Barth, 1991; Olds, 1993). Wasik and Roberts (1994) summarise the aims of home visitation:

- Home visitors seek out the families rather than waiting for families to come to the agency, i.e. it is proactive;
- Home visitors provide the link between families and service providers thereby decreasing isolation;
- Home visitors learn about the individual needs of the parents in relation to their children;
- Home visitors can detect stress before abuse occurs and can take preventative measures.

This is summarised by Daro (1988) in that there is an opportunity to address the child and the parent-child relationships in the privacy of the home in a flexible and positive manner. The emphasis on high risk mothers is supported by studies which show for example that teenage

mothers engage in almost double the amount of neglect and or child abuse in their children than older mothers (Stier et al., 1993). Wolfe et al. (1988) explained the rationale behind home visitation programmes stating that: *"We theorised that agency based family support services would have a greater impact on high-risk families if they were accompanied by training in child management. Such training would assist parents in developing the skills and competencies needed to increase their levels of stimulation with their children."* A few of the home visitation programmes are compared in Table 4.3. The studies selected represent differing interventions in terms of duration of intervention and follow-up, type of intervention, qualification of person intervening, and outcome measures.

Table 4.3 Selected early intervention home visitation programmes

Study	Intervention	Outcome	Assessment
Siegal (1980) **USA -North Carolina** randomised study	202 mothers , low socio-economic status, visited by para-professionals post-natally for 3 months post partum, and with extended visits. 1 year follow up.	Little difference between 3 month home visitation group and extended intervention group in terms of child abuse and neglect or hospitalisations.	Study provided short intensive intervention - duration of intervention may be important.
Olds (1986, 1993) **USA - New York State** randomised study	Ante and post natal home visitation to 400 White primiparas defined as high risk. One group given home visitation, another group no intervention. Long term outcome studied in later paper.	Intervention group had decreased emergency room visits, less punishment and restriction in homes, higher developmental quotients in study group, less child abuse (not significant)	Assessment in 3rd and 4th year of life indicated less injuries, improved parenting, unclear results on prevalence of child abuse.
Wolfe (1988) **Canada -Ontario** randomised study	Psychology students visited 53 mothers to provide parenting skills and behavioural modification, 1 year follow up.	Improved parenting skills with increased information and behavioural programmes. Effect on child abuse not measured.	Difficult to assess. The theory that better parenting skills decreases chance of abuse is proposed.
Hardy and Street (1989) **USA** randomised study	290 Black mothers of neonates, low socio-economic status, visited by community women for 2 years. Control group compared to study group.	Significant reduction in study group hospitalisations and in suspected child abuse and neglect.	Positive outcome indicating that community women can be part of the intervention programme

The most effective research programme is that undertaken by Olds and his colleagues[12]. In a number of carefully designed research projects Olds et al. (1986; 1993) demonstrate that home visitation during pregnancy and in the first two years of life has a positive effect on parenting skills. The design of the studies are similar and they are set in differing settings, i.e. rural and urban America, differing cultural groups, and different intervention training for nurses and practitioners. Women were divided into two random groups, matched on the basis of risk factors, and other demographic characteristics, and the intervention consisted of home visitation by a nurse on a regular basis. The nurse would concentrate on parent education, with regard to foetal and child development, involvement of family and friends as a means of support, and linkage of the mother with health and human services.

In the study in rural New York there was improved parental care-giving in the intervention group, as measured by parent child relationship, better child safety, improved use of the health system, fewer behavioural and parental coping problems, and a third less visits to the accident and emergency department. Questions that are difficult to answer are whether this would work in all settings, what the level of training of the nurse or home visitor should be, how often visits should be made, and whether the changes are long lasting.

In a later study Olds et al. (1993) report that there was a degree of carry over at 25 to 50 months in some aspects of parenting, but no enduring programme effects on the rates of child abuse or neglect and children's intellectual development. The study does not answer whether the programme should be universal or restricted, particularly in view of its labour intensity. The results are in contrast to some reports, which report a less optimistic outcome (Siegel et

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12 This research will be used as an example of the home visitation concept.

al., 1980; Lealman et al., 1983). Although classified as primary prevention, the programme can also be regarded as secondary treatment for mothers possibly already damaged by their own experiences. The study by Olds et al. (1986) is well constructed and provides a model for studies of home visitation. Problems in measurement of the outcome still remain as well as how long the effect of the support will last.

Wolfe et al. (1988) assessed the effect of increasing parental coping skills by means of behavioural modification programmes aimed at parents. This is the only study to focus specifically on behaviour modification and is based on Wolfe's theory that improved parenting skills may be a key to decreasing child abuse and neglect. The subjects were parents and children under supervision from a child protection agency, and this may influence the results. The persons conducting the intervention were post graduate developmental psychology students which makes this intervention impractical on a broad scale. Outcomes are measured by self assessment and observer evaluations. They report that the intervention in a purely research project had limited results. The actual programme is not documented in detail, and improvements in parenting skills are reported, but the translation to child abuse prevention is not clear. They caution that, although their findings support the contention that an individualised programme is preferable to a family support service alone, there may be case to support both working together. The study is difficult to extrapolate from in view of the difficulty in measuring decreased risk of abuse.

Other possible interventions are mentioned by Dubowitz (1988), such as programmes for "latch-key" children teenage mothers, and community programmes. The theory is similar, early intervention should decrease the chance of child abuse. Yet none of the programmes discuss

the societal influences on child abuse in any depth. It is taken for granted that concentrating on the individual family with increased support will be effective.

In a systematic analysis of home visitation programmes, Roberts et al. (1996) conclude that home visitation programmes have the potential to reduce significantly the rates of childhood injury. They contacted the researchers to delineate problems that could not be answered from published studies to enable comparisons to be made, and for data to be pooled. They note that the assessment of child abuse as an outcome measurement is not uniform, and that inherent reporting bias in the studies makes it difficult to assess the overall outcome measures.

In a comprehensive review of 18 controlled studies on the prevention of child physical abuse and neglect, Gutterman (1997) concludes that the studies point to a number of trends that may be important in the prevention of these forms of abuse. These are:

- the role of parenting education support which aims at providing parents with parenting skills is essential;
- the linking of families with formal or informal support and information is important;
- long term interventions are probably better than short term interventions, particularly if there is a moderate degree of on-going contact;
- it is not clear whether long term interventions are more effective than short term interventions;
- para-professionals do as well as professionals in providing support, though intensity of support may be important;
- utilising a more universal intake criteria rather than a purely selective one is usually more beneficial;
- health education is valuable in reducing medically related maltreatment.

These conclusions are the early trends of a move towards early prevention of child physical abuse and neglect. It is clear that the study of early intervention studies has not been systematic and studies are difficult to compare, particularly with regard to outcome. The prevention of child physical abuse and neglect will require programmes that include the above elements, as well as a close examination of the structure of society that facilitates the conditions leading to child abuse and neglect.

Prevention of child sexual abuse

Prevention of child sexual abuse has been reviewed by Finkelhor in his book *"A Source-book on Child Sexual Abuse"* (1986). The types of programmes most favoured are child education programmes based on the premise that a knowledgeable child is a safer child. The programmes range from education in schools, stranger danger, teaching children to be assertive and to deal with potentially abusive situations, to teaching children about child abuse in general. Results from these studies are not always promising. It is difficult to say whether there is a long term effect and whether, despite the proven increase in knowledge, this will alter behaviour at all.

MacMillan et al. (1994b) analyse nineteen studies on child sexual abuse prevention representing eight types of intervention. Programmes were educational and were aimed mainly at providing children with relevant information by means of verbal instruction, videotape, the inclusion of behavioural training, role-play and plays, or combinations of these methods. They divide outcomes of child sexual abuse prevention programmes into four categories:

- Basic knowledge of prevention concepts for parents children and teachers;
- Assessment of the prevention skills of children using vignettes;

- Behavioural responses of children under simulated conditions;
- The disclosure of sexual abuse by children.

It is clear that the final of these is the most direct measure, the others not necessarily translating into actual success of the intervention. A study has yet to be published which directly supports the hypothesis that increased knowledge decreases the occurrence of child sexual abuse. Yet, as Briggs and Hawkins (1994) point out, an ignorant child is theoretically and probably practically a more vulnerable child.

MacMillan et al. (1994b) reflect that most interventions succeed in raising the level of knowledge as assessed by one of the first three measures, however they conclude that none of the studies reviewed, examined whether there was a direct positive outcome or not. A few studies (Kolko et al., 1987; Hazzard et al., 1991), attempt to do this, but not in a useful manner for interpretation. The overall conclusion is that: "*...there is evidence that education programmes aimed at the prevention of child sexual abuse and abduction can improve knowledge and prevention skills of children under experimental conditions. However, whether education of children leads to prevention of child sexual abuse in real life situations remains to be established.*" (MacMillan et al., 1994b).

The effectiveness of education programmes aimed at the public at large via the mass media is difficult to assess as there are many uncontrolled variables and the conventional wisdom is that increased awareness results in increased recognition of child sexual abuse and the resultant increased reporting of abuse.

Table 4.4 Selected programmes on prevention of child sexual abuse

Study	Intervention	Outcome	Assessment
Conte et al. (1985) randomised selection of children in a day care centre	Instruction and behavioural training for 40 children aged 4 to 10 years. Three hour programme teaching basic prevention techniques.	Increased knowledge on child sexual abuse at different ages. Control group had no increase in knowledge	Early study, short follow-up, small sample, therefore limited applicability but provides pointers for future studies.
Hazzard et al. (1991) multi-modal study randomised selection	Training for 485 children - videotapes and behaviour modification. Training for teachers. 3 combinations using *"feeling yes feeling no"* curriculum. Follow-up for 1 year	Assessment using knowledge scale and an anxiety inventory and vignettes measure. Treatment children exhibited greater knowledge post testing and at 6 weeks and 1 year post intervention.	Important study on effectiveness of programme - no evidence on whether behaviour is modified by increased knowledge
Wurtele et al. (1992a, 1992b) aimed at parents and teachers	Pre-school, parents and teachers given behavioural training. 2 month follow-up. Second study focused on children using parents and teachers as instructors. 5 month follow-up	Some negative effects, e.g. fear. Children in programme group improved knowledge on prevention techniques.	Comprehensive studies showing differences in administration of programmes emphasising the importance of the involvement of parents as well as professionals

An important study by Elliott et al. (1995) addresses the problem of prevention by analysing sex offenders in treatment programmes. The limitations of the study include a selected sample, the possibility of false responses, and the possible gratification perpetrators gain from talking about their past. They conclude that, in designing prevention programmes, the views of perpetrators can provide valuable pointers in prevention programme development. They note that secrecy is an important element to be addressed, the right to say "no" may be difficult to assert, and that a profile of potential abusers which children may be taught to recognise does not exist. High self-esteem is a vital ingredient for protection as is information on the child's emotional state. This may be useful to counteract the grooming of children by potential sex

offenders. This study, one of the first of its kind, is an important advance in the development of protection programmes.

Prevention strategies

Cohn Donnelly (1991) summarises prevention strategies as requiring a multifaceted approach comprising:

- heightened parental knowledge of child development and parenting, home and child management;
- enhanced parent-child bonding;
- increased parenting skills;
- reduced burden of child care;
- reduction in family isolation;
- increased access to social services;

and

- reduced long term effects of poor parenting.

The above broad aims could be achieved, she postulates, by programmes aimed at children, adolescents and adults. Daro (1991) notes that the programmes in the 1980's included one to one services, prevention programmes for potential victims of abuse, advocacy for children's rights, and public education aimed at increasing the awareness of abuse. Success has been achieved in raising public awareness, though whether this prevents child abuse is impossible to determine. The challenges left to us include developing preventing strategies for the poor and those living in stressful conditions. This is a reference to the possible structure of society that

facilitates abuse, although a serious analysis of the fundamental causes of child abuse in terms of power relationships within society is not given.

Helfer (1982), nine years earlier had made similar conclusions, emphasising that a multifaceted approach should be adopted. He also does not include political change as essential and comments that there has been no research on the validity and effectiveness of such changes. Helfer (1982) lists a number of approaches to child abuse prevention.

- The community must have the desire to reject violence;
- The desire to prevent violence can be facilitated by mass media campaigns (a theme reiterated by Krugman, 1996);
- There must be a commitment to improve parents' communication skills with their children;
- The extension of home visitor programmes can be an important factor;
- The introduction of interpersonal skills programmes in schools is essential;

and

- The provision of adult education and refresher courses on child protection for children provides on-going support.

This concept of a continuum of education is idealistic but does not address the roots of the problem. Education, as indicated in the review of prevention programmes is only one of the facets to be addressed. The content of the programme cannot rely only on the introduction of skills, and, as Johnson (1993) points out, programmes in schools are often not introduced as intended due to the personal views of teachers. Briggs and Hawkins (1994) conclude that the success of education programmes in Australia depends on parental participation and social

class (the higher the social class the more successful), and on the teacher's co-operation. Education programmes can be part of an overall strategy to improve child rearing, and can be part of a children's rights campaign. This may increase their relevance and chance of success.

Conclusion

As discussed in this chapter, the major thrust of child abuse prevention programmes has been threefold.

- The provision of support to families and children from the ante-natal and early childhood period with the aim of preventing child abuse by improving parenting skills, child-parent relationships and providing added support, particularly for vulnerable families.

- Mass media campaigns to increase public awareness of abuse.

- Education campaigns for children to increase knowledge in the field of child sexual abuse.

Comparison of research studies reveals lack of consistency in research methodology, lack of before and after trials, the difficulty in determining whether the interventions had any long term validity, and the absence of uniformly measured outcomes. Fink and McCloskey (1990) suggest health care measures may be the measurement of choice. This would involve the measurement of both physical and mental health, though this may be difficult to achieve. A

comprehensive overview of the child from the perspective of health, development and education may be required.

It is interesting to contrast the reviews on prevention programmes at the beginning and end of the decade. Very little has developed conceptually, and we are left with programmes which at best increase knowledge and may decrease abuse. However most researchers shy away from analysis of the power structures in society that promote abuse. Few studies approach the criteria set by Majodina (1993), with the complexity of the problem usually being recognised, but the programmes being one dimensional. Advocacy for women and children is rarely mentioned, if at all.

As will be discussed in the final chapters of this thesis, prevention must involve an analysis of the causes of child abuse, the structure of society that allows it to take place, and the ways in which this might be altered.

Chapter 5 Research design

Introduction

This study arises out of both service needs and academic interest. As the political structures in South Africa undergo transformation, it has become clear that a fresh approach to the issue of child protection in South Africa is required. It has been noted in the review of research on child abuse and neglect in South Africa that, although there has been considerable research on child abuse in South Africa, (and far more than that in Africa and other developing countries), most research has concentrated on the treatment of child abuse and neglect. Research in the areas of epidemiology and the development of prevention programmes, based on the characteristics of abuse, has not been evident.

When this research project was initiated two events determined the direction of the research as well as helping to develop the research questions.

- *A call for the implementation of Section 42 of the Child Care Act of 1995 has been made by professionals across all fields. The need for research into reporting systems has been highlighted by the practitioners, in view of their legal requirements.*

- *In many parts of South Africa there is ongoing development of prevention programmes. This is in response to the perception that there is an epidemic of child abuse and neglect in South Africa, and can be placed clearly in the political and social context of change within South Africa. Promotion of the rights of the individual*

and the broad based coalition for the Rights of Children are becoming more evident and forceful.

Research questions

Specific research questions to address the problem of child abuse in Cape Town are:

- ***Can the characteristics of abused children in Cape Town be determined?***

  At the time of the study the characteristics of abused children are anecdotal. The questions regarding abused children to be answered include age, gender, area of residence, type of abuse experienced, and outcome. The importance of developing this profile is that the profile can be used for all levels of intervention, viz. prevention, management and treatment. The *risk of abuse* will be determined, if possible. This will be achieved by the analysis of all cases of child abuse and neglect to the reporting centre. In addition, this data will be compared to published studies on child abuse in Cape Town.

  Originally the intention was to extend the study in order to develop the overall picture of the prevalence of child abuse. This part of the study is aimed to design methods for assessing the prevalence of child abuse in children who do not present clinically.

  - retrospective studies, viz. random surveys of adults and teenagers who may have been abused as children.
  - assessment of the prevalence of abuse in known high risk areas e.g. institutions and children's homes.

- a random survey of schools to assess prevalence of abuse.

The study, however, will concentrate on children reported to the reporting centre for child abuse. **It will not be able to detect the overall prevalence as this is a reported incidence study.** This study will be the first in a series of studies, and can lead to the subsequent research on child abuse prevalence. This will be discussed in the final chapters.

- ***Do the characteristics of child abuse and neglect in Cape Town differ from those reported in the literature?***

Child abuse in South Africa has been influenced by the prevailing political climate and social structure, as is the case in all societies. The general assumption made is that the incidence and prevalence of child abuse and neglect is universal. This is crucial in the development of a Child Protection Service for South Africa, the lack of comprehensive studies implies that policy makers are dependent on data from the literature. The findings of the study will be contrasted with those in the international literature. It must be stressed that comparison of studies is not always possible as the methodology and definitions are not uniform. Despite this an attempt will be made to make some comparison, though the limitation of the comparison will be emphasised.

- ***Should and can a child abuse reporting system be developed and implemented?***

In order to plan prevention and intervention strategies programmes, it is necessary to document the prevalence of the problem and develop agreed methods of collating data on child abuse. A consistent method of reporting child abuse is not in place in Cape

Town. The development of a reporting system would have major service implications for the child protective services, and could provide the first data on child abuse that had any claim to accuracy. The study aims to develop a reporting system, implement it, and then critically evaluate the merits of a mandatory reporting system.

- ***Can prevention and intervention strategies be developed based on the epidemiological data that has been collected?***

  The collection of data on child abuse and neglect is essential for the development of prevention strategies that aim to reduce the prevalence of child abuse. All prevention strategies that have been documented in the literature originated in developed countries with strong social service infra-structures. The data from this study will provide some information that can underpin the theoretical basis for prevention programmes.

- ***Can the results provide the basis for a National Plan of Action on child abuse and neglect?***

  This study on child abuse in Cape Town is one that could possibly lay the groundwork for the development of child protection services in the post apartheid South Africa. The merits of this will be considered with reference to the development of similar programmes elsewhere.

- ***Can the study in Cape Town provide an impetus for further research in the field of child abuse and neglect?***

  The field of child abuse has developed into a major area of research over the past few years, as indicated in the literature review. Research in South Africa has been unco-ordinated. The data and the analysed results can provide key directions for further research in this field. This final question should be answered by an assessment of key indicators in the data. Recommendations for further research will be made.

The study of child abuse in South Africa offers many possibilities. This study is one of the first of its kind in South Africa, and was conducted many years after similar studies in the United States and Europe. This is a reflection of the state of our knowledge of child abuse in South Africa, and also of how marginalised the problem has been. While this study concentrates on child abuse and neglect in South Africa, and in Cape Town in particular, the implications of the results and the conclusions made on the basis of the results, can be applied in other countries.

Consultation with service providers

The process of consultation in the two years preceding this collection of data reflects the political climate in South Africa in the run up to the elections of 1994. State Departments attempted to alter their attitude to working with non-governmental organisations by entering into dialogue with them, and accepting many of the criticisms of child protection legislation and practice. The area of reporting of child abuse had been contentious, with the State Social Service departments wanting central control from Pretoria. This had been challenged by professionals in Cape Town, and a consultation process commenced in 1992.

The development of the research tool was part of an extensive consultative process that took place in 1992 and 1993. The process had been facilitated by a growing sense of dissatisfaction and frustration in the Cape Peninsula across the full spectrum of practitioners, non-governmental organisations and State Departments, with regard to the application of Section 42 of the *Child Care Act.* A large number of professionals working in a wide variety of settings, many of them alone or in isolated groups, were (and still are) required to report any suspicion that a child was being ill-treated or neglected. Non-compliance with this procedure still constitutes a criminal offence, with a penalty of a fine of R4000-00 or twelve months' imprisonment, or both.

Prior to the amendment of the *Child Care Act*, mandated reporters had been instructed to report *"in the prescribed manner"* to the Regional Director of Health and Welfare. Reporting in the past was impeded by the bureaucracy of apartheid, as in all regions there were three Regional Directors. The Department of National Health and Population Development as well as the Provincial Administration had an interest in reporting. A uniform *"prescribed manner"* was not specified. This resulted in each Department developing their own procedure and reporting form.

When the *Child Care Act* was amended (operative from 20 June 1991), the 'Director-General' (or an officer designated by him) became the person to whom the report should be made, with the requirements that the report be *"prescribed manner"* falling away. At the time of the consultation, regulations to the amended Act had not been issued, nor had 'officers' been designated by the Director-General. The only apparent improvement in the relevant section of the Act was the inclusion of social workers as mandated reporters. The continued exclusion of psychologists, teachers, crèche owners, law-enforcement officers and other health

professionals remains a potential problem, if one accepts that mandatory reporting was and still is an essential exercise.

Professionals providing services to the children and their families in the Cape Peninsula concurred that reporting in terms of Section 42 bore no resemblance to the incidence or prevalence of abuse as suspected by mandated reporters.

It was also agreed that the reporting system was inaccessible due to the confusing picture it presents. The statistical picture was incomplete, making proper evaluation and planning extremely difficult. It was this situation which initiated the development of a model to address the need for accurate statistics.

At a quarterly meeting of the Cape Peninsula Child Abuse Liaison Unit on 2nd September 1992, it was agreed to form a working group to address certain issues of protocol and procedures, with regard to the report and management of child abuse (including Section 42). On 6th October 1992, as part of the Community Paediatric Services Study Group (COMPS), the Regional Office (Western Cape) of the Cape Provincial Administration: Hospital and Health Services convened a meeting to explore ways of simplifying and making reporting procedures in terms of Section 42 of the Child Care Act more effective. (The COMPS study group was represented by all the major hospitals, community and primary health care services providers). The following bodies/departments were represented at the meeting:

- Cape Provincial Administration (CPA) Regional and Head Offices;
- Western Cape Regional Services Council;
- Department of Health Services and Welfare

- Administration of the Houses of Assembly and Representatives (Regional Offices);
- Child Abuse Liaison Unit;
- Cape Provincial Administration (CPA) Community Services.

Recommendations from this meeting included the call for a single register for each region, and a simplified system for feedback to reporters.

A seminar was held at the University of the Western Cape on 'Child Abuse and the Law' on 23rd October 1992. Although this event was independent of the process underway, a large portion of the plenary session was taken-up with discussion regarding the problems surrounding the proper application of Section 42. A resolution was passed to form a working group to address various protocol issues, including those related to Section 42.

As a follow-up to the COMPS meeting, a meeting was convened and hosted by the CPA (Hospital and Health Services) on 23rd November 1992 to discuss a plan of action to address the issue. This meeting was preceded by consultations with all and interested parties, including representatives from the organisers of the University of the Western Cape seminar. The meeting comprised representatives from the following organisations and departments:

- Department of National Health and Population Development (Regional Director);
- Western Cape Regional Services Council (Chief Executive Officer);
- Cape Town City Health Department;

- Departments of Health Services and Welfare, Administration: Houses of Assembly and Representatives and Delegates;
- Community Services, Cape Provincial Administration;
- Hospital and Health Services, Cape Provincial Administration;
- Day Hospital Services;
- Centre for Child Guidance, University of the Western Cape;
- Department of Paediatrics and Child Health, University of Stellenbosch and Tygerberg Hospital;
- Department of Paediatrics and Child Health, University of Cape Town and Red Cross War Memorial Children's Hospital;
- SAFELINE, a non-governmental child protection agency;
- Cape Town Child Welfare Society;
- The Progressive Primary Health Care Network;
- Child Abuse Liaison Committee of the Western Cape.

It was agreed that the forum would replace those structures that preceded it to discuss the reporting of child abuse and neglect. It was decided that the most appropriate course of action would be to hold a task-orientated workshop to generate a workable model for the proper application of Section 42. It was resolved that as soon as this model was finalised, it would be presented to the appropriate bodies for purposes of adoption and implementation at a regional level. The workshop was made open to all those present and to all members of the Child Abuse Liaison Committee not already involved.

The proposed workshop was held on 10th December 1992. A working group of five persons was appointed to prepare the model which would be circulated for comment, before being presented to the relevant forums for consideration.

Development of the reporting procedure

The working group represented the key agencies in Health, Governmental Social Services, NGO and semi-autonomous Social Service organisations. The working group considered all the reporting mechanisms in operation, both internally and to the Social Services Department, i.e. from Cape Town Child Welfare Society, Red Cross War Memorial Children's Hospital, Tygerberg Hospital, Cape Town City Council, Regional Services Council, and SAFELINE. It was noted that only the hospitals regularly reported child abuse. The reporting forms used in New York and California were used as guidelines. The form was to be computer compatible, and was piloted at the Red Cross War Memorial Children's Hospital. The form was reviewed by all the participating agencies, and was adopted in October 1993 for immediate implementation.

The components of the reporting system were to consist of a report form, a reporting centre, a reporting and referral procedure, follow-up and feedback procedures, and access to the information gathered. The function of the reporting procedure was to develop a system whereby abused children could be identified, accurate statistics gathered, and an appropriate response made.

- **The report form**

The form was to be easy to complete, contain only essential information, promote rapid computer compatible follow-up and management, and provide relevant statistics. The form would be distributed as widely as possible and be available to every mandated reporter, as well as non-mandated professionals such as teachers, psychologists and law-enforcement officers. The form was primarily designed to have four functions:

- To provide *statistical data* on abused children in terms of age, gender, area of origin, type of abuse and outcome. The form provided the basic details of the child. After a prolonged debate it was decided not to include any reference to race or ethnicity. A number of agencies indicated that they would withdraw if race classification was included. Most forms in the USA or United Kingdom indicate ethnic origin of the child. The political changes in South Africa mitigated against the inclusion of a race category.

- To provide a mechanism to request urgent intervention for a child from the State Social Services Department. This would be done both by the form and by telephone.

- To provide a mechanism to request long term follow-up for the child and the family.

- To provide a brief profile of the alleged perpetrator. This was approved by the legal advisor and formed the first prospective collection of such data.

- **The reporting centre**

Physical Requirements

The minimum requirements for this were an office providing privacy, staffed by a computer literate senior social worker with experience in the field of child abuse, and with an extensive knowledge of the relevant regional resources.

Logistical Requirements

The office space, basic office equipment and administrative support were to be provided by the Department of National Health and Population Development. The social work services were to be provided by a State Welfare Department.

Functions

The functions of the Reporting Centre included receiving reports, maintaining the register, referring for follow up, ensuring that follow-up had taken place, providing feedback to reporters, acting as a resource and information centre, promoting and developing the reporting system, and identifying problems and deficiencies in the reporting and intervention systems. A research component was recommended and encouraged.

- **Reporting procedures**

When a child had been referred to an organisation for further management, a follow-up report form was to be forwarded by the Centre to the organisation concerned, to be completed and returned by a given date. This form would contain information on confirmation of abuse or neglect; action taken to protect the child; nature of current

intervention or treatment; details on the alleged abuser; status of the case in terms of criminal procedure; difficulties encountered; a management plan; and the evaluation of co-ordination and co-operation between role players. This system would have three types of reporting to agencies:

- Feedback (on request) to the original reporter regarding follow-up actions;
- Regular statistical reports to mandated reporters and other relevant persons;
- The circulation of relevant research findings.

- **Access to information**

Access to all records was to be controlled by means of a clear policy and procedural code. The following principles were to apply:

- The promotion of the protection and interests of children;
- The promotion of confidentiality without compromising the interests of children;
- The adherence to ethical codes of conduct to be developed by the working group.

Degrees of suspicion

The working group determined that three levels of suspicion or proof of child abuse were to be reported.

- **Low suspicion**

The reporter suspects that the child is being abused in some way but has no firm evidence.

- **High Suspicion**

  Child abuse has not been confirmed but is likely to have taken place e.g. the child has a sexually transmitted disease but there is no other evidence of sexual abuse.

- **Confirmed abuse**

  Those cases of child abuse and neglect which had been confirmed by medical, social work or legal evidence.

Definitions of child abuse and neglect

The evolution of the concept of child abuse and neglect has been a gradual process since it became a focus of concern in society. Gough (1996) emphasises the problems of not having a shared understanding of what is meant by child abuse and neglect. Definitions vary culturally, historically, and within different sectors of society. The growing concern about the rights of the child is discussed by Marzouki (1997), and has resulted in a broad definition of the rights of the child, while most research studies, epidemiological surveys, and professional agencies utilise fairly narrow definitions of child abuse and neglect. As Gough (1996) notes, over the past twenty years research has taken place without an agreed conceptual framework of what actually constitutes child abuse and neglect. This has resulted in difficulty in comparative analysis of research reports in the literature.

In this study operational definitions of child abuse were developed, and were based on those in use by the Social Service agencies. It is recognised that these definitions were narrow, but they allowed for tight entry criteria to the study.

- **Child physical abuse (cpa)**

  Child physical abuse involves a physical injury to a child that is inflicted purposefully by any person. The person may be a parent or caretaker, or stranger.

- **Child sexual abuse (csa)**

  Child sexual abuse involves the exposure of a child to sexual stimulation inappropriate for the child's age, level of psycho-social development or role in the family. Sexual abuse may be within or outside the family structure.

- **Child neglect and inadequate care**

  Child neglect and inadequate care involves a parent's or caretaker's failure to provide a child with sufficient nourishment, supervision, medical care, clothing, shelter, comfort and stimulation, as well as when the parent or caretaker abandons the child. The failure to provide for the child is not the result of poverty, but is the result of a deliberate act of omission or commission on the part of the parent or carer.

- **Child emotional abuse**

  Child emotional abuse is intentional use of language/attitudes/behaviour to damage the self image of the child. For the purpose of the study this is included with neglect.

Guidelines to complete the form were developed and were part of the report form pack.

Pilot study

The system of reporting was introduced in October 1993. A pilot study was undertaken to assess the validity of the form, the ease of use of the form, the applicability of the definitions and the understanding of the procedure by potential reporters.

The pilot study, over a two month period, was undertaken at the Red Cross War Memorial Children Hospital, where a high level of reporting occurred, and up to 20 children with child protection related issues were seen each week. The definitions were found to be simple and easy to apply. The form layout was critiqued by the hospital social workers, and modifications were made to its initial design. The pilot study enabled the researcher to modify some of the variables, adapt the data collection system and to develop the form for computer input onto EPI-INFO[13]. The form was referred back to the committee for assessment after the pilot study was completed.

Study population

As it was difficult to predict how many children would be reported and whether a high level of compliance with the system would be achieved, it was decided to collect data for a minimum of twelve months. This was to overcome the potential problem of seasonal variation, and the possibility of initial low reporting. It was also recognised that the sample size would also be influenced by the timing of the research within the changing political scene in South Africa. Co-operation of all the referral agencies had been obtained, but the changes in welfare policy

[13] EPI INFO is a data entry and statistical package developed by the Centre for Infectious Disease Control, Atlanta Georgia, USA.

and the amalgamation of agencies resulted in a poor compliance in the later stages of reporting.

Initially it was hoped to include the first 1000 children reported. After an initial analysis of the finding, it was decided to increase this to 2000 as agencies tended to refer in batches. Fifteen months of reporting coincided with approximately 2000 reports.

Information gathering system

The mechanism for data collection was negotiated with the local office of the Department of Health which had a good track record of data collection for childhood diseases and immunisation. The Department offered to provide a temporary home for the data collection system until the Social Services departments had completed their amalgamation and were in a position to take over the system. The problem of providing immediate intervention and rapid referral was addressed by improving communication between the relevant State departments.

Data input

Data was entered onto an IBM compatible desk top computer by three data entry clerks. All forms were numbered and each could be readily identified. Data was coded by the researcher where relevant, and the forms and the data entered were cleaned and checked by the researcher.

Analysis of data

The data has been analysed using the SSPSS/PC Plus 4.0 (1990) statistical package. The data has been analysed at various stages in order to determine trends. Statistical significance has

been determined by the Pearson Chi square test with continuity correction. The data has been analysed by a biostatistician and interpreted by the researcher.

Ethical Considerations

Research in the field of child abuse carries a number of ethical problems that need to be addressed. The major issues concerned the following broad areas:-

Confidentiality

The data base consists of children reported to a reporting centre for child abuse. The information on the reporting forms is sensitive and requires protection from dissemination. All forms were seen only by the researcher, the data entry clerk, and by the administrator of the reporting centre. Coding removed identifying details of the child and abuser, though each report was allocated a research number. The information collected was used for management purposes where indicated.

Intervention and service provision

Where referral agencies indicated that intervention was required, the child was referred to the relevant agency or State department in the area. This was completed on receipt of the form. As part of this study it was not possible to monitor the extent of the intervention provided by the agencies, though it is understood that, when requested, feedback was provided by the reporting centre.

Raised expectations

All research can raise expectations on the part of the research subjects and the providers of services. It initially was hoped to provide children with services where needed as discussed above, and providers of services with the reports of the data. Referral agencies have received a summary of the results.

Named alleged abusers

It was decided that should a pattern of child abuse be noticed, e.g. a repeated name of an abuser, appropriate referrals would be made either to the Police or to a welfare agency in the area, to ensure protection of children exposed to the alleged abuser. It must be stressed that the naming of an alleged abuser does not hold any weight in the legal sense until conviction occurs in court.

The Research Ethics Committee of the University of Cape Town approved the research protocol and sanctioned the research to be conducted.

CHILD ABUSE REPORT FORM

CONFIDENTIAL

DEPARTMENT NATIONAL HEALTH AND POPULATION DEVELOPMENT

FOR OFFICE USE ONLY : Registration no.

Completion of this form complies with Section 42 of the Child Care Act no. 74 of 1983 (as amended) Mandated reporters (dentists, doctors, nurses and social workers) are protected from legal action in terms of the Act.

Telephonic reports can be made and are to be followed by this written report immediately thereafter

Please send this report to :
The Regional Director (Western Cape),
Department of National Health and Population Development,
Private Bag X19, Bellville 7535. *Tel : (021) 946 3366*
For Attention : Miss Z R Airey *Fax : (021) 94 1276*
***NB!** ensure correct fax no.* *AFRIKAANS OP KEERSY*

☑ *APPROPRIATE BOX*

FOR OFFICE USE ONLY : Magisterial Code

REASON FOR REPORT Immediate intervention (not reported elsewhere) ☐ Long term follow-up ☐ Statistical recording only ☐ **DATE OF REPORT** .....

DETAILS OF REPORTER

NAME .....
Signature .....
PLACE OF WORK .....
Work address .....
Tel. no. ..... Fax no. .....
Organization ref. no. .....

RELATIONSHIP OF REPORTER TO CHILD / SOURCE OF INFORMATION
☑ *appropriate reporter category and* ☒ *the source of information*

Dentist ☐ Social worker ☐ Teacher ☐
Doctor ☐ Other health professional ☐ Psychologist ☐
Nurse ☐ Police ☐ Other ☐
Family member ☐ Other law enforcement ☐ *specify other :* .....
Friend ☐

DETAILS OF CHILD

NAME OF CHILD ..... AGE OR DATE OF BIRTH .....
SEX Male ☐ Female ☐ TEL. NO. ..... SCHOOL .....
HOME ADDRESS ..... POSTAL CODE .....

DETAILS OF ALLEGED ABUSER (if known)

Name ..... Address ..... Age .....
RELATIONSHIP TO CHILD Parent ☐ Known person ☐ Family member ☐ Stranger ☐ Unknown ☐
GUILTY OF PREVIOUS ABUSE Conviction obtained Yes ☐ No ☐ Suspected ☐ Unknown ☐

TYPE OF ABUSE / NEGLECT (fill in one or more)	Low suspicion	High suspicion	Confirmed abuse	REASON FOR SUSPICION
PHYSICAL				**Complication** Death ☐ Disability ☐ Other ☐ Specify other .....
SEXUAL				**Complication** STD ☐ Other ☐ Specify other .....
NEGLECT				**Type of neglect** Emotional ☐ ; Malnutrition by intent ☐ Educational ☐ Lack of supervision ☐ Withholding medical care ☐ Abandonment ☐
OTHER				Specify other .....

POLICE INVESTIGATION Yes ☐ No ☐ Requested ☐ Case number ..... Police station ..... Contact person .....

ACTION TAKEN (fill in one or more)

Private removal ☐ Child Care Act Removal ☐ Medical intervention ☐ Referred to welfare agency ☐ None ☐ Unknown ☐

CONTACT PERSON TRUSTED BY CHILD Name ..... Relationship .....
Address ..... Tel. no. .....

OUTCOME OF PRESENT INVESTIGATION .....
LEGAL OUTCOME .....

PREVIOUS HISTORY OF ABUSE (fill in one or more)

No ☐ Suspected ☐ Proven ☐ Unknown ☐
Known to hospital/clinic Yes ☐ No ☐ Hosp./clinic folder no. ..... Name of hosp./clinic .....

ALLEGED PREVIOUS ABUSE : •Address ..... (nursery school, neighbourhood etc.)
•Date ..... •Type (physical etc.) .....

Chapter 6: Results

The analysis of the reports of child abuse to the reporting centre from October 1993 to March 1995 form the basis of the results. The data that evolve out of the study provide an overview of reported child abuse in greater Cape Town. The validity of the results is dependent on the accuracy of the reports and the compliance with the reporting requirements of mandated reporters.

In this chapter some of the research questions posed in Chapter 5 will be addressed.

- *What is the overall picture of child protection in Cape Town?*
- *What are the characteristics of the children abused, in particular, the differences between male and female children?*
- *Is there any uniform profile of the alleged perpetrator?*
- *What is the geographical distribution of child abuse?*
- *What action is taken by child protection agencies?*

In Chapter 7, rates of child abuse and neglect and risk factors for child abuse will be discussed. The results will be compared data from the literature and specific findings will be considered in further detail.

The term "child abuse and neglect" is used in terms of the limited definitions given in the previous chapter, and represent a few of the of potentially harmful behaviours towards children.

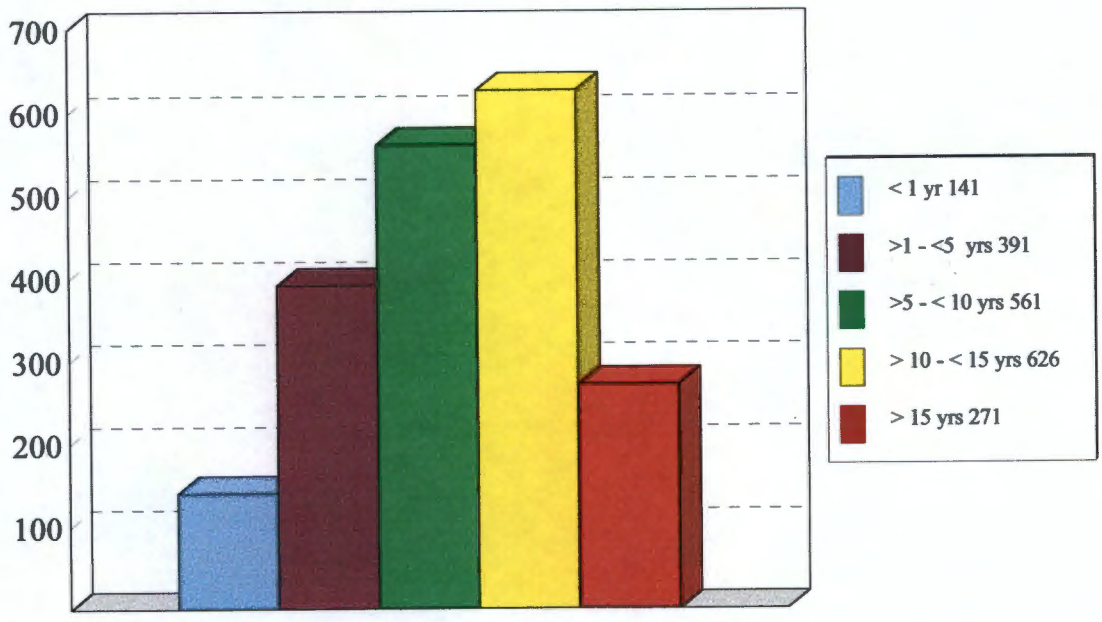
An overview of reported child abuse in Cape Town

The study was conducted from October 1993 until March 1995. For the period of study 2077 children aged under 18 years of age, living in greater Cape Town, are reported to the child abuse reporting centre. The average number of children reported per month is 115.

The children who are abused

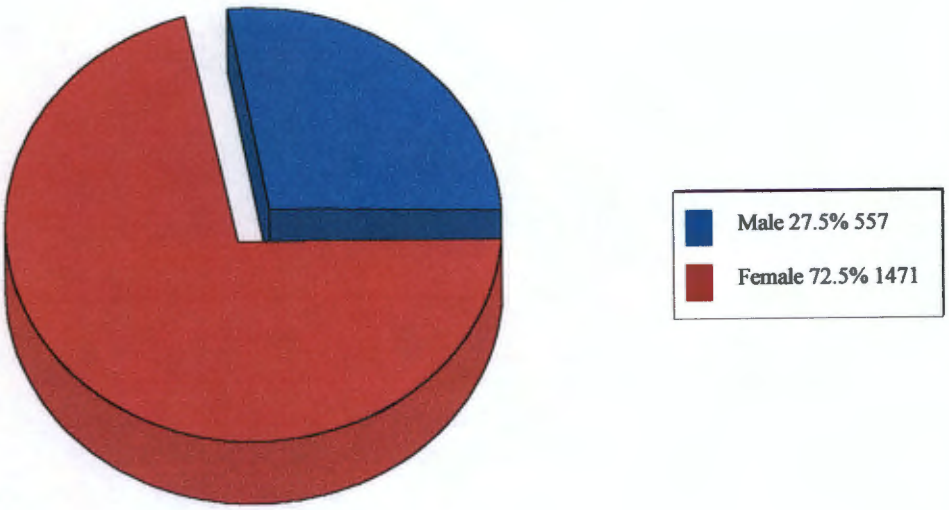
The age range of the children reported is shown in Figure 6.1. There is a fairly equal distribution in the middle age ranges.

Figure 6.1 Age of children



Female children outnumber the male children quite substantially as indicated in Figure 6.2

Figure 6.2 Gender of the children

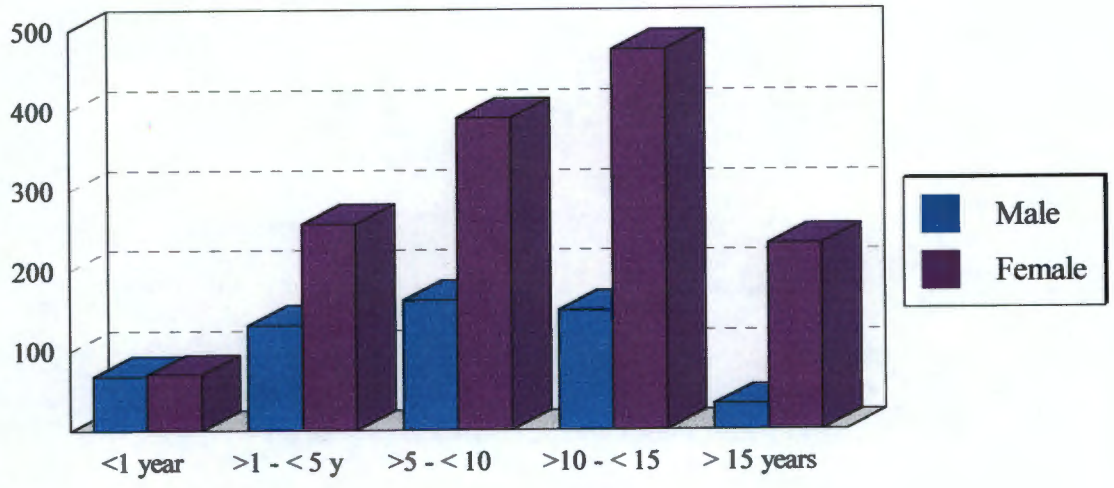


Age and gender of the children have an influence on the presentation of abuse as indicated in Table 6.1 and Figure 6.3.

Table 6.1 Child gender by child age

Column % shown	<1 year	>1 - < 5 years	>5 - < 10 years	>10 - < 15 years	>15 years	Row Total
Male	68 49.0%	131 33.6%	162 29.3%	149 31.7%	32 13.8%	542 27.5%
Female	70 51.0%	258 66.4%	390 70.7%	475 68.3%	232 86.2%	1425 62.5%
Total	**138**	**389**	**552**	**624**	**264**	**1967**

Figure 6.3 Child gender by child age



There is a significant variation in the distribution of children according to age and gender with an excess of young males and older females, and fewer older males and younger females than expected (p>0,00001). This is related to the age distribution of the type of abuse for males and females (see Table 6.15).

Pattern of reporting

The monthly pattern of reporting is not uniform as indicated in Figure 6.4.

Figure 6.4 Quarterly pattern of reporting to the reporting centre

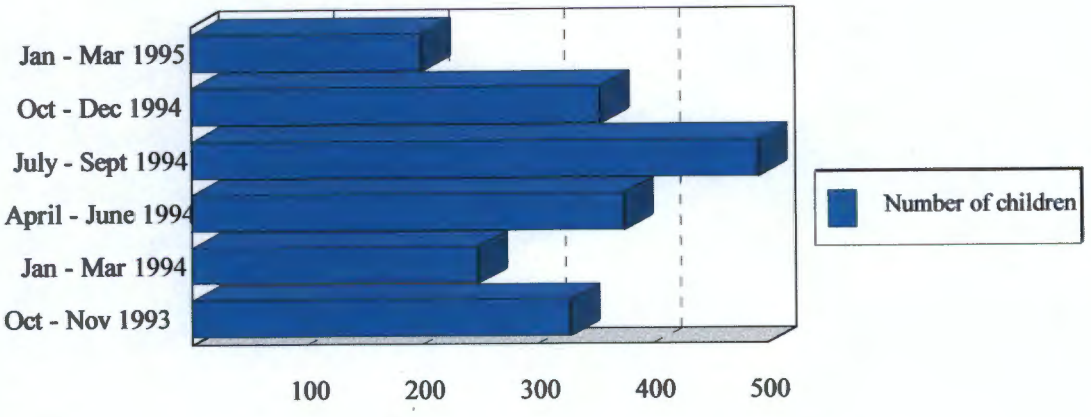


Table 6.2 indicates, the reason for reporting is mainly for "statistical purposes only". This may imply that children had their needs met, though the level of intervention by the different reporting agencies is not necessarily equal.

Table 6.2 Reason for reporting

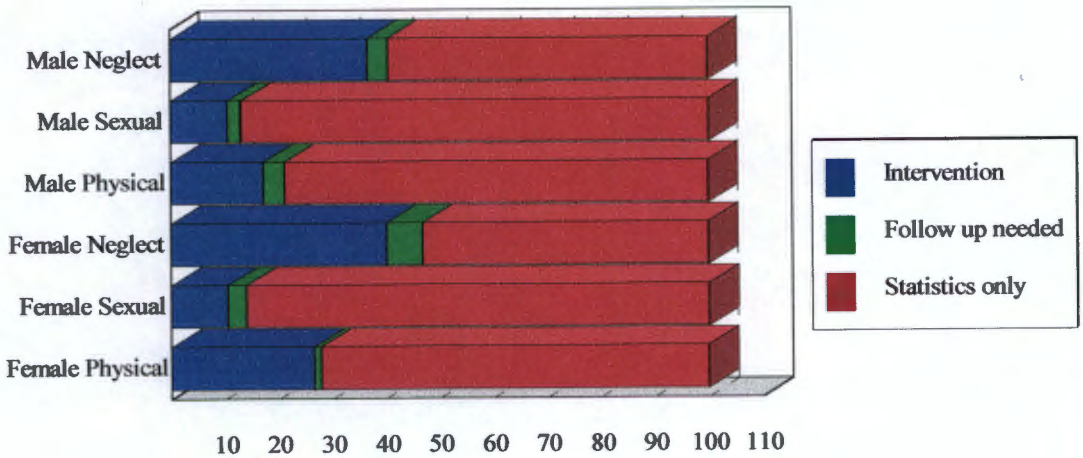
Reason	Frequency	%	Cumulative %
Intervention required	368	17.8	17.8
Long term Follow-up	74	3.6	21.3
Statistics only	1630	78.7	100. 0
Total	**2072**	**100**	missing = 5

The above pattern of reporting does not imply that every child has received long term follow up, or more than short term intervention, and is a reflection of the practice of the agencies that refer the children, and the level of intervention provided by these agencies. There is no real difference for reporting to the reporting centre if one considers gender of the child (Table 6.3), though there are differences between the different types of abuse.

Table 6.3 Comparison of reporting pattern by gender

	Female			Male		
	Physical	**Sexual**	**Neglect**	**Physical**	**Sexual**	**Neglect**
Intervention	56 6.5%	110 10.5%	77 40.1%	34 17.2%	18 10.7%	66 36.6%
Follow up needed	3 1.5%	37 3.5%	13 6.8%	8 4.0%	4 2.5%	7 4.0%
Statistics only	152 72.0%	901 86.0%	102 53.1%	156 78.8%	146 86.9%	107 9.4%
Total	**211**	**1048**	**192**	**198**	**168**	**180**

Figure 6.5 Reporting patterns - male and female



Children who were neglected generate more requests for further intervention than children with the other forms of abuse, probably because management of neglect is perceived to be a long term commitment.

An initial concern about the reporting mechanism was that it would not cope with the number of children requiring further management. This does not occur to any degree, and all those reports requesting further action were referred to the appropriate Welfare Agency or State department.

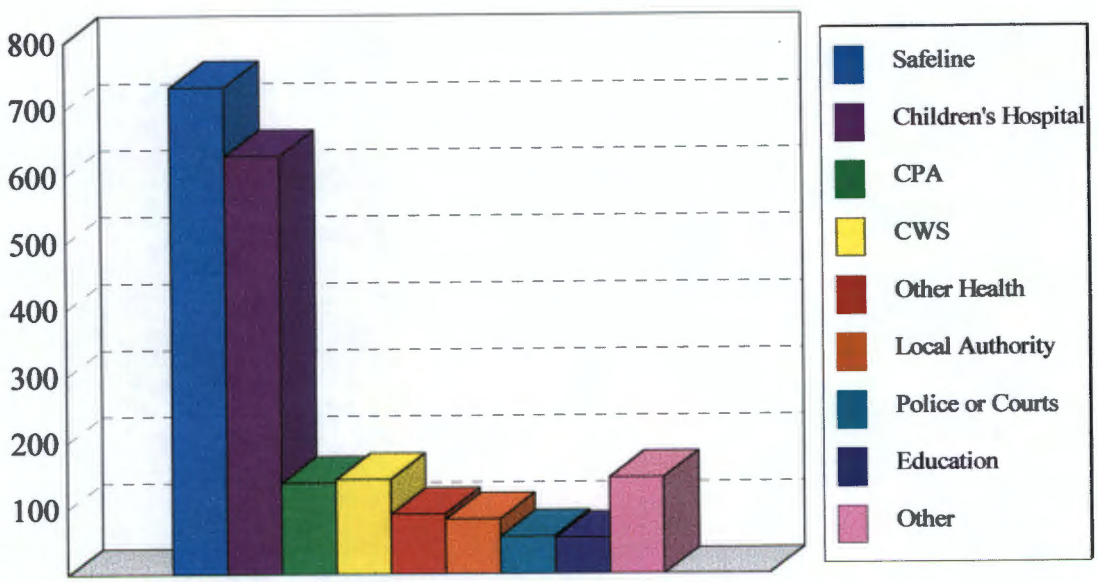
Reporting Agencies

All members of the Child Abuse Liaison Forum of the Western Cape were requested to report all cases of child abuse to the reporting centre. As indicated in Table 6.4, almost 80% of the children are reported by the four main agencies.

Table 6.4 Reporting agencies

Agency	Number	%	Cumulative %
SAFELINE - NGO	733	35 .3	35.3
Children's Hospital	629	30 .3	65.6
CPA Community Services	139	6 .7	72.3
Child Welfare Society (CWS)	144	6 .9	79.2
Other Health Agencies	91	4 .4	83.6
Local Authority Clinics (LA)	84	4 .0	87.6
Police or Courts	57	2.7	90.3
Education or School	54	2.6	92.9
Other	146	7.1	**100 .0**
Total	**2077**	**100 .0**	

Figure 6.6 Reporting agencies



Two agencies, one a non-governmental agency specialising in child abuse and the other the major health facility dealing with child abuse, account for two thirds of all reports. It is possible that only these two agencies complied with the reporting process.

SAFELINE, a non-governmental organisation, provides a package of child abuse prevention and management. The major focus at SAFELINE is on child sexual abuse, although all forms of child abuse are seen. The Red Cross War Memorial Children Hospital (referred to as The Children Hospital) is the major hospital for children in greater Cape Town, and has a well established child protection team, (Argent et al., 1995). Many children are referred to the hospital by other agencies. The Cape Provincial Administration (CPA) refers to the former welfare agency of the provincial administration, in addition to some community nurses. The Child Welfare Society (CWS) is a semi-private agency, and one of the larger welfare agencies. The number of children reported by this agency appears to be lower than expected. The other agencies were all party to the initial negotiations regarding the design of the reporting mechanism (Chapter 5). The Police were involved in the planning process, and were aware of the need to report. Despite the large number of children seen by the police (Argent et al., 1995), few children are reported by the police. All the reports categorised as "legal" are from the Social Worker at the Magistrates Court, i.e. children who had reached the specialised child abuse courts.

Reporters of child abuse

The *Child Care Act* specifies dentists, doctors, nurses and social workers to be mandated reporters of child abuse. In Table 6.5 the reporting patterns of mandated and potential reporters is given.

Table 6.5 Reporters of child abuse

Reporter	Number	%	Cumulative %
Dentist	0	0	0
Doctor	38	1.8	1.8
Nurse	105	5.1	6.9
Social Worker	1594	76.9	88.6
Family friend	103	5 .0	88.8
Legal: police & courts	60	2.9	91.7
Teacher	23	1.1	92.8
Psychologist	3	0.1	93 .0
Other	57	2.8	95.7
Not specified	94	4.3	100 .0
Total	**2077**	**100**	

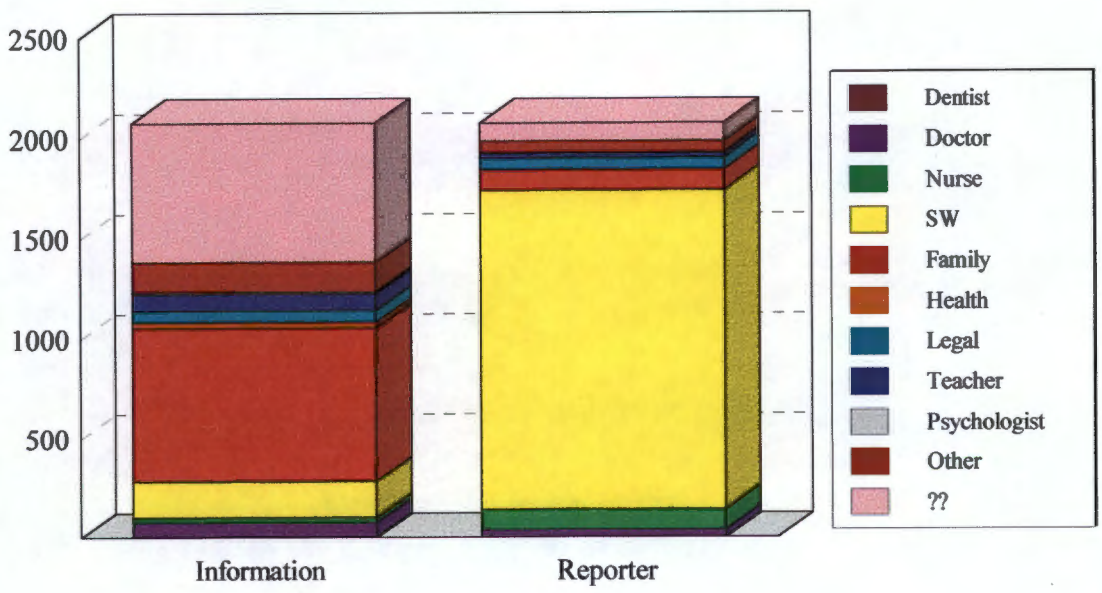
(Mandated reporters in *italics*)

As noted in previous chapters, this provision for mandated reporting in the Child Care Act has generally been ignored. The reporting system allows for other potential reporters to use it, though it was not widely advertised. The data in Table 6.5 emphasises the failure on the part of the police to report cases of child abuse, despite the existence of an over-worked Child Abuse Unit. The reports are made by the court social worker. Teachers do not use the reporting procedure to any degree, and psychologists, in keeping with the general perception that reporting may be a breech of their client relationship, do not report. An alternative approach to analysing this information is to examine the source of the information, given that one would expect social workers to provide the information, as indicated in Table 6.6.

Table 6.6 **Information source for reporting of child abuse** (Mandated reporters in *italics*)

Information source	Number	%	Cumulative %
Dentist	4	0.2	0.2
Doctor	72	3.5	3.7
Nurse	26	1.3	5 .0
Social Worker	181	8.7	13.7
Family or friend	772	37.2	50.9
Health professional	29	1.4	52.3
Legal: police & courts	61	2.9	55.2
Teacher	82	4 .0	59.2
Psychologist	11	0.5	59.7
Other	147	7.1	66.8
Not specified	686	33.1	100 .0
Total	**2071**	**100 .0**	

Figure 6.7 **Reporters of child abuse and providers of information**



As expected, there is a difference in reporting patterns and the provision of information to initiate the report. Social workers are the major reporters, family members are the major providers of information. Teachers remain low providers of information or reports.

Information on Alleged Abusers

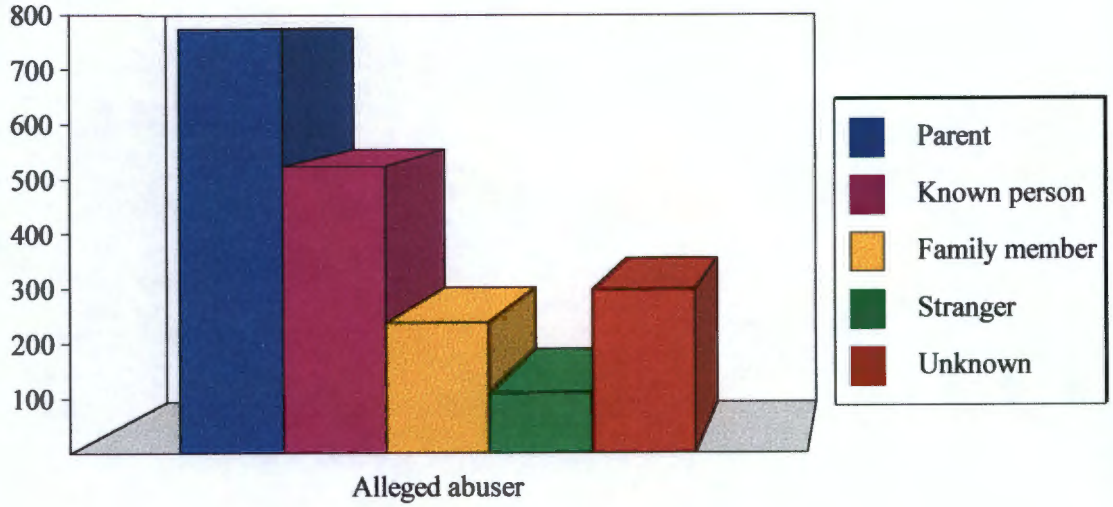
Reporters were requested to provide information on alleged abusers, should this information be available. Details on alleged abusers are not usually available or reliable, and this section of the study has the least detail to it. Reporters provide information on the relationship of the abuser to the child in most cases (Table 6.7), and supplement this with further detail in a third of all reports.

Table 6.7 Alleged abuser

Alleged abuser	Frequency	%	Cumulative %
Parent	773	39.8	39.8
Known person	523	26.9	66.7
Family member	238	12.3	79 .0
Stranger	110	5.7	84.7
Unknown	298	15.3	100 .0
Total	**1942**	**100 .0**	

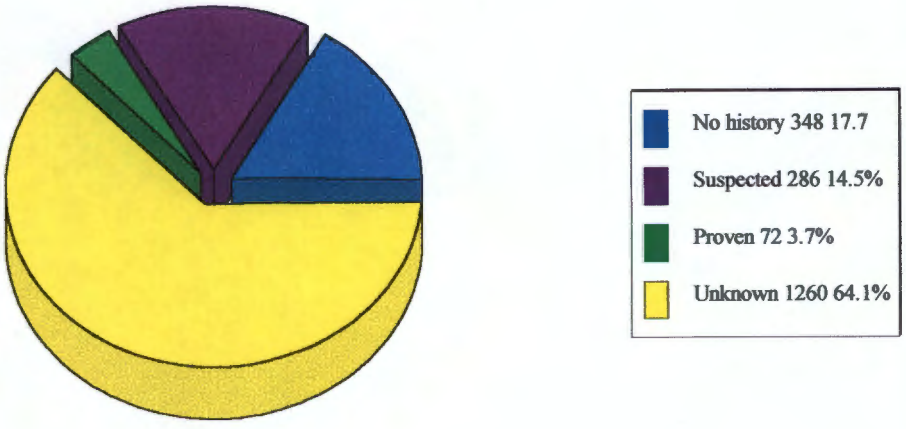
Missing = 13

Figure 6.8 Alleged abuser



The data in the above table and figure indicate that in Cape Town child abuse is part of the spectrum of family violence in almost four fifths of all reported abuse, and higher if the unknown category is excluded. This refutes the emphasis on the "stranger danger "concept of child abuse as postulated in many prevention programmes. Half of those alleged abusers for whom details are available have a previous history of abuse, either confirmed or suspected.

Figure 6.9 Previous history of abuse by alleged abusers



Type of abuse reported

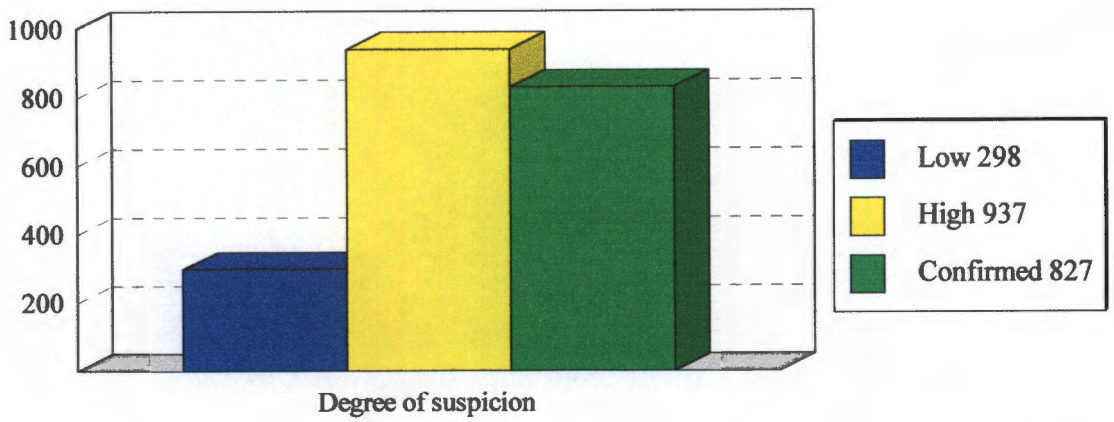
Reporters were requested to assess the degree of certainty of the abuse having occurred. This was a means of self-validation, hoping to provide the reporting system with a degree of reliability. In addition it could allow the reporting centre staff to assess whether or not intervention was required. The majority of children reported are in the high degree and confirmed categories.

Table 6.8 Degree of suspicion of reported abuse

Degree of suspicion	Frequency	%	Cumulative %
Low	298	14.5	14.5
High	937	45.4	59.9
Confirmed	827	40.1	100
Total	**2062**	**100 .0**	

missing = 15

Figure 6.10 Degree of suspicion of reported abuse



A minority of reported children are in the category of low suspicion and this indicates that most reports are of reasonable certainty, as defined in Chapter 5. This may imply that the

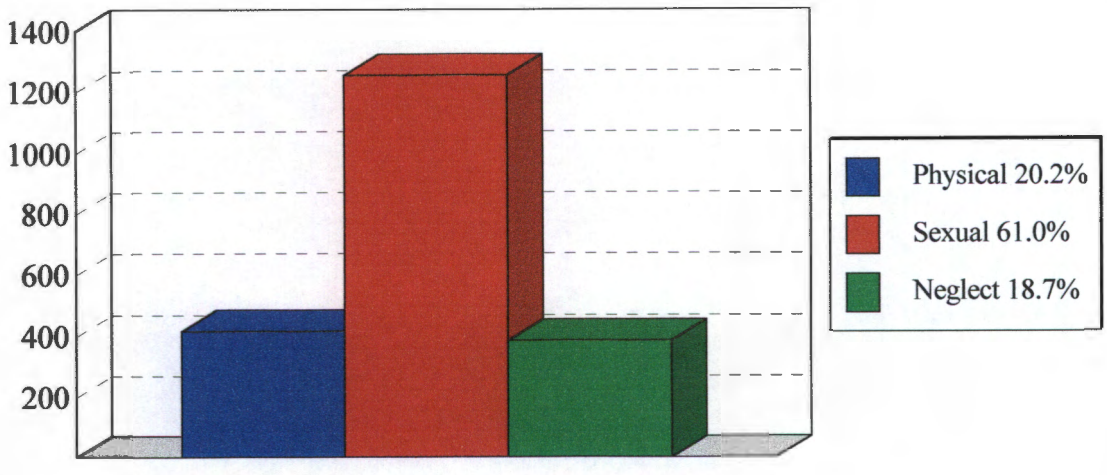
reporters do not report children if the degree of suspicion is low, although the *Child Care Act* stipulates that any degree of suspicion requires a report. The reporters are mainly social workers experienced in risk assessment who would be able to assess the level of certainty. The types of abuse reported indicates that child sexual abuse is the predominant reported child abuse in the Cape Town area.

Table 6.9 Type of reported abuse

Type	Frequency	%	Cumulative %
Physical	415	20.2	20.2
Sexual	1251	61 .0	81.3
Neglect	384	18.7	100 .0
Total	**2050**	**100 .0**	

missing = 20

Figure 6.11 Type of reported abuse

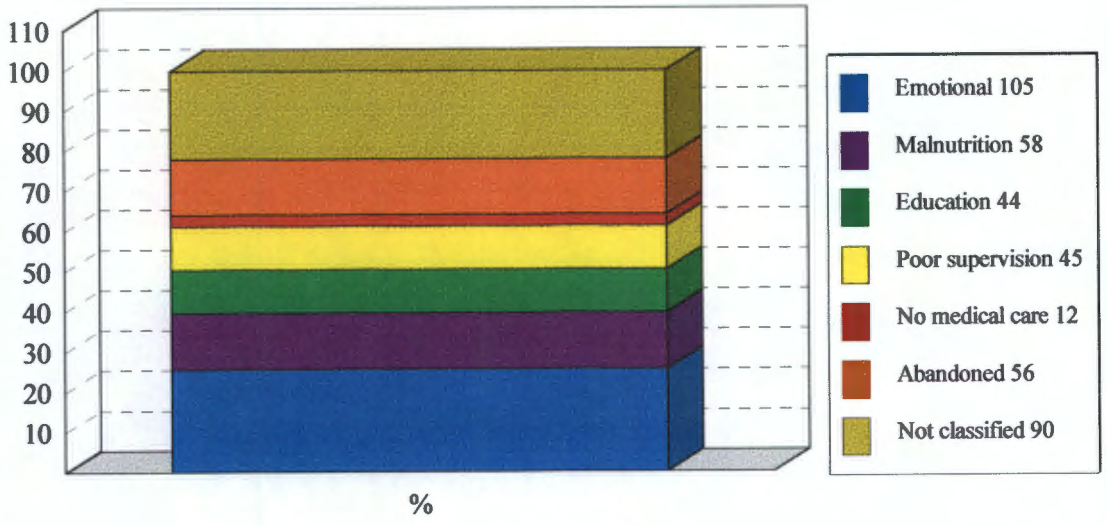


As will be discussed in Chapter 7, these results indicate a high level of sexual abuse as opposed to physical abuse. This result is of importance for developing a response to child

abuse both in terms of management and prevention. Neglect is reported in 18.7% of cases, and is divided into six categories, as indicated in Figure 6.12. The reporting of neglect is often rather low in the literature as definitions of neglect may be subjective, and the assessment is more difficult than that for physical abuse.

The *Child Care Act* calls for reporting of malnutrition as a form of neglect, viz. this is interpreted as the deliberate withholding of food. The number of children reported in this instance does not reflect the level of malnutrition in the region. An area of concern is the number of abandoned children. This is lower than reported elsewhere (SASPCAN, 1992), and can hinge on definitions of abandonment.

Figure 6.12 Type of neglect[14]



14 The number given is more than that in Table 6.9 as neglect is occasionally reported with other forms of abuse.

Complications of child abuse

Complications of child abuse, where known, are reported by the reporters. In an incidence study it is difficult to record long term complications, and an underestimation of the number of complications recorded is to be expected. The complications of physical abuse are either childhood fatality or disability, and may provide an insight into some of the long term problems of physical abuse. There are 93 reported complications, though these usually are short-term incapacity due to the injury. Long term complications are not reported, nor are childhood fatalities.

Figure 6.13 Complications of physical abuse

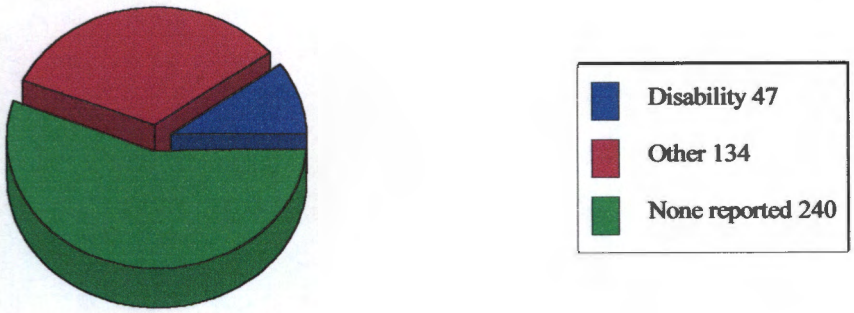
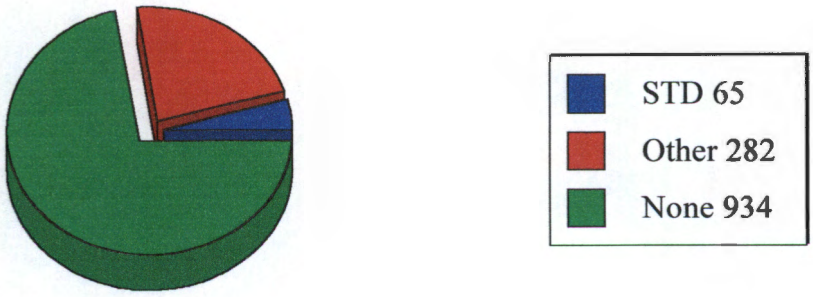


Figure 6.14 Complications of child sexual abuse



It is not surprising that there are no reported childhood fatalities secondary to child abuse, as reported child physical abuse is low, and fatality secondary to child abuse is usually under recognised. Very few complications of child sexual abuse are reported. Long term psychological complications cannot be detected in this type of study. The failure to report complications could be the result of the design of the reporting form which could only pick up complications where these are the presenting problem. Long term complications of child sexual abuse are not detected.

Intervention offered to abused children

Intervention is considered on two levels, viz. referral to the police for further investigation, and action taken by the reporter.

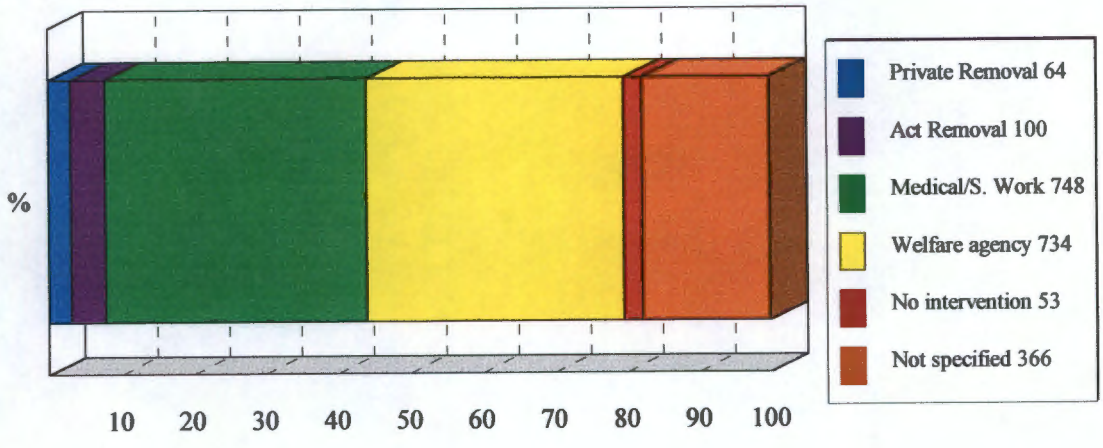
Table 6.10 Police involvement

	Investigation conducted		Assistance Requested	
	Frequency	**%**	**Frequency**	**%**
Unknown	343	16.5	1785	85.9
No	939	45.2	57	2.7
Yes	795	38.3	235	11.3
Total	**2077**	**100 .0**	2077	**100. 0**

Less than 40 % of reported child abuse is referred to the police for investigation. The outcome of the police investigations is not reported in the majority of cases, and is not known unless an investigation of police records is made. The action taken by the reporting agency is mainly social work intervention, with medical examinations forming part of all those children

reported by health agencies. Very few children are subject to formal care proceedings, most remain at home after the abuse in the care of a responsible adult entrusted with ensuring their safety as indicated in Figure 6.15.

Figure 6.15 Action taken by reporting agency



The medical care social work intervention affects the process at the Children's Hospital, where all children are seen by both doctor and social worker as part of a multi-disciplinary team approach. The reporting form allowed for the most important intervention to be recorded as some children may have had additional interventions not recorded. The welfare agency intervention included the work conducted by SAFELINE, Child Welfare Society and CPA.

Characteristics of the abused children

The reporting of child abuse indicates that more females than males are reported for child abuse. In this section the results will be discussed with age and gender being the controlling variables. Based on the literature review, one would expect that younger children are more at risk than older children for abuse, and that females have a greater chance than males of experiencing child sexual abuse.

More females than males are reported for child abuse to the authorities as indicated in Table 6.11.

Table 6.11 Reason for report and gender of the child

column % shown	Physical abuse Female	Physical abuse Female	Sexual abuse Male	Sexual abuse Female	Neglect Male	Neglect Female
Intervention requested	34 17.0%	56 26.5%	18 11.0%	110 10.5%	66 36.7%	77 40.0%
Follow-up requested	8 4.0%	3 1.5%	4 2.4%	37 3.5%	7 3.9%	13 7.0%
Statistics only	156 78.8%	152 72.2%	146 86.9%	901 86.0%	107 59.4%	102 53.0%
Column total	**198**	**211**	**168**	**1048**	**180**	**192**

On further analysis of the data presented in Table 6.11, it is evident that gender does not influence the decision to report to the reporting centre in either physical abuse, child sexual abuse or neglect. Gender and age did not influence the reason for reporting of abuse except in the case of child sexual abuse in females, which constitutes the largest number of reported child abuse. As shown in Table 6.12, the reason for reporting abuse in females who are sexually abused differs significantly ($p < 0.00048$).

Table 6.12 Reason for reporting female child sexual abuse

column % shown	0 - < 5 years	>5 - < 10 years	>10 - < 15 years	>15 years	Row Total
Intervention requested	5 3.0%	21 5.6%	50 13.5%	24 12.6%	100 9.8%
Follow-up	2 1.0%	8 2.8%	18 4.9%	8 4.2%	36 3.5%
Statistics only	161 96.0%	259 89.9%	303 81.7%	158 83.2%	881 86.7%
Column total	**168**	**288**	**371**	**190**	**1017**

In the younger and older children intervention is not requested as it may have occurred already. For example, reports from the social worker in the court are for statistical reasons only as the intervention was completed, and the children are older. In the case of the younger children intervention probably is completed by the referring agency. The middle age range of children significantly required intervention more frequently than all other forms of abuse.

Influence of Age on child abuse

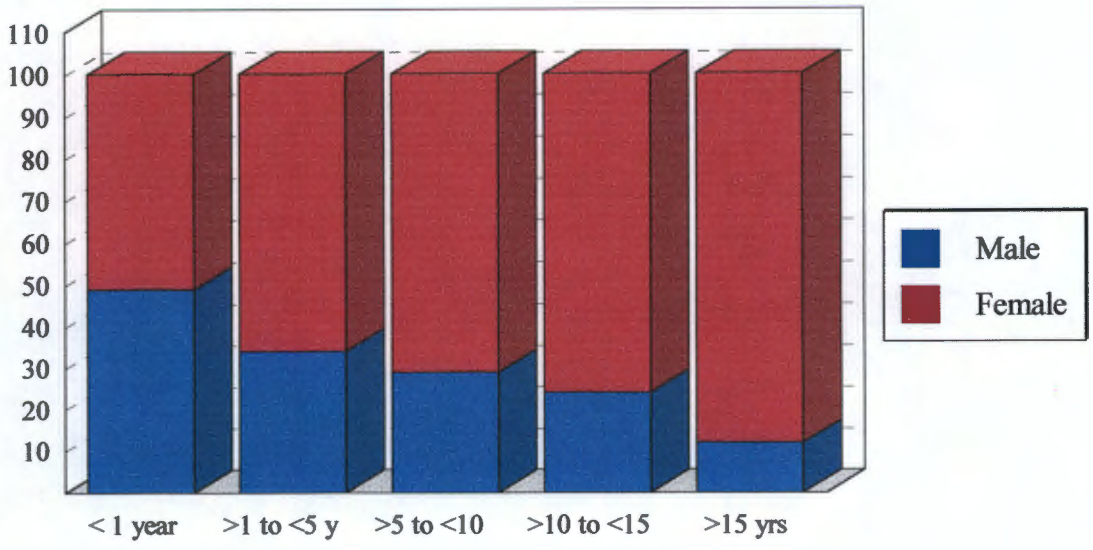
With increasing age the number of females reported increases as indicated in Table 6.13 and Figure 6.16. This is accompanied by an increase in reported child sexual abuse, and a decrease in the reporting of physical abuse and neglect.

Table 6.13 Relationship of age to gender of the child

Gender	< 1 year	>1 to <5 years	>5 to <10 years	>10 to <15 years	>15 years
Male	68 49.0%	131 34.0%	162 29.0%	149 24.0%	32 12.0%
Female	71 51.0%	258 66.0%	389 71.0%	475 76.0%	232 88.0%
Total	**139**	**389**	**551**	**624**	**264**

Missing106

Figure 6.16 Relationship of age to gender of the child



The decreasing proportion of males with increasing age in the reported sample is statistically significant ($p<0.00001$). In Table 6.14, the increasing amount of sexual abuse is evident as the children become older. This could be a real trend, a decline in the reporting of physical abuse, as it may be more acceptable to hit older children, or older children are physically abused less than younger children.

The trend is for neglect to decrease with age, and child sexual abuse to increase with age. If gender is considered, the predominance of sexual abuse as a problem of females is apparent.

Table 6.14 Age and the type of abuse - all children

column % shown	**Physical abuse**	**Sexual abuse**	**Neglect**	**Total**
less than 1 year	53 37.8%	13 9.2%	75 53.0%	**141**
> 1 to <5 years	97 25.2%	176 46.0%	110 28.8%	**383**
> 5 to <10 years	90 16.7%	364 65.4 %	101 18.9%	**555**
> 10 to <15 years	126 20.3%	436 70.3%	58 9.3%	**620**
> 15 years	37 13.1%	214 80.4%	15 6.5%	**266**
Total	**403**	**1203**	**35**	**1965**

For all children there is an increase in the percent of sexual abuse as the children become older, with a decrease in the other forms of abuse.

Figure 6.17 Age and the type of abuse -all children

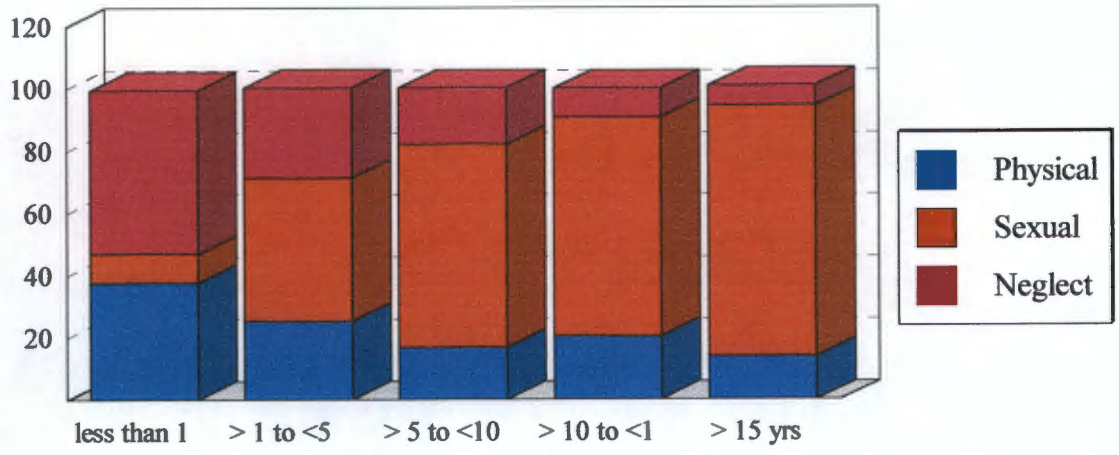
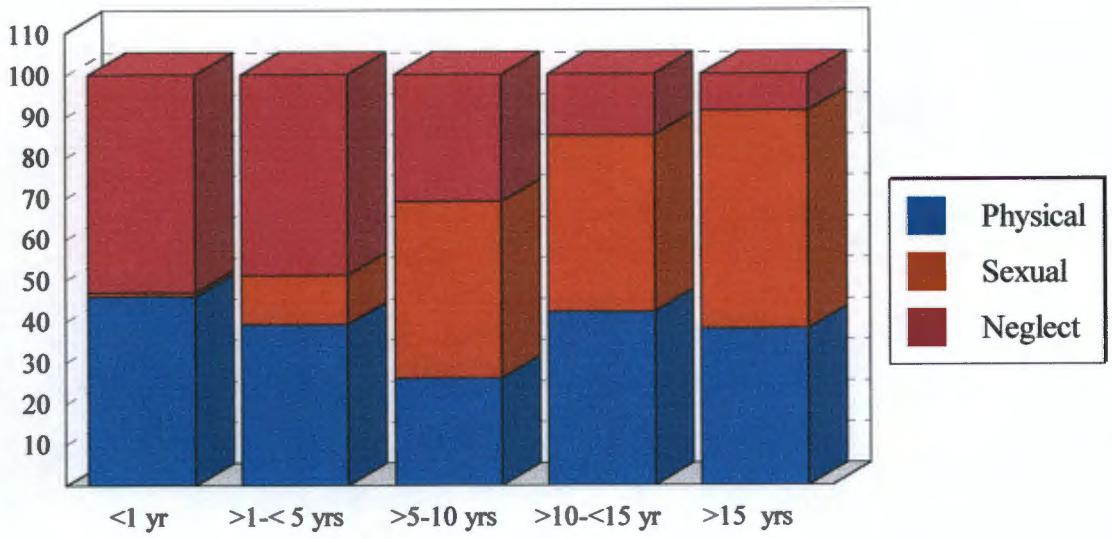


Table 6.15 Age and the type of abuse - males and females

column % shown	Physical abuse		Sexual abuse		Neglect	
	Male	Female	Male	Female	Male	Female
less than 1 year	31 18.9%	21 10.3%	1 0.6%	12 1.2%	36 20.7%	37 20.3%
> 1 - <5 years	49 29.9%	46 22.5%	15 9.1%	161 15.7%	63 36.2%	47 25.8%
> 5 - <10 years	41 25.0%	49 24.0%	68 41.5%	288 28.2%	50 28.8%	50 27.6%
> 10 - <15 years	12 7.3%	63 30.8%	63 38.4%	372 36.4%	22 12.6%	36 19.7%
> 15 years	31 18.9%	25 12.4%	17 10.4%	190 18.5%	3 1.7%	12 6.6%
Total	**164**	**204**	**164**	**1023**	**174**	**182**

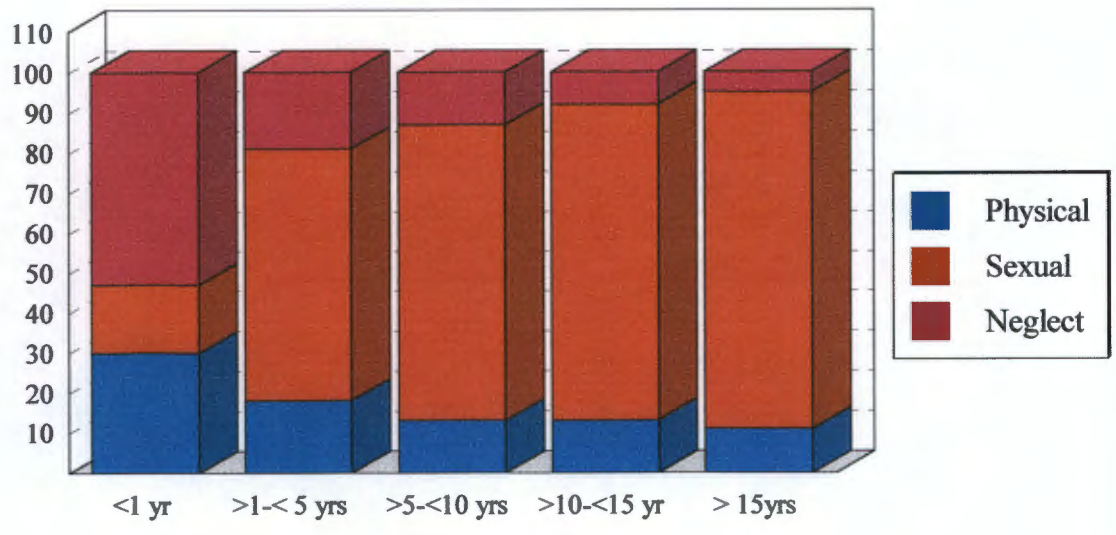
p< 0.00001

Figure 6.18 Age and the type of abuse - males



For males, neglect decreases with age, sexual abuse increases at a slower rate than that of females, and physical abuse is relatively stable.

Figure 6.19 Age and the type of abuse - females



For females, sexual abuse is always present and dominates as the age increases, neglect decreases significantly with age, physical abuse is relatively stable over the age ranges.

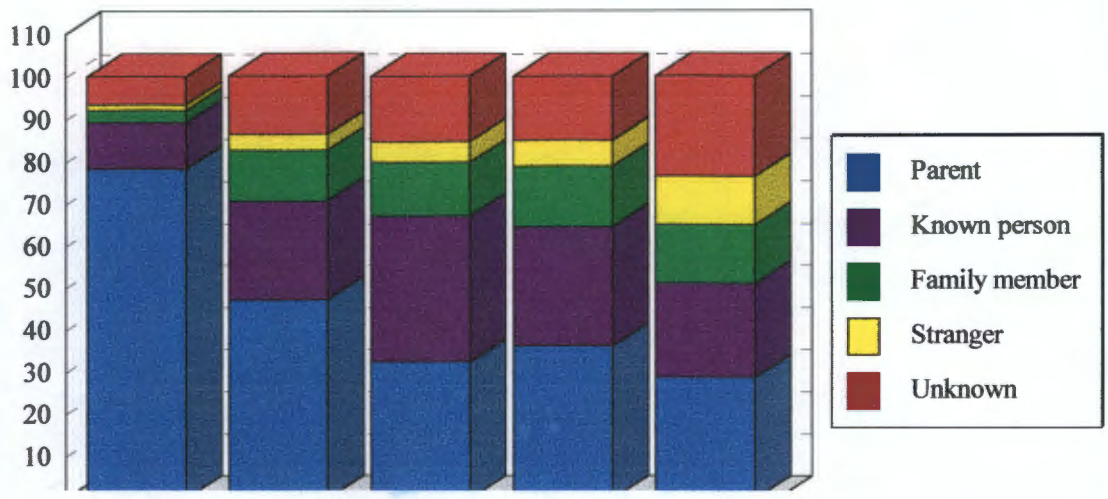
In Table 6.16 and Figure 6.20 the relationship between the age of the child and the abuser is shown.

Table 6. 16 Abuser and age of the child

column % shown	< 1 year	>1 to <5 years	>5 to <10 years	>10 to <15 years	> 15 years	Row Total
Parent	108 78.3%	174 47.3%	171 32.4%	212 36.2%	70 28.8%	**735**
Known person	15 10.9%	86 23.4%	183 34.7%	166 28.4%	54 22.2%	**504**
Family member	4 2.9%	44 12.0%	67 12.7%	83 14.2%	34 14.0%	**232**
Stranger	2 1.4%	14 3.8%	26 4.9%	36 6.2%	28 11.5%	**106**
Unknown	9 6.5%	50 13.6%	81 15.3%	88 15.0%	57 23.5%	**285**
Total	**138**	**368**	**528**	**585**	**243**	**1862**

missing = 215

Figure 6.20 Abuser and age of the child



This relationship is highly significant ($p<0.00001$), as would be expected with parents being the major abusers in the younger age groups. In the older age group strangers and unknown individuals are at higher levels than by random expectation. This may add credence to the belief that strangers are a threat to children. The main picture, however is that abuse occurs in the home, but as children leave home they are exposed to the risks of the prevailing violence in society.

Neglect

Neglect is a problem of the younger age group as indicated in Figure 6.21 and Table 6.16. Abandonment occurs in the younger age groups and the children under five are more prone to lack of supervision. Very few children are categorised under lack of medical provision.

Figure 6.21 Age and neglect

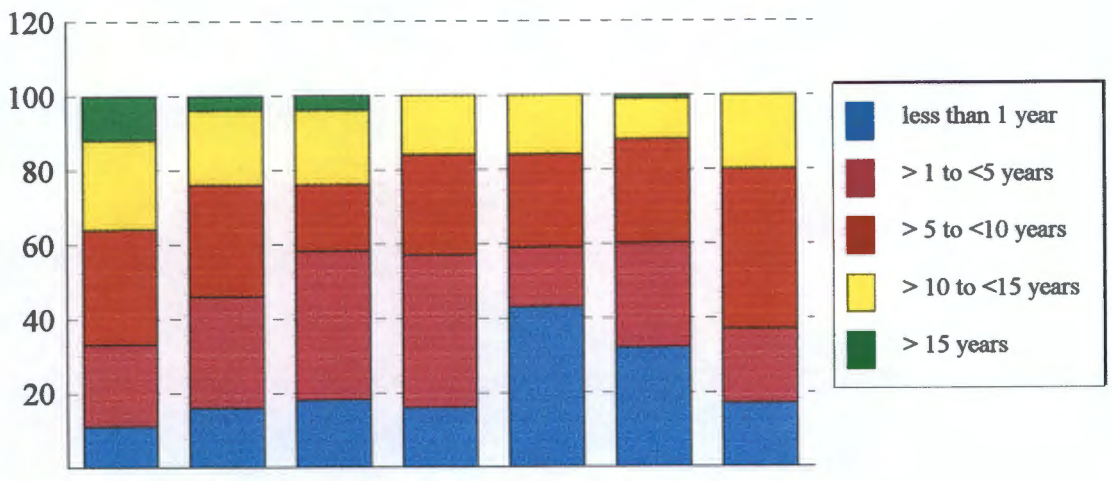


Table 6.17 **Age and Neglect**

	type of neglect						
column % shown	**emotional**	**malnutrition**	**education**	**poor supervision**	**lack of medical care**	**abandoned**	**not specified**
less than 1 year	10 10.6%	8 15.7%	7 17.5%	7 15.9%	5 41.8%	17 31.4%	15 17.4%
> 1 to <5 years	21 22.3%	15 29.4%	16 40.0%	18 40.9%	2 16.6%	15 27.8%	17 19.8%
> 5 to <10 years	29 30.8%	15 29.4%	7 17.5%	12 27.3%	3 25.0%	15 27.8%	32 19.8%
> 10 to <15 years	23 24.5%	11 21.6%	8 20.0%	7 15.9%	2 16.6%	6 11.1%	17 19.8%
> 15 years	11 11.8%	2 3.9%	2 5.0%	0 0%	0 0%	1 1.9%	5 5.8%
Total	**94**	**51**	**40**	**44**	**12**	**54**	**86**

As has been noted in Chapter 2, the study of neglect has been ignored in the literature. This is in part due to the difficulty in defining neglect. In this study neglect has been divided into six categories. This has resulted in low numbers being reported in some of the categories. In order to gain meaningful data, the categories of neglect are collapsed into three groups - emotional abuse, lack of general care (lack of supervision, educational, lack of medical care, other) and abandonment. The figures are still low and it is not possible to determine statistical significance between the different age groups, or between different types of neglect.

In Table 6.18 neglect is reported for males and females. The differences are not significant, though trends are elicited that may indicate a pattern of neglect in Cape Town.

Table 6.18 Age; gender and neglect: Males and Females

column % shown	< 1 yr		>1 to <5 yrs		>5 to <10 yrs		>10 - <15 yrs		>15 yrs	
	M	F	M	F	M	F	M	F	M	F
Emotional	2	7	11	10	16	13	10	7	4	10
	7.7%	25.9%	25.0%	23.3%	42.1%	31.0%	40%	40.6%	100%	58.3%
General care	13	14	26	25	16	20	13	15	0	4
	50%	51.9%	59.1%	58.1%	42.1%	47.6%	52.0%	46.9%	0%	33.3%
Abandonment	11	6	7	8	6	9	2	4	0	1
	42.3%	22.2%	15.9%	18.6%	15.8%	21.4%	8%	12.5%	0%	8.3%
Total	**26**	**27**	**44**	**43**	**38**	**42**	**25**	**32**	**4**	**12**

[1] general care refers to lack of supervision, lack of medical care, withholding education, and intentional malnutrition

The trend is for abandonment to be a problem of the younger age group, with gradual increase in emotional abuse as the child ages. There is minimal difference in the presentation between males and females - only in the upper age group. This trend is highlighted in Figures 6.22 and 6.23. Further research on neglect is required to obtain significant numbers that can be analysed meaningfully.

Figure 6.22 Age, gender and neglect: Males

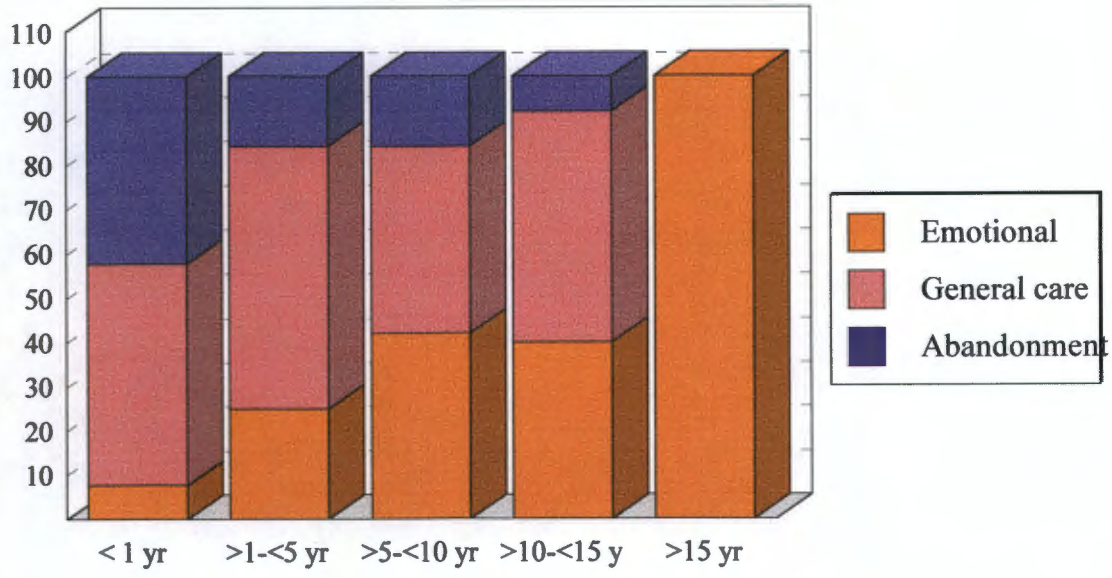
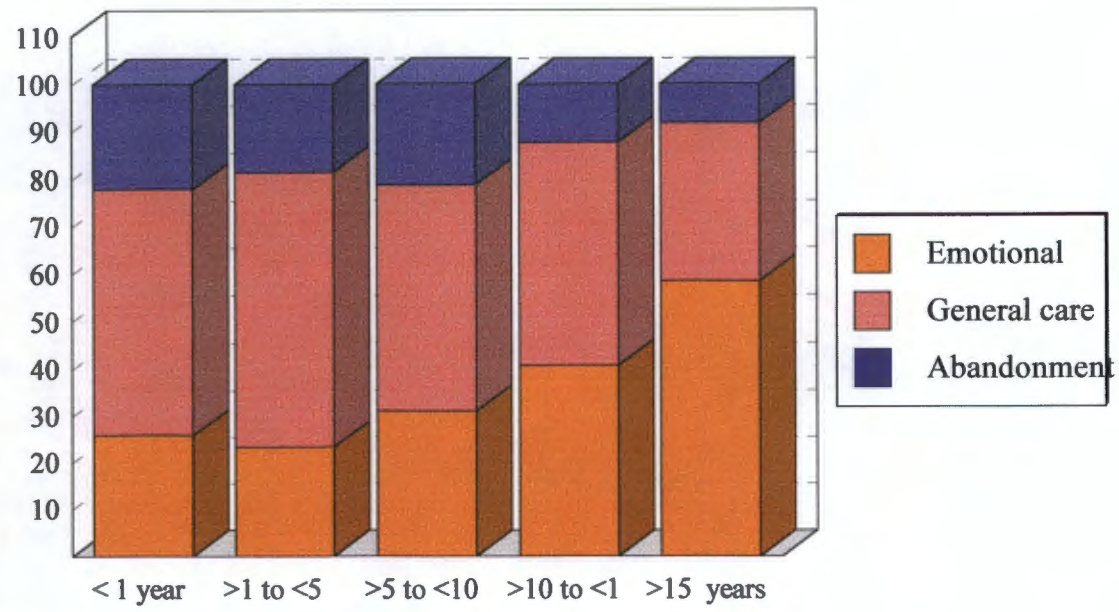


Figure 6.23 Age, gender and neglect: Females



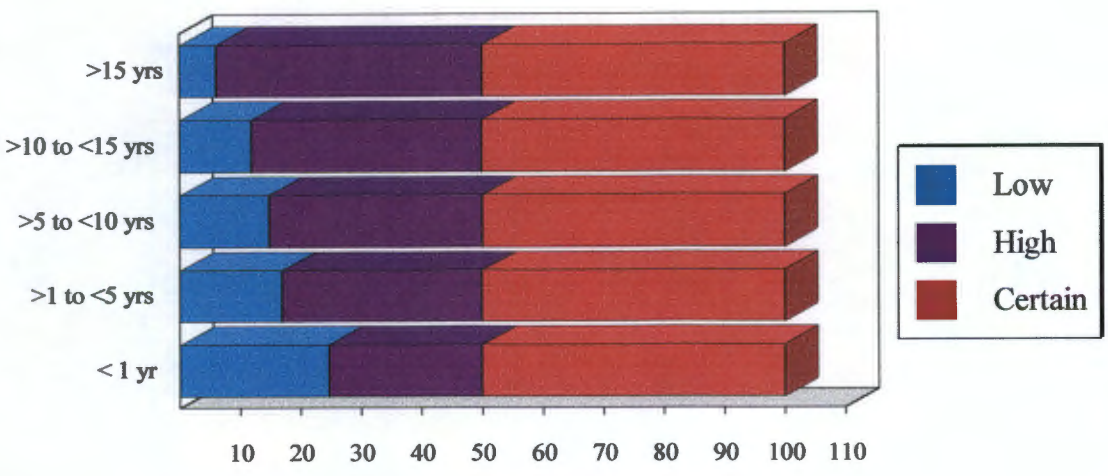
Degree of certainty and type of abuse

Age influenced the certainty of the report only in the "*low degree of suspicion*" category where, as is to be expected, the younger the child, the less likely an accurate history is obtained unless there are clear clinical signs of abuse. Degree of certainty is dependent on clear clinical signs of child abuse.

Table 6.19 Age and degree of suspicion of abuse - all children

Column % shown	< 1 yr	>1 to <5 yrs	>5 to <10 yrs	>10 to <15 yrs	>15 yrs
Low	68 24.6%	131 16.9%	162 14.7%	149 11.9%	32 6.0%
High	71 25.4%	258 33.1%	389 35.3%	475 38.1%	232 40.0%
Certain	139 50.0%	389 50.0%	551 50.0%	624 50.0%	264 50.0%

Figure 6.24 Age and degree of suspicion of abuse - all children



The analysis of the influence of age on the degree of suspicion indicates that there is no significant influence for physically abused males, numbers are too small to interpret for sexually abused and neglected males, and there is no significant influence for neglected females. Age does have a significant bearing ($p<0.00001$) on sexually abused females, with an excess of "high suspicion" for older girls, and a deficit for younger girls. The "*confirmed*" cases are less than one would expect by chance. This can be explained by the nature of the category of high suspicion. An example is a sexually transmitted disease (STD) which cannot be explained by a history, but which is suggestive of child sexual abuse. This could be categorised as high suspicion of child sexual abuse.

Table 6.20 Age and degree of suspicion of child sexual abuse - females

Degree of suspicion	< 1 year	>1 to <5 years	>5 to <10 years	>10 to <15 years	>15 years
Low	3 25.0%	22 13,8%	43 4.4%	43 3.8%	27 5.1%
High	1 8.3%	53 33.1%	389 39.6%	475 42.2%	232 44.3%
Certain	8 66.7%	85 53.1%	551 56.0%	624 55.5%	264 50.6%

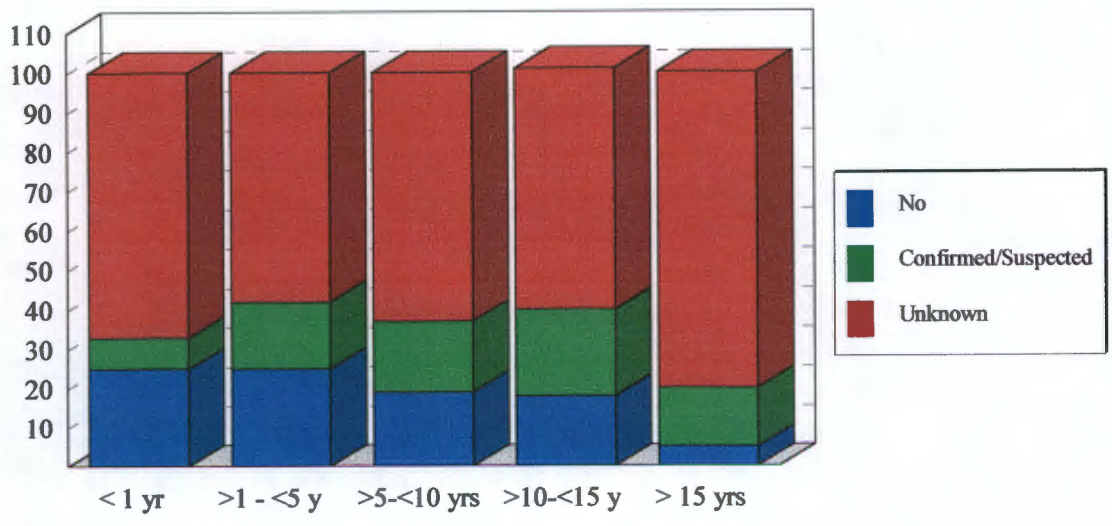
There is no relationship between history of previous abuse and gender, though in the age range 10 to 14 years there is an excess of children with a proven history of abuse ($p<0.00001$). As expected there are many younger children with no history of previous abuse. Conversely, the older the child, the more likely there is to be a history of previous child abuse as indicated in

Table 6.21. In a large proportion of the children the history of previous abuse is not known, or not reported at all.

Table 6.21 Age and previous abuse of child

column % shown	< 1 yr	>1 to <5 yrs	>5 to <10 yrs	>10 to <15 yrs	>15 yrs
No	34 24.6%	92 24.6%	101 19.1%	103 17.7%	13 5.0%
Confirmed or Suspected	12 8.7%	65 17.4%	94 17.8%	127 21.8%	39 15.1%
Unknown	92 66.7%	217 58.0%	334 63.1%	352 60.5%	207 79.9%
Total	**138**	**374**	**529**	**582**	**259**

Figure 6.25 Age and previous abuse of child



The large amount of unknown information makes the value of this result questionable, though the amount of unrecorded or unknown information indicates a potential problem in itself.

The reporting agencies and children referred

Agencies have varied clientele and expertise. SAFELINE concentrates on child sexual abuse, the Children's Hospital covers all types of abuse, but less neglect, and the Child Welfare Society concentrates on child sexual abuse and neglect. The different agencies therefore dealt with children of differing ages and gender as indicated in Table 6.22.

Table 6.22 Referral agency, age and gender

Agency	Mean age (yrs)		Male %	Female %	Total (number)
SAFELINE	10.8		22	78	700
RXH	6.2		26	74	621
CPA	12		7	93	137
CWS	7.1		44	56	142
Health	5.5		38	62	91
Local Authority	5.7		49	51	82
Legal	12		9	91	57
Education	9.3		31	69	54
Other	6.5		47	53	131
Overall Mean	**8.45**	**Total**	**38**	**72**	**2015**

Figure 6.26 Mean age of child as reported by different agencies

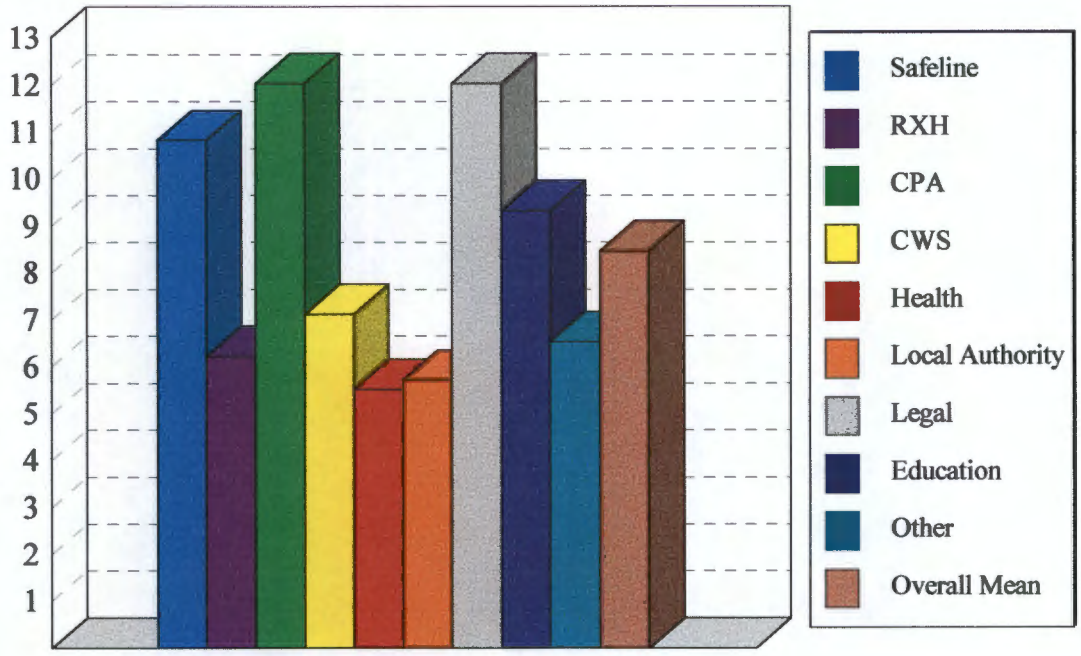
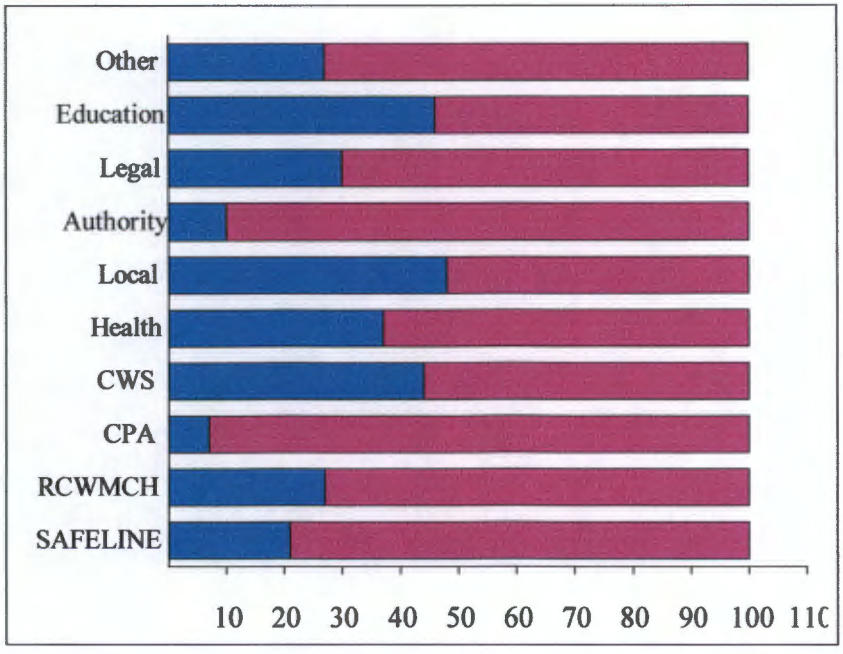


Figure 6.27 Differences in reporting of males and females by agency



The age range presenting to each agency is influenced by this practice. SAFELINE provides a service to older children than does the Children's Hospital and Child Welfare Society. The

major referral agencies do not have any differences in the gender profile. The referrals from the legal system are on the whole female, reflecting the type of focus of the legal system in child sexual abuse. Older children are notified by the courts, which reflects the practice that mainly older children reach travel the legal route. The agencies did not differ substantially if one considers the type of abuse and gender of the child reported, as indicated in Table 6.23.

Table 6.23 Agency, type of abuse reported, and gender of the child abuse

	Physical Abuse		Sexual Abuse		Neglect		Total	
	M	F	M	F	M	F	M	F
SAFELINE	33	62	100	445	18	31	151	538
Red Cross War Memorial Children Hospital	94	76	40	355	30	20	164	451
CPA	2	5	4	116	4	4	10	125
CWS	16	25	2	16	44	34	62	79
Health	14	10	0	22	19	4	33	56
Local Authority	14	11	6	3	19	16	39	40
Legal	2	0	0	41	3	10	5	52
Education	2	8	7	19	8	10	17	37
Other	18	14	9	21	33	35	60	70
Total	**195**	**211**	**168**	**1038**	**178**	**164**	**541**	**1448**

Most agencies had no showed no difference in gender served, though the CPA social workers and the court social worker mainly reported females (possibly indicating which cases go to trial).

The alleged perpetrator

As indicated earlier in the chapter, there is limited information on the abusers or alleged abusers of the children reported in the study. A reason for this is that until a conviction is obtained, the abuser remains the "alleged" abuser. In the majority of reported cases this is the case. Nonetheless, reporters provide information on the alleged abuser's relationship to the child and where possible the area where the abuser lived. On occasion, the name of the alleged abuser is given, as is the age. The age range of the abuser is not accurate as reporters often did not have this information. In the next three tables and figures, the relationship of abuser to the type of abuse committed is shown.

Table 6.24 Abuser and the type of abuse: all children

column % shown	Physical abuse	Sexual abuse	Neglect	Row Total
Parent	261 64.6%	195 16.9%	310 85.2%	**766**
Known person	73 18.1%	425 36.9%	17 4.7%	**515**
Family member	27 9.2%	188 16.3%	12 3.3%	**237**
Stranger	8 2.0%	98 8.5%	3 0.8%	**109**
Unknown	25 6.2%	245 21.3%	22 6.0%	**292**
Total	**404**	**1151**	**364**	**1919**

$p<0.00001$

Figure 6.28 Abuser type of abuse: all children

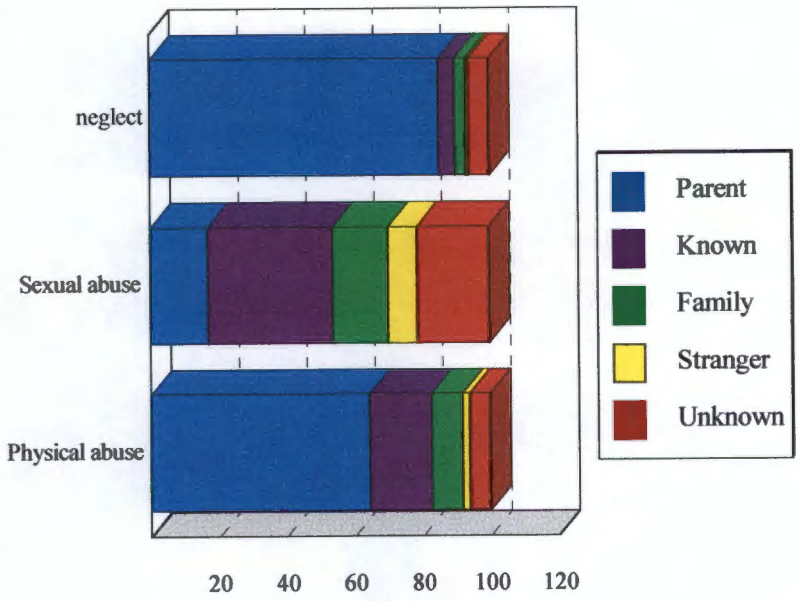


Table 6.25 Abuser and type of abuse: males and females

	Males			Females		
column % shown	**Physical abuse**	**Sexual abuse**	**Neglect**	**Physical abuse**	**Sexual abuse**	**Neglect**
Parent	128 66.0%	22 14.1%	153 86.9%	132 65.4%	172 17.8%	150 83.8%
Known person	38 19.6%	68 43.6%	5 2.8%	34 16.6%	341 35.4%	12 6.7%
Family member	3 5.7%	11 12.2%	19 5.1%	25 12.2%	164 17.0%	3 1.7%
Stranger	5 2.6%	23 14.7%	0 0%	2 0.9%	73 7.6%	3 1.7%
Unknown	12 6.2%	24 15.4%	9 5.1%	12 5.9%	214 22.2%	11 6.1%
Total	**194**	**156**	**176**	**205**	**964**	**179**

p>0.00001

Figure 6.29 Abuser and type of abuse: males

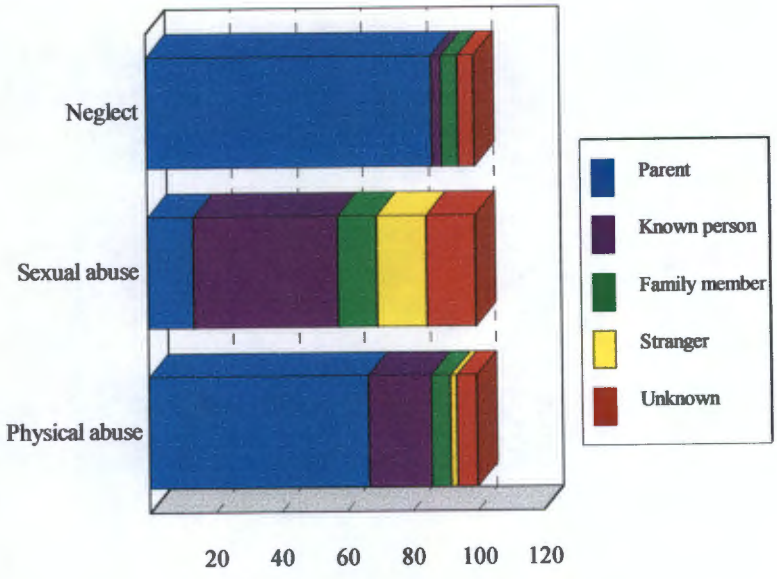
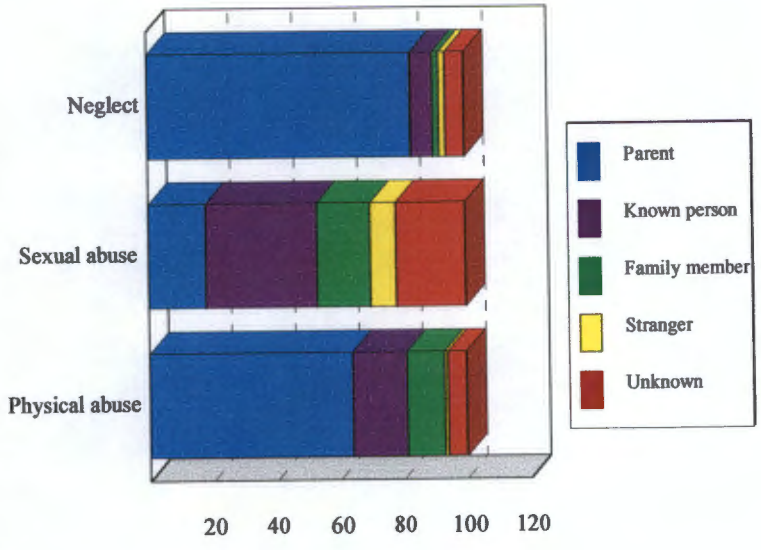


Figure 6.30 Abuser and type of abuse: females



The pattern is the same for males and females. There is a significant association between type of abuse and category of abuser ($p<0.00001$). Parents predominate in physical abuse and in neglect. With sexual abuse, abusers other than parents are present, and thus parents are

represented relatively less in this area. This is to be expected as extra-familial child sexual abuse is a problem.

In summary, the above two associations confirm that parents abuse children at a younger age, are more involved in physical abuse and neglect, and that children are prone to abuse from abusers out of the home once they reach the older age group. This could influence the type of programmes developed, targeted at parenting for younger children and safety skills for older children.

Geographical distribution of children

The ecological approach to child abuse relates the neighbourhood environment to risks of child abuse. It is postulated that stresses in society, such as poverty, are related to higher levels of child abuse (refer to chapter 2). In 85% of reports an accurate address of the child was provided. This can provide a child abuse profile of the city. The analysis of the residential areas of the children is made on three levels:

- the magisterial district, which is the broadest grouping of children and allows for comparison to the census in terms of age and gender;
- selected groupings of suburbs in the city collated according to proximity, and possible socio-economic similarities[15];
- the individual suburbs which allows for comparisons to be made to the census in terms of age, but not gender.

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[15] Lachman and Stander (1990) developed a similar classification of suburbs to assess referral patterns to the Children's Hospital. The suburb list has been developed from that used by Rip et al. (1986)

This approach is adopted in order to assess the influence of residential address on reporting patterns. In order to have any statistical significance, and to obtain meaningful rates, the suburbs are grouped into neighbourhoods that may, in some cases, be homogeneous, and in other cases not. Cape Town has areas with great heterogeneity in terms of class, poverty and race. The grouping is an attempt to provide an indicator for the development of possible intervention strategies.

The Table 6.26 and Figure 6.30, different reporting patterns in the magisterial districts are clearly indicated. The more central districts of Cape Town and Wynberg have higher levels of reporting than the more outlying districts such as Kuils River[16] and Simonstown. This does not imply that levels of actual abuse are lower in the areas with low numbers of reported child abuse and neglect.

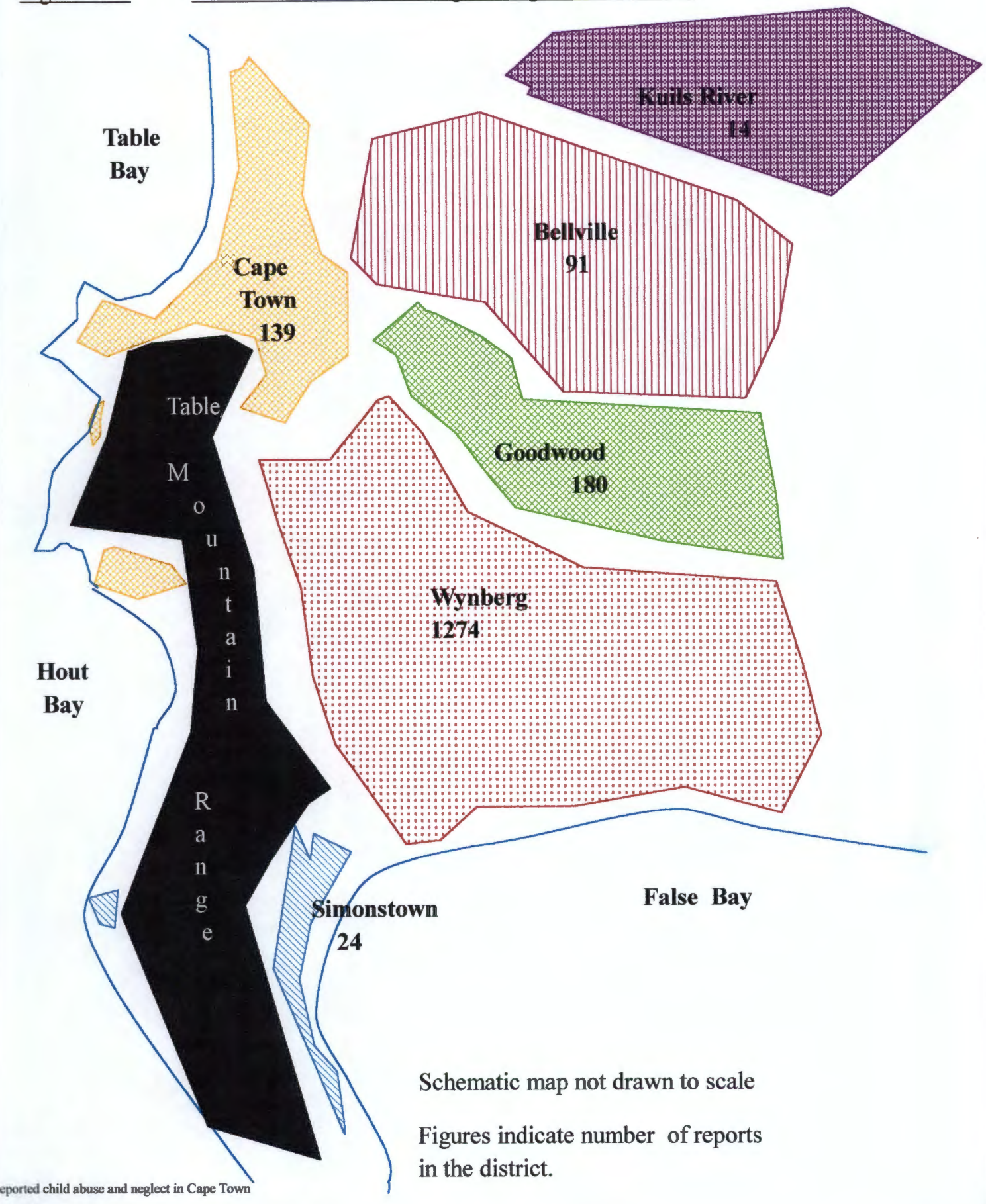
Table 6.26 Residential areas of children in study according to magisterial district

Magisterial District	Male		Female	Total
Bellville	28	(0.44)	63	**91**
Goodwood	46	(0.34)	134	**180**
Cape Town	47	(0.51)	92	**139**
Kuils River	4	(0.40)	10	**14**
Wynberg	332	(0.35)	942	**1274**
Simonstown	9	(0.60)	15	**24**
Total	**466**	**(0.37)**	**1256**	**1722**

Note: The proportion of boys in the study is indicated in brackets. The magisterial district of Wynberg includes Mitchells Plain and Khayalitsha.

16 Kuils River is included in this table as some reports came in from the district. Kuils River is in development region 2. Kuils River will not be discussed in any detail.

Figure 6.31 Residential areas according to Magisterial Districts



eported child abuse and neglect in Cape Town

The above figures indicate that reporting of child abuse during the study period is concentrated in the Wynberg magisterial district. This area, and Cape Town magisterial district, is served by the Children's Hospital, and has a number of well established social service agencies such as SAFELINE and Cape Town Child Welfare. It is interesting to note that the further one moves from the Children's Hospital the less reports are made. SAFELINE is situated a few kilometres from the hospital. The reports from Bellville would ordinarily be made by Tygerberg Hospital and by different social service agencies to those in Wynberg.

These suburb groups are arbitrary and do not necessarily reflect an equal economic distribution within each grouping. However, the groupings show a more widespread reporting pattern than is shown in the magisterial districts

Table 6.27 Residential areas of children in study according to suburb groups

	< 1yrs	>1-<5yrs	>5-<10yrs	>10-<15yr	>15 yrs	Total
Northern suburbs	10	29	41	58	21	**159**
Milnerton	2	6	4	4	2	**18**
City	8	23	31	29	11	**102**
Cape Town suburbs	15	34	55	54	20	**178**
Cape Flats A	24	85	148	172	94	**533**
Cape Flats B	12	57	80	73	26	**248**
Cape Flats C	1	4	8	12	5	**30**
Mitchells Plain	9	29	48	69	42	**197**
Khayalitsha	13	45	72	52	13	**195**
Phillipi	7	14	22	10	6	**59**
Total	**111**	**326**	**509**	**533**	**240**	**1719**

Figure 6.32 Residential areas of children according to Suburb groups

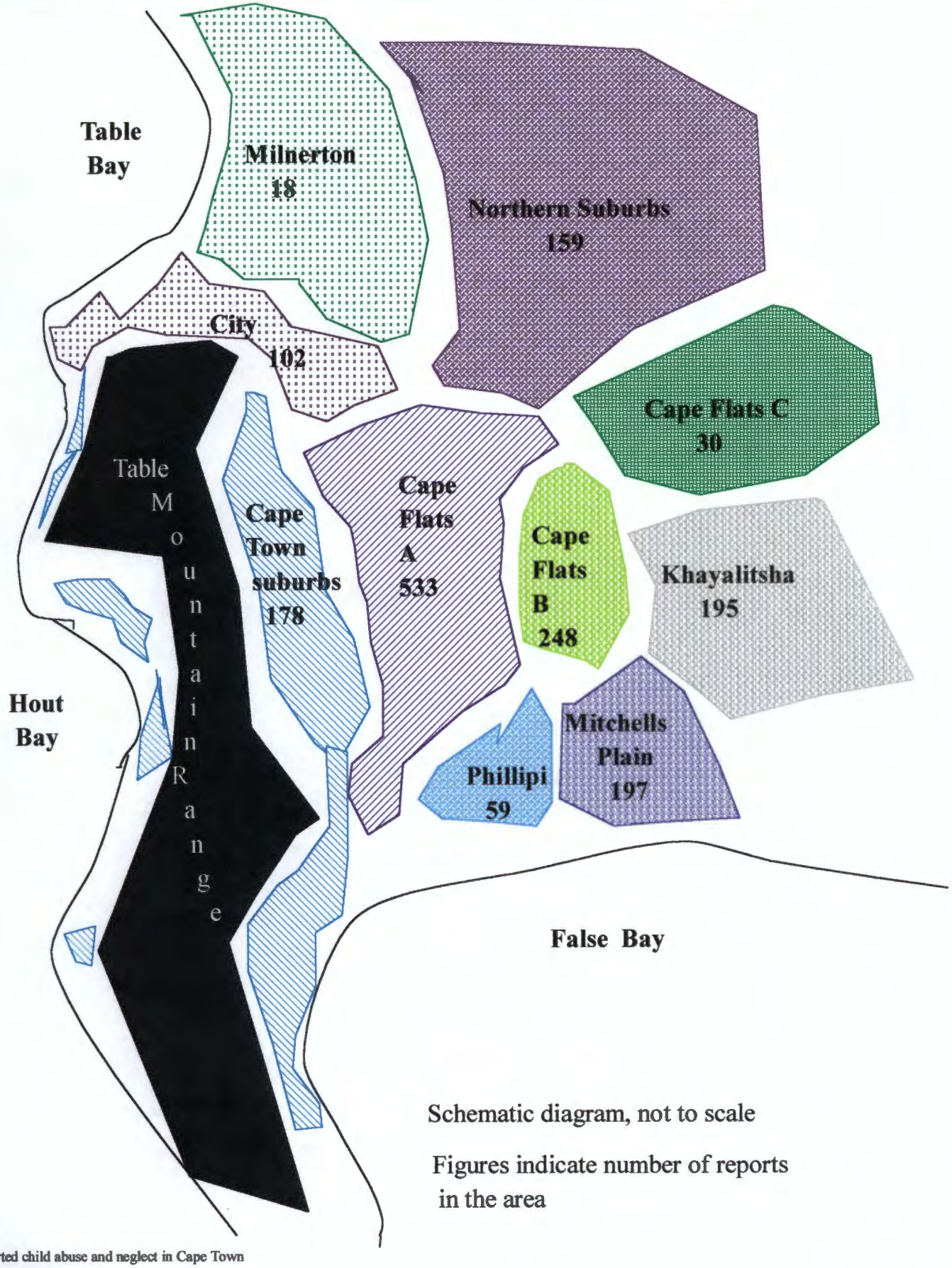


Table 6.27 indicates that reported child abuse varies form area to area. It demonstrates that in this study, the Cape Flats areas have high levels of child abuse.[17] The number of reports made are influenced by the number of children living in the area as discussed in Chapter 7, and by the activity of social services in each particular area. Most reports are from well established areas of greater Cape Town. Reports from individual suburbs are given in Chapter 7 with the rates of abuse. In Table 6.28 the relationship between area of residence of the abused child and that of the alleged abuser is shown.

Table 6.28 Child victims and abusers: residential suburbs[18]

Abuser / Child	A	B	C	D	E	F	G	H	I	J	K	L	Row Total
A	**84**		1		9		3				4	61	**162**
B		**14**					2					4	**20**
C	1		**68**	3	2		1			1		29	**105**
D	1		6	**108**	4	2					5	61	**187**
E	6	4	6	7	**300**	8	8		7		3	202	**551**
F				1	3	**97**	1	3	1		2	145	**253**
G					14	1	**100**	1		1	2	87	**206**
H				1		1		**82**					**202**
I									**34**				**60**
J	2				1		1			**19**			**39**
K	3		1	2							**80**		**122**
L	9	1	3	5	10		4	2		1	3	**131**	**169**
Total	**106**	**19**	**85**	**127**	**343**	**107**	**122**	**88**	**42**	**23**	**104**	**910**	**2076**

[17] This finding may be unique to this study.

[18] Suburbs are grouped according to proximity and similarity (see Appendix 2)

A= Northern Suburbs B= Milnerton C= City D= Cape Town suburbs
E = Cape Flats A F= Cape Flats B G= Mitchells Plain H= Khayalitsha
I = Phillipi J= Cape Flats C K= Out of Cape Town L= Unknown

The abusers and the abused children tend to come from the same suburbs. This fit implies that the abused children are likely to be abused in their own neighbourhood, which is not unexpected as the abusers are mainly known to the children, and are family members.

Although details on almost 50% of abusers are unknown, the closeness of fit between the children's addresses and those of the abusers is important in that it does not lend credence to the theory of roving abusers which is postulated by the popular media.

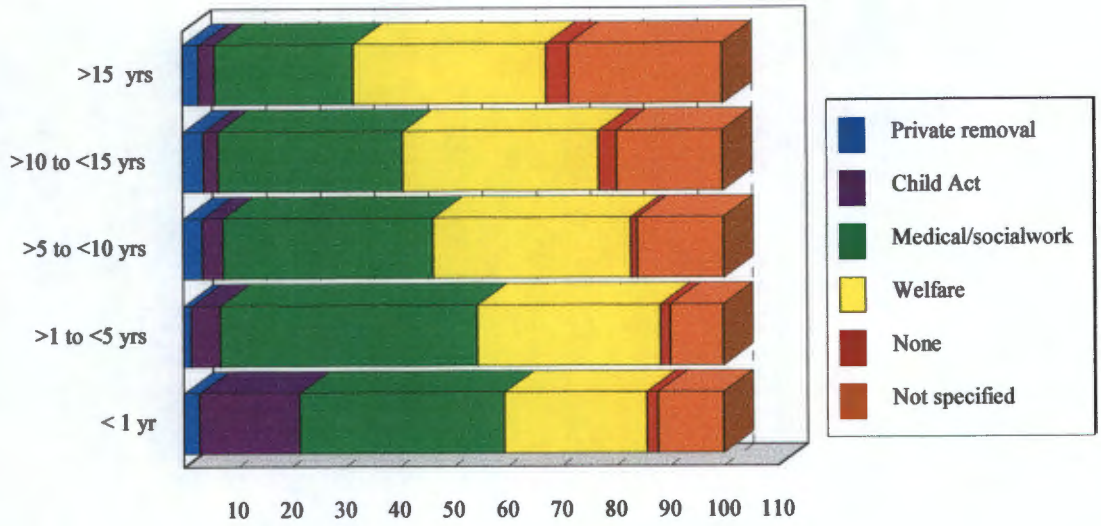
Action taken by the agencies

As most children are reported by social workers, further referral is not required in the majority of cases. There is no difference in the action taken with regard to gender. The reported action taken at each age groups differs, with more *Child Care Act* removals in the younger age group. Otherwise age does not really influence the action taken.

Table 6.29 Action taken - all children

column % shown	< 1 years	>1 to <5 years	>5 to <10 years	>10 to <15 years	>15 years
Private removal	4 2.9%	6 1.5%	20 3.6%	24 3.9%	8 3.0%
Child Act	26 18.6%	21 5.4%	21 3.8%	17 2.7%	8 3.0%
Medical/ social work	53 37.9%	185 47.6%	218 39.0%	213 34.2%	69 25.7%
Welfare	37 26.4%	132 33.9%	204 36.5%	227 36.4%	96 35.7%
None	3 2.1%	7 1.8%	7 1.3%	20 3.2%	11 4.1%
Not specified	17 12.1%	38 9.8%	89 15.9%	122 19.6%	76 28.4%
Total	**140**	**389**	**559**	**623**	**268**

Figure 6.33 Action taken



Almost half the children are referred for medical examination (45%), while 42% are referred to a welfare agency. Only 8% of the children are removed. A police investigation is held in 43% and very few continue through the courts to the point of conviction.

Table 6.30 Police investigation

	< 1 yr	>1 to <5 yrs	>5 to <10 yrs	>10 to <15 yrs	>15 yrs
No	74	211	241	257	108
Yes	31	103	214	293	131
Total	101	214	255	590	239

Requested	7	14	18	13	3
Not requested	21	46	86	60	17
Total	28	60	104	73	20

Records are not readily available from the police. Although there is a Child Protection Unit in Cape Town, most children who have been abused would receive police services from the regular police force. Training of police officers is not uniform and the standard of police investigation varies from station to station. The outcome of the investigation is not available for this study.

Summary

Considering the questions posed at the beginning of this chapter, the results of the study indicate that the answers are as follows:

- *What is the overall picture of child protection in Cape Town?*
  - Child abuse and neglect primarily affects females in the Cape Town area;
  - younger children are more likely to be physically abused or neglected;
  - older children are more likely to be sexually abused.

- *What are the characteristics of the children abused, in particular, the differences between male and female children?*
  - Females are at a high risk of child sexual abuse,
  - Males are more prone to physical abuse.
  - There is an absence of reported fatal child abuse.

- *Is there any uniform profile of the alleged perpetrator?*
  - most of the abuse is either intra-familial, or inflicted by a person known to the child.

- *What is the geographical distribution of child abuse?*
  - the distribution of abuse is influenced by the reporting agencies. In this study the incidence of reported child abuse and neglect is predominantly from the Cape Flats areas, though this does not reflect the rate of reported child abuse and neglect (see Chapter 7).

- *What action is taken by child protection agencies?*
  - the majority of reported child abuse and neglect is managed by social service agencies;
  - the police do not investigate child reported child abuse and neglect in the majority of cases.

These findings will be discussed in relation to reports from the literature in Chapter 7.

Chapter 7 Discussion of the results

Introduction

This study on child abuse in Cape Town provides an opportunity for practitioners and researchers in the field to gain insight into the nature of reported child abuse in the area. The study, one of the first comprehensive incidence studies in Cape Town on child abuse and neglect, provides data that may influence the development of child protection programmes in the Cape peninsula and possibly in other areas of South Africa. The data presented in the previous chapter provides details on the problem of child abuse and neglect, but reporting of child abuse cannot provide a complete overview of the phenomenon. In this chapter the aim is to consider whether the incidence and prevalence of reported child abuse and neglect in South Africa follows the pattern for other countries which is reported in the literature. This entail answering two research questions:

- "*Can the characteristics of abused children be determined?*"
- "*Do the characteristics of child abuse and neglect in Cape Town differ from those reported in the literature*?" Incidence of reported child abuse and neglect will be considered as the prevalence of child abuse cannot be determined as this is in essence an incidence study.

In Chapters 9 and 10, the final 3 research questions will be addressed. These relate to the significance of the data for practice, research and policy development.

The mechanism for reporting child abuse and neglect

The first quarter of each year has a lower number of reports, coinciding with the summer months. This suggests a possible seasonal variation in the incidence of abuse, or a seasonal variation in the reporting of abuse. Reporters from agencies that met the immediate needs of the children they served, tend to send in reports in batches. This does not meet with the requirement to report within 24 hours of the incident being detected, as required by the *Child Care Act.* There is a fall off in reporting in the last quarter of the study. This may reflect a waning in enthusiasm on the part of reporters rather than a real decrease in the number of children experiencing child abuse.

A reporting system has four basic functions:

- to provide data on incidence in the short term and on prevalence in the long term;
- to facilitate urgent intervention;
- To provide a mechanism to request long term follow-up for the child;
- To provide a brief profile of the alleged perpetrator.

The *Child Care Act* requires mandated reporting so that appropriate intervention can take place. In view of the overloaded resources in the community, the perceived increase in child abuse cases, and the lack of an appropriate growth of the services for abused children, it is expected that many of the reports would require further action.

The reliability of the reports of child abuse and neglect is essential if we are to accept the findings reported in the previous chapter. It is hoped that all agencies in the Cape Town area

accepted the use of the form as routine practice. In order to encourage reporting, a letter had been published in the South African Medical Journal aimed at health professionals both in hospitals and the community (Lachman, 1994). All community day centres, local authority health centres, clinics and welfare agencies were informed of the reporting system. Despite this, social workers form the bulk of referrers to the reporting centre. Reports from the Red Cross War Memorial Children Hospital are in effect joint medical and social work reports, as social workers report on behalf of doctors.

The majority of reporters are social workers. Doctors, dentists and nurses, the other mandated reporters do not feature highly, though the procedure at the Children's Hospital is for the hospital social worker to report. The low rate of reporting by doctors is in keeping with the rates determined by Collings (1996) in his survey of doctors in Durban, and in keeping with the finding in the literature as discussed in Chapter 3.

Dentists do not report at all which can indicate a possible failure to recognise child abuse among this group of professionals. This is a problem also recognised in the United States (Loos, 1991; Von Burg and Hibbard, 1995). Prior to the development of the reporting system there was no record as to the extent of the problem of child abuse in Cape Town, other than that reported in annual reports from various agencies.

Table 7.1 compares the annual reports of the major referrers of child abuse to this study.

Table 7.1 Comparison of reporting in this study to annual reports

	1992-1993	1993-1994	1994-1995	This study
SAFELINE	806	668	not available	733
Children Hospital	440	542	605	629

The two major organisations involved in child abuse management appear to have utilised the system effectively. Reporting by some of the other hospitals, such as Tygerberg Hospital appears to be lower than expected, and some welfare agencies did not report at all. These were in the main the smaller agencies. It has been noted that the Police did not report at all, though their reports may involve duplication as agencies are required to report first. In 1991 15,333 cases of child abuse were reported to the Child Protection Unit of the South African Police, though these were for investigation, and were not necessarily validated. Many of the children reported to the Child Protection Unit of the South African Police may not have been abused. Nonetheless, it is worrying that the police do not report. This may be due to the confusion as to where one should report as a result of the *Prevention of Family Violence Act of 1993.* The reporting system replaced that which had been in operation previously. This system, reporting to the various government departments on a racial basis, had been unsuccessful. The relative success of the new reporting system is demonstrated in Table 7.2.

Table 7.2 Reported child abuse in South Africa[19]

	1989	1990	1991
House of Assembly (White)	2707 for the three year period		
House of Representatives (Coloured)	691	488	594
Provincial Governments (Black)	figures unavailable	311	641
Police Child Protection Unit (all races)	9552	11176	15333

Patel (1993) reported that in 1991, 892 new cases of physical abuse, and 1139 cases of child sexual abuse were reported to Child Welfare Societies in South Africa as a whole. The 2077 children reported in this study exceed the numbers reported in a given year nationally. Although this provides the study with some degree of reliability, one cannot assume that the true incidence of child abuse has been measured. The figures presented are probably the most comprehensive to date.

The relative success of the reporting programme indicates that it is possible to introduce a reporting mechanism that practitioners accept. The inducement to report was facilitated by the involvement of the practitioners in the design of the reporting form, and the process of reporting. Initially it was hoped that regular reports would be distributed to indicate the trends detected. This was not possible due to the changes that subsequently took place in the Department of Health. This emphasises the need for an infra-structure to support a reporting

[19] Personal communication from State Departments. The use of racial categories is an indication of how statistics were collected in the past. This study does not differentiate children on the basis of race.

system. (A sample of previous reporting forms and the guidelines for reporting in South Africa are included in Appendices 5 and 6)

The conclusion that it is feasible to introduce a reporting mechanism is not an endorsement of the philosophy that mandatory reporting is required for effective child protection. This issue is discussed in chapters 9 and 11.

The providers of information on child abuse are similar to a those reported in a paper by Winefield and Bradley (1992) who, in a study on substantiation of child abuse reports, note that information in their study in South Australia came from relatives in 25.5%, teachers in 20.9%, non professionals in 17.6%, social workers in 8.9%, the victim in 6.6%, the police in 6%, paramedics in 6.3%, doctors in 4.7% and nurses in 1.3%. The most striking difference between their study and this study is the low reporting rate from school teachers, but teachers are not mandatory reporters. If a mandatory reporting system is to be developed, a change in attitude would be necessary, and training of reporters together with a public education campaign would be required.

Comparison of the results to South African data

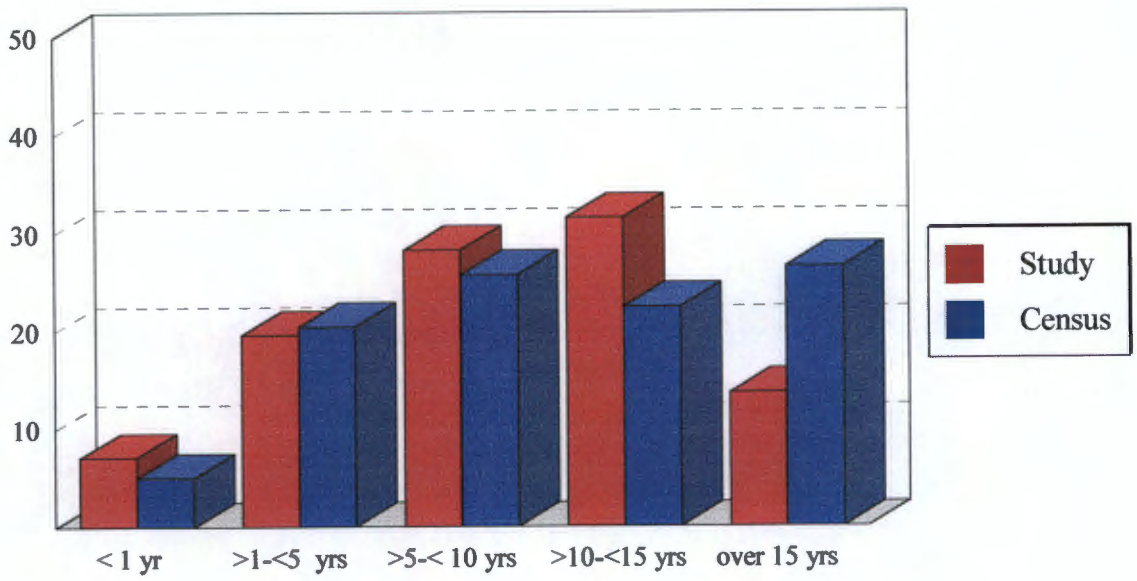
The 1991 Census

When compared to the percentage of children as reflected in the 1991 Census (Central Statistics Office, 1993) there is a fairly close match, except for two age groups, with a higher number of children than expected in the 10-15 year age group, and a lower number of children in the over 15 years age group. This could be explained by the older teenagers being referred to adult services, or not being reported at all.

Table 7.3 Age of reported children and the 1991 Census

Age	Number	%	1991 Census
less than 1 year	141	7.1	5. 0
>1 to <5 years	391	19.6	20.4
>5 to < 10 years	561	28.2	25.7
> 10 to < 15 years	626	31.5	22.4
over 15 years	271	13.6	26.5
Total	**1990**	**100. 00**	**100. 00**

Figure 7.1 Comparison of study age range and the 1991 Census (%)



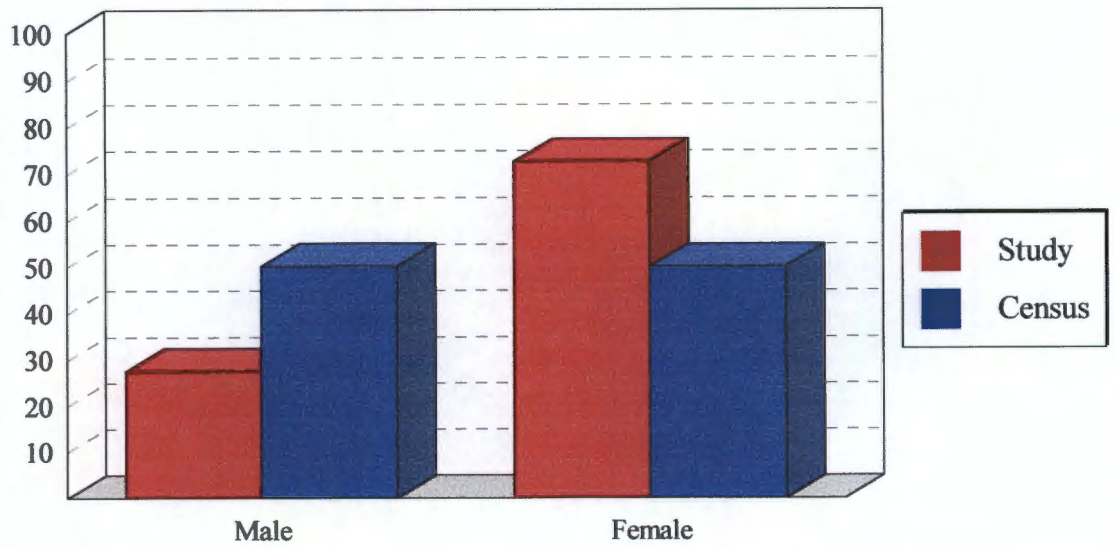
Females are over represented in the sample as compared to the figures in the 1991 census. As will be discussed in greater detail in the section on the influence of gender on reporting, this may imply that abuse is over-looked in males, or it is a true reflection of the distribution, thereby confirming the previously unsubstantiated impression among professionals in the field that females are more prone to sexual abuse.

Table 7.4 Gender of the children and the 1991 Census

Gender	Frequency	%	Census %
Male	557	27.5	50.1
Female	1471	72.5	49.9
Total	**2028**	**100**	**100**

Missing = 42

Figure 7.2 Gender of the children and the 1991 Census (%)



As noted in the literature review, there have been no major epidemiological studies of child abuse in South Africa, and few studies if any in the rest of Africa. Comparison of results is difficult as each study has a different focus, and results do not necessarily refer to the same problem. There have been few community based surveys although there have been a number of studies that have concentrated on the prevalence of child sexual abuse (Levett and Lachman, 1991). Some of these are discussed in Chapter 2.

The finding that more females than males are reported (Table 6.11) may imply:

- that females are at a greater risk of abuse;
- that of the children who are abused females are more likely to be reported;
- that the nature of the abuse influences the decision to report;
- that there is a higher incidence of child sexual abuse;
- or that gender is a determining variable in child abuse statistics.

It is possible that age and gender may influence the reporter in the decision to file a report on child abuse. The younger child may be perceived to be at more risk of further abuse, and males may not be seen as needing intervention in terms of physical abuse. This would go against the guidelines on reporting.

South African Studies

In Table 7.5, a number of recent South African studies are listed and commented on. The studies are hospital based and represent the type of epidemiological study conducted in South Africa in the past. This emphasises the central role paediatricians play in child abuse research in South Africa, a trend which is similar to that in developed countries. Other hospital based

studies have reported similar results (e.g. Chapman and Winship, 1993). The studies listed in Table 7.5 represent the type of epidemiological study conducted previously.

The studies report mainly on child sexual abuse, with the pattern of widespread abuse of female children. Intra-familial abuse is the most common type of child sexual abuse. This is similar to the reports from this study. The overall comparison to other local studies is that physical abuse remains under-reported. However, most other studies concentrate on child sexual abuse. Few hospital based studies comment on neglect, though the Coronation Hospital study included poor nutrition as an indicator of neglect, hence the high numbers. The Children's Hospital study, which reports on the children seen at the Children's Hospital, has a similar profile of characteristics as reported in Chapter 6, modified by the differences of children referred by other agencies.

Table 7.5 Specific South African studies on child abuse

Study	Design	Results	Rates	Comment
Coronation Hospital Johannesburg **Berrington et. al (1986)** **All forms of abuse**	Hospital based descriptive study by review of hospital records and questionnaire of staff	9821 summaries reviewed and 23 confirmed cases of physical abuse determined.	Rates per 1000 hospital admission physical 2.48 abandoned 3.23 neglect 301.8 High rate for neglect due to very broad definition of neglect to include all forms of malnutrition	Limited hospital based study. The high rate of neglect is unusual and reflects a very broad based definition. Rates not comparable as they refer to hospital admissions.
Perspectives from Child abuse clinics in Johannesburg **Hyslop et al., (1993)** **All forms of abuse**	Comparison of statistics from child abuse teams attached to the Johannesburg (TMI) Coronation and Baragwanath Hospitals, and Alexandra Clinic.	**TMI** - 90% csa (80% female) **Coronation** - 54% csa, (66% female) 37.4% physical, **Alexandra** 84% csa (89% female) **Baragwanath** 63% csa (83% female), 25% physical	not given	Very few children in each sample - figures possibly biased. No uniform profile for abuse. Figures may be suggestive of ecological factors involved - poverty and social stresses.

Study	Design	Results	Rates	Comment
R K Khan Hospital, Durban - Indian children **Haffejee (1985)** **Child sexual abuse**	Prospective study over 42 months	44 cases - 8 csa, 33 physical abuse 3 poisoning. 18 male and 24 female Perpetrator parent 56.8% unrelated 13'6% unknown 2.3% family 24%	Rates not provided	Valuable study - an early prospective study, limited as it is hospital based.
R K Khan Hospital, Durban - Indian children **Haffejee (1985)** **Child sexual abuse**	Data collected from 1981-1986	162 children of which 22.8% have csa, female male ratio of 11:1 In 40% the perpetrator is the father, 30% of cases were extra-familial.	None given	Limited study to one area. Hospital based, continuation of earlier study.
Red Cross War Memorial Children's Hospital Cape Town **Jaffe and Roux (1985)** **Child sexual abuse**	Review of children presenting to the hospital	232 child abuse of which 85 cases were csa, of which 53% were confirmed All social strata affected. 90% female Abusers were: neighbour 32%, parent 28%, family member 24%, friend 4%.	7.3 cases of csa seen per month, most cases in school holidays -March, June, September and December.	Second csa study in Cape Town at Children's Hospital. Provides some detail on the characteristics of the children and alleged abusers
Red Cross War Memorial Children's Hospital Cape Town **Argent, Bass and Lachman (1995)** **All forms of abuse**	Review of children seen from June 1989 to July 1990.	503 children, median age 7,3. Abuse confirmed in 77.3% - 160 physical abuse and 231 sexual abuse. In csa 207 females and 24 males, physical abuse 91 males and 69 females	Rates not calculated	Provides insight into the major service for children. Limited as it is a hospital study. Sexual abuse the major problem Provided the impetus for this study

The lack of large scale community based studies in South Africa, or in the rest of Africa, has made comparison with this study difficult. In Table 7.6, a recently published study from the Children's Hospital in Cape Town is compared to the results from this study.

Table 7.6 Comparison of this study to the Children's Hospital study

	Argent et al. (1995b)				This Study			
Type of abuse	**Female**	**Male**	**Total**	**Median age (months)**	**Female**	**Male**	**Total**	**Median age (months)**
Physical	69	91	160 31.8%	37	204	195	399 20.5%	males 84 females 108
Sexual	207	24	231 45.5%	79	1023	164	1187 61.1%	males 114 females 128
Suspected Physical	20	21	41 8.25%	21	N|A	N|A	N|A	N|A
Suspected Sexual	58	13	71 14.5%	58	N|A	N|A	N|A	N|A
Neglect	0	0	0	0	182	174	356 18.4%	males 43.6 females 66

As noted in Chapter 6, agencies have different profiles for the children reported, and this is reflected in the comparison between this study and the hospital based study (Argent et al., 1995b). It emphasises the value of a study that includes community based agencies. This study has a similar incidence of child sexual abuse, and neglect is not reported in the hospital based study. The median ages for both physical abuse and child sexual abuse are higher in this study, indicating that older children are seen in the community.

Children under the age of 14 years constitute 29.2% of the population of metropolitan Cape Town (Central Statistical Services, 1992). If one accepts the rate of abuse to be 1% per year,

(US Department of Health and Human Services, 1988), one can expect approximately 9000 cases of child abuse a year in the Cape Town area. This study reports on approximately one quarter of the expected number, emphasising the limitations of a study of reported child abuse, and the problems with reporting of child abuse and neglect.

Rates of child abuse and neglect

The incidence and prevalence[20] of child abuse are commonly reported as rates of child abuse. This study provides incidence rates of reported child abuse, and does not provide information on prevalence. The validity of the rates quoted is dependent on reporting of the abuse and on the accuracy of the census figures. The rates of reported child abuse must be viewed with caution as they probably represent the minimum rate of actual abuse.

The comparison between the census figures and the study population as indicated in Table 7.7 shows that, in Wynberg and Cape Town magisterial districts, proportionately more children are reported than in the general population, whilst there is relative under reporting in the other districts. *This assumes that the rate of child abuse is constant in all areas, which may not necessarily be true.* The districts are not homogeneous from a socio-economic standpoint, and some areas such as Wynberg, have extensive areas of intense poverty. Wynberg and Cape Town magisterial districts are the base of the largest two reporting agencies, viz. SAFELINE and the Children's Hospital.

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20 *Incidence rate* is defined as the number of new cases of child abuse reported in the study period. *Incidence rate* is usually reported as for a given period, usually one year. In this study it refers to reported child abuse.

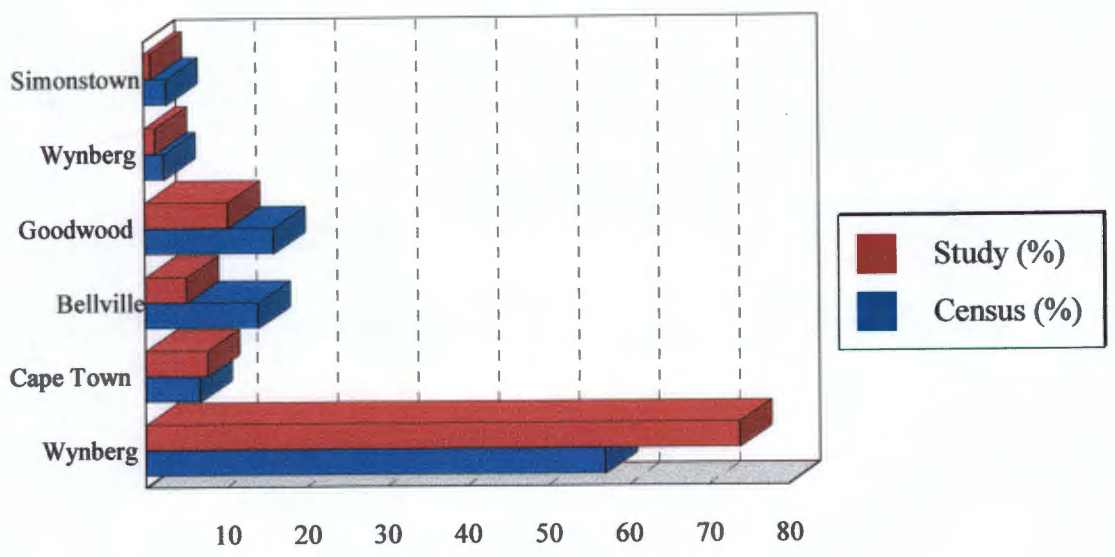
Prevalence rate is the number of child abuse cases that are in the community, both those newly discovered and those already present for a given period, usually one year.

Table 7.7 Census population and study population by magisterial districts

Magisterial District	Male		Female		Total	
	Population	Study	Population	Study	Population	Study
Bellville	47336 (0.4959)	28 (0.44)	48113	63	95449 **14.15%**	91 **5.28%**
Goodwood	54581 (0.5028)	46 (0.34)	53966	134	108547 **16.10**	180 **10.45%**
Cape Town	22828 (0.4953)	47 (0.51)	23262	92	46090 **6.84%**	139 **7.78%**
Kuils River	9370 (0.5070)	4 (0.40)	9112	10	18482 **2.74%**	14 **0.81%**
Wynberg	195569 (0.5028)	332 (0.35)	193398	942	388967 **57.25%**	1274 **73.98%**
Simonstown	8270 (0.4989)	9 (0.60)	8308	15	16578 **2.45%**	24 **1.39%**
Total	337954 (0.5013)	466 (0.37)	336159	1256	674113	1722

Note: The proportion of boys in the population and in the study is indicated in brackets. The number of children in the population is taken from the 1991 Census. There may well have been an under count, and an increase in the number of children living in the areas at the time of the study since the census count. Percentages given are the percentage of the total population and the percentage of the study population in each district respectively.

Figure 7.3 Census population and study population by magisterial districts



The rates for child abuse in the magisterial districts are given in Table 7.8.

Table 7.8 Rates per 1000 children per study period in magisterial districts

	< 1 year	>1 to <5 years	>5 to <10 years	>10 to <15 years	> 15 years	0 -< 18 years	Comment
Bellville							low rate
physical	0.44	0.10	0.11	0.25	0.14	**0.17**	generally
sexual	0.00	0.35	0.60	1.32	0.34	**0.64**	but csa
neglect	0.88	0.25	0.08	0.04	0.00	**0.13**	reported
Goodwood							low rate
physical	0.90	0.47	0.27	0.35	0.21	**0.35**	generally
sexual	0.18	0.98	1.11	1.51	1.00	**1.11**	but csa
neglect	1.08	0.26	0.30	0.08	0.00	**0.21**	reported
Cape Town							average rate -
physical	1.96	0.65	0.68	0.74	0.26	**0.65**	more neglect,
sexual	0.78	1.08	1.94	1.84	1.03	**1.45**	csa most
neglect	1.96	1.62	1.01	0.83	0.00	**0.89**	common
Wynberg							high rate of
physical	1.46	0.69	0.57	0.94	0.29	**0.67**	csa;. most
sexual	0.33	1.27	2.36	2.98	1.71	**2.02**	children live
neglect	2.12	0.69	0.63	0.47	0.17	**0.59**	in this area
Simonstown							low rate
physical	0. 00	0.59	0.00	0.00	0.00	**0.12**	but csa
sexual	0.00	0.29	1.94	1.97	0.83	**1.27**	reported most
neglect	0.00	0.00	022	0.00	0.00	**0.06**	
All areas							csa 3 times as
physical	**1.20**	**0.56**	**0.44**	**0.67**	**0.23**	**0.52**	common as
sexual	**0.31**	**1.07**	**1.80**	**2.30**	**1.28**	**1.61**	other forms
neglect	**1.66**	**0.59**	**0.49**	**0.34**	**0.10**	**0.45**	of abuse

Agencies in the northern suburbs of the city reported less than in the more central areas, as indicated by the rates of reported child abuse across the age groups. The rate of physical abuse follows the same pattern in all districts, viz. higher at the younger age groups, and then decreasing, though there is another peak in the 10 to 15 year age group.

Reported child sexual abuse increases with age, peaking in the 10 to 15 year age group, and then decreasing. In the older teenager abuse is possibly not reported as frequently. As expected, neglect is a problem of the younger age group.

Analysis of the gender breakdown reveals that females have higher rates of child sexual abuse in all areas (Table 7.9), viz. 3-4 times the rate of males. If one considers Wynberg district, which has the largest number of children in the city, one finds rates of child sexual abuse of up to 5.18 per 1000 children per year in the 10 to 15 year age group. These are remarkably high rates in comparison to the rates quoted in the literature (see below). The composite rate of 3.53 per 1000 children per year for child sexual abuse is high, considering that reported child sexual abuse is an underestimation of the actual problem.

Rates for neglect and physical abuse do not show significant differences between males and females overall. It is probable that the rates listed in the table are an underestimation of the true rate of neglect and of physical abuse.

Table 7.9 Rates per 1000 male and 1000 female per study period children in magisterial districts

	< 1 year		>1 to <5 years		>5 to <10 years		>10 to <15 years		> 15 years		0 -< 18 years	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Bellville												
physical	0.45	0.43	0.00	0.20	0.15	0.08	0.00	0.51	0.20	0.09	**0.11**	**0.23**
sexual	0.00	0.00	0.29	0.41	0.23	0.90	0.51	2.11	0.20	0.46	**0.30**	**0.96**
neglect	1.34	0.00	0.29	0.20	0.08	0.08	0.00	0.08	0.00	0.00	**0.15**	**0.10**
Goodwood												
physical	1.09	0.71	0.51	0.43	0.13	0.41	0.15	0.55	0.0	0.33	**0.26**	**0.44**
sexual	0.00	0.36	0.00	1.99	0.73	1.42	0.54	2.51	0.17	1.82	**0.37**	**1.83**
neglect	0.36	1.79	0.17	0.35	0.53	0.07	0.08	0.08	0.00	0.00	**0.22**	**0.20**
Cape Town												
physical	1.57	2.35	0.63	0.67	0.80	0.51	0.56	0.91	0.55	0.00	**0.70**	**0.60**
sexual	0.78	0.78	0.21	2.00	1.17	2.73	0.93	2.73	0.00	1.95	**0.61**	**2.28**
neglect	1.57	2.35	1.68	1.56	0.50	1.36	0.75	0.91	0.00	0.00	**0.74**	**0.99**
Wynberg												
physical	1.72	1.21	0.71	0.66	0.50	0.65	1.09	0.78	0.14	0.44	**0.67**	**0.67**
sexual	0.00	0.65	0.21	2.37	0.65	4.03	0.69	5.18	0.24	3.11	**0.43**	**3.56**
neglect	2.29	1.76	0.80	0.59	0.59	0.67	0.36	0.58	0.07	0.27	**0.56**	**0.60**
Simonstown												
physical	0.00	0.00	0.00	1.16	0.00	0.00	0.00	0.00	0.00	0.00	**0.00**	**0.24**
sexual	0.00	0.00	0.00	0.58	2.12	1.75	1.51	2.40	0.00	1.65	**0.97**	**1.56**
neglect	0.00	0.00	0.00	0.00	0.42	0.00	0.00	0.00	0.00	0.00	**0.12**	**0.00**
All areas												
physical	**1.36**	**1.06**	**0.55**	**0.57**	**0.39**	**0.49**	**0.69**	**0.67**	**0.16**	**0.31**	**0.50**	**0.54**
sexual	**0.06**	**0.56**	**0.20**	**1.97**	**0.66**	**2.93**	**0.66**	**3.95**	**0.19**	**2.30**	**0.43**	**2.70**
neglect	**1.70**	**1.56**	**0.65**	**0.53**	**0.48**	**0.49**	**0.26**	**0.42**	**0.04**	**0.15**	**0.43**	**0.46**

Unfortunately the census figures do not give a gender breakdown other than in magisterial districts. The broad picture is that females are more at risk of reported child sexual abuse. If one considers the grouped suburbs, a more detailed analysis of the rate of child abuse is possible.

Table 7.10 Child Population in suburb groups[21]

	< 1 yrs		>1-<5 yrs		>5-<10 yrs		>10-<15 yr		>15 yrs		0 - 18 yrs	
	Census	Study	Census	Study	Census	Study	Census	Study	Census	Study	Census	Study
Northern suburbs	7822	10	34509	29	46003	41	41063	58	36240	21	**167630**	159
											24.87%	9.2%
Milnerton	1152	2	5348	6	6070	4	5058	4	4414	2	**22045**	18
											3.27%	1.04%
City	1681	8	6722	23	8680	31	7961	29	8371	11	**33414**	102
											4.96%	5.9%
Cape Town suburbs	3398	15	12568	34	16997	55	16062	54	16871	20	**65903**	178
											9.78%	10.35%
Cape Flats A	6274	34	29183	85	36584	148	33329	172	33511	94	**138879**	533
											20.60%	31.06%
Cape Flats B	4055	12	12399	57	14767	80	14733	73	12929	26	**58881**	248
											8.73%	14.42%
Cape Flats C	338	1	1525	4	1974	8	1214	12	869	5	**5920**	30
											0.89%	1.74%
Mitchells Plain	4752	9	22194	29	29919	48	25748	69	20551	42	103163	248
											15.30%	14.42%
Khayalitsha	5499	3	20328	45	22080	72	13600	52	12188	13	**73693**	195
											10.93%	1.34%
Phillipi	617	1	1659	4	1543	8	1388	12	1373	5	**6580**	59
											0.98%	3.43%
Total	**35588**		**146435**		**184617**		**160156**		**147317**		**674108**	

[21] The suburb groups are listed in Appendix 2.

7.11 Rates per 1000 children per study period in suburb groups

		< 1 year	>1 to <5 years	>5 to <10 years	>10 - < 15 years	> 15 years	0-18 years	Comment
Northern suburbs	physical	0.38	0.17	0.11	0.15	0.08	**0.15**	Mainly csa
	sexual	0.13	0.46	0.63	1.17	0.50	**0.71**	
	neglect	0.77	0.20	0.13	0.05	0.00	**0.13**	
Milnerton	physical	0.87	0.19	0.16	0.00	0.23	**0.18**	Low reporting -mainly csa
	sexual	0.87	0.37	0.49	0.59	0.23	**0.50**	
	neglect	0.00	0.56	0.00	0.20	0.00	**0.18**	
City	physical	1.19	0.74	0.69	0.88	0.26	**0.69**	Average -all forms mainly csa
	sexual	1.19	1.19	1.96	2.01	0.96	**1.56**	
	neglect	2.38	1.49	0.81	0.63	0.00	**0.84**	
Cape Town suburbs								average - mainly csa
	physical	1.77	0.72	0.47	0.81	0.18	**0.61**	
	sexual	0.59	0.56	1.65	1.99	0.95	**1.37**	
	neglect	2.06	1.35	1.12	0.56	0.06	**0.85**	
Cape Flats A								Increased rates csa as well as other forms of abuse
	physical	1.28	0.89	0.87	1.41	0.42	**0.94**	
	sexual	0.48	1.27	2.35	3.15	2.21	**2.22**	
	neglect	3.67	0.72	0.77	0.60	0.18	**0.74**	
Cape Flats B								high rates csa
	physical	0.99	0.97	0.68	0.81	0.23	**0.70**	
	sexual	0.25	3.15	4.06	3.73	1.78	**3.09**	
	neglect	1.73	0.40	0.61	0.41	0.00	**0.48**	
Cape Flats C								high rates csa
	physical	0.00	1.31	1.52	0.82	1.15	**1.18**	
	sexual	0.00	1.31	2.53	9.06	4.60	**3.72**	
	neglect	2.96	0.00	0.00	0.00	0.00	**0.17**	
Mitchells Plain								low neglect & physical abuse
	physical	1.68	0.45	0.10	0.43	0.24	**0.38**	
	sexual	0.00	0.63	1.27	2.14	1.51	**1.40**	
	neglect	0.21	0.23	0.20	0.12	0.19	**0.19**	
Khayalitsha								Average
	physical	1.09	0.30	0.32	0.51	0.00	**0.35**	
	sexual	0.00	1.38	2.36	2.87	0.82	**1.75**	
	neglect	1.27	0.39	0.59	0.44	0.16	**0.49**	
Phillipi	physical	4.86	3.01	3.24	2.16	0.73	**2.74**	Very high csa
	sexual	1.62	2.41	9.72	2.88	1	**4.26**	
	neglect	4.86	2.41	1.30	2.16	0.73	**1.98**	
All Areas								
	physical	**1.20**	**0.56**	**0.44**	**0.67**	**0.23**	**0.52**	
	sexual	**0.31**	**1.07**	**1.80**	**2.30**	**1.28**	**1.61**	
	neglect	**1.66**	**0.59**	**0.49**	**0.34**	**0.10**	**0.45**	

Although the areas with low levels of reporting have low rates it is significant to note that areas with high levels of poverty such as Phillipi have markedly higher rates than other areas. The overall rate of child sexual abuse in Phillipi is 4.26 per 1000 children, though the rate for the >5 to <10 year age group is 9.72 per 1000 children. This may be a result of the low number of children in this area as a result of an under-count in the census, however the rates are more likely to be a true reflection of the level of all forms of child abuse and neglect in Phillipi, which is an area of extreme socio-economic deprivation. The high rate of child sexual abuse the >5 to <10 year age group is a recurring pattern.

Overall the pattern of the rates of abuse are similar to that for the magisterial districts as noted above. The rates can be used to develop programmes for prevention and management of child abuse and neglect in each particular area, though in the areas of low reporting the rates cannot be accepted as being a true reflection of child abuse and neglect. Individual suburb rates are listed in Appendix 5 and can be used to for community programme development. Areas with few children in the population may have distorted rates.

The ecology of child abuse

In keeping with the ecological theory of child abuse, the areas with socio-economic deprivation have rates above the norm, e.g. in areas of the Cape Flats. The reporting system in this study does not allow for a detailed analysis of social class and its relationship to child abuse. The area distribution indicates that areas of lower social class have high referral rates and may reflect underreporting from other areas rather than higher rates. This is in keeping with similar studies of reported cases of child abuse (National Center on Child Abuse and Neglect, 1981).

Risk factors for child abuse that have been determined include:

- a child living without one or both of her natural parents as opposed to a child living within a stable family environment (Finkelhor et al., 1989);
- children with a mother who is out of the home (Finkelhor and Baron, 1986);
- children with poor parenting or in a situation of family violence resulting in emotional neglect. (Wolfe, 1993).

As the research design was dependent on the reporting system, details on the socio-economic background of the children in terms of parental income and education, and housing, was not available. Details on family structure and the cohesiveness of the neighbourhood are not readily available. This is crucial in the next phase of the research, although it is highly probable that the higher levels of child abuse in the specific areas in Cape Town can be explained by an ecological approach to child abuse, as discussed in Chapter 2. Low socio-economic status is not necessarily a cause of child abuse and neglect. Rather the associated effects of low socio-economic status such as increased economic stress, alienation, and decreased power within society may be important factors in the causation of child abuse and neglect.

If one considers the rates of child abuse in Cape Town, the highest rates are from areas which are prone to high levels of strain, areas of impoverished social networks, and the absence of community strengths. Caution must be exercised in interpreting these results. As Korbin et al. (1995) indicate in the risk assessment of a neighbourhood, false positive and negatives may occur, and predicted rates may not be the same as reported rates. A study of reported child abuse and neglect cannot provide a risk assessment of a neighbourhood, and can only indicate that a problem may exist. In the analysis of the rates of child abuse, the grouped areas of the

city and the individual suburbs with high levels of child abuse appear to be the areas with high levels of social disorganisation. (refer to Tables 7.10 and 7.11.)

Comparison of the results to international studies

The epidemiology of child abuse in other countries is reviewed in Chapter 2. In this chapter a number of studies are compared to the results noted in Chapter 6. The comparison of studies is difficult with differing methods used and differing definitions of child abuse. Studies are reported on in detail in Chapter 2. The discussion and comparison attempts to place this study in context reports in the developed world. Similar studies have not been conducted in Africa.

Comparison of rates of child abuse and neglect

The rates of child abuse in this study are compared to available figures from England and Belgium and the USA. Rates and figures from African countries are not available. The national incidence rates in the USA reported rates of 2.11 children per 1000 per year for sexual abuse, and 4.95 children per 1000 per year for physical abuse (Cappelleri et al., 1993). Straus and Gelles (1986) reported a prevalence rate of 140 children per 1000 for physical abuse in children aged 3-17 years after two national samples of parents using anonymous telephone surveys. Corrected for the sampling technique the rate is 107 per 1000 per year. In the United States the number of reports of all forms of child abuse has more than doubled between 1980 and 1990, with a reporting rate of 43 children per 1000 per year in 1990 (reported rates are not equivalent to rates of child abuse). This may be due to a rise in reporting, or as result of a change in the definitions of abuse, or can be a real increase in the incidence of child abuse. As not all reports are substantiated, it is difficult to assess which of the above is applicable. As

Rosenburg and Krugman (1991) conclude, reporting does not provide an accurate picture of child abuse.

The rates are compared to those in the 2nd National Incidence Study (Cappelleri et al., 1993) in Table 7.12.

Table 7.12 Child abuse and neglect in the USA compared to this study

2nd National Incidence Study			**This study**		
	Sexual	**Physical**	**Age groups this study**	**Sexual**	**Physical**
Age 0-2	0.36	2.43	**Age** 0 - <1	0.31	1.2
3-5	2.41	4.17	>1 - <5	1.07	0.56
6-8	2.07	4.91	>5 - <10	1.8	0.44
9-11	2.46	5.18	>10 - <15	2.3	0.67
12-14	2.58	6.61			
15-17	2.87	6.33	>15	1.28	0.23
Gender Female	3.28	5.55	**Gender** Female	2.7	0.54
Male	1. 00	4.33	Male	0.43	0. 50
Difference Female - Male	2.28	1.3	**Difference** Female -Male	2.27	0.04
Rates are per 1000 children per year			Rates are for the study period		

The studies are not entirely comparable as the source of data for the study in the United States is more extensive than solely reported child abuse. Nonetheless, the rates of physical abuse are substantially less in Cape Town, possibly indicating marked underreporting. The rates for sexual abuse are lower in Cape Town, though this may be a superficial reading of the situation

as the Cape Town data reflects reported child sexual abuse which one would anticipate to be lower. The female and male difference for child sexual abuse is almost identical in both studies.

In Table 7.13 this study is compared to studies from the USA and Europe. The figures are comparable as they reflect reported child abuse in the four countries.

Table 7.13 Comparison of this study with rates from California, England and Belgium

	California 1990-1992 [22] Karski, 1995)		**UK 1994** (NSPCC, 1996)		**Belgium 1994** (Marneffe, 1995)		**This Study 1994-1995**	
	%	**Rate per 1000**	**%**	**Rate per 1000**	%	no rates given	**%**	**Rate per 1000**
Physical	32.5	**1.78**	30	**0.9**	28.4	-	20.5	**0.52**
Sexual	18.2	**1.02**	37	**1.2**	34.2	-	61.1	**1.61**
Neglect	36	**2.2**	28	**0.9**	11.4	-	18.4	**0.45**
Emotional or at risk	3.9	**0.21**	13	**0.4**	26.0	-	with neglect	
Other	9.4	**0.62**	2	-		-		-

Rates are per 1000 children per year

The figures indicate that in South Africa there is a lower rate of reported child physical abuse and a higher rate of child sexual abuse (which occurs mostly in females) than in both the other studies. The figures for neglect are much lower than those in England and Belgium (combined

[22] This is representative of other parts of the USA as indicated in national studies.

emotional abuse with neglect), as are the rates for neglect. The lower rates for child physical abuse could be related to the high level of violence that is evident in South Africa, while the discrepancy in the reporting of neglect could be related to the high threshold in the recognition of neglect in South Africa due to high levels of poverty, and few elements of a welfare state. In California, more females are reported than boys (57%: 43%).

There is a similarity between Belgium and Cape Town, with regard to age distribution, though an exact comparison is difficult as indicated in Table 7.14.

Table 7. 14 Comparison of age distribution in this study to Belgium

Belgium

(Marneffe, 1995)

Age	%
0 to <6 years	36.7
>6 to < 15 years	47.5
> 15 years	15.8
Total	100 .0

This study

Age	%
0 to < 5 years	26.7
>5 to < 15 years	59.7
> 15 years	13.6
Total	100 .0

Although not exactly comparable, the figures reflect a younger population of abused children in Belgium, which could be explained by the lower level of physical abuse reported in South Africa.

Child sexual abuse

There have been numerous reports on child sexual abuse. Finkelhor (1993) in a paper on the epidemiological factors of child abuse, cites estimates of prevalence for child sexual abuse in the community to be between 6 and 62% for females and 3 to 16% for males, i.e. 1 in 3 girls and 1 in 10 boys will experience some form of child sexual abuse. He notes that the ratio of 2.5 girls to 1 boy is probably an under-representation of abuse of boys who usually represent less than 20% of the victims. This implies the need to be more vigilant in the detection of child sexual abuse in males. There have been few studies which are very similar to the one reported in this thesis. MacKenzie et al. (1993) report on an epidemiological study in Northern Ireland, a country beset with high levels of violence, in which the levels of reported child sexual abuse are determined. Although the numbers are not large, 408 cases reported in 1987, the results can be compared to the ones from this study, as the origins of the figures are similar and they reflect incidence rather than prevalence of child abuse.

Table 7.15 Northern Ireland age related incidence rates of child sexual abuse per 1000 children per year and this study

	Northern Ireland (MacKenzie et al. (1993)			This Study		
Age (years)	**Males**	**Females**	**Total**	**Males**	**Females**	**Total**
0 - <5	0.14	0.42	0.28	0.17	1.68	1.47
>5 - <10	0.5	1.21	0.85	0.66	2.93	1.8
>10-<15	0.41	1.89	1.13	0.66	3.95	2.3
>15	0.24	3.73	1.91	0.19	2. 30	1.28

The comparison of the Irish study with this study reveals substantially higher levels of reported child sexual abuse at all ages except the over 15 year age group, where reporting is lower in South Africa.

Comparative rates of child sexual abuse have been difficult to determine as indicated in Chapter 2. The lack of uniform methodologies and the lack of agreement on definitions, as well as the secrecy involved with child sexual abuse, implies that any quoted rate is likely to be an under-representation of the actual rate. Finkelhor (1994) attempts to determine a comparative rate for over 20 countries. This is reflected in Table 7.16 which indicates that the rates for child sexual abuse in this study are comparable to those reported in the literature.

Table 7.16 Child Sexual abuse rates in selected countries (Finkelhor 1994)

	Prevalence per 1000 children per year		% intra-familial	
	Female	**Male**	**Female**	**Male**
Australia	2.8	0.9	35%	17%
Austria	3.6	1.9	26%	9%
Belgium	1.9	-	34%	-
Canada	1.8	0.8	44%	6%
Costa Rica	3.2	1.3	43%	19%
Denmark	1.4	0.7	42%	25%
Finland	0.7	0.4	-	-
France	0.8	0.5	23%	6%
Germany	1	0.4	50%	50%
Great Britain	1.2	0.8	14%	13%
Ireland	0.7	0.5	37%	37%
Netherlands	3.3	-	46%	-
New Zealand	1.9	0.9	38%	-
South Africa[23]	**3.4**	**2.9**	**30%**	**17%**
Spain	2.3	1.5	16%	4%
Sweden	0.9	0.3	18%	0%
Switzerland	1.1	0.3	56%	0%
USA	2.7	1.6	29%	11%
This study (incidence)	**2.7**	**0.43**	34.8% family 35.4% by a known person	26.3% family 43.6% by a known person

[23] The studies used for this estimation are by Levett (1989) and Collings (1991). These are prevalence figures.

One cannot really compare the figures but they give some indication of the problem in various countries. The rate is likely to be higher once further studies are undertaken. The rates quoted for South Africa are based on studies reporting interviews with university students. The rate are not comparable, though they give some insight into the differences between prevalence and incidence figures. The high prevalence rate of male sexual abuse can be attributed to the study design, a university interview, and to the very broad definition of child sexual abuse. This emphasises the need for additional studies to cover all possible methods of ascertaining the actual rate of child abuse.

The risk of reported child abuse for children in Cape Town

The risk of child abuse is a concept that could help to determine the direction of intervention of prevention and management intervention programmes. The data has been analysed by logistic regression to determine whether a reliable statistical model can be developed to predict the risk of child abuse in terms of type of abuse, gender of the child and suburb of residence. Although the risk assessment is only for reported child abuse and not for child abuse as a whole, it may present the first idea on risk for children in the Cape Town area.

The model is based on that developed by Cappelleri et al., (1993). The logistic regression indicates that, compared with physical abuse, sexual abuse is:-

- more likely in females than in males;
- less likely in children between the ages of 0-4 than in older children;
- more likely in Khayalitsha, and Cape Flats B than in other areas.

With physical abuse:-

- the odds of physical abuse is highest for males aged 0-4 years in Phillipi with the odds of physical abuse being lowest for children aged 5-9 years in the Northern Suburbs.

The model generated by logistic regression predicts sexual abuse fairly well, but fails to do likewise with physical abuse. Neglect is not included in this analysis. The findings are comparable to those reported by Cappelleri et al. (1993).

Table 7.17 Odds ratio for child sexual abuse relative to physical abuse - age

Age	Odds Ratio
0-<5	0.27
>5-<10	0.94
>10-<15	0.74
>15	1. 00

Table 7.18 Odds ratio for child sexual abuse relative to physical abuse - gender

Gender	Odds Ratio
Male	0.17
Female	1. 00

Table 7.19 Odds ratio for child sexual abuse relative to physical abuse - area of residence

Suburb	Odds Ratio
Northern Suburbs	2.58
Khayalitsha	2.11
Cape Flats B	2.03
Mitchells Plain	1.69
Milnerton	1.35
City	1.21
Cape Town Suburbs	1.09
Cape Flats A	1.09
Cape Flats C	1. 00
Phillipi	0.73

The statistical risk of child abuse is a restricted concept in terms of the results of the study and the logistic regression. Nonetheless, the data does allow for conclusions that indicate that girls are at particular risk of child sexual abuse. Prevention programmes can aim at child sexual abuse in females. The relatively low level of reported child physical abuse influences the impact of the data on this form of abuse. Child sexual abuse in males may be under reported, though most studies (see chapter 2) have shown a higher incidence in females.

Specific areas of child abuse not addressed in the study

There are number of areas of child abuse that are not addressed in the results due to the absence of reporting, or to the study design. These are considered at this point as, while they are not dealt with, the issues should be raised .

Children with special needs

This study failed to address the issue of childhood disability and child abuse and neglect. The reporting form did not allow for collection of data on whether the child was disabled or not. Browne and Lynch (1992) note that the connection between disability and child abuse has been relatively neglected. The early reports of child abuse did not include disability as a possible factor in the causation of abuse. Kelly (1992) notes that the majority of studies fail to include disability in their study design. The knowledge base is drawn from the clinician's and parent's perceptions of abuse, rather than from research on disabled children. Little is known on prevalence and even less on the coping mechanisms that disabled children use in response to abuse. The need for specialised programmes and research studies is discussed in Chapters 9 and 10.

Childhood fatality due to physical abuse.

Studies on fatality as a result of child abuse has been discussed in Chapter 2. It is well recognised that children may die as a result of the abuse to which they are exposed. In this study there were no reports of child deaths due to child abuse. This is surprising, considering the figures quoted by Lynch and Browne (1995) for England, i.e. 103 child homicides a year in England (nine per million). On further analysis for children under the age of one year, the rate is 48 per million children. In this study childhood fatality has not been reported at all. Childhood fatalities may not be classified by the police, or may not be recognised as such. The need for research in this area is discussed in Chapter 10.

Complications of child sexual abuse - sexually transmitted diseases (STD)

In a study of sexually transmitted diseases (STD) and child sexual abuse Argent et al. (1995a) reported on all children presenting to the Red Cross War Memorial Children's Hospital who had an identified STD. Over the period of study from June 1989 to March 1991, 107 children were identified and 96 analysed. Of these 62 had no history of child sexual abuse while 33 had history of child sexual abuse. Vaginal discharge was the presenting symptom in 79% of the children. De Villiers et al. (1992) report on a child abuse clinic in Johannesburg where, of 227 children presenting with a history of sexual abuse, 13 (6%) had a proven STD. Although reporters had the opportunity to record whether or not a child had an STD or not, on the whole this was not done. STDs may not be apparent at the time of reporting unless it is the presenting feature of the child abuse. This is a limitation of a reporting system.

Conclusion

This study has provided an initial appraisal of the extent of child abuse and neglect in Cape Town South Africa. The results have been compared with key studies in the literature and the questions posed at the start of the chapter, viz.: "*can the characteristics of abused children be determined?*, and *"do the characteristics of child abuse and neglect in Cape Town differ from those reported in the literature?*" have been answered. The essential conclusions are that:

- the rate of reported child sexual abuse is high;
- the rate of physical abuse are lower than in other studies;
- the rate of neglect is lower than in other studies;
- females are at highest risk of reported child abuse, particularly child sexual abuse;
- most abuse occurs within families;

- specific areas of the city have higher rates of child abuse; these are likely to be areas with high levels of social disintegration and poverty;
- the lack of published studies from other developing countries in Africa, Asia or South America inhibits comparative analysis with these developing countries. Despite this, the results of this study may represent the situation in countries with comparable profiles.

The study provides some data which can provide support for the development of programmes as discussed in Chapter 9. The information can act as a stimulus for further research as discussed in Chapter 10.

Chapter 8 Constraints to the study

A study on the incidence of child abuse in a community is difficult to achieve. The constraints placed on the researcher are numerous. For this reason the research results must be interpreted with caution.

Sample

The sample for the study included all children reported to the reporting centre for possible or confirmed child abuse over a 15 month period. This sample should take into account initial delay in the use of the report form, and possible seasonal variation. Although clear guidelines were provided to reporters, the sample is determined by the reporters. Under-reporting is to be expected as routine reporting was new to the area, and there had been a culture of non-compliance with the previous reporting system. Some agencies may have decided not to report child abuse. Not all abused children were reported. In view of these factors the sample in this study may not be truly representative of child abuse in the area, despite its including all those reported to the reporting centre. There is a need to extend the research to include those children not reported. In addition, studies of prevalence are required to complete the picture.

Definitions

The definitions on child abuse used in this study were negotiated between the researcher and professionals in child protection agencies. The definitions were simple and easy to interpret. The definitions covered the traditional classification of child abuse. More encompassing definitions of child abuse which included child labour and societal violence could not be introduced at the time of the study, and warrant individual attention.

As is evident in the literature (Chapter 2), professionals interpret definitions of child abuse and neglect according to their own personal experience, values and morès, and their willingness to be involved. It has been assumed that the reporters used the definitions as instructed, that they classified the degrees of certainty uniformly, and that they reported all cases of child abuse and neglect that came to their attention. In addition the reporters were asked to classify the degree of certainty of the abuse into three categories, low suspicion, high suspicion, and confirmed abuse. Different reporters may have interpreted the guidelines in varying ways. This is mitigated by the repeated reports by a small number of reporters.

Reporting system

The reporting system was introduced at the time of the study. This may have influenced the decision to report, and the newness of the system may have resulted in either under reporting or inaccurate reporting. Some agencies may have shown more enthusiasm to the reporting mechanism, and other agencies may have decided not to utilise the reporting system at all.

Reporting agencies

The success of the study depended on the co-operation of many different social workers and other professionals working for child protection agencies and hospitals. The completion of the form was not time consuming, but added to the workload of the individual professionals. This may have influenced the compliance with the study. As the forms were filled out by the case worker, there was no guarantee of the experience of the individual professional in the field of child abuse.

Report form

The report form was a product of consultation with professionals in child protection. It was piloted at the Red Cross War Memorial Children Hospital, and changes were made where indicated. The form was designed to be simple to complete, and to serve primarily as a reporting form rather than as a research instrument. Information on whether the child had special needs or not was not included. This is a major oversight, as data on disability and child abuse is of increasing importance.

Demography

A problem in determining rates of child abuse is the lack of accurate census figures. The 1991 census is inaccurate for many reasons, including political and logistical factors, and non-compliance with the census process. Although the figures were adjusted by the Central Statistics Service in order to improve the validity of the figures, it is apparent that an under count is likely. The rates quoted in the study are to be viewed in this light. These rates of child abuse should be viewed with caution.

Locality

This study was conducted in the Cape peninsula. It is possible that the results pertain to this region only. There is the temptation to extrapolate the results to South Africa as a whole. The experience of professionals in Cape Town is that child abuse in Cape Town is no different from that in other parts of the country. It is prudent to concede that one cannot accept this assumption, and that while these results provide a guide to child abuse in South Africa, they are but a guide.

Problems of reporting systems

As has been discussed in earlier chapters, the reporting process is open to under-reporting or over-reporting, bias and lack of substantiation. In order to carry out the study, validation of reports was the responsibility of the responsible agencies, all of which had experience in child abuse management. The majority of reports came from professionals, and from agencies which dealt with child abuse. Over half of the reports came from two agencies. It has been accepted that these agencies validated and checked their reports. As not all cases are reported, the figures quoted will be an underestimation of the extent of child abuse.

Comparisons with other studies

The aim of any research is to attempt to analyse and interpret the results and conclusions in the broader context of reports in the local and international literature. As noted elsewhere in the text, this is difficult to achieve due to different definitions of child abuse and neglect, different entry criteria, and incompatible study designs and methodology. This problem is particularly true in this type of study. In view of this, the findings could be misinterpreted.

It has been decided to attempt a comparison with other studies bearing the constraints that are present. The reader is advised to take this in consideration when reading the discussion and conclusions.

Data entry

The data was entered into the computer programme by a data entry clerk. Each entry was then checked and coded by the researcher. In this way accuracy of the entries was ensured, and any discrepancies within the forms were corrected.

Despite the above constraints, it is contended that this study provides data that can serve as the start of serious epidemiological research in the field of child abuse and neglect in South Africa.

Chapter 9 The development of child protection services in South Africa: - from research to intervention to prevention.

- *Can the results provide the foundation for a "National Plan of Action" on child abuse and neglect?*

The development of child protection programmes has been a priority for the welfare systems in most societies. If one examines the more advanced child protection systems one finds complex child protection systems in place. However, the amount of abuse has not necessarily decreased. Programmes have generally focussed on children already abused, i.e. secondary and tertiary prevention. Primary prevention has been advocated, but is difficult to implement. The reason for this is that primary prevention penetrates the very core of the values and morès in the society. Very few child protection systems are prepared to take the vital step required to eliminate child abuse.

The themes at the *2nd African Conference on Child Abuse and Neglect* held in Cape Town in 1993 (Lachman and Cockburn (editors), 1993) reflect areas of concern for practitioners and researchers alike:-

- One of the difficulties in defining child abuse in the African context, is that the cultural attitude to abuse varies a great deal. The distinction between abuse and discipline is

blurred. A problem in determining the incidence is the continued perception of abuse as *"being private"*. Garbarino (1996) stresses that this is a position to be rejected.

- The importance of male domination and female subservience is emphasised by a number of authors as being at the root of child sexual abuse. Advocacy for the rights of women is central to any action against child abuse.

- Socio-economic factors and political instability have drastic effects on the position of the child in African society, and these include war, poverty and economic deprivation.

- Specific areas of abusive practice remain major problems, e.g. child labour, female circumcision and the effects of societal violence.

These themes are not new, as noted in Chapter 2 (Okeahialam, 1984; Wilson-Oyelaran, 1986). South Africa has a long history of research in the field of child abuse and neglect influenced by the experience in Europe and the United States. Definitions of child abuse and neglect have moved from the early narrow concepts once propagated by theorists, to the inclusion of structural abuse and the effects of political policies on child abuse. The danger in this latter approach is that child abuse cannot be attributed solely to societal factors.

A key factor in child abuse in South Africa (and probably the rest of Africa) has been the breakdown of family structure. The path to addressing the problem of child abuse and neglect lies in the approach to all kinds of violence, both domestic and societal.

From research to prevention

In Chapter 4 the difficulty of preventing child abuse is emphasised, and the limited success that has been reported is considered. On reflection, the research on the prevention of child abuse, as reported in the literature, offers little cause for optimism. The individual studies and the reviews on research on the prevention of child abuse (Helfer, 1982; Dubowitz, 1989; Wolfe, 1993; MacMillan et al., 1994a; 1994b) do not come up with conclusive arguments. The solutions on offer are *home visitation and family support* in the case of physical abuse and neglect, and *increased knowledge* in the case of sexual abuse. These are not complete solutions in themselves. They are a start, though the effectiveness of such interventions has not been tested in developing countries.

The risk factors for child abuse are problems related to the family context, child treatment needs, and problems of the parents (Wolfe, 1993). This, by implication, encompasses societal causes of child abuse, and addresses the growth of the child's self esteem and self-identity. This is achieved by improving the parent-child relationship, teaching social sensitivity, and developing the possibilities for older children to develop outside their families' environment. These principles can be applied in Africa, but the needs of children are broader and more demanding because of the context of violence and societal disruption.

An appropriate response to child abuse in developing countries

The results from this study suggest that children in Cape Town, and probably in the rest of the South Africa, are at great risk of abuse. Female children are at particular risk of sexual abuse. All children are at risk of physical abuse which society tends to neglect. It is for this reason that a one dimensional approach to the problem of child abuse cannot be adopted. Advocacy

for children in general, and for the protection of children in particular, is the basis for intervention (Majodina, 1993). The process of advocacy has a number of steps that are essential to development of effective programmes.

- *Analysis of the problem:* a clear understanding of the problem is vital for the process of programme development. It is hoped that the results of this study will help to lead to an understanding of child abuse.

- *Elaboration of the issues to be addressed:* the development of aims and objectives of an advocacy or intervention programme are a prerequisite for programme development. This will lead to the *evolution of a policy agenda* which defines how the problem is to be addressed.

- *Development of a coherent and effective programme of action:* to influence policy makers and politicians at all levels it is essential to ensure programme adoption.

- *Popularisation of the issue* with the public to gain support, and *raising public awareness* are goals as well as means for change. The effective use of the media is vital (as discussed below).

Advocacy for children is the foundation of all child protection programmes. Child abuse prevention can be multifaceted and operate at two broad levels. ***Macro*** programmes aimed at altering the structures of a society that promotes child abuse and neglect can go together with ***micro*** programmes which are localised, and operate on the community level. This approach involves a political agenda which cannot be avoided. The forces aligned against children

include economic issues, education policies, and traditional values and attitudes. The *United Nations Convention on the Rights of the Child* of 1989 attempts to address the issue, but the document is merely an ideal. It is a reflection of what does **not** exist. Child care activists are obliged to challenge the structures in society that oppose child protection, in an attempt to improve the plight of children. The politics of child abuse has been neglected in the past, and should be at the forefront of all programmes on child abuse prevention.

Micro programmes, aimed at preventing abuse in all neighbourhoods and at all levels, are essential as part of an overall strategy. The problems in programme development include a lack of appropriately trained people, and the absence of a support system for practitioners. Funds are limited, and there are often unsympathetic legal and law enforcement systems.

A simple appropriate data collection system to determine the prevalence and incidence of child abuse is needed. Mandatory reporting is **not** necessarily a solution, and can raise expectations for intervention that cannot be met. Data collection can be focussed towards programme development and implementation, but in a country without an infrastructure to collect and collate data this may be a difficult task. In most developing countries the use of short rapid assessments and situation analysis assessments may be more beneficial.

Development of a National Plan of Action

The first step is to encourage the development of ***macro*** solutions. Possible macro solutions include:

- The empowerment of children and adults by informing them of the *United Nations Convention on the Rights of the Child* - a process adopted by the National Campaign for Children's Rights;

- Placing children at a high level in the political agenda of all provinces, and in central government. This requires the changing of laws that negatively affect children;

- Creation of the position of an Ombudsperson for children in each province;

- The enlistment of the media in a re-education campaign.

- A national campaign to end physical punishment of children (Newell and Kibel, 1995).

The ***macro*** programme could be supplemented by successful programmes adapted to local conditions. Examples of ***micro*** programmes, based on research data include:

- Neighbourhood based programmes that meet the needs of individual areas in the city. The implication is that a flexible approach is required, targeting resources where needed. Programmes should be designed for the children who are to receive them. This is the foundation for the *macro* programmes discussed above.

- The use of risk assessment of neighbourhoods, rather than the traditional risk assessment of individual families alone, would help to broaden the approach to

prevention. This can allow the development of appropriate preventive intervention (Daro, 1995).

- Programmes designed to change attitudes and perceptions of adults via the media and public education programmes can aim at changing parental attitudes to children, discipline and child rearing. Garbarino (1996) is optimistic that activists in the field of child abuse can follow the lead of activists in the field of the prevention of smoking to alter attitudes towards children. Child abuse should not be accepted in any form. Campaigns to end physical punishment of children may be marginal at present, but they can move to the forefront of the campaign to prevent child abuse. Prevention of child abuse and neglect is part of an overall strategy to increase knowledge on child rearing.

- Programmes to increase support for all families, e.g. home visitation, as discussed in Chapter 4, may be an effective and possibly useful tool if adapted for local use.

- Programmes aimed at school children and children **not** in school are critical. In Africa the majority of children at risk of abuse are not at school and alternative strategies are essential.

- Child labour is a relatively ignored issue in South Africa and is not reported in this study. Programmes can be developed with the focus on children who work, often out of economic necessity, so that their rights as workers are protected, and their basic education and training are not neglected.

The path to prevention and intervention

The prevention of child abuse is a complex issue that requires a concerted and co-ordinated approach on the part of all members of society. Based on the experience reported in the literature and on the results of this study, the strategy could include a number of the following areas:-

Developing a response to violence and children in society

The prevention of violence will play a key part in any future strategy and the values of society may need to be challenged and altered. Child abuse prevention is an essential ingredient of any child protection service, rather than concentrating on containment of child abuse. The issue of children and violence has been addressed by the Gulbenkian Commission in England (Gulbenkian Foundation, 1995). A conclusion is that if a mother is abused, her child has a high risk of experiencing abuse. The Commission recommends a co-ordinated strategy against violence in the country. This will comprise the following approach:

- Making an active commitment to non-violence:
  - expectations of children should be realistic;
  - all discipline should be positive;
  - non-violence should be consistently preferred and promoted;
  - adults should take responsibility for protecting children and preventing violence against children.

  These goals are fairly simple and could become the core of a campaign within the country.

- Legal reforms are required to provide the back-up to the commitment to the anti-violence campaign. This includes a review of all laws pertaining to children, and consideration of the banning of corporal punishment (Newell and Kibel, 1995).

- Support for children and families, particularly those affected by inequality and poverty.

- Particular attention should be paid to other issues that may predispose to a violent society, viz. alcohol and drug abuse, violence in the media, violence in sport, suicide and self-harm.

A Child Protection Service must take the elimination of physical violence against children as a central theme of its policy. This study has shown that physical abuse and violence against children is not reported in Cape Town as it is possibly ignored by professionals and practitioners.

Accurate documentation of all forms of abuse

To plan for the future prevention of child abuse, professionals must know the magnitude of the problem. Intervention is best based on accurate and relevant statistics as poor data collection results in poor programmes. This study is a start to the collection of the data. As gaps in the information on child abuse still remain, it may be necessary to conduct a situational analysis to ascertain the needs of specific target groups. A reporting system is not the sole means of documentation.

Evaluation of prevention and intervention programmes

The process of prevention entails ongoing evaluation of all programmes in operation (Fink and McCloskey, 1990). It is important to ensure that the programmes are well documented from planning to execution. One of the weaknesses of most programmes is the failure to include audit or evaluation as a built-in part of the programme. This may become more important as there is increasing pressure on projects to obtain funding.

Education of children by means of pre-school and school programmes

As discussed in Chapter 4, provision of classroom-based instructions for children of all ages is a recommended form of prevention. For children with special needs these programmes are often inappropriate or in the wrong place. Many children with special needs may not have an understanding of what abuse means, and because of their dependency on adults, are more vulnerable.

Daro (1988) points out that there has been little evaluation of the effectiveness of these programmes. Reports in the literature have been based on small samples, and thus cannot be interpreted with confidence. There has been minimal research in the area of child abuse and disability.

The positive aspects of these reports are that children do learn, although retention may be uneven. Most studies showed that important factors are age, prior exposure to the subject and the child's level of self-esteem, often difficult to assess with disabled children. The most positive programmes are those selected for the community by the community, that are related to the child's cognitive development, and that are stimulating and varied (Daro, 1988)

Careful evaluation of the effectiveness of the programmes is needed. The programmes can aim at providing the child with the correct knowledge and understanding of the problem. There can be an opportunity for educators and parents to work together.

Alternative forms of education, e.g. the child to child approach, can be effective ways of ensuring that the ideas of prevention are carried home at all levels (Ramsden, 1993). The educational aspects of a programme should include training of school teachers, parental education in prevention techniques, and how to respond to abuse. Additional aspects include community and parent support programmes, altering the abusive aspects of school education, and prevention programmes in the classroom.

Public education and the role of the media

The past few years have seen the adoption of child abuse as an issue by the media (Goddard, 1996; Gough 1996). This has had some positive effects, with child abuse being placed on the political agenda of society. McDevitt (1996) compared the increase in media coverage on child abuse to the increased reporting of child abuse in the United States from 1969 to 1994. She finds that there has been an increase in media reports, both positive and negative, matching the rapid increase in reported cases of child abuse. She emphasises that there is no causal relationship between the two increases. Nonetheless, the media has considerable influence on public opinion towards child abuse. Franklin and Horwarth (1996) assert that the media can be in a position to abuse children by the manner in which children are represented, particularly after the Bulgar case.

The standard of reporting can be questioned, as well as the effect it has had on the public's perception of child abuse. Dramatisation of the issues often distorts the public's idea of

perpetrators. Reports on paedophiles and sex rings may take precedence over the more "mundane" reports on children with special needs or female child sexual abuse. Kitzinger (1996) contends that the preoccupation of the media with the sensational extra-familial types of abuse tends suppress reports of intra-familial abuse. Krugman (1996) sees a role for the media which could include making politicians aware of the issue, informing the public of what works and what does not, and helping the public understand how to respond to abuse. Practitioners and the media can help the public to understand the complexity of the problem. Appropriate programmes are required to debunk the myths surrounding child abuse. To this end, the media should work closely with child protection practitioners in the development of responsible media coverage of child abuse and neglect.

Response to the children traumatised by violence

The issue of violence and its effects on children in South Africa requires increased impetus. Magwaza et al. (1993) report on post-traumatic stress syndrome (PTSD) in South African children as a result of the extensive violence in Natal. They conclude that *"sadly the most significant finding of this study is that pre-school children exposed to violence are likely to suffer from PTSD, with a significant number of children suffering from severe forms of this disorder."* The millions of children who experience violence either directly or as witnesses, are not usually classified as having special needs. This issue can be included in the prevention programme to be developed. The narrow definitions of child abuse excludes these children who could be included in an analysis of child abuse in terms of either physical or emotional abuse.

Training of professionals and educators

Training of workers at all levels is essential, though this is not an easy task as skills are often lost, and backup support is needed. Child protection may be added as an optional item to training programmes, and professionals are not specifically trained in the complexities of the issue. When one considers children with special needs, the issue becomes more difficult, as an understanding of disability and the effect it has on cognition, emotion, the family and society, is often not appreciated.

Response to the needs of children with special needs

Children with special needs comprise up to three per cent of the child population. This includes visible and hidden disabilities. One can identify children at risk of abuse if they are physically disabled, but there are many children who have disabilities that are recognised late or not at all. The services for disabled children are patchy and often non existent. Rural children and children living in the informal settlements are doubly discriminated against. The disability implies that any discrimination on the grounds of race or poverty is intensified as a result of the disability. This picture is not restricted to South Africa. It is essential that disabled children receive additional support in any prevention programmes, as well as specific protocols of management. As noted earlier, this study failed to provide any data on children with special needs, and further research will be required. Childhood factors that increase abuse in the disabled include:

- *Cultural attitudes* which may be detrimental to the well-being of the child;
- *Dependency* on adults to a greater degree than other children, with higher levels of trust;
- *Compliance* with adult authority;

- *Powerlessness* in the face of abuse and the lack of ability to defend oneself;
- *Physical vulnerability* to abusive acts, and the inability to run away;
- *Verbal inadequacies* that result in poor levels of reporting. Reports are often incomplete and may be regarded to be inaccurate. Articulation of abuse differs from that with normal children and denial may become a major factor. The fear of losing the care-taker on whom the child is dependent can deter reporting;
- *Lack of credibility,* particularly in the legal system, implies that the legal system often discounts reports of abuse of disabled children, or is unwilling to accept the evidence or history as admissible in court;
- *Inability to make informed decisions* results in the child being unable to decide whether an act is acceptable or not;
- *Lack of understanding* of what constitutes abuse or whether an act is appropriate or not;
- *Lack of knowledge* of normal sexuality by parents and practitioners implies that sexuality in disabled children is almost a taboo subject, and disabled children are regarded to be asexual beings (Blackburn, 1996). The rights of disabled children to receive sexual education has not been recognised in most societies.
- *Institutionalisation* creates greater exposure to potential abuse (Kelly, 1992; Kennedy, 1992).

These factors all contribute to a higher degree of risk of abuse in the able bodied child and even more so in the disabled or handicapped child. There is debate whether the children are in "high risk" families, or whether the handicap is the cause of the abuse. While these may not necessarily result in abuse, unless one equips and trains caregivers in abuse prevention and

general child care, disabled children may be at increased risk for child abuse. It is essential that these children receive additional attention in any prevention programme development, as well as protocols of management.

It is known that caring for a disabled child may result in increased stress in the family, that disabled children are stigmatised and discriminated against, but that this does not necessarily result in child abuse or neglect. Browne and Lynch (1992) conclude that the picture is not as clear as it was initially thought to be. Disabilities are different and each may present with differing needs, and varying risks for abuse. Kennedy (1992) emphasises the difficulty in communication with disabled children, and notes that researchers have not addressed this in research methodology. The failure of this study to quantify the extent of the problem should highlight the need to address disability in future research.

The proposed model for a new Child Protection Service in South Africa

Models of child protection delivery are influenced by the theoretical foundation on which the service is based. It has been noted that Patel's (1993) analysis of the welfare system in South Africa suggests that the apartheid system provided a repressive system that did not meet the needs of the majority of children in the country.

The development of child protection services in the newly formed welfare structure in South Africa attempts to move away from the restricted and under resourced service of the past. A proposal, published by the Department of Social Services, Provincial Administration of the Western Cape in May 1996, calls for a joint multi-disciplinary approach to the management of child abuse be developed. The overriding principle is that "*the safety and welfare of the child*

is paramount and must override all other considerations". The aim is to develop an agreed protocol, i.e. agreement among child protection agencies for a service delivery that ensures minimum optimum service standards for all child protection services to be delivered to children. The protocol provides the broad principles that will underlie the Child Protection Service, and leaves day to day practices and techniques to be implemented to the individual agencies. The protocol concentrates on intervention, with the prevention of child abuse to be community based, and agencies expected to participate in the development of prevention strategies.

The development of the protocol is to ensure that abused children receive the best available service from agencies working together in a systematic and agreed manner. Services are to be offered within an appropriate time scale. Accountability for the service to be offered is central to the policy. The goals of the service are to protect abused children from further abuse, to maintain the child in the family, to provide stability in the intervention offered, family support, and an appropriate response to child abuse. The family is expected to be a central part of the management, and the State intervenes with alternative placement only when this is not possible. The importance of stability, assessment and permanency in the intervention strategies is stressed. The service developed is based on four levels of intervention and provides the framework for the Child Protection Service (CPS).

The basis of this system is the traditional judicial-criminal investigative model. Child abuse is regarded to be a crime, and the process concludes with conviction of the abuser and the administration of the appropriate punishment. The Child Protection Service is tempered by the consideration of the needs of the child and family, and aims to work in the best interests of the child. Reporting remains mandatory, and the police are involved from an early stage.

Table 9.1 Proposed Structure for a Child Protection Service in the Province of the Western Cape (1996)

Structure	Function	Comment
Provincial Child Protection Centre **Policy body**	Manage the CPS budget; Maintain the CPS register; Develop and establish policy; Facilitate co-ordination; Initiate or arrange training; Provide accreditation for professionals in the field; Conduct or commission research; Provide links both inter-departmentally and nationally.	The establishment of this structure is essential in the development of any child protection service. The most important functions appear to be policy development , training, the maintenance of standards co-ordination and research. This body would require substantial funding and would influence the development of the prevention and intervention strategies.
District Child Protection Centre **Intervention co-ordination body**	To provide 24 hour screening and assessment for activation of intervention; To confirm referrals, and monitor progress on intervention; To organise and co-ordinate local services - including all agencies involved; To provide links with the provincial centre; To organise the district child protection committee To promote reporting of abuse	This structure is appropriate in terms of the geographical size of the province and the differing needs of each area. Some functions overlap with other structures.
Local Child Protection Teams **Intervention at grass root level**	Consists of two members - social worker and police officer trained in child abuse intervention working in partnership. Tasks of investigation, validation, risk assessment, involvement of other agencies where needed, facilitate the legal process, complete the investigation, submit progress reports, and to make necessary referrals	This proposal is **heavily dependant on the acceptance of the investigative-criminal model of child protection.** It is based on the models used in England and the United States.
Community Based Structures **"Grass roots co-ordination"**	District Child Protection Committees (DCPC) to serve as an interagency forum to facilitate policy development and interagency co-operation, consider training and procedure, review significant issues, and to liaise with the community	Similar to the ACPC committees in England, though those are more akin to the provincial centre. Is aimed at providing community links - but this is not explicitly stated.

The structures of the proposed Child Protection Service include:

- a central body that will develops policy, and maintain standards;

- district bodies that will organise the investigative service and acute response to abuse;
- local child protection teams that will carry out the policy measures for investigation and protection;
- and community based structures that will promote the prevention of child abuse.

An important innovation is the introduction of joint investigations by a police officer and a social worker. The implications of such an approach are enormous as training of the police and social workers would be a difficult task. Lloyd and Burman (1996) emphasise the need for joint investigations to be conducted according to set procedures, by police officers and social workers trained in risk assessment, interviewing techniques, and child development. Joint investigation is seen to be child centred, with the opportunity for communication between agencies. Problems of joint investigation include the differing approaches of the agencies and possible professional conflict. If an investigative approach is to be adopted, joint investigation facilitates the investigative process. It is unlikely that there are sufficiently trained police officers and social workers to provide a comprehensive service in South Africa for many years.

The evolution of this policy reflects the current interests of agencies in the child protection field. The Police and Courts have taken an interest in child protection together with the traditional Social Service departments. Consequently the proposal for the province is an extension of the system previously in place. This requires mandatory reporting, and the early involvement of the police in child abuse management. The protocol proposes a structure for the Child Protection Service, and innovations include the involvement of the community in decisions, and the emphasis is on the needs of the family and the importance of good uniform

practice. The proposed Child Protection Service has the potential to increase the conflict professionals experience when attempting to balance therapy with investigation, and meeting the needs of the family while punishing the perpetrator.

Critique of the investigative approach to child abuse

A recent appraisal of the investigative model in the United Kingdom furnishes a basis against which the protocol can be measured. The United Kingdom Department of Health document, *Child Protection, Messages from Research* (UK DOH, 1995) provides critical analysis of the investigative model adopted in England, particularly considering the experience in England that the Social Services are overloaded with investigation, and that protection per se is limited. Child Protection Services are caught in the investigation trap. Investigative procedures are time consuming and labour intensive; few end in criminal proceedings, and protection and family support is limited.

The overall conclusions provide important lessons for the development of a child protection system.

- *Research studies now allow for a clearer definition of child abuse.*

  This is central to any child protection service as definitions of abuse determine when to intervene and the nature of the intervention. The definitions in the protocol for a CPS in the Province of the Western Cape are similar to those used in this study. In England the idea of significant harm or the risk of significant harm to the child is not clearly defined in the *Children Act,* but is central to the initiation of any intervention. Normal behaviour in families needs to be determined, and this changes with time. An example of this is parental attitudes to spanking and discipline in general.

- *The abusive incident has to be seen in its context before the extent of its harm can be assessed, and interventions agreed.*

  Child abuse is not an absolute concept, as maltreatment is usually part of a sequence of events in a particular context. It is proposed that a continuum of behaviour be determined in the assessment of abusive or potentially abusive behaviour. Professionals are required to establish a threshold after which intervention is required. Each society determines the threshold after which an act is abusive, e.g. in Sweden hitting children as part of the disciplinary process is abusive. The threshold is being changed with time, and possibly the relatively low reporting rate for physical abuse in this study as opposed to sexual abuse, indicates the current thresholds in South Africa. The DOH document indicates that the factors influencing threshold are moral issues in the society that influence the law, policy that determines procedures set by agencies, pragmatic issues for professionals working at grass root level, and the perceived effect of any intervention.

- *Outcome studies indicate that one-off abusive episodes have few long term sequelae, and that the unfavourable environment in which the child lives is a more important factor in determining the outcome.*

  This conclusion is vital to the decision to initiate the investigative process. It alludes to the need for a flexible service that responds to the individual needs of the child and family. Long term effects of child abuse are not always known, and perhaps the effect of the investigation may be more harmful than the abuse itself. Research on the outcome of abuse is essential to determine when to intervene. It may be morally

correct to accept that discipline that involves the occasional hitting of a child is abusive, but one needs to assess whether in pragmatic terms this is an issue with which to be concerned. Thresholds for intervention should be influenced by knowledge of what influences the optimum development of children.

- *A difficult task is deciding which of the many abusive episodes require further investigation.*

  It is important to be able to determine which incidents of abuse require further investigation and which type of intervention would be best for that particular episode or sequence of events. Training and experience are essential to achieve this balance.

- *Family support is an intervention that may do more to prevent long term problems than investigation.*

  While in some cases of abuse investigation is essential to resolution of the abusive situation, investigation is not the main purpose of a child protection service. It can consume much of the time of the service and mitigate against providing the necessary support to help the family through the crisis. The possible conflict between the interests of the child and that of the family should be acknowledged.

- *Social service agencies should reconsider the balance between investigation and support.*

  The report concludes that features of a successful intervention include sensitivity on part of the professionals, informed client relationships, an appropriate power balance

between families and child protection services, consideration of the wider context rather than the abusive incident alone, and building on the strengths of the family.

The document provides some evidence as to the re-development of services in England. At present Social Services are burdened by the investigative process, and support for families and children is compromised. **The central recommendation is to decrease the intensity of the investigation process, and to concentrate on primary prevention and support to those families in need.** Primary prevention is difficult to achieve and may require an examination of the structure of society. This conclusion is crucial for the development of a service in South Africa.

As discussed in the analysis of the results of this thesis, an effective programme development is dependent on research of the nature of abuse, the context in which abuse is found, and on the actual needs of the children. Practitioners in South Africa have the opportunity to develop a Child Protection Service divorced from the coercive process of the past. This could include the removal of the obligation of mandatory reporting, and the development of a procedure based on family support, with prevention strategies, appropriate intervention for those children at risk of significant harm, and limited targeted intervention for those children who are abused and are not with significant risk.

Prevention can be the major feature. This implies an acceptance that abuse does occur and that the causes and not the effects deserve the main attention. Abuse cannot be eradicated as there always will be some casualties. In some respects the proposed structures meet this requirement, with the emphasis on agreed response to abuse and on definitions and training. The basis of the protocol is *investigation linked to the police*. An alternative approach is a

compassionate positive response, founded on early prevention strategies, family support when stresses occur, a focus on the socio-economic causes of child abuse, and attention paid to the inherent power relationships in society that influence the incidence of abuse.

An alternative philosophy to Child Protection Services

The "*confidential doctor* " approach to child protection, which has operated for a number of years in parts of Europe, offers a different view of child protection. Marneffe (1995) states that the process is based on three core assumptions:

- A critical analysis of the value of traditional interventions is essential as there is no assurance that the traditional approach adopted in most countries is more beneficial or harmful;

- Child abuse should be analysed in a broad socio-economic and political context;

and

- Analysis of all models of child abuse management is essential before the traditional model of intervention is selected.

Marneffe (1995) contends that the aim is *"not on reporting and investigation, but on comprehension of the larger social and psychological factors underlying human violence and on the offer of non-coercive help to the child and parents"*. The duality of the child protection worker's role is emphasised, i.e. the balance between help offered, and control of the parents' behaviour towards the child. This conflict often led to the problems experienced in England, as shown by the Cleveland incident. (UK DOH, 1995). Marneffe poses a pertinent question, viz.

is the aim of child protection to help the child and the family, or is it to support the legal system? The goal is to avoid turning the professional into an "investigative enemy" of the family - rather the professional avoids the inevitable conflicts that an investigative model implies. Marneffe (1995) asserts that the legal or court route often does not protect the child as the child may have no better protection than before legal proceedings commenced. This approach may rather serve to protect the professional. **It is an ideological issue that can be decided before a child protection system is adopted.**

Marnaffe suggests that violence against children should be understood with socio-psychological, cultural, political and gender issues (reflecting the arguments of Wolff, 1991 and Gil, 1975). She argues that the families most prone to domestic violence are isolated, with little power or prestige or support, and as a result experience high levels of stress. This does not preclude abuse occurring in families with prestige where the dynamics might be the power relationships within the family. The emphasis on societal change as a means to address the fundamental causes of child abuse has been popular in apartheid South Africa, though the structures of society are not easily altered. (Garbarino 1977, Pelton 1978).

Marneffe and Broos (1994) distinguish two traditional responses to child abuse.

- The *judicial model* which concentrates on investigation, determining the criminal offence, punishment of the perpetrator, and thereby protecting the child. Failure to punish and to have legal sanctions is seen to condone. Foucault (1967) referred to this in his analysis of the controls that society has developed in response to deviant behaviour. The judicial model has been developed in numerous forms, with increasing elements of family support and actual child protection.

- The *medico-psycho-social model* concentrates on family dysfunction as a major causative factor in child abuse. The abuser and abused are both victims and help is required to normalise relationships (Gelles 1979). Often this model complements the judicial model with sanctions applied if parents fail to co-operate. Reporting and investigation is central to the process before help is provided.

Marneffe and Broos (1994) propose a new model for child protection based on *"offering help instead of punishment, respecting confidentiality instead of implementing control, solidarity instead of reporting, mobilisation of the family's own resources instead of maintaining their passivity, and collaboration between professionals rather than competition"*. To achieve the optimum therapeutic intervention, separation from the judicial system is required so that the therapeutic relationship is based on trust and equality, rather than being under the threat of legal sanction. Immediate crisis intervention is the key with 24 hour services available for all families experiencing stress. It is stressed that such a programme is dependent on a comprehensive social programme that targets poverty, unemployment and other socio-economic factors associated with family stress.

In the model specialised centres for child abuse management have been established. These centres have three main functions, viz. direct assistance to and management of abused children and their families, support and supervision for professionals who come across child abuse, and prevention of child abuse. Reporting of child abuse is not mandatory and people are encouraged to report without any legal requirement to do so. Definitions of abuse are similar to those used in South Africa and other countries. There is no threat of legal or criminal proceedings for a parent who self-refers, or who is referred to the child abuse centre.

The process consists of early contact when stress occurs so that preventive measures can be introduced. Seeking help replaces reporting. Once contact with a centre is made, evaluation of potential risk is made, with the focus on the child and family, and not solely on the child and injuries. This is followed by the offer of therapeutic intervention. The therapeutic process that follows is dependent on the situation, but the police are not involved. This approach draws on the work of Alice Miller (1977). The final stage involves the reintegration of the child in the family. Marneffe concludes that the flaw of the traditional approach to child abuse and neglect is that it does not result in the empowerment of the children and families because the legal sanction ensures a power differential in the professional-client relationship. It accepts that in some cases, despite any intervention, either legal or therapeutic, re-abuse will occur, and in some cases a child may die. Analysis of the past few years experience in Belgium, indicates a low re-abuse rate, and one child fatality in 4000 cases presenting to the centres. This does not indicate how the selection of children presenting to the centres influences the figures quoted. It may well be that more serious child abuse escapes the attention of the confidential doctor clinic network.

The attractiveness of this approach is that it is focuses on primary prevention of child abuse, equal partnership with families and children, and avoids the investigative trap. The lack of mandatory reporting is attractive in that services are not overwhelmed by over-reporting of unsubstantiated reports (as experienced in the United States, Besharov, 1985; Karski, 1995) The professionals in the field report positively about the process of working together with parents rather than against them. Lindsay and Regehr (1993) contend that child welfare systems should be relieved of the role of investigation of severe child abuse, and rather concentrate on helping families in prevention of abuse and in aspects of child care.

A dilemma with the non-investigative approach is that it may deny the child the right to justice, a concept which is at the heart of the legal system. Butler (1996) argues that in child protection, one is **not** deciding between the interests of justice as opposed to the interests of the child. This is an issue that requires debate, as more than often investigation does not result in the serving of justice.

It is probable that the model proposed for the Western Cape provinces could draw on elements of both models, and avoid the problems as documented by Besharov (1985) and by the experience in England, that reporting and investigation may take precedence over assistance to the family. The confidential doctor concept cannot simply be imported into South Africa. It has been developed in a society with a tradition of compassion and tolerance, and with a strong welfare base that addresses the problems of socio-economic deprivation. Class differentials in Belgium are not as apparent as in South Africa, and the population is relatively uniform (only two cultural groups).

The legacy of violence left by the apartheid years, and the predominant themes of intolerance and family breakdown, imply that the "confidential doctor" model would require major adaptation. Issues to be addressed include parents who refuse to co-operate, and the problem of severe physical abuse and neglect. In child sexual abuse, in particular with incest, the very complexity of the relationship may preclude the family from approaching the authorities for help and intervention, yet the non-legal approach works for some families. In the Netherlands child sexual abuse is treated differently from physical abuse and neglect, and the abuser is subject to legal sanction. This is to avoid the denial and secrecy that characterises incest. Physical abuse is more open. Myers (1996) goes further and calls for clear legislative measures to protect children from child sex offenders, including the registration of offenders, and public

notification of their presence in a community. Yet as child sexual abuse occurs mainly in the home environment, this may not be a solution to the problem.

Child protection therefore may be best served by abuse policies specific to each type of abuse. Physical abuse and neglect can be dealt with by a "confidential doctor" type model, and child sexual abuse can follow a modified investigative model. This flexible option is one that could be adopted and developed within a child protection policy founded on prevention of abuse.

Conclusion

The results in the study provide information that is applicable in the development of the new Child Protection Service. It is important to recognise that the development of a Child Protection Service cannot be successful without the examination of the underlying broad philosophy of child care and the role of the law in the service. The enormity of the problem in South Africa as demonstrated in this study, and the problems experienced by the child protection systems adopted in England and the United States, suggest that policy makers should carefully examine the underlying philosophy of the service to be developed.

Any service that is developed requires a central commitment to prevention, and to the *macro* and *micro* policies that make prevention possible.

The data from this study could aid in the development of micro programmes. The *macro* approach requires a sound foundation, based on an underlying philosophy and an ethos that is in the child's best interest.

The lessons to be learnt from alternative models of child protection are that the new Child Protection Service need not be based on failed models from developed countries, but could be innovative and relevant to the needs of the children in South Africa, and to the available resources. This should be considered in the development of child protective services in South Africa. A post investigative approach is essential.

Chapter 10 Implications for research

- *Can the study in Cape Town provide an impetus for further research in the field of child abuse and neglect?*

The problem of research in child abuse

Child abuse and neglect has developed from a relatively under researched topic at the time of the first major paper, (published in 1962 by Kempe and his colleagues), to a subject which features in major medical, psychology, social work, and sociology journals. There has been a rapid growth in academic research. Research has tread the path of defining child abuse, to determining the prevalence and incidence, to examining risk factors, and more recently to studying the prevention of child abuse. The focus of interest has moved from child physical abuse and neglect, to sexual abuse, and finally to the assessment of child abuse in the terms of family or domestic violence. Research has been conducted in the main by researchers based in developed countries, and the bulk of research data and theories on child abuse are based on the findings of studies in the United States. In addition, child abuse has been influenced by the quantitative research ethos that has dominated the medically oriented journals such as *Child Abuse and Neglect*. Qualitative research has recently become more acceptable in the mainstream journals.

The study of child abuse in Africa has been limited. The lack of formal research in developing countries is well recognised, and reasons for the lack of formal research are numerous. Child protection is overshadowed by political and economic problems, lack of resources, the enormity of the phenomenon, and the lack of a research culture and research experience. The

publication of African research in international journals has been restricted to a few articles. Over the past few years a number of articles have been published in *Child Abuse and Neglect* and other journals on child abuse in Africa (e.g. Haffejee, (1991); Sumba & Bwibo, (1993); Magwaza et al., 1993; Argent et al., 1995a; Argent et al., 1995b). There is a need to refine research programmes, to publish the findings in a format accessible to the professionals in the area, and to act on these findings. Conferences and seminars on child abuse and neglect in Africa have provided the arena for debate and discussion.

In developing countries research has generally been experiential and qualitative. The challenge for practitioners and professionals in developing countries is to develop a *"culture of research"*, and to establish the ethos that the service to children who have been abused, in terms of prevention and management, can form the basis for on-going research and evaluation. Many programmes neglect the potential for research.

In a review of the research in South Africa, Levett and Lachman (1991) find that a large body of research exists, in the main unpublished, and therefore not able to influence practice in the field. It was out of this review that this study developed, as it was apparent that there have been few if any epidemiological studies in the field of child abuse in South Africa.

This study does not aim to encompass the entire field of child abuse. It is a start to the process of determining the extent of child abuse in South Africa. The study may raise a number of research topics that can be developed.

The basis for research

Finkelhor (1986) makes a number of important suggestions as far as research in the field of child sexual abuse is concerned. These can be accepted for all research in the field, and can be adapted for research in South Africa. To this end the basic requirements for research in child abuse can include the following:

- A need to free child abuse research from political pressures. Research should be conducted in the best interest of the child. Studies can be designed to answer specific questions, with the aim of influencing policy formation in the field of child protection. It is possible that the current development of child protection policy in South Africa is operating in a relative research vacuum.

- Research can be separated from any reporting process that may be implemented. It is argued that the value of mandatory reporting of child abuse is to be questioned (this is discussed in Chapter 11). Reporting cannot serve research needs efficiently. One of the major problems of this study is the dual purpose the reporting form served. Reporting, if mandatory, can provide some data, but is entirely dependent on the goodwill of reporters, and the accuracy of the data input. Validation and substantiation is a problem that is difficult to resolve.

- The development of appropriate methodology that will lead to valid results comparable to other studies, and applicable to practice is required. Research in child abuse is dominated by studies that have a complex statistical bias. As such this precludes research by many practitioners in the field.

Research techniques developed in the USA may not be adaptable to conditions in South Africa. Researchers need to look at alternative and acceptable ways to collect data, e.g. from agency records (respecting confidentiality), from therapists and doctors (easier if the research is divorced from the legal requirements of reporting), and from community groups and schools.

- The research questions should be clearly formulated and can aim to provide as complete a picture of child abuse as possible. If one considers past SASPCAN conferences, it is clear that there are many researchers who have conducted research, but research has not been co-ordinated. While central control of research is not advocated, a national forum for child abuse and child protection research could be considered, or a unit established for the purpose of research in the field.

- Training of researchers is required so that research can be effectively conducted. This is required in both qualitative and quantitative research methodology. South African research will benefit from the lessons in the USA, where qualitative research is regaining its position in the field following the dominance of quantitative research over the past 3 decades.

- Research can focus on providing the evidence to develop intervention in terms of prevention and management, and esoteric research should be minimised. The support of practitioners and researchers is needed to develop programmes as all practitioners cannot be researchers.

Underlying research questions that remain include:

- *what are the characteristics of the abused children and the abuser?;*
- *can we measure the effectiveness of intervention programmes in terms of outcome and long term effects of child abuse?;*

and

- *can child abuse be prevented?*

Possible areas of research

A number of areas for research are discussed below. Although there are researchers conducting studies at present in some of these areas. It would be useful to have a central register for research so that findings can be published, and collaborative research can take place.

Incidence and prevalence studies

Oates (1996), in a commentary on the medical model of child abuse, suggests that there should be more emphasis on epidemiology, accurate data collection and screening for high risk cases. The incidence and prevalence of child abuse in South Africa remains as a whole unknown, despite the results of this study. The original intention was to study the epidemiology of child abuse in Cape Town. A study based on a reporting system can only provide a partial answer to the question *"what are the risk factors associated with child abuse?"* On-going longitudinal prevalence studies are required. Clear and agreed definitions are essential to allow for comparisons between studies.

Careful design is required to ensure that the research answers are met. Incidence and prevalence studies can be undertaken with the goal of providing the data for service development, prevention programme development, and to initiate research in other areas of the field. This can lead to more specific studies.

Domestic violence

Domestic violence possibly plays a central role in the occurrence of child abuse as indicated in this study. The influence of domestic violence on child abuse is an area receiving increasing attention in the academic journals (refer to the abstracts of the 4th International Conference on Family Violence, Durham, New Hampshire, July 1995). Research is required to develop an understanding of child abuse, and for the emergence of child protection programmes. The study of child rearing patterns in South Africa is central to the development of prevention programmes.

Child sexual abuse

Research in child sexual abuse continues to expand world wide, with numerous studies being conducted in South Africa as noted by Levett and Lachman (1991). The present study has demonstrated that child sexual abuse is a major problem in Cape Town. Finkelhor's (1986) guidelines for research in child sexual abuse can be adapted for South Africa. The areas that require further study include:

- *Incidence and prevalence of child sexual abuse.* Reported child sexual abuse is only one approach to determining the incidence of child abuse. Strategies are required to address the problem of causing potential emotional trauma to participants of any study.

It is recommended that a national study be conducted using a variety of methodologies to determine the actual incidence and prevalence.

- *Research into violent extra-familial child sexual abuse* is required, as it is a phenomenon that is symptomatic of violence in the society.

- *Study of the long term effects of child sexual abuse* would help to determine which children require intervention, and what type of intervention should be offered and developed.

- *Evaluation of prevention programmes* is essential so that successful ones can be duplicated. Many programmes are not evaluated, and unverified effectiveness of programmes is claimed by programme organisers.

- *Development of rapid research techniques* are required to allow communities to conduct research at a community level as part of normal intervention strategies.

- *Cross-cultural research* may be useful in determining the protective factors in different communities and neighbourhoods (Fontes, 1995).

- *Research on child sexual abusers* is urgently required as long term follow-up studies are rare. The questions to be answered include why do abusers abuse? does treatment work? can one rely on the treatment offered? what is the degree of recidivism of abusers? can prevention programmes be developed?

Finkelhor (1993) stresses that most prevalence studies have focussed on the occurrence of the problem rather than on the extent of its effects. There is a need to determine the characteristics of the abuser and the abused child, and the situation that leads to child sexual abuse. This study could not look at this dimension in any detail, and further studies are required. It would be useful to determine the characteristics of children who are at risk of abuse so that intervention can be planned.

Physical abuse

The problem of physical abuse remains to be determined. In this study physical abuse is clearly under reported. It is hypothesised that this is a result of the overwhelming violent nature of the society, as the societal violence and loss of the mores of tolerance have influenced attitudes towards children. Research is urgently required into the different aspects of physical abuse in order to develop comprehensive prevention programmes. EPOCH (End Physical Punishment of Children) is an NGO that has approached this subject (Newell and Kibel, 1995). Topics for research include the following issues:

- *Knowledge of the attitudes of all sectors of the society to discipline and child-rearing* is essential in programme development A cross cultural study could provide information that would be helpful in appropriate programme development.

- *Studies into extra familial violence against children,* e.g. bullying at schools and discipline administered by teachers in schools, could be one of the first steps in the

campaign to limit extra familial physical abuse. Bullying of children is often neglected in the assessment of physical abuse.

- *Evaluation studies of parenting programmes* and other prevention programmes could aid in the development of nation wide programmes in all communities.

Research into all aspects of physical abuse is needed to provide the impetus for a campaign to end physical abuse of children in all forms. This is a long term goal, and is part of the implementation of the *United Nations Convention on the Rights of the Child.*

Childhood Fatalities

The results in this study indicate that childhood fatalities are not reported as child abuse. While validation of the cause of childhood fatality may be difficult to achieve, this raises an important research question, i.e. *what is the prevalence of childhood fatalities as a result of child abuse?* Browne and Lynch (1995) indicate that there is increased interest in the topic, and that research in this field is limited. A number issues can be addressed:

- If one accepts that childhood fatalities as a result of physical abuse is under-reported, research into all childhood deaths is required to determine the actual extent of the problem. This can be achieved by assessing all childhood deaths that cannot be attributed to natural causes. In South Africa numerous children have died as a result of the endemic violence. Statistics are available in some cases and this can be reported as a form of abuse.

- Research into the characteristics of the families in which childhood fatalities as a result of abuse occur. The information gained from these studies can be used to develop strategies for intervention and for appropriate risk assessment.

- Studies of the sudden infant death syndrome in South Africa are required as childhood fatality is often reported as a sudden infant death (Hobbs et. al., 1995).

Neglect

Areas that have been highlighted in the research is the extent of abandonment as a problem. Research in the field of neglect is limited. A study to determine the risk factors for abandoned children for the development of prevention strategies is suggested.

Research into the management strategies used to manage neglect such as fostering and removal of children would enable informed decisions to be made as to the approach to be adopted by the new Social Services departments.

The number of abandoned children has increased over the past few years. (SASPCAN, 1992). Clear definitions of what constitutes abandonment, and further research into the causation of abandonment of children at different ages is required. McKerrow et al. (1992) suggest an approach consisting of short term goals to improve the immediate condition of abandoned children, medium term goals to place the children in appropriate environments, and long term gaols to address the root causes of abandonment viz. teenage pregnancy, family breakdown, AIDS, and poverty.

Children with Special Needs

This study neglected groups of children with whom further study would be helpful in the development of programmes for prevention and intervention.

- Street children continue to be a growing phenomenon in South Africa (Cockburn 1993). Research may be helpful in the development of the strategies for street children. This includes research into societal attitudes to street children, and how these attitudes can be changed. In addition, research into the resilience of street children would be an important way of understanding their adaptation to chronic violence.

- There has been minimal research in South Africa on the abuse of children with physical, cognitive, and sensory disabilities. Jacklin (1993) has reported on early research, but this is an area that could be developed in terms of prevalence, prevention strategies, and evaluation of intervention. Kelly (1992) raises a number of issues that require consideration:
  - How does one measure the extent of the problem?
  - Can domestic violence in pregnancy affect the foetus?
  - Is there a causal relationship between disability and abuse?
  - Is the prevalence higher than in able bodied children?

  and
  - Has there been a generalisation about disability?

- The effects of endemic violence and the post traumatic stress syndromes have been researched by Straker (1991), Killian (1993) and others. As violence continues the

effect of the violence on children and the effect it will have on the next generation of parents in terms of parenting should be studied as a long term goal in prevention of physical abuse.

Prevention programmes

Over the past few years the development of child abuse prevention programmes has been a priority. As prevention is the foundation of the Child Protection Service, urgent attention is required to develop relevant and effective programmes that are applicable to the broad mass of children. Careful evaluation of prevention programmes is required as research methodology has been inconsistent, particularly with regard to selection criteria and measurement of outcome.

In the review *Lessons from Research* (UK DOH, 1995) it is noted that child abuse prevention programmes should be part of any child protection intervention service. Development of local home visitation programmes, with built-in evaluation to assess effectiveness and the model of delivery, is vital to the provision of prevention services. Landman (1994) has started an evaluation in Cape Town, but further study is required.

Risk Assessment

This study has demonstrated areas of high risk and of low risk for child abuse in Cape Town. A study of the protective factors in the areas which have low levels of child abuse as opposed to the areas with high areas could help to develop prevention strategies that can be applied elsewhere, as mentioned in relation to child sexual abuse.

The concept of risk assessment can be used to develop prevention strategies, as indicated by Korbin et al. (1995), and Daro (1995), who analyse the use neighbourhood risk assessment, and the development of prevention programmes based on the determined risk of abuse. Risk assessment tools developed in the welfare states of Europe and in the United States may be inappropriate for a developing country such as South Africa. A risk assessment is best developed by practitioners in the field to take into account the social conditions of the society. Many children in Cape Town are at risk of child abuse, and using criteria from the literature may warrant unnecessary intervention. Wells (1995) calls for "*enhanced clarity of purpose; more effective application of knowledge pertaining to decision making; ...clear terminology and constructs; the more effective translation of current knowledge for use in the field*". This is extremely relevant for South Africa at the time of the development of a National Child Protection Service. Knowledge as it pertains to South African children is essential.

Conclusion

A number of possible research options have been suggested. The development of a Research Institute for Child Abuse and Neglect (RICAN) to conduct and commission research, is a possible solution. Research can include grassroots research to encompass work conducted by practitioners in the field.

A forum for the dissemination of research findings to both professionals, practitioners and the public is desirable. A journal on child abuse research and practice could assist in disseminating the results and implications of research. Research can form the foundation for the development of policy and the formation of a relevant Child Protection Service in South Africa.

Chapter 11 Conclusions and recommendations

In the opening chapter it was stated that:

> *"The central tenet of this paper is that there must be a continuum from research to practice, from epidemiology to prevention. To plan prevention and intervention programmes, it is necessary to document the prevalence of the problem and develop agreed methods of collating data.*
>
> *It will be argued that the implications of the societal causes of abuse can be taken into account when developing a national strategy and plan of action. Finally, it will be argued that the mere adoption of management and prevention strategies from the developed world is insufficient and inappropriate in addressing the problem. The investigative approach to child abuse will be challenged and an argument for a post investigative approach based on a partnership with parents and families will be made."*

The aims and objectives have been addressed in Chapters 7 to 11, in which specific areas in the field of child abuse have been discussed. This includes the development of child protection policy, with a service based in prevention, and the need for on-going research in the field. It is hoped that the results reported in this thesis will stimulate policy development and further research. The development of an appropriate Child Protection Service, based on the needs of the children in the country, and not on the perceived needs gleamed from research in other countries, is an urgent need in South Africa. The temptation to evolve a service based on the models currently in practice in Europe and the United States is great as these models have

been the inspiration of our service in the past. The recommendations made in this chapter are based on the pertinent results reported and discussed in Chapters 6 and 7.

Conclusions

The research questions have been answered in the previous chapters. The answers to the questions *"can the characteristics of abused children be determined, and do the characteristics of child abuse and neglect in Cape Town differ from those reported in the literature?"* have been addressed. Salient aspects of the results include the following:

- **The characteristics of reported child abuse as presented in this study differ from that in the literature.** It may well be that once further research is conducted the differences may become less apparent.

- **Reported child physical abuse is under-reported in comparison to other countries**. This could be explained by the high levels of violence in South Africa. Violence has become a norm and violence against children is either ignored or not reported. The political history of South Africa, and the ongoing struggle against apartheid, has created an environment where violence is endemic. Reported physical abuse represents a fraction of the violence perpetrated against children as routine physical abuse may not come to the attention of the Child Protection Service.

- **Reported child sexual abuse occurs more frequently than in other studies.** The low levels of reported physical abuse may explain the proportionately high levels of child sexual abuse. Alternatively it may be explained that child sexual abuse in South

Africa is a greater problem than elsewhere. It is likely that child sexual abuse is a problem and will continue to be one unless the underlying causes are addressed.

- **Females are at a high risk of reported child sexual abuse, and most of this abuse is either intra-familial, or inflicted by a person known to the child**. This has clear implications for the type of prevention programmes to be developed

- **Males are more prone to reported physical abuse.** Male sexual abuse may be under-reported, though this finding is in keeping with trends in the literature.

- **Rates of reported abuse are higher than those noted in the literature.** This may indicate that the areas in the city exposed to stress and poor social cohesiveness have the highest levels of child abuse. It is not possible to comment on the racial distribution of child abuse. Rates of child abuse are difficult to compare due to the differing study designs, definitions of abuse and entry criteria for each study.

- **There is an absence of reported fatal child abuse.** Fatalities due to child abuse require further study.

The above conclusions are made despite the difficulty in comparing results from different as noted in Chapter 8. It may appear to be self defeating to make such comparisons, yet until a multi-centre international study of child abuse is made, comparisons will be difficult. At this juncture one cannot expect to make more than tentative conclusions.

Recommendations

A number of recommendations are made. These can be implemented by the new Child Protection Service.

Introduction of a mandatory reporting system

The question *"should a mandatory child abuse reporting system be developed and implemented?"* is central to the national debate on child protection policy. The Multi-disciplinary Management of Child Abuse and Neglect in the Province of the Western Cape (1996) is based on reporting - "*It is regarded as a minimum requirement that a single known facility in every CPS District is available so that any person can report instances or suspected instances of child abuse and neglect and can be confident that such a report will be immediately and properly followed up.*" If reporting fails the remaining steps in the process - referral, registration and investigation cannot take place.

This research commenced with the aim of developing an effective reporting service for the area. The legal requirements for reporting provided an impetus for the study. The information gathered has been valuable, and represents the most comprehensive data set so far in South Africa. Nonetheless, the data does not present the full picture of child abuse. As discussed in Chapter 3, the reporting of child abuse can be the first step in the Child Protection Service. It evolves from a medical solution to a social problem, similar to the reporting of infectious diseases. If one follows this model, one assumes that child abuse is a "disease that can be cured", if practitioners know the extent of the problem. This is not the experience in many countries as reported in Chapter 3, 4 and 9. Reporting identifies some of the abused children and children at risk of abuse. Reporting suffers from bias, high rates of invalidated reports,

over-reporting and under-reporting as indicated in the result, and serious ethical issues for many practitioners.

The decision whether or not to develop a mandatory reporting system for child abuse is important as it will influence the development a Child Protection Service. Within this decision lies the ethos of the child abuse protection system that is to be developed. It has been argued in Chapter 9 that a non-legal approach be adopted, and that an alternative to the standard western model of child protection be developed. Once this underlying philosophy of child care has been determined, the nature of a reporting system, if any, can be decided.

The negative implications of a mandatory reporting system include:

- Raised expectations of professionals, parents and children that something will be done despite limited resources;
- Possible negative impact on families where investigation reveals unsubstantiated reports;
- Investigations that may be negative experiences;
- Overburdening of professionals with unnecessary investigation;

and

- A change in the professionals' function from a therapeutic to a conflicted combative role.

As mentioned previously, substantiation of reports is not possible in all cases. It is not clear whether reporting makes much difference to the child. Reporting cannot be equated to

protection. The quality of reporting is dependent on the expertise of the reporter, as indicated in the case of dentists by Von Burg and Hibbard (1995).

Levine and Doueck (1995) conclude their analysis of reporting systems with a call for neighbourhood centres which would address the needs of children at risk or children who have been abused in a non-coercive way. This concept is similar to the confidential doctor in Europe. Child protection is not dependent on mandatory reporting.

It is recommended that mandated reporting for all forms and levels of child abuse, as proposed in the child protection proposals, and by the current *Child Care Act,* **is not introduced** as part of the new child protection system in South Africa. The arguments for and against mandatory reporting have been discussed in Chapter 3, and can be summarised thus:

- The model of new child protective service hopefully will move away from the emphasis on investigation and "criminal justice" to one of prevention and support;
- South Africa does not have the capacity to run an effective reporting system;
- Validation and substantiation of reports is not possible given the lack of resources;
- Targeted and discretionary reporting could be a more effective use of resources (Finkelhor and Zellman, 1991).

An alternative, flexible system can be developed whereby data is collected for statistical purposes by individual agencies, and only certain categories of child abuse are reported, viz.

the most severe cases of child abuse, and severe injury childhood fatality. A uniform system for collecting data on child abuse related deaths is required. Cases that do not require investigation can be ruled out using clear definitions of risk assessment at the community level. **The focus can be on family support rather than reporting**. If one adopts this position on reporting, one can move on to the development of a child protection policy that addresses the structural inequalities in society that facilitate the occurrence of child abuse. As an alternative to mandatory reporting, on-going research into child abuse can provide the necessary information for the development of prevention and intervention programmes.

Child protection policy

The results may provide an impetus to *an appropriate policy on child abuse and neglec*t. It has been argued that an alternative child protection policy is required to meet the specific needs of the children of South Africa (Chapter 9) Patel (1993) summarises the need for change in social welfare stating that social welfare should encompass a comprehensive system of social service which includes programmes and policies aimed at the promotion of physical, economic, political and social development. Child protection cannot be seen in a vacuum, particularly in South Africa. Child protection policy **cannot be imported** from the United States and Europe. Elements of the experience in these countries can be incorporated in a programme for South Africa that is based on a foundation of prevention.

The medically (or public health) inspired investigative model is **not** necessarily the answer to solving the problem of child abuse and neglect (see Chapter 9). Important lessons can be learnt from the epidemiological approach to child abuse (Oates, 1996), but it is not the sole solution. Parton (1991) emphasises that this model, and the supporting paradigm, ignores the social arrangements that govern people's lives, and results in the failure to acknowledge the social

context of abuse. This leads in neglect of the social and economic factors that influence child abuse. To accept this approach implies a re-evaluation of the medical model of child abuse developed by Kempe, and espoused in international journals. The work of Gil, Pelton, Garbarino, and Parton is crucial for the development of services in South Africa.

In South Africa the concept of structural abuse was used to explain the effects of the apartheid system. Structural abuse is not another form of child abuse, rather it is part of each type of abuse. Child sexual abuse, physical abuse, and neglect all reflect the social structure and values of the society. In order to address these forms of abuse, a dynamic and radical child protection policy is required, and some ideas are provided in Chapter 9. **It is important that the trap of the medical and investigative model be recognised. A fundamental shift in the philosophical approach to child abuse and neglect is required. This can only take place if the structural causes of child abuse are acknowledged.**

Marneffe (1996) summarises this debate succinctly "*Successful therapeutic responses to child abuse and neglect are perfectly possible if a new model in child protection is offered based on empathy, trust, and encouragement for those who fail in raising their children instead of the traditional approaches based on mandatory reporting, control, judgment and sanctions.*"

Advocacy for children

It has been stressed that advocacy for children is essential and the *United Nations Declaration for the Rights of the Child* (1989) can play a central role in the protection of children. In the long term children require an independent advocate to promote their needs at the highest level. A solution based on the Norwegian experience of the Child Commissioner or Ombudsperson could be considered. The purpose of this post (or posts, if one for each province is created)

would be to protect the interests of children at all levels and to provide children with an avenue to develop their rights. The programme could be adopted for South Africa, and functions could include monitoring of relevant legislation, proposing measures to improve laws relating to and affecting children, developing solutions to the inevitable conflict between the needs of Society and the needs of children, and monitoring the implementation of the UN Convention. The Child Commissioner could represent the interests of children to Parliament, and could report directly to the President. Children require direct access to policy makers at the highest level.

Development of prevention and intervention strategies

As alluded to in the recommendation on policy development, prevention of child abuse is the preferred basis of all policy. This is the trend in the United States and England where policy makers and practitioners are attempting to reduce the investigative model and increase the preventive and positive aspects of their child protection systems. It is important not to build a programme devoid of prevention programmes. Options have been discussed, and *macro* and *micro* programmes proposed. One cannot prevent all child abuse, but one can move towards creating a society in which:

- Physical punishment of children is not approved or sanctioned;
- Girls are empowered and sexual abuse is prevented;

and

- Families have help **before** abuse or neglect occurs.

The development of home visitation programmes has been stressed and should be encouraged. Child prevention centres such as RAPCAN (Resources Aimed At the Prevention of Child

Abuse and Neglect, Cape Town) should be critically evaluated, and if found to be effective, supported and developed in other parts of the country. Proactive moves to dealing with the effects of violence are required (Swartz and Levett, 1989). Prevention is the key intervention.

Impetus for further research future research

The possible areas from research are discussed in Chapter 10. It is recommended that a research institute for child abuse and neglect be established to collate and co-ordinate child abuse research in South Africa. Child abuse research aimed at influencing policy development and service provision is urgently required. Specific areas that require urgent research include:

- *Prevalence studies*
  - a continuation of epidemiological studies on child abuse;
  - addressing the problem of childhood fatalities;
- *Intervention*
  - evaluation of management programmes;
  - assessing the long term effects of child sexual abuse and defining types of abuse that occur;
  - effects and intervention for children exposed to violence;
- *Prevention*
  - determining factors in areas with low levels of child abuse that prevent abuse;
  - prevention strategies on a community basis;
  - evaluation of prevention programmes;
- *Other areas for research*
  - social practices such as child labour require detailed research.

All professionals and practitioners require support and encouragement to include evaluation and audit as part of their programme development. Research findings should be made available to policy makers and practitioners, and not only to academic journals and conferences.

Final word

This study has analysed the data collected from a reporting system introduced to Cape Town in 1994. The results lend support to the viewpoint that child protection in South Africa is an extensive problem, and that a fresh approach to its prevention and management is required. If we can accept that for some children abuse and neglect is inevitable, despite the best efforts to prevent it occurring, we can progress to the aim of creating a climate in which the vast majority of children will be safe from child abuse and neglect. This will require radical rethink on the conventional concept of child abuse and neglect in terms of definitions of the problem, aetiology, and the development of an appropriate response.

Prevention of child abuse and neglect is the goal. The approach to child protection discussed in the thesis can be adapted for implementation in other areas of the developing world. A fundamental change in the philosophy of child protection is required to realistically protect the children of the developing world. This is a challenge for the new millennium.

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Appendices

Appendix 1 Reporting form used in the study

Appendix 2 Groupings of suburbs of Cape Town by:

Individual suburbs

Magisterial district

Suburb groupings

Suburbs are grouped to allow for meaningful interpretation of data. Grouping is made in three ways:

Proximity and like characteristics (type of housing, socio-economic status where possible)

Magisterial district

Grouped according to predominant socio-economic status

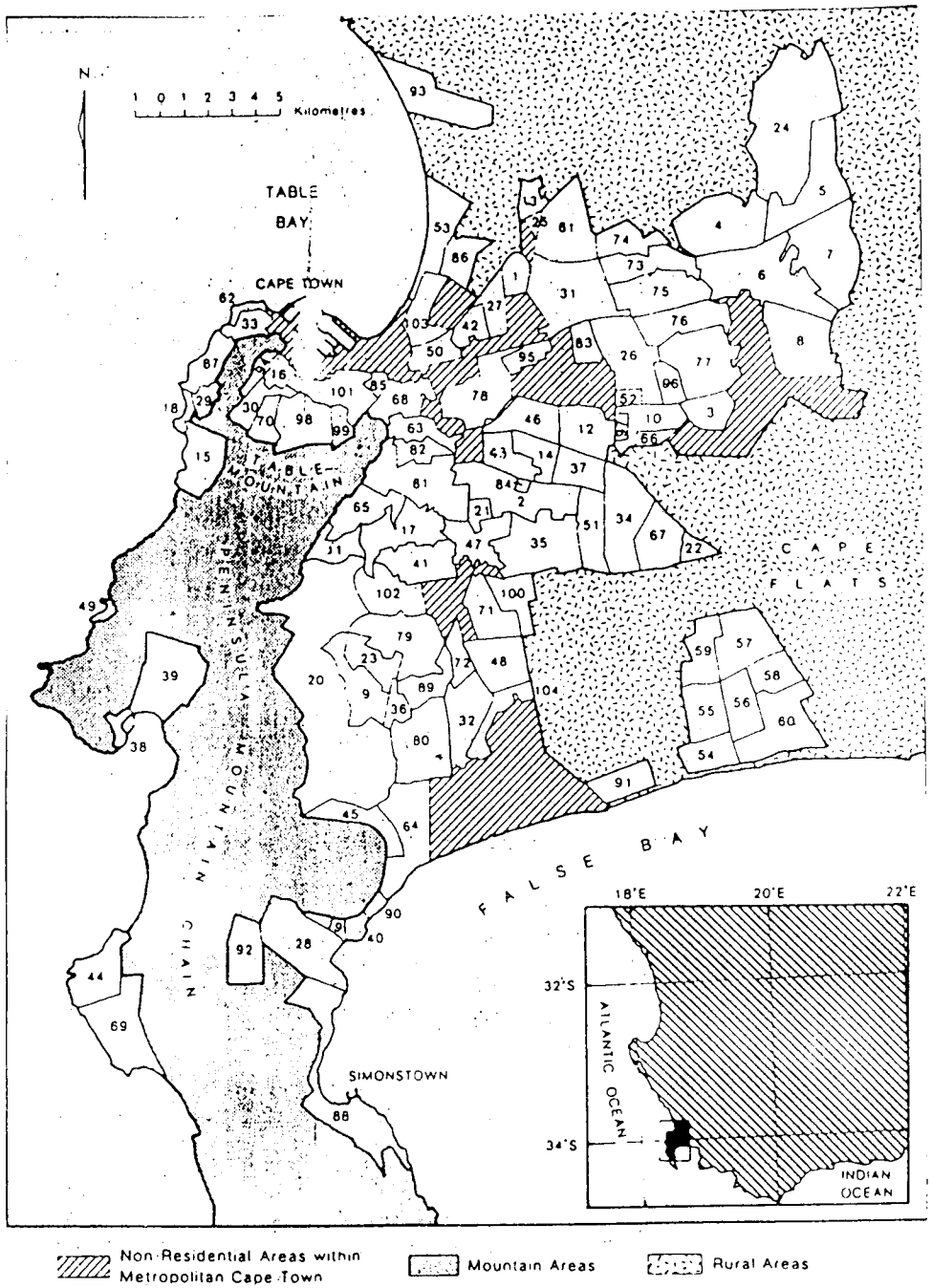


Fig. 1. Map showing the 104 suburbs of Metropolitan Cape Town.

Suburb No.	Suburb/area name
1	Acacia Park
2	Athlone
3	Belhar
4	Bellyille North 1
5	Bellville North 2
6	Bellville Central
7	Bellville East
8	Bellville South
9	Bergvliet
10	Bishop Lavis
11	Bishopscourt
12	Bonteheuwel
13	Bothasig
14	Bridgetown
15	Camps Bay
16	Cape Town
17	Claremont
18	Clifton
19	Clovelly
20	Constantia & Tokai
21	Crawford
22	Crossroads
23	Diep River
24	Durbanville
25	Edgemead
26	Elsies River
27	Factreton
28	Fish Hoek
29	Fresnaye
30	Gardens
31	Goodwood
32	Grassy Park
33	Green Point
34	Guguletu
35	Hanover Park

Suburb No.	Suburb/area name
36	Heathfield
37	Heideveld
38	Hout Bay Harbour
39	Hout Bay
40	Kalk Bay
41	Kenilworth
42	Kensington
43	Kewtown
44	Kommetjie
45	Lakeside
46	Langa
47	Lansdowne
48	Lotus River
49	Llandudno
50	Maitland
51	Mannenberg
52	Matroosfontein
53	Milnerton
	Mitchell's Plain:
	54 Rocklands
	55 Westridge
	56 Portlands
	57 Lentegeur
	58 Beacon Valley
	59 Woodlands
	60 Eastridge & Tafelsig
61	Monte Vista
62	Mouille Point
63	Mowbray
64	Muizenberg
65	Newlands
66	Nooitgedacht
67	Nyanga
68	Observatory
69	Ocean View
70	Oranjezicht

Suburb No.	Suburb area name
71	Ottery
72	Parkwood
73	Parow North 1
74	Parow North 2
75	Parow Central
76	Parow South 1
77	Parow South 2
78	Pinelands
79	Plumstead
80	Retreat
81	Rondebosch
82	Rosebank
83	Ruyterwacht
84	Rylands
85	Salt River
86	Sanddrift
87	Sea Point
88	Simonstown
89	Southfield
90	St James
91	Strandfontein
92	Sun Valley
93	Table View
94	Tamboerskloof
95	Thornton
96	Uitsig
97	Valhalla Park
98	Vredehoek
99	Walmer
100	Wetton
101	Woodstock
102	Wynberg
103	Ysterplaat
104	Zeekoeivlei

Census Areas, Study Areas, Magisterial districts, Study Districts and Grouped Districts in Cape Town

(in order of Study District number)

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
1	AKASIA PARK	Acacia Park	3 Goodwood	23 Maitland	3 City
2	ATHLONE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	BELGRAVIA	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	BELTHORN ESTATE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	GATESVILLE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	PENLYN ESTATE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	SILVERTOWN	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	SURREY	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
3	BELHAR	Belhar	1 Bellville	5 Bellville C	1 Northern Suburbs
3	BELLAIR	Belhar	1 Bellville	5 Bellville C	1 Northern Suburbs
4	BELVILLE NU 1	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BELVILLE-EAST	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BOQUINAR	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BRACKENFELL	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	NORTHPINE	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	PEERLESS PARK	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	SCOTTSDENE	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
5	BELVILLE NU 2	Belville N 2	1 Bellville	2 Bellville A	1 Northern Suburbs
5	BLOMTUIN	Belville N 2	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BELLVILLE-CENTRAL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BELLVILLE-WEST	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BO-OAKDALE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BOSBELL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BOSTON	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	CHISMAR	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	CRAVENBY (BELLVILLE)	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	DOOR DE KRAAL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	EVERSDAL (BELLVILLE)	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	OAKDALE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	OAKGLEN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	PROTEAVALLEI	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	RICHMOND	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	RICHWORTH	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	SANLAMHOF	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STELLENBERG	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STELLENRIDGE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STIKLAND	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	THALMAN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	VREDENBERG	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	WELGELEGEN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	WELGEMOED	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
7	AVONDALE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	CHURCHILL	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
7	CLAM-HALL	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	FAIRFIELD	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GLENHAVEN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GLENLILY	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GROENVALLEI	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	HOHEIZEN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	KEMPENVILLE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	KENRIDGE (BELLVILLE)	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LA ROCHELLE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LABIANCE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LOEVENSTEIN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	MAASTRECHT	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	OOSTERZEE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	RICHWOOD 1	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	RICHWOOD 2	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	WINDSOR ESTATE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	WINDSOR PARK	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	ZOO PARK	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
8	BELLVILLE-SOUTH	Belville S	1 Bellville	2 Bellville A	1 Northern Suburbs
9	BERGVLIET	Bergvliet	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
10	BISHOP LAVIS	Bishop Lavis	3 Goodwood	5 Bellville C	1 Northern Suburbs
11	BISHOPS COURT	Bishopcourt	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
12	BONTEHEUWEL	Bonteheuwel	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
12	PRIMROSE PARK	Bonteheuwel	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
13	BOTHASIG	Bothasig	3 Goodwood	6 Milnerton	2 Milnerton
14	BRIDGETOWN	Bridgetown	5 Wynberg	12 Athlone	5 The Cape Flats (A)
15	BANTRY BAY	Camps Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
15	CAMPS BAY/ BAKOVEN	Camps Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
16	CAPE TOWN CENTRE	Cape Town	2 Cape Town	7 City A	3 City
16	CAPE TOWN REST (CAPE)	Cape Town	2 Cape Town	7 City A	3 City
16	FORESHORE	Cape Town	2 Cape Town	7 City A	3 City
16	ZONNEBLOEM	Cape Town	2 Cape Town	7 City A	3 City
17	CLAREMONT	Claremont	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
18	CLIFTON	Clifton	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
19	CLOVELLY	Clovelly	4 Simonstown	11 False Bay	4 Cape Town suburbs
20	CONSTANTIA 1	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	CONSTANTIA 2	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	KIRSTENHOF	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	MEADOWRIDGE	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	TOKAI	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	WESTLAKE	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
21	CRAWFORD	Crawford	5 Wynberg	12 Athlone	5 The Cape Flats (A)
23	DIEP RIVER	Dieo River	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
24	DURBANVILLE PROPER	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	EVERSDAL (DURBANVILLE)	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	KENRIDGE (DURBANVILLE)	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	MORNING STAR	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
25	EDGEMEAD	Edgemead	3 Goodwood	6 Milnerton	2 Milnerton
26	ELSIES RIVER INDUST	Elsies River	3 Goodwood	1 Goodwood	1 Northern Suburbs
27	FRACTRETON	Factreton	2 Cape Town	23 Maitland	3 City
28	FISH HOEK	Fish Hoak	4 Simonstown	11 False Bay	4 Cape Town suburbs
29	FRESNAYE	Fresnaye	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
30	GARDENS	Gardens	2 Cape Town	7 City A	3 City
31	ADRIAANSE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	AVON	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	AVONWOOD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	BALVENIE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CLARKES	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CONNAUGHT	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CRAVENBY (GOODWOOD)	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	ELNOR	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EPPING FOREST	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EPPING INDUSTRIAL	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EUREKA	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	GOODWOOD ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	LOUW'S BUSH	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	MONTANA/DURHEIM	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	MOWBRAY (GOODWOOD)	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	NDABENI (GOODWOOD) 1	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	NORWOOD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	RICHMOND ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	RIVERTON	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	SALBERAU	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	THE RANGE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	TOWNSEND ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	TYGERDAL	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	VASCO ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	WINGFIELD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
32	GRASSY PARK	Grassy Park	5 Wynberg	14 South Flats	5 The Cape Flats (A)
33	GREEN POINT	Green Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
34	GUGULETU	Guguletu	6 Mitchells Plain	15 Mid Cape Flats (B)	6 The Cape Flats (B)
35	CHARLESVILLE	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
35	HANOVER PARK	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
35	PINATI	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
36	HEATHFIELD	Heathfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
37	HEIDEVELD	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
37	VANGUARD	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
37	WELCOME	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
38	HOUT BAY HARBOUR	Hout Bay harbour	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
39	HOUT BAY	Hout Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
40	KALK BAY	Kalk Bay	4 Simonstown	11 False Bay	4 Cape Town suburbs
41	KENILWORTH	Kenilworth	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
42	KENSINGTON	Kensington	2 Cape Town	23 Maitland	3 City
43	KEW TOWN	Kewtown	5 Wynberg	12 Athlone	5 The Cape Flats (A)

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
44	KOMMETJIE	Kommetjie	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
44	NOORDHOEK	Kommetjie	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
45	LAKESIDE	Lakeside	4 Simonstown	11 False Bay	4 Cape Town suburbs
45	MARINA DA GAMA	Lakeside	4 Simonstown	11 False Bay	4 Cape Town suburbs
46	LANGA	Langa	3 Goodwood	15 Mid Cape Flats (B)	6 The Cape Flats (B)
46	LWANDLE	Langa	3 Goodwood	15 Mid Cape Flats (B)	6 The Cape Flats (B)
47	LANDSDOWNE	Landsdowne	5 Wynberg	14 South Flats	5 The Cape Flats (A)
48	LOTUS RIVER	Lotus River	5 Wynberg	14 South Flats	5 The Cape Flats (A)
48	MONTAGU'S GIFT	Lotus River	5 Wynberg	14 South Flats	5 The Cape Flats (A)
49	LLANDUDNO	Llandudno	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
50	BROOOKLYN	Maitland	2 Cape Town	23 Maitland	3 City
50	MAITLAND	Maitland	2 Cape Town	23 Maitland	3 City
50	MAITLAND GARDEN VILLAGE	Maitland	2 Cape Town	23 Maitland	3 City
50	NDABENI (CAPE)	Maitland	2 Cape Town	23 Maitland	3 City
50	RUGBY	Maitland	2 Cape Town	23 Maitland	3 City
51	MANENBERG	Mannerberg	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
52	MATROOSFONTEIN	Matroosfontein	3 Goodwood	5 Bellville C	1 Northern Suburbs
53	BLOUBERGSTRAND	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MBEKWENI	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MELKBOSSTRAND	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MILNERTON	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MILNERTON REST	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
54	ROCKLANDS	Rocklands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
55	WESTRIDGE	Westridge	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
56	PORTLANDS	Portlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
57	LENTEGEUR	Lentegeur	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
58	BEACON VALLEY	Beacon Valley	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
59	COLORADO	Woodlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
59	WOODLANDS	Woodlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	CENTRE MITCHELL'S PLAIN	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	EASTRIDGE	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	TAFELSIG	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
61	MONTE VISTA	Monte Vista	3 Goodwood	6 Milnerton	2 Milnerton
62	MOUILLE POINT	Mouille Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
63	MOWBRAY (WYNBERG)	Mowbray	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
63	SYBRAND PARK	Mowbray	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
64	MUIZENBERG	Muizenberg	4 Simonstown	11 False Bay	4 Cape Town suburbs
65	NEWLANDS	Newlands	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
66	NOOITGEDACHT	Nooitgedacht	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
67	NYANGA/ CROSSROADS	Nyanga	6 Mitchells Plain	15 Mid Cape Flats (B)	6 The Cape Flats (B)
68	OBSERVATORY	Observatory	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
69	OCEAN VIEW	Ocean View	4 Simonstown	11 False Bay	4 Cape Town suburbs
70	ORANJEZICHT	Oranjezicht	2 Cape Town	7 City A	3 City
71	FAIRWAYS	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)
71	OTTERY	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)
71	OTTERY EAST	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)
72	PARKWOOD	Parkwood	5 Wynberg	14 South Flats	5 The Cape Flats (A)

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
73	PAROW-NORTH	Parow N 1	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW VALLEY	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW-EAST	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PLATTEKLOOF	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
77	PANORAMA	Parow S 2	1 Bellville	4 Parow	1 Northern Suburbs
78	PINELANDS	Pinelands	3 Goodwood	10 Southern suburbs	4 Cape Town suburbs
79	PLUMSTEAD	Plumstead	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
80	RETREAT	Retreat	5 Wynberg	14 South Flats	5 The Cape Flats (A)
81	RONDEBOSCH	Rondebosch	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
81	RONDEBOSCH EAST	Rondebosch	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
82	ROSEBANK	Rosebank	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
82	ROYAL CAPE	Rosebank	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
83	RUYTERWACHT	Ruyterwatch	3 Goodwood	1 Goodwood	1 Northern Suburbs
84	RYLANDS	Rylands	5 Wynberg	12 Athlone	5 The Cape Flats (A)
85	SALT RIVER	Salt River	2 Cape Town	8 City B	3 City
85	SCHOTSCHEKLOOF	Salt River	2 Cape Town	8 City B	3 City
87	SEA POINT	Sea Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
87	THREE ANCHOR BAY	Sea Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
88	SCARBOROUGH	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SILVER MINE (SIMONSTOWN)	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 1	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 3	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 4	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
89	ELFINDALE	Southfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
89	SOUTHFIELD	Southfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
90	ST JAMES	St James	4 Simonstown	11 False Bay	4 Cape Town suburbs
91	STRANDFONTEIN	Strandfontein	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
92	SUN VALLEY	Sun Valley	4 Simonstown	11 False Bay	4 Cape Town suburbs
92	ZERILDA PARK	Sun Valley	4 Simonstown	11 False Bay	4 Cape Town suburbs
93	TABLE VIEW	Table View	3 Goodwood	6 Milnerton	2 Milnerton
94	TAMBOERSKLOOF	Tamboerskloof	2 Cape Town	7 City A	3 City
95	THORNTON	Thornton	3 Goodwood	1 Goodwood	1 Northern Suburbs
96	UITSIG	Uitsig	1 Bellville	4 Parow	1 Northern Suburbs
97	VALHALLA	Valhalla Park	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
98	TIJGERHOF/SANDDRIFT	Vredehoek	2 Cape Town	7 City A	3 City
98	VALHALLA PARK	Vredehoek	2 Cape Town	7 City A	3 City
98	VREDEHOEK	Vredehoek	2 Cape Town	7 City A	3 City
100	WETTON	Wetton	5 Wynberg	14 South Flats	5 The Cape Flats (A)
101	WOODSTOCK	Woodstock	2 Cape Town	8 City B	3 City
102	CAPE TOWN EAST (WYNBERG)	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	SILVER MINE (WYNBERG)	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	WYNBERG	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	YOUNGSFIELD	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
103	WYNBERG NU 1	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
103	WYNBERG NU 2	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
103	WYNBERG NU 3	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
103	YSTERPLAAT	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
104	PELIKAN PARK	Zeekoeivlei	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
104	ZEEKOEVLEI	Zeekoeivlei	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
106	BROWNSFARM	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
106	PHILIPPI	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
106	PHILIPPI RURAL	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
107	DELFT	Delft	6 Mitchells Plain	20 New Cape Flats	10 The Cape Flats (C)
108	KAYA MANDI	Kayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
108	KHAYELITSA/ LINGELETHUU	WKayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
108	MFULENI	Kayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
109	FRANSCHOEK 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	FRANSCHOEK 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	GORDON'S BAY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSAR 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSAR 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSARSTRAND	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MALMESBURY NU 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MALMESBURY NU 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MAMRE	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MANDALAY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	STRAND	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	STRAND NU	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	SUNNYDALE	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WEBERSVALLEI	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WELLINGTON	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WELLINGTON NU	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WELTEVREDEN VALLEY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER 1	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER 2	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER-SUID	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	GAYLEE	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	KLEINVLEI	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	KLEINVLEI ANNEX	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	ROTTERDAM	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	WESBANK	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
112	RAVENSMEAD	Ravensmead	1 Bellville	5 Bellville C	1 Northern Suburbs
113	ATLANTIS	Atlantis	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
114	LAVENDER HILL	Lavender Hill	5 Wynberg	14 South Flats	5 The Cape Flats (A)
115	KALKSTEENFONTEIN	Kalksteenfontein	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
116	STEENBERG	Steenberg	5 Wynberg	11 False Bay	4 Cape Town suburbs
118	BLACKHEATH	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	FAURE (KUILSRIVER)	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 1	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 2	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 3	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVIER	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
118	KYLEMORE	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	SAREPTA	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
119	FAURE (SOMERSET WEST)	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	FAURE (STELLENBOSCH)	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 3	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 4	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL NU	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PENHILL	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PHILADELPHIA	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PNIEL	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RAITHBY	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RUSTDAL 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RUSTDAL 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SIR LOWRY'S PASS	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SOMERSET-WEST	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SOMERSET-WEST NU	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH NU 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
121	BELMONT PARK	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	BONNIE BROOK	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	EIKENDAL	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	KRAAIFONTEIN RES 1	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	KRAAIFONTEIN RES 3	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	MODDERDAM	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
122	NEWFIELDS	Newfields	6 Mitchells Plain	19 Phillipi	9 Phillipi
125	HAZENDAL	Hazendal	5 Wynberg	20 New Cape Flats	10 The Cape Flats (C)
127	SCOTTSVILLE	Scottsville	1 Bellville	5 Bellville C	1 Northern Suburbs

Census Areas, Study Areas, Magisterial districts, Study Districts and Grouped Districts in Cape Town

(in order of Grouped District number)

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
26	ELSIES RIVER INDUST	Elsies River	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	ADRIAANSE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	AVON	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	AVONWOOD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	BALVENIE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CLARKES	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CONNAUGHT	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	CRAVENBY (GOODWOOD)	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	ELNOR	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EPPING FOREST	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EPPING INDUSTRIAL	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	EUREKA	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	GOODWOOD ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	LOUW'S BUSH	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	MONTANA/DURHEIM	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	MOWBRAY (GOODWOOD)	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	NDABENI (GOODWOOD) 1	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	NORWOOD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	RICHMOND ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	RIVERTON	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	SALBERAU	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	THE RANGE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	TOWNSEND ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	TYGERDAL	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	VASCO ESTATE	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
31	WINGFIELD	Goodwood	3 Goodwood	1 Goodwood	1 Northern Suburbs
83	RUYTERWACHT	Ruyterwatch	3 Goodwood	1 Goodwood	1 Northern Suburbs
95	THORNTON	Thornton	3 Goodwood	1 Goodwood	1 Northern Suburbs
4	BELVILLE NU 1	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BELVILLE-EAST	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BOQUINAR	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	BRACKENFELL	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	NORTHPINE	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	PEERLESS PARK	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
4	SCOTTSDENE	Belville N 1	1 Bellville	2 Bellville A	1 Northern Suburbs
5	BELVILLE NU 2	Belville N 2	1 Bellville	2 Bellville A	1 Northern Suburbs
5	BLOMTUIN	Belville N 2	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BELLVILLE-CENTRAL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BELLVILLE-WEST	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BO-OAKDALE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BOSBELL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	BOSTON	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	CHISMAR	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
6	CRAVENBY (BELLVILLE)	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	DOOR DE KRAAL	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	EVERSDAL (BELLVILLE)	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	OAKDALE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	OAKGLEN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	PROTEAVALLEI	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	RICHMOND	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	RICHWORTH	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	SANLAMHOF	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STELLENBERG	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STELLENRIDGE	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	STIKLAND	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	THALMAN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	VREDENBERG	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	WELGELEGEN	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
6	WELGEMOED	Belville C	1 Bellville	2 Bellville A	1 Northern Suburbs
7	AVONDALE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	CHURCHILL	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	CLAM-HALL	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	FAIRFIELD	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GLENHAVEN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GLENLILY	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	GROENVALLEI	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	HOHEIZEN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	KEMPENVILLE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	KENRIDGE (BELLVILLE)	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LA ROCHELLE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LABIANCE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	LOEVENSTEIN	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	MAASTRECHT	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	OOSTERZEE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	RICHWOOD 1	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	RICHWOOD 2	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	WINDSOR ESTATE	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	WINDSOR PARK	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
7	ZOO PARK	Belville E	1 Bellville	2 Bellville A	1 Northern Suburbs
8	BELLVILLE-SOUTH	Belville S	1 Bellville	2 Bellville A	1 Northern Suburbs
24	DURBANVILLE PROPER	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	EVERSDAL (DURBANVILLE)	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	KENRIDGE (DURBANVILLE)	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
24	MORNING STAR	Durbanville	7 Kuils River	2 Bellville A	1 Northern Suburbs
118	BLACKHEATH	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	FAURE (KUILSRIVER)	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 1	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 2	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVER NU 3	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	KUILSRIVIER	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
118	KYLEMORE	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
118	SAREPTA	Kuilsrivier	7 Kuils River	3 Bellville B	1 Northern Suburbs
121	BELMONT PARK	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	BONNIE BROOK	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	EIKENDAL	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	KRAAIFONTEIN RES 1	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	KRAAIFONTEIN RES 3	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
121	MODDERDAM	Kraiifontein	1 Bellville	3 Bellville B	1 Northern Suburbs
73	PAROW-NORTH	Parow N 1	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW VALLEY	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PAROW-EAST	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
75	PLATTEKLOOF	Parow C	1 Bellville	4 Parow	1 Northern Suburbs
77	PANORAMA	Parow S 2	1 Bellville	4 Parow	1 Northern Suburbs
96	UITSIG	Uitsig	1 Bellville	4 Parow	1 Northern Suburbs
3	BELHAR	Belhar	1 Bellville	5 Bellville C	1 Northern Suburbs
3	BELLAIR	Belhar	1 Bellville	5 Bellville C	1 Northern Suburbs
10	BISHOP LAVIS	Bishop Lavis	3 Goodwood	5 Bellville C	1 Northern Suburbs
52	MATROOSFONTEIN	Matroosfontein	3 Goodwood	5 Bellville C	1 Northern Suburbs
112	RAVENSMEAD	Ravensmead	1 Bellville	5 Bellville C	1 Northern Suburbs
127	SCOTTSVILLE	Scottsville	1 Bellville	5 Bellville C	1 Northern Suburbs
13	BOTHASIG	Bothasig	3 Goodwood	6 Milnerton	2 Milnerton
25	EDGEMEAD	Edgemead	3 Goodwood	6 Milnerton	2 Milnerton
53	BLOUBERGSTRAND	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MBEKWENI	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MELKBOSSTRAND	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MILNERTON	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
53	MILNERTON REST	Milnerton	3 Goodwood	6 Milnerton	2 Milnerton
61	MONTE VISTA	Monte Vista	3 Goodwood	6 Milnerton	2 Milnerton
93	TABLE VIEW	Table View	3 Goodwood	6 Milnerton	2 Milnerton
103	WYNBERG NU 1	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
103	WYNBERG NU 2	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
103	WYNBERG NU 3	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
103	YSTERPLAAT	Ysterplaat	2 Cape Town	6 Milnerton	2 Milnerton
16	CAPE TOWN CENTRE	Cape Town	2 Cape Town	7 City A	3 City
16	CAPE TOWN REST (CAPE)	Cape Town	2 Cape Town	7 City A	3 City
16	FORESHORE	Cape Town	2 Cape Town	7 City A	3 City
16	ZONNEBLOEM	Cape Town	2 Cape Town	7 City A	3 City
30	GARDENS	Gardens	2 Cape Town	7 City A	3 City
70	ORANJEZICHT	Oranjezicht	2 Cape Town	7 City A	3 City
94	TAMBOERSKLOOF	Tamboerskloof	2 Cape Town	7 City A	3 City
98	TIJGERHOF/SANDDRIFT	Vredehoek	2 Cape Town	7 City A	3 City
98	VALHALLA PARK	Vredehoek	2 Cape Town	7 City A	3 City
98	VREDEHOEK	Vredehoek	2 Cape Town	7 City A	3 City
85	SALT RIVER	Salt River	2 Cape Town	8 City B	3 City
85	SCHOTSCHEKLOOF	Salt River	2 Cape Town	8 City B	3 City
101	WOODSTOCK	Woodstock	2 Cape Town	8 City B	3 City

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
1	AKASIA PARK	Acacia Park	3 Goodwood	23 Maitland	3 City
27	FRACTRETON	Factreton	2 Cape Town	23 Maitland	3 City
42	KENSINGTON	Kensington	2 Cape Town	23 Maitland	3 City
50	BROOOKLYN	Maitland	2 Cape Town	23 Maitland	3 City
50	MAITLAND	Maitland	2 Cape Town	23 Maitland	3 City
50	MAITLAND GARDEN VILLAGE	Maitland	2 Cape Town	23 Maitland	3 City
50	NDABENI (CAPE)	Maitland	2 Cape Town	23 Maitland	3 City
50	RUGBY	Maitland	2 Cape Town	23 Maitland	3 City
15	BANTRY BAY	Camps Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
15	CAMPS BAY/ BAKOVEN	Camps Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
18	CLIFTON	Clifton	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
29	FRESNAYE	Fresnaye	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
33	GREEN POINT	Green Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
38	HOUT BAY HARBOUR	Hout Bay harbour	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
39	HOUT BAY	Hout Bay	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
44	KOMMETJIE	Kommetjie	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
44	NOORDHOEK	Kommetjie	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
49	LLANDUDNO	Llandudno	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
62	MOUILLE POINT	Mouille Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
87	SEA POINT	Sea Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
87	THREE ANCHOR BAY	Sea Point	2 Cape Town	9 Atlantic seaboard	4 Cape Town suburbs
9	BERGVLIET	Bergvliet	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
11	BISHOPS COURT	Bishopcourt	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
17	CLAREMONT	Claremont	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	CONSTANTIA 1	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	CONSTANTIA 2	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	KIRSTENHOF	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	MEADOWRIDGE	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	TOKAI	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
20	WESTLAKE	Constantia & Tokia	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
23	DIEP RIVER	Dieo River	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
41	KENILWORTH	Kenilworth	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
63	MOWBRAY (WYNBERG)	Mowbray	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
63	SYBRAND PARK	Mowbray	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
65	NEWLANDS	Newlands	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
68	OBSERVATORY	Observatory	2 Cape Town	10 Southern suburbs	4 Cape Town suburbs
78	PINELANDS	Pinelands	3 Goodwood	10 Southern suburbs	4 Cape Town suburbs
79	PLUMSTEAD	Plumstead	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
81	RONDEBOSCH	Rondebosch	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
81	RONDEBOSCH EAST	Rondebosch	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
82	ROSEBANK	Rosebank	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
82	ROYAL CAPE	Rosebank	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	CAPE TOWN EAST (WYNBERG)	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	SILVER MINE (WYNBERG)	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	WYNBERG	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
102	YOUNGSFIELD	Wynberg	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
104	PELIKAN PARK	Zeekoeivlei	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
104	ZEEKOEVLEI	Zeekoeivlei	5 Wynberg	10 Southern suburbs	4 Cape Town suburbs
19	CLOVELLY	Clovelly	4 Simonstown	11 False Bay	4 Cape Town suburbs
28	FISH HOEK	Fish Hoak	4 Simonstown	11 False Bay	4 Cape Town suburbs
40	KALK BAY	Kalk Bay	4 Simonstown	11 False Bay	4 Cape Town suburbs
45	LAKESIDE	Lakeside	4 Simonstown	11 False Bay	4 Cape Town suburbs
45	MARINA DA GAMA	Lakeside	4 Simonstown	11 False Bay	4 Cape Town suburbs
64	MUIZENBERG	Muizenberg	4 Simonstown	11 False Bay	4 Cape Town suburbs
69	OCEAN VIEW	Ocean View	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SCARBOROUGH	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SILVER MINE (SIMONSTOWN)	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 1	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 3	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
88	SIMONSTOWN NU 4	Simonstown	4 Simonstown	11 False Bay	4 Cape Town suburbs
90	ST JAMES	St James	4 Simonstown	11 False Bay	4 Cape Town suburbs
92	SUN VALLEY	Sun Valley	4 Simonstown	11 False Bay	4 Cape Town suburbs
92	ZERILDA PARK	Sun Valley	4 Simonstown	11 False Bay	4 Cape Town suburbs
116	STEENBERG	Steenberg	5 Wynberg	11 False Bay	4 Cape Town suburbs
2	ATHLONE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	BELGRAVIA	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	BELTHORN ESTATE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	GATESVILLE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	PENLYN ESTATE	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	SILVERTOWN	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
2	SURREY	Athlone	5 Wynberg	12 Athlone	5 The Cape Flats (A)
14	BRIDGETOWN	Bridgetown	5 Wynberg	12 Athlone	5 The Cape Flats (A)
21	CRAWFORD	Crawford	5 Wynberg	12 Athlone	5 The Cape Flats (A)
43	KEW TOWN	Kewtown	5 Wynberg	12 Athlone	5 The Cape Flats (A)
84	RYLANDS	Rylands	5 Wynberg	12 Athlone	5 The Cape Flats (A)
12	BONTEHEUWEL	Bonteheuwel	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
12	PRIMROSE PARK	Bonteheuwel	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
35	CHARLESVILLE	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
35	HANOVER PARK	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
35	PINATI	Hanover Park	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
37	HEIDEVELD	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
37	VANGUARD	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
37	WELCOME	Heideveld	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
51	MANENBERG	Mannerberg	5 Wynberg	13 Mid Cape Flats (A)	5 The Cape Flats (A)
66	NOOITGEDACHT	Nooitgedacht	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
97	VALHALLA	Valhalla Park	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
115	KALKSTEENFONTEIN	Kalksteenfontein	3 Goodwood	13 Mid Cape Flats (A)	5 The Cape Flats (A)
32	GRASSY PARK	Grassy Park	5 Wynberg	14 South Flats	5 The Cape Flats (A)
36	HEATHFIELD	Heathfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
47	LANDSDOWNE	Landsdowne	5 Wynberg	14 South Flats	5 The Cape Flats (A)
48	LOTUS RIVER	Lotus River	5 Wynberg	14 South Flats	5 The Cape Flats (A)
48	MONTAGU'S GIFT	Lotus River	5 Wynberg	14 South Flats	5 The Cape Flats (A)
71	FAIRWAYS	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
71	OTTERY	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)
71	OTTERY EAST	Ottrey	5 Wynberg	14 South Flats	5 The Cape Flats (A)
72	PARKWOOD	Parkwood	5 Wynberg	14 South Flats	5 The Cape Flats (A)
80	RETREAT	Retreat	5 Wynberg	14 South Flats	5 The Cape Flats (A)
89	ELFINDALE	Southfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
89	SOUTHFIELD	Southfield	5 Wynberg	14 South Flats	5 The Cape Flats (A)
100	WETTON	Wetton	5 Wynberg	14 South Flats	5 The Cape Flats (A)
114	LAVENDER HILL	Lavender Hill	5 Wynberg	14 South Flats	5 The Cape Flats (A)
34	GUGULETU	Guguletu	6 Mitchells Plain	15 Mid Cape Flats (B)	6 The Cape Flats (B)
46	LANGA	Langa	3 Goodwood	15 Mid Cape Flats (B)	6 The Cape Flats (B)
46	LWANDLE	Langa	3 Goodwood	15 Mid Cape Flats (B)	6 The Cape Flats (B)
67	NYANGA/ CROSSROADS	Nyanga	6 Mitchells Plain	15 Mid Cape Flats (B)	6 The Cape Flats (B)
54	ROCKLANDS	Rocklands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
55	WESTRIDGE	Westridge	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
56	PORTLANDS	Portlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
57	LENTEGEUR	Lentegeur	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
58	BEACON VALLEY	Beacon Valley	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
59	COLORADO	Woodlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
59	WOODLANDS	Woodlands	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	CENTRE MITCHELL'S PLAIN	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	EASTRIDGE	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
60	TAFELSIG	Eastridge & Tafelsig	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
91	STRANDFONTEIN	Strandfontein	6 Mitchells Plain	16 Mitchells Plain	7 Mitchells Plain
108	KAYA MANDI	Kayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
108	KHAYELITSA/ LINGELETHUU W	Kayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
108	MFULENI	Kayalitsha	6 Mitchells Plain	17 Khayalitsha	8 Khayalitsha
106	BROWNSFARM	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
106	PHILIPPI	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
106	PHILIPPI RURAL	Phillipi	6 Mitchells Plain	19 Phillipi	9 Phillipi
122	NEWFIELDS	Newfields	6 Mitchells Plain	19 Phillipi	9 Phillipi
107	DELFT	Delft	6 Mitchells Plain	20 New Cape Flats	10 The Cape Flats (C)
125	HAZENDAL	Hazendal	5 Wynberg	20 New Cape Flats	10 The Cape Flats (C)
109	FRANSCHOEK 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	FRANSCHOEK 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	GORDON'S BAY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSAR 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSAR 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MACASSARSTRAND	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MALMESBURY NU 1	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MALMESBURY NU 2	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MAMRE	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	MANDALAY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	STRAND	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	STRAND NU	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	SUNNYDALE	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WEBERSVALLEI	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WELLINGTON	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town

Study Ref	Census Area	Study Area	Magisterial District	Study District	Grouped Districts
109	WELLINGTON NU	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
109	WELTEVREDEN VALLEY	Out of Cape Town	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER 1	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER 2	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	EERSTERIVIER-SUID	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	GAYLEE	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	KLEINVLEI	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	KLEINVLEI ANNEX	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	ROTTERDAM	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
111	WESBANK	Eerste River	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
113	ATLANTIS	Atlantis	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	FAURE (SOMERSET WEST)	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	FAURE (STELLENBOSCH)	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 3	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL 4	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PAARL NU	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PENHILL	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PHILADELPHIA	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	PNIEL	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RAITHBY	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RUSTDAL 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	RUSTDAL 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SIR LOWRY'S PASS	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SOMERSET-WEST	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	SOMERSET-WEST NU	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH 2	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town
119	STELLENBOSCH NU 1	Paarl or Stellenbosch	8 Out of Cape Town	21 Out of Cape Town	11 Out of Cape Town

Appendix 3 Census figures by Magisterial District

The figures are taken from the national data set issued by the Central Statistical Services, 1992.

1 OUDERDOM VOLGENS ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK (STEDELIK, SEMI-STEDELIK EN NIE-STEDELIK)
1.1 TOTAAL

1 AGE BY DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT (URBAN, SEMI-URBAN AND NON-URBAN)
1.1 TOTAL

ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT		TOTAAL TOTAL	-1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-59	60-64	65 +
STREEK 01/REGION 01														
BELLVILLE														
STEDELIK/URBAN	T	243 961	3 581	15 285	21 311	19 867	23 020	26 767	42 174	35 115	25 622	9 187	7 173	14 856
	M	115 958	1 749	7 774	10 629	9 901	10 860	12 519	19 787	16 682	12 410	4 371	3 368	5 907
	V/F	128 003	1 832	7 512	10 682	9 966	12 160	14 248	22 388	18 432	13 212	4 817	3 805	8 949
SEMI-STEDELIK/SEMI-URBAN	T	9 282	269	1 222	1 593	872	598	607	2 493	996	371	103	63	95
	M	4 508	126	639	806	407	285	247	1 191	496	185	50	32	43
	V/F	4 774	143	583	787	465	313	360	1 302	499	186	53	30	53
NIE-STEDELIK/NON-URBAN	T	16 752	343	1 663	1 599	1 119	1 538	2 014	3 377	2 345	1 529	553	286	388
	M	9 465	184	897	756	565	863	1 148	1 932	1 365	982	387	174	214
	V/F	7 287	159	766	843	554	675	866	1 445	980	547	167	112	173
TOTAAL/TOTAL	T	269 995	4 193	18 171	24 503	21 858	25 157	29 388	48 044	38 455	27 522	9 843	7 522	15 339
	M	129 931	2 059	9 309	12 191	10 872	12 009	13 914	22 909	18 544	13 577	4 807	3 574	6 164
	V/F	140 064	2 134	8 861	12 312	10 986	13 148	15 474	25 135	19 911	13 945	5 036	3 948	9 175
GOODWOOD														
STEDELIK/URBAN	T	259 620	4 497	19 877	26 247	23 220	27 319	28 379	45 309	31 700	22 644	9 455	7 233	13 741
	M	125 046	2 228	10 043	13 277	11 751	13 519	14 142	22 036	14 851	10 495	4 219	3 216	5 268
	V/F	134 574	2 269	9 834	12 970	11 469	13 800	14 237	23 272	16 848	12 149	5 235	4 017	8 473
TOTAAL/TOTAL	T	259 620	4 497	19 877	26 247	23 220	27 319	28 379	45 309	31 700	22 644	9 455	7 233	13 741
	M	125 046	2 228	10 043	13 277	11 751	13 519	14 142	22 036	14 851	10 495	4 219	3 216	5 268
	V/F	134 574	2 269	9 834	12 970	11 469	13 800	14 237	23 272	16 848	12 149	5 235	4 017	8 473
KAAP/CAPE														
STEDELIK/URBAN	T	178 999	2 366	8 510	10 382	9 292	13 332	19 575	34 075	24 903	19 548	8 431	7 771	20 813
	M	84 694	1 182	4 381	5 238	4 585	6 276	9 583	16 756	12 042	9 387	3 765	3 520	7 978
	V/F	94 305	1 183	4 129	5 144	4 708	7 056	9 992	17 319	12 861	10 160	4 666	4 251	12 835
NIE-STEDELIK/NON-URBAN	T	538	4	47	51	29	37	73	120	89	57	7	12	12
	M	281	4	19	23	20	23	30	58	54	34	4	6	6
	V/F	256	-	28	28	9	14	44	62	35	23	3	6	6

1 OUDERDOM VOLGENS ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK (STEDELIK, SEMI-STEDELIK EN NIE-STEDELIK)
1.1 TOTAAL

1 AGE BY DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT (URBAN, SEMI-URBAN AND NON-URBAN)
1.1 TOTAL

ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT		TOTAAL TOTAL	-1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-59	60-64	65 +
KAAP/CAPE														
TOTAAL/TOTAL	T	179 537	2 369	8 557	10 433	9 321	13 369	19 649	34 195	24 993	19 605	8 438	7 783	20 825
	M	84 975	1 186	4 400	5 260	4 605	6 299	9 613	16 814	12 097	9 422	3 769	3 526	7 984
	V/F	94 562	1 183	4 157	5 173	4 716	7 070	10 036	17 381	12 896	10 183	4 668	4 257	12 841
SIMONSTAD														
STEDELIK/URBAN	T	53 615	854	3 451	4 659	4 066	4 623	4 688	9 065	7 029	5 382	2 097	1 979	5 721
	M	25 971	455	1 693	2 360	1 995	2 283	2 370	4 512	3 460	2 554	998	884	2 407
	V/F	27 643	399	1 757	2 299	2 071	2 340	2 319	4 553	3 569	2 828	1 099	1 095	3 314
SEMI-STEDELIK/SEMI-URBAN	T	3 234	31	247	382	251	149	245	591	534	251	110	66	376
	M	1 590	15	126	196	113	91	111	285	269	145	58	32	149
	V/F	1 644	16	121	186	139	58	134	307	265	106	52	34	227
NIE-STEDELIK/NON-URBAN	T	1 474	32	134	165	113	98	143	377	224	108	28	24	29
	M	750	15	65	94	56	49	64	187	103	66	20	18	14
	V/F	725	17	69	71	57	49	79	190	121	41	7	6	15
TOTAAL/TOTAL	T	58 323	917	3 832	5 206	4 431	4 870	5 077	10 033	7 787	5 740	2 235	2 069	6 127
	M	28 311	485	1 884	2 650	2 164	2 423	2 545	4 984	3 833	2 765	1 076	933	2 570
	V/F	30 012	432	1 948	2 556	2 267	2 447	2 532	5 050	3 955	2 975	1 158	1 136	3 557
WYNBERG														
STEDELIK/URBAN	T	1 086 101	21 516	87 527	108 099	92 638	107 980	119 962	207 454	144 358	92 866	32 773	24 783	46 144
	M	543 870	10 687	44 419	54 925	45 529	54 487	61 427	102 930	73 584	47 894	16 729	12 139	19 122
	V/F	542 230	10 829	43 108	53 175	47 110	53 492	58 535	104 524	70 774	44 972	16 044	12 644	27 022
SEMI-STEDELIK/SEMI-URBAN	T	14 408	560	1 417	1 233	1 037	1 257	1 665	3 150	2 004	1 278	294	215	299
	M	7 296	195	680	567	568	637	784	1 576	1 111	743	182	79	173
	V/F	7 112	365	737	665	469	619	880	1 574	893	535	113	136	126
NIE-STEDELIK/NON-URBAN	T	1 159	11	35	40	18	470	390	112	25	35	14	3	7
	M	1 007	5	15	12	11	457	372	79	14	23	12	3	4
	V/F	152	6	20	27	6	13	18	34	12	11	2	-	3

1 OUDERDOM VOLGENS ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK (STEDELIK, SEMI-STEDELIK EN NIE-STEDELIK)
1.1 TOTAAL

1 AGE BY DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT (URBAN, SEMI-URBAN AND NON-URBAN)
1.1 TOTAL

ONTWIKKELINGSTREEK, STATISTIESE STREEK EN DISTRIK DEVELOPMENT REGION, STATISTICAL REGION AND DISTRICT		TOTAAL TOTAL	-1	1-4	5-9	10-14	15-19	20-24	25-34	35-44	45-54	55-59	60-64	65 +
WYNBERG														
TOTAAL/TOTAL	T	1 101 668	22 087	88 979	109 372	93 693	109 706	122 016	210 717	146 387	94 178	33 082	25 000	46 450
	M	552 173	10 887	45 114	55 504	46 108	55 581	62 583	104 585	74 708	48 660	16 923	12 220	19 299
	V/F	549 495	11 201	43 865	53 867	47 584	54 125	59 433	106 132	71 679	45 518	16 159	12 780	27 151
TOTAAL STREEK 01/TOTAL REGION 01														
STEDELIK/URBAN	T	1 822 296	32 814	134 650	170 699	149 084	176 274	199 371	338 078	243 105	166 061	61 943	48 939	101 276
	M	895 540	16 301	68 310	86 429	73 761	87 426	100 040	166 022	120 621	82 740	30 082	23 127	40 682
	V/F	926 756	16 513	66 340	84 270	75 324	88 849	99 331	172 056	122 484	83 321	31 862	25 813	60 594
SEMI-STEDELIK/SEMI-URBAN	T	26 924	860	2 887	3 208	2 160	2 003	2 517	6 234	3 533	1 899	507	344	771
	M	13 394	336	1 446	1 569	1 088	1 014	1 143	3 051	1 876	1 073	290	142	365
	V/F	13 531	524	1 441	1 638	1 073	990	1 374	3 183	1 657	826	217	201	406
NIE-STEDELIK/NON-URBAN	T	19 923	389	1 879	1 854	1 278	2 143	2 620	3 986	2 683	1 728	602	325	436
	M	11 503	207	995	885	653	1 392	1 613	2 255	1 536	1 105	423	201	238
	V/F	8 421	182	884	970	626	751	1 007	1 731	1 147	623	179	124	198
TOTAAL/TOTAL	T	1 869 144	34 063	139 416	175 761	152 523	180 421	204 508	348 299	249 322	169 689	63 053	49 608	102 483
	M	920 437	16 844	70 751	88 883	75 501	89 831	102 797	171 328	124 033	84 919	30 795	23 470	41 286
	V/F	948 707	17 219	68 665	86 878	77 022	90 590	101 712	176 970	125 289	84 770	32 257	26 138	61 197
STREEK 02/REGION 02														
KUILSRIVIER														
STEDELIK/URBAN	T	128 908	2 936	12 876	14 977	11 324	11 423	12 780	30 713	16 628	8 071	2 531	1 668	2 981
	M	64 144	1 481	6 535	7 670	5 741	5 716	6 042	15 204	8 401	4 147	1 271	763	1 174
	V/F	64 764	1 455	6 341	7 307	5 582	5 707	6 738	15 510	8 226	3 925	1 260	905	1 807
NIE-STEDELIK/NON-URBAN	T	4 669	42	443	442	360	332	456	1 206	637	435	112	79	125
	M	2 542	19	224	242	170	168	227	715	350	239	71	47	71
	V/F	2 128	23	220	200	191	164	229	491	288	196	41	32	54
TOTAAL/TOTAL	T	133 577	2 978	13 319	15 419	11 684	11 756	13 235	31 919	17 265	8 507	2 643	1 747	3 106
	M	66 686	1 500	6 759	7 912	5 911	5 884	6 269	15 919	8 751	4 385	1 342	810	1 245
	V/F	66 891	1 478	6 561	7 507	5 773	5 871	6 967	16 000	8 514	4 121	1 301	937	1 861

Appendix 4 1991 Census figures by suburbs

The statistics are provided by the Cape Town City Council and reflect population in each suburb of greater Cape Town

1991 Census statistics by suburb

	Suburb	Total	<1		1-4		5-9		10-14		15-18	
			Fr	%	Frq	%	Frq	%	Frq	%	Frq	%
15	BANTRY BAY	134	7	5	22	17	34	25	27	21	44	32
50	BROOOKLYN	1402	79	6	303	21	387	27	318	24	315	22
15	CAMPS BAY/ BAKOVEN	1297	50	4	226	17	306	23	361	29	355	27
16	CAPE TOWN CENTRE	222	9	4	48	21	48	21	49	23	68	31
16	CAPE TOWN REST (CAPE)	126	9	7	31	24	51	40	26	22	9	7
18	CLIFTON	95	7	7	22	23	22	23	22	24	22	22
27	FRACTRETON	4479	179	4	924	20	1244	28	1129	27	1003	22
16	FORESHORE	451	18	4	80	17	126	28	104	24	124	27
24	FRESNAYE	564	34	6	66	11	116	20	167	31	181	32
30	GARDENS	1200	57	5	175	14	266	22	243	21	459	38
33	GREEN POINT	750	143	17	143	19	141	19	128	19	195	27
42	KENSINGTON	4259	165	4	873	19	1140	27	1061	26	1021	24
50	MAITLAND	1628	78	5	376	22	423	26	359	23	390	24
50	MAITLAND GARDEN VILLAGE	640	34	5	106	16	181	28	133	22	187	29
62	MOUILLE POINT	129	8	6	26	20	21	16	29	23	46	35
50	NDABENI (CAPE)	131	9	7	23	17	41	31	27	21	32	24
68	OBSERVATORY	1180	214	16	224	19	212	18	187	17	344	30
70	ORANJEZICHT	689	28	4	118	17	187	27	164	25	192	28
50	RUGBY	771	58	7	197	24	188	25	171	24	157	21
85	SALT RIVER	1985	101	5	404	19	519	26	455	24	505	25
85	SCHOTSCHEKLOOF	1711	74	4	338	19	436	26	422	26	442	26
87	SEA POINT	1127	77	7	208	18	271	24	256	24	316	28
94	TAMBOERSKLOOF	678	35	5	111	16	128	19	172	26	232	34
87	THREE ANCHOR BAY	234	12	5	49	20	48	20	49	22	77	33
98	TIJGERHOF/SANDDRIFT	1311	39	3	226	17	286	22	296	24	463	35
98	VREDEHOEK	870	67	8	187	21	221	25	191	23	204	23
101	WOODSTOCK	4716	256	5	1037	21	1284	27	1101	25	1038	22
103	YSTERPLAAT	119	13	11	31	26	36	30	12	10	27	22
16	ZONNEBLOEM	631	127	19	122	19	114	18	131	22	137	22
53	MILNERTON	1359	53	4	268	19	344	25	351	27	342	25
53	MILNERTON REST	688	9	1	234	29	175	27	107	17	164	25
93	TABLE VIEW	4802	306	6	1280	26	1340	28	1016	22	860	18
18	CLOVELLY	146	5	3	25	16	45	31	36	26	35	23
40	KALK BAY	234	13	5	49	21	62	26	52	23	58	25
45	LAKESIDE	396	29	7	97	24	107	27	88	23	75	19
45	MARINA DA GAMA	361	24	7	101	28	103	28	79	23	54	15
64	MUIZENBERG	1471	65	4	354	23	400	27	370	27	283	19
88	SILVER MINE (SIMONSTOWN)	16	0	0	6	40	6	40	2	13	1	7
90	ST JAMES	99	4	4	18	19	30	30	18	20	28	28
92	ZERILDA PARK	4858	256	5	967	19	1439	30	1174	25	1022	21
92	SUN VALLEY	728	35	5	136	19	208	28	169	24	181	24
28	FISH HOEK	1710	71	4	276	16	442	25	455	25	466	27
3	BELLAIR	280	9	3	49	17	69	24	83	31	70	25
4	BELVILLE-EAST	244	15	6	50	20	75	30	58	25	47	19
6	BELLVILLE-CENTRAL	87	16	18	28	33	9	10	15	19	18	21
8	BELLVILLE-SOUTH	5654	299	5	1107	19	1393	25	1312	25	1543	27
6	BELLVILLE-WEST	391	60	15	53	13	65	16	90	24	123	31
5	BLOMTUIN	226	8	3	33	15	57	25	70	32	57	25
6	BO-OAKDALE	299	17	6	69	23	83	27	78	27	52	17
6	BOSBELL	127	4	3	26	20	25	19	39	32	32	25
6	BOSTON	1171	53	4	179	15	276	23	339	30	324	27
6	CHISMAR	411	11	3	64	15	93	22	90	23	153	37
6	DOOR DE KRAAL	575	26	4	126	22	196	34	127	23	101	17
6	EVERSDAL (BELLVILLE)	1542	37	2	212	14	447	28	507	34	338	22
7	GLENHAVEN	939	20	2	118	12	252	27	312	35	237	25
7	GROENVALLEI	291	7	2	66	22	86	29	67	24	66	22
7	HOHEIZEN	305	10	3	63	21	82	26	93	32	56	18
7	KEMPENVILLE	357	16	4	69	19	94	26	82	24	95	26
7	KENRIDGE (BELLVILLE)	151	3	2	39	25	43	28	38	26	28	18
7	LA ROCHELLE	408	17	4	78	19	119	29	105	27	90	22
7	LABIANCE	410	13	3	86	21	105	25	106	27	101	24
7	LOEVENSTEIN	860	33	4	149	17	256	29	215	26	206	24
7	MAASTRECHT	27	0	0	8	28	11	40	7	28	1	4
6	OAKDALE	1039	40	4	193	18	272	26	282	28	252	24
6	OAKGLEN	505	14	3	86	17	165	32	148	30	92	18
6	PROTEAVALLEI	709	31	4	280	39	226	32	113	17	59	8

6	RICHWORTH	538	28	5	85	15	152	28	143	28	131	24
6	SANLAMHOF	330	14	4	64	19	83	25	63	20	107	32
6	STELLENBERG	1302	30	2	197	15	365	28	387	31	323	24
6	STELLENRIDGE	440	16	4	148	33	148	33	75	18	53	12
6	STIKLAND	130	6	4	25	19	30	23	39	31	29	22
6	THALMAN	560	17	3	79	14	147	26	163	30	154	27
6	VREDENBERG	298	17	6	65	21	111	37	77	27	28	9
6	WELGEMOED	1063	37	3	177	16	309	29	314	31	226	21
24	DURBANVILLE PROPER	3405	152	4	603	17	963	28	928	28	760	22
24	EVERSDAL (DURBANVILLE)	2013	80	4	379	19	632	31	562	29	360	18
24	KENRIDGE (DURBANVILLE)	795	35	4	121	15	195	24	239	31	205	25
24	MORNING STAR	565	43	7	131	22	165	30	109	21	116	20
6	CRAVENBY (BELLVILLE)	260	13	4	61	21	74	28	69	29	44	18
6	MODDERDAM	175	3	2	12	7	39	22	60	36	60	33
6	BELMONT PARK	1207	40	3	207	17	290	24	341	29	330	27
6	BONNIE BROOK	420	14	3	80	19	123	29	132	33	71	17
6	EIKENDAL	2032	90	4	374	18	568	28	516	27	484	23
121	KRAAIFONTEIN RES 1	24	0	0	2	9	10	41	6	27	6	23
121	KRAAIFONTEIN RES 3	21	3	16	7	32	5	26	1	5	4	21
999	PEERLESS PARK	1648	80	5	300	18	452	27	409	26	407	24
127	SCOTTSVILLE	4299	211	5	901	20	1144	27	1076	26	968	22
7	WINDSOR ESTATE	368	9	2	69	19	111	30	93	26	86	23
7	WINDSOR PARK	1364	48	4	299	22	395	29	360	27	262	19
7	ZOO PARK	446	28	6	108	24	123	27	110	26	78	17
7	RICHWOOD 1	501	48	10	186	37	139	28	83	17	44	9
7	RICHWOOD 2	1	0	0	1	100	0	0	0	0	0	0
7	AVONDALE	911	46	5	155	17	232	25	247	28	231	25
7	CHURCHILL	1305	47	4	228	17	333	25	353	28	344	26
7	CLAM-HALL	264	11	4	47	18	62	23	65	25	80	30
7	FAIRFIELD	532	34	6	112	21	111	21	123	24	151	28
7	GLENLILY	613	9	1	105	17	175	28	170	29	154	25
7	OOSTERZEE	184	3	2	31	17	40	21	48	27	62	33
77	PANORAMA	1338	88	6	200	15	350	26	365	28	335	25
75	PAROW	446	29	6	110	24	117	26	90	21	101	22
73	PAROW-NORTH	598	22	4	85	14	157	26	144	25	191	32
75	PAROW-EAST	28	1	4	14	50	5	19	2	8	5	19
75	PAROW VALLEY	2264	180	8	469	20	570	25	470	22	576	25
75	PLATTEKLOOF	306	19	6	47	15	69	22	92	31	78	25
112	RAVENSMEAD	9515	503	5	1939	19	2596	27	2346	26	2131	22
6	RICHMOND	90	4	5	20	23	25	27	14	17	26	29
6	WELGELEGEN	1438	60	4	303	21	440	30	352	26	283	19
31	ADRIAANSE	3589	167	4	740	20	1026	29	900	26	755	21
31	AVON	2417	122	5	529	21	688	29	590	26	488	20
31	AVONWOOD	2260	149	6	487	21	633	28	521	24	470	21
31	BALVENIE	1716	73	4	381	21	484	28	395	24	383	22
31	CLARKES	2015	70	3	416	20	574	29	509	27	446	22
31	CONNAUGHT	3318	142	4	628	18	950	29	885	28	714	21
31	CRAVENBY (GOODWOOD)	942	40	4	204	19	239	25	228	26	231	26
31	ELNOR	500	19	4	100	19	135	27	129	27	117	23
31	EPPING FOREST	2097	97	4	399	18	566	27	537	27	497	23
31	EUREKA	1942	91	4	437	21	526	27	483	26	405	21
31	LOUW'S BUSH	2934	140	5	557	18	778	27	773	28	687	23
31	NORWOOD	1017	60	6	244	23	284	28	231	24	199	19
31	RIVERTON	875	63	7	161	18	231	27	229	28	192	22
31	SALBERAU	2196	105	5	432	19	565	26	596	29	498	22
31	THE RANGE	1082	19	2	229	20	288	27	265	26	281	26
96	UITSIG	4408	222	5	901	19	1202	27	1078	26	1006	23
97	VALHALLA	303	13	4	59	18	80	27	69	24	83	27
25	EDGEMEAD	2728	124	4	662	24	863	31	689	26	390	14
26	ELSIES RIVER INDUST	115	6	5	30	25	35	30	30	27	15	13
31	GOODWOOD ESTATE	1349	37	3	204	15	394	29	351	27	363	26
31	MONTE VISTA	1487	62	4	284	19	376	25	382	27	383	25
31	RICHMOND ESTATE	848	45	5	180	21	215	25	194	24	214	25
31	TOWNSEND ESTATE	1513	68	4	220	14	401	26	385	27	440	29
31	TYGERDAL	814	33	4	192	23	265	32	199	25	124	15
31	VASCO ESTATE	1437	66	5	256	18	356	24	371	27	387	27
1	AKASIA PARK	273	19	7	82	30	108	39	54	21	10	4
12	BONTEHEUWEL	18599	917	5	4066	21	4970	27	4184	24	4462	24
35	CHARLESVILLE	584	21	4	92	15	160	27	166	30	144	24
31	EPPING INDUSTRIAL	20	3	12	8	35	2	12	3	18	4	24
115	KALKSTEENFONTEIN	2635	142	5	591	21	776	30	593	24	533	20

31	MONTANA/DURHEIM	1345	47	3	310	22	427	32	334	26	227	17
31	MOBRAY (GOODWOOD)	7	1	14	3	43	2	29	1	14	0	0
31	NDABENI (GOODWOOD) 1	33	1	3	8	24	6	18	4	12	14	42
95	THORNTON	847	71	7	179	20	246	29	164	21	187	22
98	VALHALLA PARK	5241	240	4	961	17	1302	25	1355	27	1383	26
31	WINGFIELD	87	7	8	29	34	22	26	12	15	16	17
13	BOTHASIG	3047	164	5	773	25	840	27	670	23	599	19
111	EERSTERIVIER 1	8601	650	7	2522	28	2641	31	1659	20	1129	13
111	EERSTERIVIER 2	311	29	9	96	30	101	33	50	17	35	11
111	EERSTERIVIER-SUID	2550	151	6	580	22	583	23	422	18	814	32
999	GAYLEE	4218	214	5	1100	25	1323	32	926	23	655	15
999	KLEINVLEI	5076	267	5	1176	22	1472	29	1222	25	939	18
111	KLEINVLEI ANNEX	3998	273	7	1117	27	1165	29	817	22	627	16
999	ROTTERDAM	1086	75	7	345	31	321	30	205	20	140	13
999	WESBANK	251	16	6	85	32	76	31	53	22	21	9
118	KUILSRIVIER	3419	117	3	670	19	989	28	926	28	718	21
118	SAREPTA	5774	320	5	1275	21	1470	26	1400	26	1309	22
20	CONSTANTIA 1	4068	151	4	727	17	1051	26	980	25	1159	28
20	CONSTANTIA 2	626	10	1	9	1	0	0	17	3	590	94
20	TOKAI	1114	49	4	215	19	302	27	288	27	259	23
20	WESTLAKE	951	63	7	312	32	303	32	164	18	110	11
32	GRASSY PARK	7348	330	4	1599	21	1940	27	1789	26	1690	23
48	LOTUS RIVER	6230	270	4	1266	19	1635	26	1521	26	1538	24
48	MONTAGU'S GIFT	6301	238	4	1202	18	1572	25	1626	27	1662	26
38	HOUT BAY	2388	112	5	559	23	676	29	576	25	464	19
49	LLANDUDNO	168	6	3	24	14	43	25	59	37	36	21
2	ATHLONE	3492	141	4	678	18	937	27	866	26	871	25
58	BEACON VALLEY	11952	487	4	2618	21	3712	31	3076	27	2060	17
2	BELGRAVIA	2466	69	3	522	20	646	26	615	26	614	25
2	BELTHORN ESTATE	1126	58	5	237	20	265	24	267	25	300	26
9	BERGVLIET	1318	26	2	183	14	386	29	379	30	343	26
11	BISHOPS COURT	334	7	2	41	12	96	29	96	30	94	28
14	BRIDGETOWN	3864	158	4	828	20	1032	27	925	25	921	24
102	CAPE TOWN EAST (WYNBERG)	35	0	0	1	3	13	38	13	38	8	22
60	CENTRE MITCHELL'S PLAIN	22	1	5	7	32	7	32	3	16	3	16
17	CLAREMONT	3294	175	5	641	19	865	26	819	26	793	24
21	CRAWFORD	1628	79	5	352	21	465	29	365	24	366	22
23	DIEP RIVER	437	22	5	99	22	122	28	90	21	104	23
60	EASTRIDGE	10388	498	5	2361	22	3071	30	2572	26	1887	18
999	ELFINDALE	812	30	3	119	14	176	22	231	30	256	31
999	FAIRWAYS	1108	41	4	171	15	300	27	306	29	290	26
2	GATESVILLE	1005	46	4	202	18	245	24	249	27	264	27
35	HANOVER PARK	11126	497	4	2323	20	2809	25	2714	26	2784	25
125	HAZENDAL	1717	79	4	363	20	436	26	402	25	437	25
36	HEATHFIELD	1371	60	4	265	18	370	27	337	26	338	24
37	HEIDEVELD	5831	246	4	1300	21	1521	26	1375	25	1389	24
41	KENILWORTH	1448	96	7	322	22	367	25	301	22	362	25
43	KEW TOWN	2477	105	4	523	20	674	27	576	25	599	24
20	KIRSTENHOF	980	43	4	186	19	285	29	280	30	186	19
47	LANDSDOWNE	4773	228	5	990	20	1238	26	1151	25	1165	24
114	LAVENDER HILL	5878	304	5	1249	20	1571	27	1364	24	1390	23
57	LENTEGEUR	14911	655	4	3017	19	4120	28	3866	27	3254	21
51	MANENBERG	16505	753	4	3575	21	4420	27	3989	25	3768	23
20	MEADOWRIDGE	1107	43	4	186	17	299	27	306	29	273	24
63	MOBRAY (WYNBERG)	625	41	6	135	21	145	23	127	21	177	28
122	NEWFIELDS	1330	52	4	236	17	308	23	348	28	385	29
65	NEWLANDS	1620	63	4	231	14	343	21	508	33	473	29
71	OTTERY	1794	63	3	350	19	437	25	393	23	552	30
72	PARKWOOD	4328	164	4	978	22	1154	27	1027	25	1005	23
72	PELIKAN PARK	1139	47	4	295	23	388	34	253	24	156	15
72	PENLYN ESTATE	1764	68	4	276	14	438	25	463	28	518	30
72	PINATI	1443	76	5	292	19	348	24	358	26	369	25
74	PLUMSTEAD	3895	231	6	684	17	1011	26	958	26	1011	26
56	PORTLANDS	11035	510	4	2162	19	3063	28	2921	28	2378	21
999	PRIMROSE PARK	575	24	4	85	14	152	27	129	24	186	32
80	RETREAT	11336	570	5	2476	21	2916	26	2691	25	2683	23
54	ROCKLANDS	12853	578	4	2512	19	3475	27	3405	28	2882	22
81	RONDEBOSCH	3882	272	6	516	13	795	21	991	27	1307	34
81	RONDEBOSCH EAST	918	39	4	208	21	242	26	236	27	194	21
82	ROSEBANK	996	20	2	86	8	106	11	123	13	661	66
82	ROYAL CAFE	139	7	5	27	19	42	30	30	23	32	23

84	RYLANDS	1880	80	4	427	20	484	25	469	27	421	23
102	SILVER MINE (WYNBERG)	8	0	0	1	14	2	29	3	43	1	14
2	SILVERTOWN	2044	108	5	445	21	596	29	464	24	430	21
89	SOUTHFIELD	1083	56	5	222	20	319	29	267	26	220	20
116	STEENBERG	2077	89	4	466	21	558	27	488	25	477	23
91	STRANDFONTEIN	6535	358	5	1719	25	1919	30	1380	22	1159	18
2	SURREY	2898	129	4	614	20	762	26	692	25	700	24
63	SYBRAND PARK	270	20	7	43	16	82	30	76	29	48	18
60	TAFELSIG	17199	881	5	4175	23	5470	32	3888	24	2785	16
999	VANGUARD	674	32	5	139	20	167	25	162	25	174	26
999	WELCOME	656	29	4	115	17	181	28	166	27	165	25
55	WESTRIDGE	8326	341	4	1477	17	2099	25	2176	27	2234	26
100	WETTON	514	25	5	89	17	149	29	142	29	110	21
59	WOODLANDS	9327	401	4	1982	20	2762	30	2340	26	1843	19
102	WYNBERG	3412	155	4	618	17	852	25	893	27	894	26
102	YOUNGSFIELD	195	0	0	2	1	3	2	47	25	142	72
113	ATLANTIS	20785	929	4	4757	22	6052	29	5029	26	4019	19
3	BELHAR	16806	703	4	3507	20	4757	28	4257	27	3583	21
4	BELVILLE NU 1	5815	340	5	1652	26	1582	28	1106	21	1136	20
5	BELVILLE NU 2	51	2	4	11	21	17	34	12	26	8	15
10	BISHOP LAVIS	11073	539	5	2365	20	3165	29	2662	25	2342	21
5	BLACKHEATH	22	1	5	7	29	8	38	4	19	2	10
53	BLOUBERGSTRAND	160	10	6	32	20	48	30	31	20	39	24
4	BOQUINAR	6	0	0	1	20	4	60	0	0	1	20
4	BRACKENFELL	4523	250	5	1130	25	1330	29	1098	25	715	16
106	BROWNSFARM	2795	427	15	786	27	569	21	484	18	530	19
59	COLORADO	615	42	7	164	26	221	36	121	21	66	11
107	DELFT	4203	259	6	1162	26	1538	37	812	20	432	10
118	FAURE (KUILSRIVER)	15	0	0	6	36	5	36	1	7	3	21
109	FRANSCHOEK 1	542	29	5	89	15	112	20	156	31	157	30
109	FRANSCHOEK 2	962	62	6	213	21	272	28	213	23	203	21
109	GORDON'S BAY	978	75	8	231	23	271	28	213	23	189	19
34	GUGULETU	17570	1280	6	3535	19	4236	26	4739	26	3781	22
38	HOUT BAY HARBOUR	2026	82	4	436	20	573	28	525	27	410	20
999	JOOSTENBURGVLAKTE	227	10	4	60	26	55	24	61	28	41	18
999	CAPE NU 1	162	4	2	47	26	51	32	29	19	31	20
108	KAYA MANDI	1257	127	9	292	19	302	26	244	22	292	24
108	WKHAYELITSA/ LINGELETHUU	71167	5298	7	19731	27	21377	31	13119	19	11643	16
44	KOMMETJIE	382	21	5	106	28	107	28	71	20	76	20
118	KUILSRIVER NU 1	1409	31	2	399	26	405	29	332	25	243	17
118	KUILSRIVER NU 2	129	11	8	35	25	32	25	22	18	29	23
118	KUILSRIVER NU 3	24	0	0	9	36	6	27	6	27	2	9
118	KYLEMORE	910	46	5	183	19	251	28	222	26	209	23
46	LANGA	8408	735	5	1819	21	2175	24	1721	27	1957	23
46	LWANDLE	152	0	0	19	10	38	24	36	24	61	43
109	MACASSAR 1	8496	442	5	1887	21	2435	29	1984	25	1748	20
109	MACASSAR 2	737	30	4	146	19	183	25	178	26	200	27
109	MACASSARSTRAND	348	27	8	70	19	84	24	76	23	91	26
104	MALMESBURY NU 1	2954	139	4	758	24	783	27	642	23	633	21
104	MALMESBURY NU 2	216	10	4	48	21	62	29	46	22	51	23
104	MAMRE	2242	110	5	447	19	632	28	564	26	490	22
104	MANDALAY	2220	141	6	596	26	687	31	477	23	320	14
52	MATROOSFONTEIN	1572	84	5	325	20	435	28	377	25	351	22
53	MBEKWENI	5793	326	5	1438	21	1562	27	1418	26	1048	21
53	MELKBOSSTRAND	1434	74	5	312	22	447	31	364	26	236	16
104	MFULENI	1269	74	6	305	24	401	29	237	19	253	22
66	NOOITGEDACHT	1927	81	4	344	17	531	28	510	28	462	24
44	NOORHOEK	1031	31	3	247	24	382	35	251	25	119	12
999	NORTHPINE	3812	197	5	1021	26	1262	33	828	23	506	13
67	NYANGA/ CROSSROADS	32751	2040	6	7026	21	8318	27	8237	25	7130	21
69	OCEAN VIEW	5207	247	5	1080	20	1433	28	1281	26	1166	22
71	OTTERY EAST	501	23	5	122	24	148	30	118	25	89	17
119	PAARL 1	27055	1348	5	5593	20	7231	27	6410	25	6472	24
119	PAARL 2	13	0	0	2	18	5	36	3	27	2	18
119	PAARL 3	168	17	10	47	27	36	22	37	23	31	18
119	PAARL 4	42	2	5	12	27	16	39	8	20	4	10
119	PAARL NU	14889	881	6	3470	22	4070	28	3326	24	3142	21
119	PENHILL	177	0	0	40	22	48	27	42	25	46	26
119	PHILADELPHIA	126	10	8	18	14	38	30	31	25	29	23
106	PHILIPPI	18	5	25	5	25	3	19	3	19	2	13
106	PHILIPPI RURAL	2437	133	5	632	25	663	27	553	24	456	19

Appendix 5 Rate of child Abuse in individual suburbs of Cape Town

The rates listed are to be viewed with caution. Areas with low levels of reporting will have lower rates than those areas with higher levels of reporting. These rates reflect reported abuse only and must not be quoted out of context

Child Abuse Frequency and Rate for age 0 - 18 years by Child's Residential Suburb

(in alphabetic order of suburb)

Key: P - Physical Abuse; S - Sexual Abuse; N+E - Neglect or Emotional Abuse
T - Abuse Total (Physical, Sexual, Neglect or Emotional)

Child's Suburb	Census Total	Observed Freq of Abuse				Rate per 1000 children of Child Abuse			
		P	S	N+E	T	P	S	N+E	T
2 Athlone	14795	21	45	17	83	1.42	3.04	1.15	5.61
3 Belhar	17086	4	16	9	29	0.23	0.94	0.53	1.70
4 Belville N 1	21805	5	16	0	21	0.23	0.73	0.00	0.96
8 Belville S	5654	1	6	0	7	0.18	1.06	0.00	1.24
9 Bergvliet	1318	0	1	1	2	0.00	0.76	0.76	1.52
10 Bishop Lavis	11073	1	16	5	22	0.09	1.44	0.45	1.99
11 Bishopcourt	334	1	0	0	1	2.99	0.00	0.00	2.99
12 Bonteheuwel	19174	14	39	2	55	0.73	2.03	0.10	2.87
13 Bothasig	3047	2	2	0	4	0.66	0.66	0.00	1.31
14 Bridgetown	3864	6	8	4	18	1.55	2.07	1.04	4.66
15 Camps Bay	1431	1	2	0	3	0.70	1.40	0.00	2.10
16 Cape Town	1430	8	7	4	19	5.59	4.90	2.80	13.30
17 Claremont	3294	7	6	4	17	2.13	1.82	1.21	5.16
19 Clovelly	146	0	1	0	1	0.00	6.85	0.00	6.85
20 Constantia & Tokai	8846	2	3	9	14	0.23	0.34	1.02	1.58
21 Crawford	1628	3	0	6	9	1.84	0.00	3.69	5.53
22 Crossroads		1	16	1	18	(see Nyanga)			
23 Diep River	437	2	2	1	5	4.58	4.58	2.29	11.40
25 Edgemead	2728	0	1	0	1	0.00	0.37	0.00	0.37
26 Elsies River	115	2	12	1	15	17.40	104.00	8.70	130.00
27 Factreton	4479	0	4	2	6	0.00	0.89	0.45	1.34
28 Fish Hoak	1710	0	1	0	1	0.00	0.58	0.00	0.58
30 Gardens	1200	2	1	2	5	1.67	0.83	1.67	4.17
31 Goodwood	36353	0	1	0	1	0.00	0.03	0.00	0.03
32 Grassy Park	7348	1	13	2	16	0.14	1.77	0.27	2.18
33 Green Point	750	0	0	1	1	0.00	0.00	1.33	1.33
34 Guguletu	17570	14	88	14	116	0.80	5.01	0.80	6.60
35 Hanover Park	13153	23	37	20	80	1.75	2.81	1.52	6.08
36 Heathfield	1371	2	3	0	5	1.46	2.19	0.00	3.65
37 Heideveld	7161	4	23	10	37	0.56	3.21	1.40	5.17
38 Hout Bay harbour	2026	0	0	1	1	0.00	0.00	0.49	0.49
39 Hout Bay	2388	1	2	5	8	0.42	0.84	2.09	3.35
41 Kenilworth	1448	2	2	4	8	1.38	1.38	2.76	5.52
42 Kensington	4259	2	14	1	17	0.47	3.29	0.23	3.99
43 Kewtown	2477	0	2	3	5	0.00	0.81	1.21	2.02
46 Langa	8560	11	17	4	32	1.29	1.99	0.47	3.74
47 Landsdowne	4773	1	4	0	5	0.21	0.84	0.00	1.05
48 Lotus River	12531	6	14	7	27	0.48	1.12	0.56	2.15
50 Maitland	4572	3	11	0	14	0.66	2.41	0.00	3.06
51 Mannenberg	16505	14	46	10	70	0.85	2.79	0.61	4.24
52 Matroosfontein	1572	0	4	1	5	0.00	2.54	0.64	3.18
53 Milnerton	9434	2	7	3	12	0.21	0.74	0.32	1.27
54 Rocklands	12853	11	48	9	68	0.86	3.73	0.70	5.29
55 Westridge	8326	2	8	2	12	0.24	0.96	0.24	1.44
56 Portlands	11035	0	12	2	14	0.00	1.09	0.18	1.27
57 Lentegeur	14911	5	10	3	18	0.34	0.67	0.20	1.21
58 Beacon Valley	11952	4	15	2	21	0.33	1.26	0.17	1.76
59 Woodlands	9942	3	11	0	14	0.30	1.11	0.00	1.41
60 Eastridge/Tafelsig	27609	13	33	2	48	0.47	1.20	0.07	1.74

Child's Suburb	Census Total	Observed Freq of Abuse				Rate per 1000 children of Child Abuse			
		P	S	N+E	T	P	S	N+E	T
63 Mowbray	895	0	3	2	5	0.00	3.35	2.23	5.59
64 Muizenberg	1471	0	5	1	6	0.00	3.40	0.68	4.08
65 Newlands	1620	0	1	0	1	0.00	0.62	0.00	0.62
66 Nooitgedacht	1927	1	0	0	1	0.52	0.00	0.00	0.52
67 Nyanga	32751	15	61	9	85	0.46	1.86	0.27	2.60
68 Observatory	1180	3	2	2	7	2.54	1.69	1.69	5.93
69 Ocean View	5207	2	12	0	14	0.38	2.30	0.00	2.69
71 Ottrey	3403	12	12	9	33	3.53	3.53	2.64	9.70
72 Parkwood	4328	1	6	4	11	0.23	1.39	0.92	2.54
73 Parow N 1	598	1	5	0	6	1.67	8.36	0.00	10.00
78 Pinelands	2470	0	3	5	8	0.00	1.21	2.02	3.24
79 Plumstead	3895	2	4	7	13	0.51	1.03	1.80	3.34
80 Retreat	11336	5	19	3	27	0.44	1.68	0.26	2.38
81 Rondebosch	4800	1	4	2	7	0.21	0.83	0.42	1.46
82 Rosebank	1135	0	1	0	1	0.00	0.88	0.00	0.88
83 Ruyterwach	1745	2	1	2	5	1.15	0.57	1.15	2.87
84 Rylands	1880	8	3	0	11	4.26	1.60	0.00	5.85
85 Salt River	3696	0	4	2	6	0.00	1.08	0.54	1.62
87 Sea Point	1361	2	6	3	11	1.47	4.41	2.20	8.08
88 Simonstown	1369	0	1	0	1	0.00	0.73	0.00	0.73
89 Southfield	1895	1	2	3	6	0.53	1.06	1.58	3.17
91 Strandfontein	6535	1	7	0	8	0.15	1.07	0.00	1.22
92 Sun Valley	5586	0	2	0	2	0.00	0.36	0.00	0.36
94 Tamboerskloof	678	0	1	0	1	0.00	1.47	0.00	1.47
95 Thornton	847	0	2	0	2	0.00	2.36	0.00	2.36
96 Uitsig	4408	1	2	0	3	0.23	0.45	0.00	0.68
97 Valhalla Park	303	1	10	1	12	3.30	33.00	3.30	39.60
98 Vredenhosk	7422	0	1	1	2	0.00	0.13	0.13	0.27
100 Wetton	514	1	8	2	11	1.95	15.60	3.89	21.40
101 Woodstock	4716	6	7	16	29	1.27	1.48	3.39	6.15
102 Wynberg	3650	6	11	3	20	1.64	3.01	0.82	5.48
103 Ysterplaat	547	0	1	1	2	0.00	1.83	1.83	3.66
104 Zeekoeivlei	1600	1	0	2	3	0.63	0.00	1.25	1.88
106 Phillipi	5250	18	24	13	55	3.43	4.57	2.48	10.50
107 Delft	4203	4	13	1	18	0.95	3.09	0.24	4.28
108 Khayalitsha	73693	26	129	40	195	0.35	1.75	0.54	2.65
111 Eerste River	26091	3	5	1	9	0.11	0.19	0.04	0.34
112 Ravensmead	9515	2	12	2	16	0.21	1.26	0.21	1.68
113 Atlantis	20785	2	12	2	16	0.10	0.58	0.10	0.77
114 Lavender Hill	5878	2	10	0	12	0.34	1.70	0.00	2.04
115 Kalksteenfontein	2635	3	5	0	8	1.14	1.90	0.00	3.04
116 Steenberg	2077	7	15	3	25	3.37	7.22	1.44	12.00
118 Kuilsrivier	11680	2	13	0	15	0.17	1.11	0.00	1.28
119 Paarl or Stellen	74871	4	6	2	12	0.05	0.08	0.03	0.16
120 Netreg		2	4	0	6	(Population statistics unavailable)			
121 Kraiifontein	3879	2	4	2	8	0.52	1.03	0.52	2.06
122 Newfields	1330	0	4	0	4	0.00	3.01	0.00	3.01
123 Orchard		3	0	5	8	(Population statistics unavailable)			
124 Diazville		0	0	3	3	(Population statistics unavailable)			
125 Hazendal	1717	1	5	0	6	0.58	2.91	0.00	3.49
126 Blue Downs		2	4	0	6	(Population statistics unavailable)			
127 Scottsville	4299	0	4	0	4	0.00	0.93	0.00	0.93
109 Out of Cape Town	47033	26	25	23	74	0.55	0.53	0.49	1.57
110 Unknown		19	111	33	163				

Child Abuse Frequency and Rate for age 0 - 18 years by Child's Residential Suburb

(in decreasing order of total abuse rate)

Key: P - Physical Abuse; S - Sexual Abuse; N+E - Neglect or Emotional Abuse
T - Abuse Total (Physical, Sexual, Neglect or Emotional)

Child's Suburb	Census Total	Observed Freq of Abuse				Rate per 1000 children of Child Abuse			
		P	S	N+E	T	P	S	N+E	T
26 Elsies River	115	2	12	1	15	17.40	104.00	8.70	130.00
97 Valhalla Park	303	1	10	1	12	3.30	33.00	3.30	39.60
100 Wetton	514	1	8	2	11	1.95	15.60	3.89	21.40
16 Cape Town	1430	8	7	4	19	5.59	4.90	2.80	13.30
116 Steenberg	2077	7	15	3	25	3.37	7.22	1.44	12.00
23 Diep River	437	2	2	1	5	4.58	4.58	2.29	11.40
106 Phillipi	5250	18	24	13	55	3.43	4.57	2.48	10.50
73 Parow N 1	598	1	5	0	6	1.67	8.36	0.00	10.00
71 Ottrey	3403	12	12	9	33	3.53	3.53	2.64	9.70
87 Sea Point	1361	2	6	3	11	1.47	4.41	2.20	8.08
19 Clovelly	146	0	1	0	1	0.00	6.85	0.00	6.85
34 Guguletu	17570	14	88	14	116	0.80	5.01	0.80	6.60
101 Woodstock	4716	6	7	16	29	1.27	1.48	3.39	6.15
35 Hanover Park	13153	23	37	20	80	1.75	2.81	1.52	6.08
68 Observatory	1180	3	2	2	7	2.54	1.69	1.69	5.93
84 Rylands	1880	8	3	0	11	4.26	1.60	0.00	5.85
2 Athlone	14795	21	45	17	83	1.42	3.04	1.15	5.61
63 Mowbray	895	0	3	2	5	0.00	3.35	2.23	5.59
21 Crawford	1628	3	0	6	9	1.84	0.00	3.69	5.53
41 Kenilworth	1448	2	2	4	8	1.38	1.38	2.76	5.52
102 Wynberg	3650	6	11	3	20	1.64	3.01	0.82	5.48
54 Rocklands	12853	11	48	9	68	0.86	3.73	0.70	5.29
37 Heideveld	7161	4	23	10	37	0.56	3.21	1.40	5.17
17 Claremont	3294	7	6	4	17	2.13	1.82	1.21	5.16
14 Bridgetown	3864	6	8	4	18	1.55	2.07	1.04	4.66
107 Delft	4203	4	13	1	18	0.95	3.09	0.24	4.28
51 Mannenberg	16505	14	46	10	70	0.85	2.79	0.61	4.24
30 Gardens	1200	2	1	2	5	1.67	0.83	1.67	4.17
64 Muizenberg	1471	0	5	1	6	0.00	3.40	0.68	4.08
42 Kensington	4259	2	14	1	17	0.47	3.29	0.23	3.99
46 Langa	8560	11	17	4	32	1.29	1.99	0.47	3.74
103 Ysterplaat	547	0	1	1	2	0.00	1.83	1.83	3.66
36 Heathfield	1371	2	3	0	5	1.46	2.19	0.00	3.65
125 Hazendal	1717	1	5	0	6	0.58	2.91	0.00	3.49
39 Hout Bay	2388	1	2	5	8	0.42	0.84	2.09	3.35
79 Plumstead	3895	2	4	7	13	0.51	1.03	1.80	3.34
78 Pinelands	2470	0	3	5	8	0.00	1.21	2.02	3.24
52 Matroosfontein	1572	0	4	1	5	0.00	2.54	0.64	3.18
89 Southfield	1895	1	2	3	6	0.53	1.06	1.58	3.17
50 Maitland	4572	3	11	0	14	0.66	2.41	0.00	3.06
115 Kalksteenfontein	2635	3	5	0	8	1.14	1.90	0.00	3.04
122 Newfields	1330	0	4	0	4	0.00	3.01	0.00	3.01
11 Bishopcourt	334	1	0	0	1	2.99	0.00	0.00	2.99
83 Ruyterwach	1745	2	1	2	5	1.15	0.57	1.15	2.87
12 Bonteheuwel	19174	14	39	2	55	0.73	2.03	0.10	2.87
69 Ocean View	5207	2	12	0	14	0.38	2.30	0.00	2.69
108 Khayalitsha	73693	26	129	40	195	0.35	1.75	0.54	2.65
67 Nyanga	32751	15	61	9	85	0.46	1.86	0.27	2.60
72 Parkwood	4328	1	6	4	11	0.23	1.39	0.92	2.54

Child's Suburb	Census Total	Observed Freq of Abuse				Rate per 1000 children of Child Abuse			
		P	S	N+E	T	P	S	N+E	T
80 Retreat	11336	5	19	3	27	0.44	1.68	0.26	2.38
95 Thornton	847	0	2	0	2	0.00	2.36	0.00	2.36
32 Grassy Park	7348	1	13	2	16	0.14	1.77	0.27	2.18
48 Lotus River	12531	6	14	7	27	0.48	1.12	0.56	2.15
15 Camps Bay	1431	1	2	0	3	0.70	1.40	0.00	2.10
121 Kraiifontein	3879	2	4	2	8	0.52	1.03	0.52	2.06
114 Lavender Hill	5878	2	10	0	12	0.34	1.70	0.00	2.04
43 Kewtown	2477	0	2	3	5	0.00	0.81	1.21	2.02
10 Bishop Lavis	11073	1	16	5	22	0.09	1.44	0.45	1.99
104 Zeekoeivlei	1600	1	0	2	3	0.63	0.00	1.25	1.88
58 Beacon Valley	11952	4	15	2	21	0.33	1.26	0.17	1.76
60 Eastridge/Tafelsig	27609	13	33	2	48	0.47	1.20	0.07	1.74
3 Belhar	17086	4	16	9	29	0.23	0.94	0.53	1.70
112 Ravensmead	9515	2	12	2	16	0.21	1.26	0.21	1.68
85 Salt River	3696	0	4	2	6	0.00	1.08	0.54	1.62
20 Constantia & Tokai	8846	2	3	9	14	0.23	0.34	1.02	1.58
9 Bergvliet	1318	0	1	1	2	0.00	0.76	0.76	1.52
94 Tamboerskloof	678	0	1	0	1	0.00	1.47	0.00	1.47
81 Rondebosch	4800	1	4	2	7	0.21	0.83	0.42	1.46
55 Westridge	8326	2	8	2	12	0.24	0.96	0.24	1.44
59 Woodlands	9942	3	11	0	14	0.30	1.11	0.00	1.41
27 Factreton	4479	0	4	2	6	0.00	0.89	0.45	1.34
33 Green Point	750	0	0	1	1	0.00	0.00	1.33	1.33
13 Bothasig	3047	2	2	0	4	0.66	0.66	0.00	1.31
118 Kuilsrivier	11680	2	13	0	15	0.17	1.11	0.00	1.28
56 Portlands	11035	0	12	2	14	0.00	1.09	0.18	1.27
53 Milnerton	9434	2	7	3	12	0.21	0.74	0.32	1.27
8 Belville S	5654	1	6	0	7	0.18	1.06	0.00	1.24
91 Strandfontein	6535	1	7	0	8	0.15	1.07	0.00	1.22
57 Lentegeur	14911	5	10	3	18	0.34	0.67	0.20	1.21
47 Landsdowne	4773	1	4	0	5	0.21	0.84	0.00	1.05
4 Belville N 1	21805	5	16	0	21	0.23	0.73	0.00	0.96
127 Scottsville	4299	0	4	0	4	0.00	0.93	0.00	0.93
82 Rosebank	1135	0	1	0	1	0.00	0.88	0.00	0.88
113 Atlantis	20785	2	12	2	16	0.10	0.58	0.10	0.77
88 Simonstown	1369	0	1	0	1	0.00	0.73	0.00	0.73
96 Uitsig	4408	1	2	0	3	0.23	0.45	0.00	0.68
65 Newlands	1620	0	1	0	1	0.00	0.62	0.00	0.62
28 Fish Hoak	1710	0	1	0	1	0.00	0.58	0.00	0.58
66 Nooitgedacht	1927	1	0	0	1	0.52	0.00	0.00	0.52
38 Hout Bay harbour	2026	0	0	1	1	0.00	0.00	0.49	0.49
25 Edgemead	2728	0	1	0	1	0.00	0.37	0.00	0.37
92 Sun Valley	5586	0	2	0	2	0.00	0.36	0.00	0.36
111 Eerste River	26091	3	5	1	9	0.11	0.19	0.04	0.34
98 Vredenhosk	7422	0	1	1	2	0.00	0.13	0.13	0.27
119 Paarl or Stellen	74871	4	6	2	12	0.05	0.08	0.03	0.16
31 Goodwood	36353	0	1	0	1	0.00	0.03	0.00	0.03
22 Crossroads		1	16	1	18	(see Nyanga)			
126 Blue Downs		2	4	0	6	(Population statistics unavailable)			
124 Diazville		0	0	3	3	(Population statistics unavailable)			
123 Orchard		3	0	5	8	(Population statistics unavailable)			
120 Netreg		2	4	0	6	(Population statistics unavailable)			
109 Out of Cape Town	47033	26	25	23	74	0.55	0.53	0.49	1.57
110 Unknown		19	111	33	163				

Appendix 6 Reporting forms in use prior to this study

The reporting forms are examples of those used in the City prior to the study.

1 Red Cross War Memorial Children's Hospital

2 Tygerberg Hospital

3 Cape Town City Council

MEMORANDUM

To: Dr P Lachman
Developmental Assessment
Services
Child Health Unit
Children's Centre

From: Ms J Hollingshead
Social Work Department
Red Cross Children's Hospital

17 November 1992

Dear Pete

re: Social Work Department Procedures for Notification of Child Abuse in terms of Section 42 of Child Care Act (no 74 of 1983) as amended

Procedures

As discussed, the following is the step-by-step procedure in our Department for notification of Child Abuse cases, on behalf of the Children's Hospital Child Abuse Management Team.

Information Sheet (see Annexure A)

1.1 Following intervention with every case of suspected or confirmed case of child abuse (inclusive of physical and sexual abuse, neglect and abandonment), each Social Worker completes above form.
This form also serves as a source of identifying information and planning.
It is contained in a comprehensive folder with medical forms (DRX 455 Annexure B), correspondence, process and other relevant reports.

1.2 During the second week of each month, all the Social Workers submit to me their combined Information Sheets of the previous month, together with the collation of this information on a Monthly Child Abuse Statistics Sheet.
The names of children on these Information Sheets are checked against a record of cases presented at a regular Tuesday morning meeting, to ensure that all cases are duly notified.

Monthly Child Abuse Statistics Sheet (see Annexure C)

Details from all the Social Workers' Statistics Sheets are combined to reflect the total monthly statistics.

Actual notification

The typed Information Sheets are then divided according to which Regional Directors they have to be submitted. These include The Regional Representative, CPA Community Services, Goodwood (black children); The Regional Directors, Department of Health Services and Welfare : Administration House of Representatives Bellville and Wynberg (coloured children) ; The Regional Director, Department of Health Services and Welfare : Administration, House of Assembly, Bellville (white children), ie 4 different offices.

The sheets are accompanied by a covering letter stating that these are notifications in terms of Section 42 of the Child Care Act.

2/.....

Follow-up

In general, once the above process is complete, we have no further feedback. On occasions in the past, if our Information Sheets indicated under "Future Plans" that the Hospital Social Worker was managing the case, we would receive requests for progress reports from the Wynberg Department only.

Issues and Concerns

Within the present system, the following points illustrate our concerns.

1. As there is no central register for abuse cases, it is impossible to check whether children presenting to our Hospital have been victims of abuse on previous occasions.

2. As there are no uniformly accepted definitions of the various kinds of abuse, we have no way of knowing whether we are meeting the criteria for notifications. This lack of uniformity complicates access to information on broader community or regional trends in abuse.

3. Our notifications are done by the beginning of the month following the month of presentation at our Hospital. If, after intensive investigation, it is decided that a notification was inappropriate we have no way of removing a name from a register.

4. It is not known who has access to the information on the registers and from previous experience it would appear that there is reluctance to provide this information. Press reports on official numbers make a mockery of the current system of reporting.

5. The process of having to report to 4 different Departments is time-consuming, inefficient and a violation of a basic human right to health and welfare care regardless of sex, race, gender or creed.

C. Proposals

1. That a non-racial single register be implemented without delay.

2. That acceptable definitions of abuse with inclusion and exclusion criteria be devised, agreed upon and circulated.

3. That a uniform notification sheet be devised and implemented.

4. That a State Department takes responsibility for co-ordinating notification, follow-up and feedback to all agencies submitting such information. The same Department should undertake to collate such information for the provision of quarterly comprehensive feedback reports, and any other statistical analyses required by service providers.

I trust that this information will be of use to you. Thank you for agreeing to represent us at the meeting.

Yours sincerely

J HOLLINGSHEAD (Ms)
Chief Social Worker

JH/na

ANNEXURE A

RED CROSS WAR MEMORIAL CHILDREN'S HOSPITAL TELEPHONE: 6585196

NFORMATION SHEET OF CASES OF NON ACCIDENTAL INJURY

AME: ..... SOCIAL WORKER: .....

OLDER NO: ..... REF. TO SW BY: .....

ORN: ..... DATE SEEN AT RXH: .....

DDRESS: .....

EFERRED TO RED CROSS HOSP. BY: .....

ATE OF INJURY: ..... ~~GROG. AREA:~~ .....

BUSER: ..... SUSPECTED/CONFIRMED: .....

RESENTING PROBLEM TO HOSPITAL: .....

LINICAL FINDINGS: .....

XPLANATION: .....

.....

HO ACCOMPANIED CHILD TO HOSPITAL: .....

AMILY COMPOSITION: (Name, Age, Occupation, Income, Telephone number).

arents: .....

.....

arital Status. .....

iblings: .....

here child lives: .....

aretaker: .....

chool: .....

ENERAL CIRCS: .....

.....

.....

CTION TAKEN: .....

.....

.....

UTURE PLANS: .....

.....

.....

.....

2/04/01

DRX 455

CHILD ABUSE RECORD FORM

STICKER

NEXT OF KIN:.....

ADDRESS:.....

TELEPHONE: .....

HISTORY

Referred in by: ..... Accompanied by: .....

Source of history: | Parent | Relative | Caretaker | Other (specify) .....

Evaluation of historian: | Reliable | Suspect (specify why).....

Details of latest abuse: Date: ...../...../..... Time: .....H.....

Place: | Home (victim/perp.) | Neighbourhood | Other

Identity: | Parent | Other relative | Known pers | Stranger

Precious medical history: _____

B. EXAMINATION

AGE: ..... SEX: M/F WEIGHT: .....kg HEIGHT .....cm

CLOTHING: | Normal | Torn | Soiled | Blood | Semen | MENTAL STATE: | Relaxed | Agitated | Anxious

General examination: (see diagrams) _____

Genitalia & Perineum: _____

C. INVESTIGATIONS

X-RAYS/SKELETAL SURVEY: .....

SWABS: | Oropharynx | Vaginal | Urethral | Rectal | RESULTS: .....

WET PREPARATION | Done | Not done | RESULTS: .....

PREG. TEST | Done | Not done | RESULTS: .....

BLOOD: | VDRL | RESULTS: .....

D. MANAGEMENT

| Admitted | Wounds Rx | Preg.Prophylaxis | S.T.D.Rx | DETAILS: .....

DOCTOR'S NAME ....

SIGNATURE

DATE OF FOLLOW-UP VISITS: .....

SOCIAL WORKER'S NAME .....

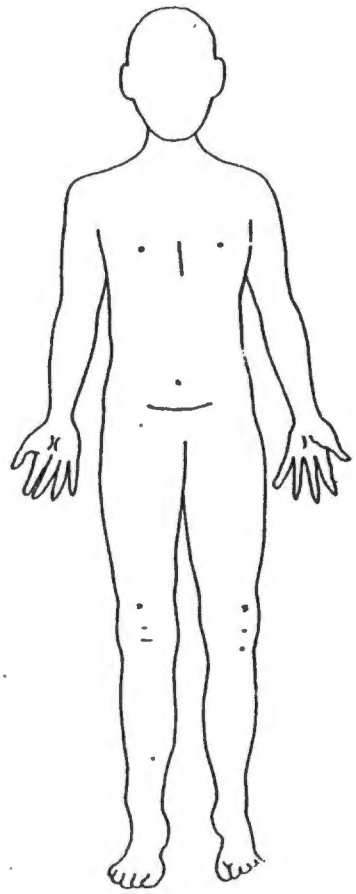
POLICEMAN'S NAME .....

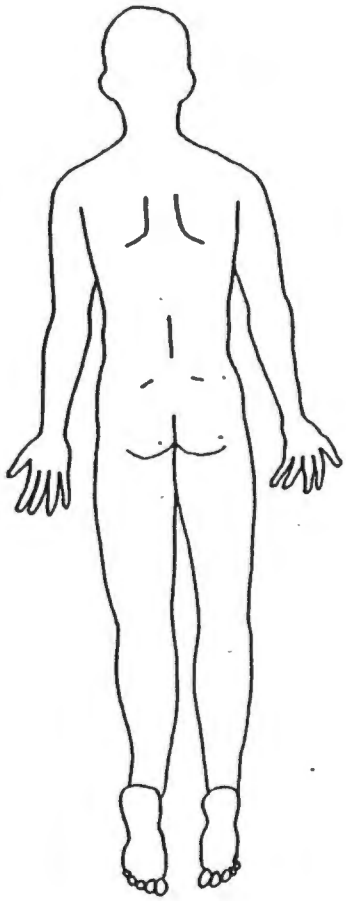
DATE SEEN:.....

TIME SEEN:.....

.....

SIGNATURE (CONSULTANT)





LABIA MAJ.....

LABIA MIN.....

VESTIBULE.....

HYMEN*.....

VAGINA.....

TOURCHETTE.....

PERINEUM.....

DISCHARGE.....

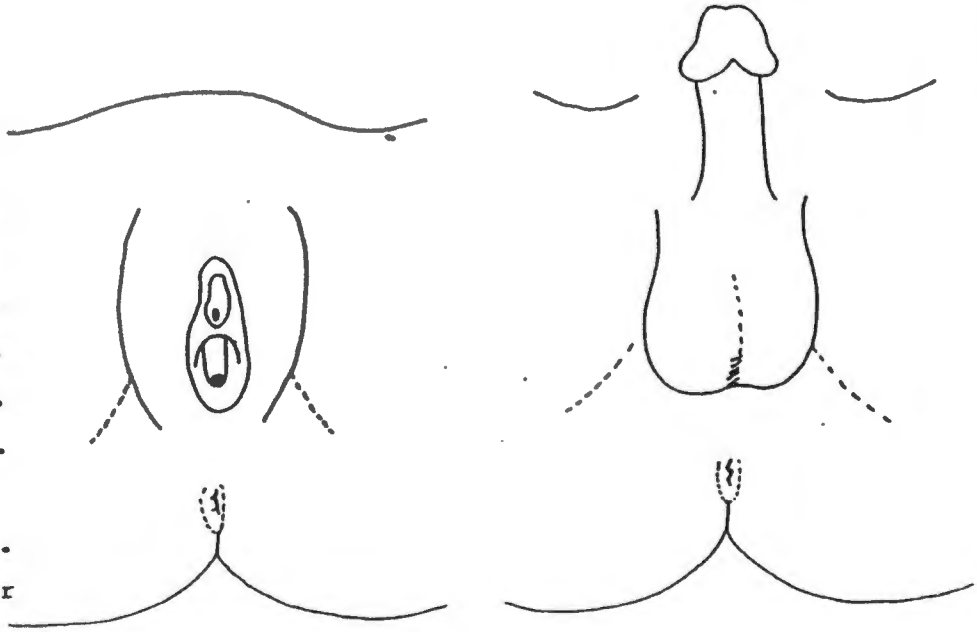
HAEMORRHAGE.....

ANUS.....

PENIS

SCROTUM.....

* If present, indicate diameter



CITY OF CAPE TOWN
HEALTH DEPARTMENT

The Regional Director
Department of Health Services and Welfare

.....
.....
.....

NOTIFICATION OF INJURED AND UNDERNOURISHED CHILDREN INCLUDING BEHAVIOURAL PATTERNS INDICATING POSSIBLE ABUSE (CHILD CARE ACT NO. 74 OF 1983 SECTION 42 (1))

1. FULL NAME & SURNAME OF CHILD: .....
   .....
2. DATE OF BIRTH:..... 3. SEX: .....
4. ADDRESS: .....
   .....
5. MOTHER'S NAME: .....
6. NATURE OF ABUSE/INJURY: .....
   .....
   .....
   .....
7. BACKGROUND INFORMATION: .....
   .....
   .....
   .....
8. PARENTAL ACCOUNT: .....
   .....
   .....
   .....
9. HAS CHILD BEEN REMOVED FROM PARENTS: .....
10. PLACE WHERE CHILD SEEN/RECEIVED TREATMENT & HOSP/CLINIC REF. NO.:
    .....
    .....
11. MANAGEMENT: .....
    .....
    .....
12. NAME AND ADDRESS OF PERSON NOTIFYING CASE: .....
    .....
    .....

SIGNATURE DATE:.....

PROVINSIALE ADMINISTRASIE
VAN DIE KAAP DIE GOEIE HOOP
OSPITAAL- EN GESONDHEIDSDIENSTE
TYGERBERG-HOSPITAAL
PRIVAATSAK, TYGERBERG, 7505
FAKS: (021) 931-1451 TELEGRAM: HOSPRO

PROVINCIAL ADMINISTRATION
OF THE CAPE OF GOOD HOPE
HOSPITAL AND HEALTH SERVICES BRANCH
TYGERBERG HOSPITAL
PRIVATE BAG, TYGERBERG, 7505
TELEFAX: (021) 931-1451 TELEGRAM: HOSPRO

Die Streekdirekteur

.....
(Spesifieke bevolkingsgroep)
.....
.....

TELEFOON
TELEPHONE : (021) 938-4911
NAVRAE
ENQUIRIES (Naam v u/w)
VERWYSING
REFERENCE (van Dept. M/W)
DATUM
DATE Meld kategorie v mishandeling ↓

Traese Nuus
Seks. Molest
Vermaarlosi
Voedingsgebr
Verlating

VERMOEDELIK MISHANDELDE KIND: ART 42(1) WET 74/83 .....

Naam en Van (van pasiënt) ..... Toelatings-datum: ..... Ontslag-datum: .....

Geboortedatum ..... Ras en Geslag ..... Lêer-nommer (Medirec lêer..)

Adres van pasiënt: .....

1. **ALGEMENE TOESTAND VAN PASIëNT**

1.1 Diagnose/Beserings: (volgens mediese rekord) .....

1.2 Verduideliking vir beserings: Ouer of verantwoordelike persoon asook pasient se verduideliking vir besering .....

.....

1.3 Datum, tyd, plek van beserings: .....

1.4 Naam, ouderdom, adres van beweerde oortreder: Ouderdom is belangrik veral om minderjarige oortreders aan te dui vir oprolg

1.5 Vorige insidente: .....

1.6 Polisiebetrokkenheid: Kantoor Ondersoekbeampte Saaknommer

....

1.7 Verwysende dr./vp: ..... Afdeling: (Hoofdoelafdeling

2. **GESINSAMESTELLING**

2.1 OUERS

	VADER	MOEDER
Naam	Belangrik aangesien ouers soms angetrou is en	
Adres	verskillende vanne en adresse het.	
	..... Tel: H..... W.....	..... Tel: H..... W.....
Geboortedatum/Ouderdom:	.....	.....
Skoolstanderd geslaag:	.....	.....

2.2 KINDERS

NAAM	GEB.DATUM/OUDERDOM	STANDERD/NAAM VAN SKOOL
.....	.....	.....
.....	.....	.....
.....	.....	.....

2.3 Gesinsbeplanning: JA ☐ NEE ☐ N.V.T. ☐

3. **GESINSVERHOUDINGE**

Huwelikstaat: GETROUD ☐ SAAMLEEF ☐ BUITE-EGTELIK (WOON APART) ☐ GESKEI ☐

Huweliksverhouding: .....

Ouer-kind verhouding: Vader: .....

Moeder: .....

4. **BEHUISING EN OMGEWING**

Grootte van huis: ..... Inwonertal: Volwassenes ..... Kinders ... ...

Geriewe: Elektrisiteit: ..... Water: ..... Sanitêre geriewe: .....

Opmerkings: (Meld waar pt slaap, veral in geval van seksuele molestering.

5. **WERKSOMSTANDIGHEDE EN FINANSIES**

	VADER	MOEDER
Werkgewer :	.....	.....
Aard van werk :	.....	.....
Werksrekord :	.....	.....
Inkomste :	.....	.....

6. **SOSIALE KONTAK**

Vriendekring: ..... Ondersteuningsfigure .....

Drank/Dwelmmisbruik: Vader: .....

Moeder: .....

Kriminele rekord: Vader: ..... Moeder : .....

7. **VERSORGING VAN PASIËNT**

Wie versorg pasiënt: .....

.....

Veiligheid tuis : VEILIG ☐ ONVEILIG ☐ ONSEKER ☐ REDE: .....

.....

8. **EVALUASIE**

POSITIEWE FAKTORE .....

.....

.....

NEGATIEWE FAKTORE .....

.....

.....

.....

9. **DIENSTE GELEWER** (Naam van betrokke maatst^e werker)

Reeds bekend aan Welsynsorganisasie: (Naam van welsynsorganisasie)

Krisisondersoek aangevra per faks ☐ Telefoon ☐ Datum: .....

By: (Naam van Welsynsorganisasie) Dringende ondersoeke m.d.o. op ontslagbeplanning word gewoonlik per faks aangevra by die dienskantoor van Dept. of ander W.O. Dit is belangrik om dat die saak reeds dringende aandag geniet

10. **GEVOLGTREKKING EN AANBEVELING** dit vir Streetdirektew aan te toon – ni

.....

Meld of hospitaal voortgaan met dienslewering

.....

HANDTEKENING: (Van Maatst^e Werker) DATUM: .....

AANMELDING VAN VERMOEDELIKE KINDERMISHANDELING INGEVOLGE ART. 42(1) VAN DIE WET OP KINDERSORG (WET 74/1983)

1. Aangeheg aanmeldingsvorm wat deur Tygerberg hospitaal gebruik word.

2. Vorm word in 3-voud voltooi. Afskrifte word soos volg aangewend:
   1 afskrif aan Streekdirekteur
   1 afskrif op maatskaplike werklêer
   1 afskrif op kinderbeskermingsregister van TBH.

3. Kinderbeskermingsregister word gehou deur Departement Maatskaplike Werk.

3.1 Alfabetiese register word gehou waarop Art. 42(1) vorms volgens pasient se van geliasseer word.

3.2 Datumregister word gehou waarin gevalle in datumvolgorde (nl. toelatingsdatums) aangedui word. Die volgende besonderhede word bondig hierin weergegee:
   Toelatingsdatum, naam en van, lêernommer ras en geslag, ouderdom & geboortedatum, adres, aard van besering, deur wie beseer, risikofaktore, besonderhede in verband met verwysing na W.O., psigiatrie, SAP en of Art. 42(1) aanmelding gedoen is asook naam van betrokke maatskaplike werker.

4. Om administrasie te beperk tot die noodsaaklike word dieselfde vorm gebruik vir:
   - Aanmelding tydens na-uurse spoeddiens
   - Eerste onderhoud deur M/W tydens amptelike diensure
   - Aanmelding Streekdirekteur
   - Vir aanvra van dringende tuisondersoek per faks
   - Verwysing na Departement Kinder-psigiatrie.

5. Gedurende die eerste 6 maande van 1992 is daar gemiddeld 46 pasiente per maand aangemeld (fisiese mishandeling, seksuele molestering, verwaarlosing, voedingsgebrek).

PROBLEME VERBOND AAN AANMELDINGSPROSEDURE

1. Aanmeldingsprosedures van staatsdepartemente verskil.

2. Geen terugvoering ten opsigte van aanmeldings is moontlik nie weens mannekragtekort by staatsdepartemente.

3. Alhoewel die name en adresse van minderjarige oortreders aangedui word, is dit onseker of hulle wel die nodige aandag geniet.

ADRESSE STREEKDIREKTEURE:

Blankes:
Die Streekdirekteur
Dept. Gesondheidsdienste en Welsyn
Admin. Volksraad
Privaatsak X55
BELLVILLE
7530

Kleurlinge:
Die Streekdirekteur
Dept. Gesondheidsdienste en Welsyn
Admin. Raad van Verteenwoordigers
Privaatsak X50
BELLVILLE
7530

Swartmense:
Die Streekdirekteur
K.P.A. Gemeenskapsdienste
Privaatsak X7
GOODWOOD
7460

Asiate:
Die Streekdirekteur
Dept. Gesondheidsdienste en Welsyn
Admin. Raad van Afgevaardiges
Privaatsak X1
GATESVILLE
7764

Appendix 7 Guidelines in use prior to this study

1 Guidelines issued by the Department of Welfare, House of Assembly.

2 Guidelines issued by the Department of National Health, Western Cape.

S Mev. Hoffman,
Vir dringende aandag van pos 20 a56.
D.A.Robertson
14/2/89.

81/172892
(Z 28)

REPUBLIC OF SOUTH AFRICA

Leer 12/4/B

Enquiries: Mrs C.E. Dempers
Telephone: 284634 x 2227
Directorate: Social Welfare

Reference No.: 12/4/16/2/1 en
12/4/B

ADMINISTRATION:
HOUSE OF ASSEMBLY
DEPARTMENT OF HEALTH SERVICES
AND WELFARE
PRIVATE BAG X730
PRETORIA
0001

5/3/1989

TO :
1. ALL NATIONALLY AND PROVINCIALLY ORGANISED WELFARE ORGANISATIONS
2. CHILDREN'S HOMES
3. REGIONAL AND SERVICE OFFICES OF THE DEPARTMENT
4. STATE PLACES OF SAFETY
5. SETTLEMENTS
6. ALL OFFICERS AT HEAD OFFICE WITH THE RANK EQUIVALENT TO ADMINISTRATIVE OFFICER AND HIGHER

CIRCULAR NO. 9 OF 1989

CHILD PROTECTION REGISTER

1. Introduction

(a) The Child Care Act, 1983, has, as its aim, the protection of children and the treatment of children and their families.

(b) As a result of the provisions contained in Section 42 of the Act, it has become necessary to adapt the procedures for reporting and handling cases of ill-treatment of children.

(c) In terms of Section 42(1) of the Act, every dentist, medical practitioner or nurse who examines a child in circumstances giving rise to the suspicion that the child has been ill-treated or is undernourished shall immediately notify the Department of those circumstances.

(d) Although the Act does not oblige any other professional group or person to report cases of child abuse or cases where ill-treatment of a child is suspected, the community, nevertheless, should be made aware of the phenomenon and the necessity of reporting such cases.

(e) The ill-treatment of children can be prevented and children and families who are involved with this can be helped. Early identification of cases ensures timely help which may have better results and so protect the child.

(f) Owners of créches and other people who are involved with children should be geared to bring such cases to the attention of the nearest departmental service office so that treatment services can be made available to the child and his family.

(g) An earnest appeal is therefore made to all social workers to promote the reporting of such cases on the part of the community and by such persons referred to in paragraph 1(f) of this circular. In addition, social workers are urged to personally ensure that the cases which come to their notice are reported to the Child Protection Register.

2. Basic Premises concerning the handling of cases of child abuse

(a) Acceptance of the fact that it is every child's right to be cared for, cherished and protected in his natural family setting;

(b) acceptance of the fact that people, who are involved with children because of the nature of their daily work, have a responsibility to ensure that children receive the necessary protection;

(c) early identification of children who are being subjected to or who are possibly being subjected to ill-treatment;

(d) prompt reporting and taking of the necessary steps for the protection of the child;

(e) shared responsibility in combatting the ill-treatment of children and rendering assistance to identified cases;

(f) continuation of services to these cases.

3. Definition of ill-treatment of a child

The Department endorses the following definition for the purpose of reporting to the Child Protection Register -

Ill-treatment of a child means that physical, psychological or mental injury or harm is inflicted on a child purposely and not by accident and includes any form of sexual molestation.

4. Child Protection Register

(a) A register for reported cases, whether these are statutory reports as intended in Section 42 of the Act or not, is to be instituted at every service office of the Department.

(b) For the purpose of the register, even those cases where it is merely suspected that the child is being ill-treated are to be noted.

(c) The register must consist of register pages which are to be stored alphabetically, according to the surnames of the children, in a loose-leaf file, and be kept in the office of the officer responsible for the register.

(d) The register must be handled confidentially and information about reported cases may only be given to professional people who require such information by virtue of their professional involvement.

(e) An example of a register page is attached to this circular in the form of Annexure A. The register number is made up as follows:

* Identification of service office (first five blocks) - a service office should use for its field of operation the code number of the magisterial district in which it is situated. Code numbers for magisterial districts are to be found in the annexure to the Filing System for the Department of Health Services and Welfare, Administration: House of Assembly.

* Code to identify the type of report (blocks 6 and 7) - 01 for statutory reports or 02 for any other report.

* Serial number (5 blocks are allowed for this) - begin with the last block and number in sequence from 1 on. The numbers of de-registered cases should not be used again. For example: a case is reported to Krugersdorp service office by a medical practitioner. This is the 10th case to be registered.

1	0	1	1	6	0	1	0	0	0	1	0

(f) Based on overseas studies and on experience acquired in this country, there is a strong nomadic element in families in which ill-treatment of children occurs. Such reports ought therefore to be centralised which will promote further effective action. The Department has therefore decided to institute a computerised register at Head Office which will, in due course, be linked to computers at the service offices. The Department has further decided that the cases which are recorded in the computerised register will only be removed when the child concerned has reached the age of 18 years.

(g) An example of the form, on which the information for computerisation is to be provided, is attached to this circular as Annexure B. The forms that have been completed by the service office in respect of every case that has been registered, in the course of a month, should be sent to the Department via the Regional Head at the end of that month. The Regional Head must ensure that the envelope containing the information is clearly marked - Confidential, for the section: Child Care : Child Protection Register and that it is despatched inside a second envelope addressed to the Department. This procedure shall be valid until every office is linked to the central computer.

5. Procedure for the reporting of cases to be recorded in the Child Protection Register

(a) Reports may be written or made in person or telephonically. It can, however, be expected that the majority of cases will be reported telephonically in view of the urgent action required to prevent further ill-treatment.

(b) It should be pointed out to officers entrusted with receiving correspondence, that letters to do with the ill-treatment of children are to be brought to the attention of the officer who keeps the register immediately.

(c) The Head of the office should appoint one of his officers to be the person responsible for the receipt of reports and the keeping of the register.

(d) The service office should control, through the central case register, whether the client is already known to a family care organisation or not. If so, the relevant family care organisation should be contacted telephonically, with the request that an investigation into the child's circumstances be undertaken within 6 hours.

(e) Should the client not be known to a family welfare organisation, or should the family welfare organisation not be able to expedite the investigation, the service office must undertake the original investigation itself and make arrangements for the protection of the child. When the original investigation has been done, the case should then be allocated to a family welfare organisation, as circumstances allow.

(f) In exceptional cases, where an ill-treated child finds himself in a remote area and a social worker is unable to reach the family quickly because of the distance, the Head of the service office may request the S.A. Police to institute an investigation into the child's safety until such time as a social worker can visit the family.

(g) The service office should open a case file for every reported case and attach a yellow strip (yellow adhesive tape) to the W.P.11 card, which is kept in the registry section of the office. The yellow strip indicates that ill-treatment of a child is suspected.

(h) As soon as a family welfare organisation accepts the reported case which has been referred to them, the necessary notation should be made on the W.P.11 card. In a case where a report of ill-treatment is received about a child who is already known to an organisation, a yellow strip should be attached to the existing W.P.11 card together with the W-number of the case file which was opened on the grounds of the report.

(i) When a report is made to a family welfare organisation, the case must be registered in the register immediately and the organisation concerned should undertake the original investigation. (The register page makes provision for the recording of the name of the organisation which is already rendering services - see Annexure A).

(j) Where a case is reported to the Regional office, the service office concerned must be notified immediately and the latter should follow the procedures as indicated above.

(k) It cannot be expected of the person who reports the case, that he should have all the information required for the register. The information that is lacking should be added after a social worker has investigated the circumstances of the case. Where a person, as so described in paragraph 1(f) of this circular, or any other person in the community, reports a case, his identity should not be made known to the family, except where such a person chooses to become involved with the family. The person who makes the report should be reassured about this, but should still realise that the social worker entrusted with the investigation will very likely approach him for more information.

Should the person making a report prefer not to furnish his name, the complaint should be dealt with, with the same urgency as any other report.

6. Treatment services to reported cases

(a) The Department will not prescribe what treatment services should be rendered to cases of child abuse. The Department's controlling function is merely aimed at ensuring that every case of ill-treatment of a child receives professional attention.

(b) The police officer and social worker should undertake the original investigation as a team and, depending on circumstances, should support each other in whatever further action is taken. The police officer is primarily responsible for the criminal investigation and the identifying of the alleged offender, while the social worker is responsible for the safety, support and treatment of the child and his family.

(c) Where the original investigation of a case reported in terms of Section 42 of the Act, indicates that it is necessary to remove the child from parental care, the Regional Head may, at the request of a social worker, issue a warrant in terms of Section 42(2) of the Act. A social worker or a police officer can, however, also remove a child who is so reported, or any other child, to a place of safety in terms of Section 12 of the Act, or, where immediate action is not necessary, bring a child before the children's court in the usual way.

(d) The service office should set return dates and ensure that progress reports, in the form of annexure C be submitted on time. Progress reports should be evaluated to ensure that the client is receiving the necessary attention and to assess when progress reports, in terms of this circular, are no longer necessary. The progress reports should be placed on the case files.

(e) The Head of the Office should decide when a case may be removed from the register. De-registration may take place as soon as the service office is satisfied that the child's safety is assured and that the parents are prepared to co-operate but not before the case has been entered into the computerised register at Head Office. As soon as a case has been de-registered, the register page should be filed in the case file.

(f) De-registration of a case does not imply that further social work services to the family should be terminated. Continuation of preventive services at the primary, secondary and tertiary level should still be made available, as circumstances demand.

(g) In a case where a family moves to another service office's area, before de-registration in the register has taken place, the service office where the case was registered must bring the fact that child abuse was reported, clearly, to the attention of the service office now concerned. The latter service office should deal with the case as per the directions regarding the handling of reported cases contained in this circular. In a case where de-registration has already taken place, the file contents should be transferred to the service office concerned in the usual way.

(h) Social workers are urged to make use of the services of specialised treatment units. The social worker to whom a reported case is allocated, however, remains responsible for that case at all times.

(i) An appeal is hereby made to Regional Heads to initiate, in co-operation with family welfare organisations and provincial hospitals, the development of services in areas where no treatment units as yet exist, and where, according to the incidence rate, there is a need for such units. Such treatment units should preferably be situated at provincial hospitals.

9. General

(a) There should be much closer liaison and consultation between social workers and police officers with regard to the handling of cases of child abuse. Service offices are therefore requested to promote the liaison between social workers and the Child Protection units of the South African Police.

(b) Inspecting officers involved with créches are particularly requested to obtain the co-operation of créche-owners in connection with the reporting of child abuse, and suspected cases of child abuse.

(c) The prevention of the ill-treatment of children should receive the highest priority. Everyone who is involved with children should identify those who are possibly being subjected to ill-treatment at an early stage and should refer such children for professional attention. An Action Committee for the Prevention of Ill-treatment of Children is formulating broad guidelines for purposeful preventive campaigns at all levels at present. As soon as these guidelines are ready, they will be made available to all interested parties.

(d) The Department requires that the procedures laid down in this circular be implemented as from 1 March 1989.

(e) The Department further requires that it be informed regarding the implementation of the procedures contained in this circular and that recommendations, if any, be made before 1 March 1990.

(f) Circulars numbers 15 and 16 of 1980 are hereby revoked.

Signed

HEAD OF DEPARTMENT

ANNEXURE A

REGISTER PAGE: CHILD PROTECTION REGISTER W NUMBER .....

Register no.: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ][ ] —

Date of notification: .....

Following notifications: .....

Identifying details of child

Surname: .....

Name: .....

Date of Birth: ..... Identity no. .....

Sex: .....

Address where child is presently: .....

.....

Identifying details of family

Name of Father: .....

Date of Birth: ..... Identity no. .....

Name of Mother: .....

Date of Birth: ..... Identity no. .....

Name of stepparent/cohabitant (delete where not applicable) .....

Date of Birth ..... Identity no. .....

Residential address: .....

.....

Details of person who reports the case

Name: .....

Address and telephone number .....

.....

Kinship/capacity .....

Ill-treatment

Nature of ill-treatment/suspected ill-treatment .....

.....

.....

Name and address of alleged perpetrator .....

Case already under attention of a family care organisation .....
(name of organisation)

Referral

Date of referral ..... Name of social worker .....

Name and address of organisation/service office .....

.....

Date when to report back ..... Results of investigation: .....

.....

Return date	Date when report is received	Remarks
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

Has child been removed to a place of safety? .....

If so in terms of which section? .....

Date of removal: .....

Address of place of safety: .....

Is the S.A. Police involved with the case? .....

Date on which case is de-registered .....

ANNEXURE B

Computer Register: Child Protection Register

ATTENTION: SECTION CHILD CARE

DEPARTMENT OF HEALTH SERVICES AND
WELFARE
ADMINISTRATION: HOUSE OF ASSEMBLY
PRIVATE BAG X730
PRETORIA
0001

Register no. | | | | | | | | | | | | |

Card no (for computer) .....

Identifying details

Name of Father: .....

Date of Birth : ..... Identity no. .....

Name of Mother: .....

Date of Birth : ..... Identity no. .....

Name of Child : .....

Date of Birth : ..... Identity no. .....

Date on which child will turn 18 : .....

Organisation/service office which renders or rendered services

Starting date	Name and address of organisation/service office	Ref. no
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....
.....	.....	.....

SERVICE OFFICE .....

DATE: .....

ANNEXURE C

CONFIDENTIAL

Reference numbers:

Register no. | | | | | | | | | | | | |

W number: .....

Organisation: .....

PROGRESS REPORT: CHILD PROTECTION REGISTER

1. NAME/DATE OF BIRTH OF CHILD: .....
.....

2. PRESENT RESIDENTIAL ADDRESS OF CHILD: .....
.....

3. PRESENT RESIDENTIAL ADDRESS OF PARENTS: .....
.....

4. NATURE OF SERVICES RENDERED: .....
.....
.....
.....
.....
.....

5. DATES WHEN CASE WAS CONTACTED (CHILD AND PARENTS): .....
.....
.....

6. NATURE OF SERVICES WHICH ARE CONTEMPLATED: .....
.....
.....
.....
.....
.....

7. REMARKS: .....
.....
.....
.....

....

SOCIAL WORKER DATE

NAME AND ADDRESS OF ORGANISATION: .....
.....
.....

DEPARTEMENT VAN NASIONALE GESONDHEID
EN BEVOLKINGSONTWIKKELING
Republiek van Suid-Afrika

DEPARTMENT OF NATIONAL HEALTH AND
POPULATION DEVELOPMENT
Republic of South Africa

Faks:
Fax: (012) 325-5706
Teleks:
Telex: (012) 32-1366
Telefoon:
Telephone: (012) 312-0671

Telegramadres: "SAGWEP"
Telegraphic address:

Privaatsak X828
Private Bag
0001 Pretoria

Navrae • Enquiries: Mrs AJ Coetzee
Verwysing • Reference: 36/2/2/10

The Regional Director
Regional Office Western Cape
Private Bag X19
BELLVILLE
7535

1994 -03- 29

For attention: Dr P T Vurgarellis

CHILD ABUSE FORM

Your letter dated 7 December 1993 has reference.

The first sentence of your letter is incorrect. It is evident that there is a misunderstanding in this regard. The function to receive notifications in respect of child abuse in terms of the Child Care Act, 1983 (Act No. 74 of 1983) has been delegated to the welfare components of the own affairs departments and provincial administrations when the said Act was promulgated on 1 February 1987. Two of these departments have their own country-wide registers for child abuse and therefore find a separate register for the Western Cape region unacceptable.

Your attention is also directed to the fact that Section 4 of the Prevention of Family Violence Act, 1993 (Act No. 133 of 1993), stipulates that "any person who examines, treats, attends to, advises, instructs or cares for any child in circumstances which ought to give rise to the reasonable suspicion that such child has been ill-treated, or suffers from any injury the probable cause of which was deliberate, shall immediately report such circumstances-

(a) to a police official; or
(b) to a commisssioner of child welfare or a social worker referred to in section 1 of the Child Care Act, 1983 (Act No. 74 of 1983)."

Although it is desirable that notifications of child abuse be done in a co-ordinated manner, neither the Regulations in terms of the Child Care Act, 1983 nor the Regulations in terms of the Prevention of Family

2.

Violence Act, 1993 prescribe the way in which these cases must be reported. This necessitates negotiations between the welfare, police and justice authorities with a view to decide who should be responsible for co-ordinating the reporting of child abuse cases. Contact has already been made with the Department of Justice and the SA Police and you will be informed of any further developments in this regard.

The enthusiasm with which your officers have embarked on the endeavour to establish the procedure with the notification of child abuse in the Western Cape, is appreciated. The work which has been done, can serve as an example together with the systems used by other departments when a country-wide procedure is established in the near future.

Thank you for your co-operation.

Signed

DIRECTOR-GENERAL

ANNEXURE D From Procedures on Dept National Health + Population Development. Dated 17th Nov 1992.

CHILD PROTECTION REGISTER

(a) A register for reported cases, whether these are statutory reports as intended in section 42 of the Act or not, is to be instituted at every Regional and subregional office of this Administration.

(b) For the purpose of the register, even those cases where it is merely suspected that the child is being ill-treated are to be noted.

PROCEDURE FOR THE REPORTING OF CASES TO BE RECORDED IN THE CHILD PROTECTION REGISTER

(a) Reports may be written or made in person or telephonically. It can, however, be expected that the majority of cases will be reported telephonically in view of the urgent action required to prevent further ill-treatment.

(b) It should be pointed out to officers entrusted with receiving correspondence that letters dealing with the ill-treatment of children are to be brought to the attention of the officer who keeps the register immediately.

(c) The head of the office should appoint one if his officers to be the person responsible for the receipt of reports and the keeping of the register.

(d) The regional office should control, through the central case register, whether the client is already known to a family care organisation or not. If so, the relevant family care organisation should be contacted telephonically, with the request that an investigation into the child's circumstances be undertaken within 6 hours.

(e) Should the client not be known to a family welfare organisation, or should the family welfare organisation not be able to expedite the investigation, the regional office must undertake the original investigation of the child. When the original investigation has been done the case should then be allocated to a family welfare organisation, as circumstances allow.

(f) In exceptional cases, where an ill-treated child finds himself in a remote area and a social worker is unable to reach the family quickly because of the distance, the regional office may request the SA Police to institute an investigation into the child's safety until such time as a social worker can visit the family.

(g) The regional office should open a case file for every reported case. All cases of child abuse are registered at the registration section of each Regional Office by means of cards which are completed and arranged in alphabetical order as well as numeric entries in a register.

(h) When a report is made to a family welfare organisation the case must be registered in the register immediately and the organisation concerned should undertake the original investigation. (The register page makes provision for the recording of the name of the organisation which is already rendering services (see Annexure A).

(i) It cannot be expected of the person who reports the case that he should have all the information required for the register. The information that is lacking should be added after a social worker has investigated the circumstances of the case. Where a person as described in paragraph 1 (f) of this circular or any other person in the community reports a case his identity should not be made known to the family, except where such a person chooses to become involved with the family. The person who makes the report should be reassured about this, but should still realise that the social worker entrusted with the investigation will very likely approach him for more information.

Should the person making a report prefer not to furnish his name, the complaint should be dealt with the same urgency as any other report.