Primary school children: Widening worlds and increasing risk of sexual abuse

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Lindiwe (not her real name) has been living with her grandmother, who works as a toilet attendant in an Eastern Cape township, since her mother died of HIV in 2004. Two years ago, she was playing outside her home with her friend from church. A neighbour called her and her friend into his house, saying that he had sweets for them. He gave the friend some money and sent him to buy cool drinks. "Then", she said to me, "he locked the door and told me to lie on the bed …" After he had raped her, the man gave Lindiwe R10. She was too scared to tell her grandmother for three days. The perpetrator was arrested, but the case was dismissed in the preliminary trial; the magistrate ruled that, because the rapist had given Lindiwe money, he was "her boyfriend". The man was 63. Lindiwe was 11.

The age between early childhood and adolescence is one of rapid development and social change. Children's worlds expand, from a context of primarily home and family, to new experiences in school and the community. These changes and opportunities also bring additional risks of violence. In particular, sexual violence has long-term and intergenerational negative effects. It is essential to intervene early to prevent sexual violence and to provide treatment to mitigate the severity of its impacts.[1]

This essay will address the following questions:

- What types of violence do primary school children experience?
- What are the key risk and protective factors?
- What are effective points for intervention?
- What are the key recommendations?

What types of violence do primary school children experience?

Sexual violence against children causes multiple, severe adverse effects. At the most extreme are cases of child rape, murder, and HIV infection. For survivors of violence, there is conclusive evidence of immediate and lifetime impacts on physical and mental health, brain functioning, life expectancy, employment and sexual health.[2]

It is difficult to get accurate information about rates of sexual abuse and child rape, and especially for this age group. Children are supposed to attend primary school from the year they turn six (in grade R) until they turn 14 in grade 7. But, with around 40% of primary school children experiencing grade delay and a third repeating at least one grade,[3] many children in primary schools – particularly in low-income areas – are aged up to 16.

A national study[4] of child homicides that used mortuary data found that sexual assault was suspected in 10% of cases (102 children). For children aged 5 – 9, sexual assault was suspected only for girls, while amongst children aged 10 – 14, sexual assault was suspected mainly for girls (86%) compared to boys (14%). South African police statistics suggest 28,000 sexual offences against children under 18 in 2010/11[5] but this would be an under-estimate because the majority of rape and sexual abuse is never reported to the police. Since then, police data on sexual offences have not been disaggregated by age.

Most research studies focus on older adolescents, or ask youth or adults about sexual abuse at any time in their childhood: in a study in the Eastern Cape, 39% of women and 17% of men reported experiencing sexual abuse before the age of 18.[6] In another study, 14% of undergraduate psychology students reported sexual abuse with genital contact, and 9% reported forced sex.[7] In a nationally-representative sample of South African women, 1.6% reported forced sex before age 18.[8] In a study of 6,000 children aged 10 – 17 in Mpumalanga, KwaZulu-Natal and the Western Cape, rates of sexual abuse (genital contact or rape) were 3.6%.[9] It is important to remember that all kinds of sexual abuse are under-reported, and that adult recall of childhood abuse may not always be reliable.

Very few studies investigate who the perpetrators of sexual abuse are, but it is clear that children are most at risk from someone known to them.[10] There is a high prevalence of child-on-child sexual assault amongst primary school children, on both male and female children by both sexes.[11] In a study of 3,400 10 – 17-year-olds, most perpetrators of sexual abuse were peers (42%) or relatives (17%).[12]

In addition to sexual abuse, primary school-aged children can be exposed to other forms of violence. A new and concerning form is sexual harassment or cyberbullying via social media or cellphones. This can include children filming or "sexting"[i] abusive situations, with 33% of South African students reporting having received pornographic images on their cellphones.[13] A recent UNICEF report also noted increasing risks of children being lured or tricked into meeting strangers or being "groomed" for involvement in sexual activities.[14]

Other types of violence include physical and emotional abuse in the home, and bullying and violence in schools. Prevalence rates as high as 27% for physical abuse[15] and 35.3% for emotional abuse have been reported.[16] Children of this age need to be able to

i Sending sexually explicit text messages.

explore and play with friends, but living in dangerous communities can mean that they are at risk of community and gang violence,[17] violent service protests, taxi violence and violent crime[18].

Studies report that the attitude of the health care workers and justice and court officials are crucial to reducing secondary trauma for the child. Many report that health care providers are supportive, provide post-exposure prophylaxis to prevent HIV infection, and give informal psycho-social support,[19] and that support workers (where available) in courts are helpful. However, qualitative research has also identified risks of secondary trauma when health and justice services are unable to cope with the needs of sexually-abused children.[20] These include case reports that some court officials and health care workers had personal opinions that guided actions contrary to legal guidelines, were unaware of the need to be sensitive to child victims,[21] or lacked skills and training in communicating with children.[22] Although there has been notable improvements in the implementation of child-friendly court procedures, in many courts, close-circuit television (CCTV) systems are unavailable or do not work and intermediaries[ii] are not available, leading to postponements and in some cases further trauma if children have to testify in an open court.[23] Nationally, conviction rates of child sexual abuse that are reported to the police are estimated to be around 7%.[24] A recent Department of Justice task team has strongly advised the re-establishment of specialised sexual offences courts, based on the systemic challenges and limited capacity to provide victim-sensitive services in the existing court system.[25] It is clear that great care needs to be taken to reduce risks of secondary trauma to child victims.

What are the key risk and protective factors?

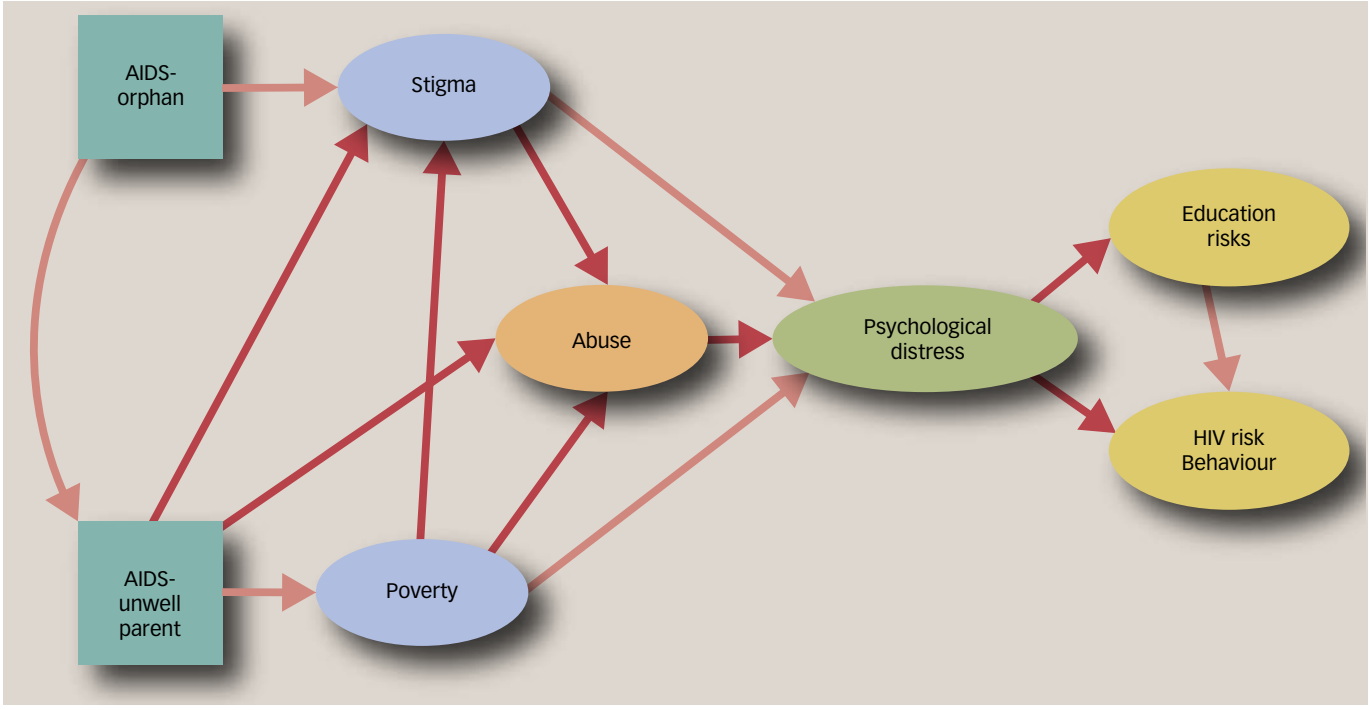
There is increasing evidence that child abuse is not caused by a single risk factor. Often, risk factors are interlinked and causally affect each other, increasing vulnerability to sexual victimisation. Studies show close associations between family AIDS, extreme poverty, stigmatisation and exposure to community violence, which combined and interacted with each other to increase the chances of a child being abused.[26]

A new review of risks for sexual abuse in Africa found a range of risks at the family level, including large families, lone parents and step-parents; exposure to domestic violence; poor parental mental health; poor parenting; and parental drug and alcohol use.[27] International research has shown that perpetrators often target those children who are least protected, for example where parents are deceased, caregivers are unavailable and families are isolated. [28]

These family-level risks can also interact with vulnerabilities at the level of the individual child. For example, children with disabilities or learning difficulties are less likely to be able to articulate or be believed when reporting abuse.[29] Reporting suggests that girls are at higher risk of sexual abuse,[30] although very little is known about rates or predictors of sexual abuse amongst boys.[31] Children who use drugs or alcohol are also at higher risk of abuse.[32]

Perpetrators of abuse may also take advantage of community-level factors such as the socialisation of children to respect and obey adults, and also conditions relating to poverty, such as overcrowding in the home.[33] Studies suggest that rapes of children

Figure 10: Social, economic and family vulnerabilities for child abuse



ii In South Africa, an intermediary system is attempting to reduce the trauma and secondary abuse often experienced by child witnesses in court cases involving sexual abuse. By separating the child from the formal courtroom and allowing an intermediary to relay questions and answers to the child via CCTV, it is hoped that the stress of the experience for these children will be reduced while retaining the rights of the accused to cross-examine witnesses, and to a fair trial. (See: Viviers A (2005) Manual on practice guidelines for intermediaries. In: *Resources Aimed at Prevention of Child Abuse and Neglect. Intermediary Training Manual, 2005*. Cape Town: RAPCAN).

are more likely in communities where the chances of prosecution are low.[34] At the broader societal level, understandings of masculinity and of hierarchy may make conditions more amenable to sexual abuse of children.[35]

A study[36] of 6,000 children in Mpumalanga, KwaZulu-Natal and the Western Cape has shown how social and economic vulnerabilities such as family AIDS, poverty and community violence can increase risks of abuse for children (see figure 10). It also showed that abuse is a key point of linkage to negative child outcomes including school drop-out, mental health distress and sexual health risks.

Research shows that it is not only the risk factors for abuse that interlink with each other, but also the different types of abuse: physical, emotional, and sexual child abuse. Children who have experienced any type of abuse, and in particular sexual victimisation,[37] are at very high risk of re-victimisation.[38]

Case 10: Building evidence for prevention – Parenting programmes

Parenting programmes are the most effective child abuse prevention approach, but too little research on these is designed for the developing world.[46] For this reason the World Health Organisation and UNICEF teamed up with the Universities of Cape Town and Oxford, and the national departments of Social Development and Basic Education with support from international research and implementation experts, the National Association of Child Care Workers and Clowns Without Borders South Africa, to develop and test parenting programmes to reduce exposure to sexual abuse in the community, and physical and emotional abuse in the home.[47]

The programmes use collaborative group problem-solving approaches that have a strong evidence-base from existing randomised trials in high-income countries. These have been adapted for South Africa and use by non-professional staff. All expertise has been donated, and the programmes are licensed under Creative Commons to ensure that they are free and non-profit.

The programmes are currently undergoing pre-post testing, adaptation and randomised controlled trials. A pilot randomised trial programme for the 2 – 9-year-olds has showed improved positive parenting and child-led play. Pre-post studies for the 10 – 17-age group show reduced child abuse, less child rule-breaking or aggression, and lower acceptance of gender violence. Tests showed improvements in involved parenting, positive parenting, supervision of children and social support. A programme for infants is also being tested. If successful, the World Health Organisation and UNICEF intend to further adapt and scale up the programmes in low- and middle-income countries.

For more information, see: http://www.who.int/violence_injury_prevention/violence/child/plh/en/

For this age group of children, risks of abuse at school are also important. Children can be more vulnerable to abuse by other children and by adults in the school environment when there is limited school management; lack of existence, implementation and enforcement of school safety policies; limited reporting mechanisms for abuse; and lack of training on or understanding amongst educators of how to identify and respond to signs of abuse.[39]

A recent report[40] also highlights key gaps in accountability systems regarding sexual violence on children in schools. These include lack of co-ordination between institutions, which means a perpetrator can go on to teach at another school. The report highlights that civil society organisations provide services for child victims, but that these are limited by lack of resources and lack of co-ordination between services. There may also be risks for children when walking or commuting to school either by taxi or other public transport.[41]

What are effective points for intervention?

The Children's Act[42] outlines four main points of intervention to address child sexual abuse: primary prevention, early intervention, protection services, and preventing perpetrators from re-offending. These are all essential components of breaking the cycle of violence against children.

Prevention and early intervention services are essential to prevent abuse before it happens. However, this is the least

Case 11: Zero tolerance in Limpopo – A multi-level community-based intervention

The Zero Tolerance Village Alliance Model was established by the Thohoyandou Victim Empowerment Programme in rural Limpopo. It uses community consultation to establish ownership of the programme and the involvement of high-ranking community officials (such as chiefs, clergy) and their constituencies. This multi-pronged intervention includes workshops on sexual rights, police training in victim empowerment, the establishment of village committees, safe houses and support groups for victims, and a "village alliance" induction ceremony.

In 2011/2012, a pre-post survey was conducted of 1,000 people in two participant villages, with a control village. Intervention villages showed an increase in knowledge of post-exposure prophylaxis, and a 5 – 6-fold increase in the reporting of sexual and gender-based violence – which is often a measure of increased awareness and success of the programme. Reporting over the subsequent 11 months demonstrated a steady decline in reports of sexual and gender-based violence in intervention villages.[48] Although the findings have not been disaggregated by age group, researchers report reductions in sexual abuse for both children and adults.

For more information, see: www.tvep.org.za.

resourced part of most child protection systems.[43] Worldwide, less than 10% of abused children access any child protection services, with even lower access to effective primary prevention programmes.[44]

There is also very little research evidence to guide effective interventions in the global South. In a recent World Health Organisation (WHO) review, 99% of rigorously-evaluated programmes were in high-income countries.[45] None were in Africa. Since then, some promising programmes have shown emerging evidence of effectiveness, but there is still not a strong evidence-base of rigorously-evaluated interventions for preventing and responding to child sexual abuse in South Africa.

This section outlines the four main types of interventions – primary prevention, early intervention, protection services, and prevention of re-offending – and discusses examples of promising programmes that operate at individual, family, school and broader community level in South Africa.

Primary prevention

Primary prevention programmes can be universal (aimed at everyone in the country), or targeted at high-risk neighbourhoods or families. They include community, school and parenting programmes (see table 6). The content of these programmes is important. A systematic review[49] found that programmes that teach children to recognise and say no to sexual abuse were effective in improving knowledge and protective behaviours, but there is no evidence that they reduce actual abuse. Evidence for media-based programmes (such as radio or other media that teach awareness of abuse) was mixed or insufficient. Parenting programmes for child abuse prevention were identified as having the best evidence in reducing child maltreatment, but these rarely measure sexual abuse as an outcome.[50]

Cases 10 and 11 (on p. 67) describe two local primary prevention programmes that aim to prevent child sexual abuse.

Table 6: Primary prevention – School- and community-based programmes

Programme	How it works	Evidence base
Teachers' Diploma in Psycho-Social Support – offered by the Regional Psycho-Social Support Initiative (REPSSI)	Trains teachers to develop a safe, protective school which seeks to realise the potential of all learners. This includes addressing barriers to learning such as abuse and being able to refer children to relevant services.	Randomised controlled trial in progress in Zambia (2013 – 2016). Qualitative evidence suggests positive results.
Parenting programmes (such as the Sinovuyo Caring Families programmes for parents, children and teenagers) – UNICEF, WHO, Oxford University and University of Cape Town	Uses collaborative, problem-solving approaches to equip guardians to reduce violent discipline and conflict with children. Works with the national departments of Social Development and Basic Education, and with NACCW and Clowns without Borders South Africa (see case 10 on p. 67).	Randomised controlled trials of programmes for 2 – 9-year-olds and 10 – 17-year-olds underway in Eastern Cape and Western Cape. Pre-post tests show reduced abuse and violence.
Isibindi Safe Parks – National Association of Child and Youth Care Workers and Department of Social Development	Provides a safe space for children after school and in the holidays, supported by home visits for vulnerable families.[51]	Qualitative evaluation reported successful provision of safe play spaces, and availability of staff to respond to reported cases of abuse.
The SAFE (Safe and Friendly Environment) programme – run by several non-governmental organisations such as Childline and The Teddy Bear Clinic	Raises children's awareness of acceptable and unacceptable behaviour, and safe and unsafe touches. School educators and supporting staff are also trained on signs and symptoms of abuse, management, legislation and referral.	No evaluation yet completed, but evaluation plans underway.
"Walking Bus" – Department of Basic Education and the International Red Cross Society	Improves safety as children walk to school in groups, led by adults.	Piloted in Western Cape, no known evaluation.
MenCare (part of the Global Fatherhood Campaign) – Sonke Gender Justice and Promundo	Aims to implement evidence-based programmes that promote men's involvement as fathers and caregivers including community-based workshops, fathers-to-fathers support groups and media advocacy.	Currently in the Western and Eastern Cape provinces. Pre-post tests suggest increases in men discussing gender-based violence and rights with family, and increases in reporting of violence.

Early intervention and protection services

Early intervention includes social work or emergency services (of assessment, removal, and placement of children into alternative care), therapeutic programmes and support to families. These are important to protect children from abusive situations, and to reduce the negative impacts of abuse on their present and future lives.

If abuse occurs, the first step is to assess the child and safety of the environment. The Children's Act, following international evidence, advises removal of children from their homes should only occur "where a serious and immediate danger to the child outweighs the trauma involved in such a removal"[52] and where prevention and early intervention services, with removal of the offender, cannot ensure the child's safety[53]. This decision is especially difficult in situations of chronic sexual abuse, where there is great tension between removing children from immediate danger, and evidence of the risks that children – especially sexually abused children – face in alternative and state care.

Very few studies worldwide examine the effectiveness of child sexual abuse response interventions. This is partly because of the major ethical issues associated with research in this area – for example it is not possible to randomise children to receive emergency abuse services or not. A recent systematic review of psychological treatments to reduce the effects of child sexual abuse found that cognitive behavioral therapy worked better than supportive, unstructured psychotherapy, but that effects were moderate.[54]

The focus of protection services is on services to support statutory intervention and prevent secondary trauma. This is particularly important in countries like South Africa, where rates of sexual abuse are high and health and justice services are often over-burdened and under-resourced. There are a number of promising programmes (see table 7), but limited evaluation of how they link to child outcomes.

Preventing perpetrators from reoffending

It is important to recognise that victims are not the only focus of intervention, and work with perpetrators is also essential in reducing risks for children. A recent systematic review of programmes to prevent re-offending by perpetrators of child sexual abuse reported that the evidence-base for effective interventions was very weak, with mixed effects of psychological and medical treatments.[57]

For young offenders, there is better evidence for multi-systemic therapy (MST).[58] This is a multi-professional intervention usually provided to the whole family. Data from Childliine South Africa indicate that around half of sexual offences against children are committed by under-18-year-olds,[59] but the evidence on MST is focused on high-income countries and requires mental health professionals for implementation. This would clearly need adaptation for a South African context, and would be extremely difficult in rural areas. Case 12 (on the next page) describes a South African programme that aims to assist children from repeating sexual abuse.

Table 7: Early intervention and protection services

Programme	How it works	Evidence base
Post-rape training for health professionals – National Department of Health	Educates health professionals about the circumstances of rape; barriers to reporting; health consequences; the social construct of gender, and sexual rights; provision of medical care including mental health care; prevention and management of pregnancies and infectious diseases; follow-up care, record-keeping and overview of the law.	In a cross-sectional study health care professionals reported increased confidence in talking with parents about supporting children who had been sexually abused.[55]
Children Are Precious Project – Resources Aimed at the Prevention of Child Abuse and Neglect (RAPCAN)	Community-based approach to child protection, including community-level (communication, after-school programmes, referral systems strengthening); school level (teacher training, school safety plans) and family level (parenting support, community mapping and Heroes workbooks for children) interventions. See the case 4 on p. 40.	Pilot programme in Cape Town evaluated for process and acceptability in a high-violence Cape Town area. Many aspects of the programme worked very well, but some challenges with slow external referral processes.
Child Witness Project Model and Toolkit – Childline and RAPCAN	Sets minimum standards and provides training for court staff, including court preparation and counseling for children and families to help children become competent witnesses and prevent secondary trauma.	Qualitative evaluation reports that children and families found the service comforting and helpful.[56]
Child Protection Residential Programmes – National Association of Child Care Workers (NACCW) and Childline	Provides a residential programme for child abuse victims and their caregivers, with therapeutic lifespace work, specialised counselling and therapy. NACCW and Childline are taking this to scale, with one residential programme planned for every province in 2014.	Quasi-experimental controlled trial in progress with Children's Institute, results expected in 2016.

Case 12: Preventing perpetrators from re-offending – The Support Programme for Abuse Reactive Children

The Support Programme for Abuse Reactive Children (SPARC) is a diversion programme for young sexual offenders offered by The Teddy Bear Clinic. The sexual behaviour of children who abuse other children goes far beyond developmentally appropriate childhood exploration or sex play. Typical behaviour may include oral sex, vaginal intercourse, and forcibly penetrating the vagina or anus of another child with fingers, sticks and/or objects. These behaviours escalate over time, and the children do not and cannot stop without intensive and specialised treatment.[60]

The SPARC aims to disrupt the cycle of abuse and prevent children from turning into adult abusers. It uses creative expression and cognitive-behavioural therapy to help children (6 – 17-years-old) understand the consequences of their behaviour, and develop the skills to prevent them from re-offending. Most children in the programme have been ordered to attend by a court, and others are referred by schools, children's homes, the police or other agencies that deal with children, and occasionally voluntary clients are included.

A series of 12 group sessions take place weekly after school. This excludes the initial intake and assessment of the child, and any individual therapy that is prescribed. The group sessions are divided into two parts: Part 1 uses creative expression (dance, boxing, art or music) to enhance self-esteem and stimulate participation. Part 2 draws on cognitive-behavioural therapy to address illogical thought processes and irrational behaviours that are frequently presented by offenders. This includes anger management, problem-solving skills, developing empathy, clear boundaries and impulse control.

Parallel group sessions help parents and caregivers manage their children's behaviour appropriately and constructively. All sessions are documented and a final report is collated by the co-ordinator of the diversion programme for submission to the court for children who were ordered to attend. A series of three follow-up sessions are held every six months to check on progress and, if there is no need for further intervention, the file is closed.

Evaluation has shown that the programme is effective in disrupting the cycle of abuse and 95% of children who attended the programme from 2001 – 2012 did not reoffend.[61]

For more information, see: www. ttbc.org.za

What are the key recommendations?

There is very clear evidence that sexual abuse has severe and long-lasting negative effects on children. There is also increasing evidence that rates of child sexual abuse and rape are disproportionately high in sub-Saharan Africa. It is essential that researchers, government and non-governmental organisations (NGOs) work together to develop a rigorous evidence-base of interventions to prevent and respond to sexual violence against children.

There are some important preventative interventions that have very strong potential to reduce risks for children. These include programmes that reduce children's time spent unaccompanied in communities by providing activities in safe settings (such as after-school care and safe parks) and accompanied travel (such as walking to and from school). Other preventative interventions with potential include parenting programmes that can help families to plan how to keep children supervised and safer. Finally, community-focused programmes that raise awareness and encourage reporting of sexual violence are promising.

There are also interventions that have potential in responding to child sexual abuse. For example, programmes that train teachers and community workers to identify signs, respond to disclosure and make referrals of child sexual abuse are important in increasing the likelihood of identification and active responses. Therapeutic programmes such as The Teddy Bear Clinic, and the National Association of Child Care Workers' child protection residential programmes, are important but unavailable to the vast majority of sexually-abused children in South Africa. In addition to these, low-resource, scaleable programmes are also necessary.

Preventing secondary trauma through services is clearly also important. Improved training of health care, social and criminal justice workers could help to make the experience of reporting and testifying about sexual abuse less traumatic for children. Facilities such as child-friendly rooms, CCTV access in courts and court preparation for children and families are likely to be of great value, and the expansion of specialised courts has been recommended to the Ministry of Justice by an internal task team.

Finally, working with perpetrators to prevent re-offending is valuable. Although there is little evidence of successful interventions for adult offenders, there is evidence suggesting value in intensive therapies for juvenile offenders.

Child sexual abuse remains a major problem in South Africa, and internationally. The challenges should not be underestimated: it is a multifaceted and often unpredictable problem that is difficult to identify, to address and to prevent. It is clear that a single approach – prevention, response or work with offenders – will never be sufficient, and that a comprehensive package of evidence-based approaches is needed. Rigorous research is needed to test these and other potential interventions,[62] and the combinations of interventions that will be most effective.

There remain challenges for responding to child sexual abuse that need to be addressed at the implementation level. It is a complex issue that requires integrated programming across departments such as Health, Justice, Basic Education and Social Development: this presents challenges in any national system and requires innovative approaches, capacity-building and strong leadership. There are also significant challenges at the service level, including insufficient numbers of social workers, lack of transport,

RAPCAN social change initiatives: Include children as agents of change

excessive caseloads and burnout, affecting the implementation of services to children and families. As with many services, children in rural areas often have the least access to services, and most NGOs focusing on child sexual abuse are located in major cities.

But South Africa also has notable strengths and potential to respond to child sexual abuse. It has one of the strongest legislative frameworks in Africa, with clear commitments at government level to prioritise violence against children. It has international NGOs such as UNICEF, Save the Children, World Vision and others, with departments dedicated to child protection. It has many examples of determined local NGOs, and social workers – both qualified and lay staff – who work with traditional and elected leaders to address abuse. And it has strong public and media support for a co-ordinated response.

Children who have been exposed to sexual abuse are already amongst the most vulnerable in the country. Those who are at risk of sexual abuse still have the opportunity to be protected from the long-term, severe impact thereof. Sexual abuse is not limited by racial group, social or economic status, and it is not restricted to cities where services are most available. The very least that these children deserve is rigorously-evaluated, effective programmes. And it is a legal, moral and public health imperative that these are scaled and maintained throughout South Africa.

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